Social and Cultural Determinants of HIV Risk among Young Jamaican Men Who Have Sex with Men

by

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Dedication

This dissertation is dedicated to my loving brother, Carlton, whose life ended prematurely. I miss you. I wish you were here to see your little brother walk across the stage as he is being greeted for the first time as Dr. Orlando Harris. Although you are not here physically with us, I can see the smile, a mile wide, across your face. I love you.

I also dedicate this work to the many young men, whether gay, bisexual, or heterosexual, whom I have had the pleasure to interact with while I was in Jamaica. Your ability to navigate complex life circumstances is an inspiration to both myself and your fellow countrymen. Your determination and passion regarding making social and cultural changes within the Jamaican society encourage me want to work hard to ensure that you have every opportunity to tell your story and, by doing so, you can make the path easier for those not only yourselves, but also those who follow you.

Finally, I dedicate this work to my parents, who have supported me along the way and encouraged me to follow my passion of improving the lives of others. I thank my mother, Leona, for the many sacrifices she has made on my behalf in order to ensure my success. Your many words of encouragement throughout this process were invaluable. I also thank my step-father, Darryl, who never stopped encouraging me along the way. Although you are not my biological father, your continued presence and support along the way were plenty to identify you as my father.
Biographical Sketch

Orlando Omar Harris was born April 13, 1984 in Kingston, Jamaica. He moved to Brooklyn, New York, during his early adolescent years, where he attended Erasmus Hall High School for Business and Technology. After graduating from high school, he attended Binghamton University where he received a Bachelor’s of Science in Nursing, a Bachelors of Science in Human Development, and a Bachelors of Arts in Africana Studies simultaneously. He received his Master’s from the School of Nursing at the University of Rochester. Mr. Harris is a Family Nurse Practitioner in the State of New York. He is interested in preserving the health and wellbeing of young Jamaican and Caribbean men both here in the United States and within the Caribbean. Mr. Harris’s research interests also include gender and racial studies, and the sexual health practices of young adolescent men. He has worked with several research investigators on a variety of projects. Mr. Harris has worked alongside Dr. Leo Wilton, an associate professor at SUNY Binghamton; Dr. Sheldon Fields, an associate professor and assistant dean at the School of Nursing at Florida International University, and Dr. Dianne Morrison-Beady, Dean at the School of Nursing at Florida Southern University. In addition, he was a 2012-2013 U.S. Fulbright Fellow to Jamaica, where he conducted in-depth collaborative research with high risk sexual minorities and collected the data for this study. Before leaving for Jamaica, Mr. Harris worked for many years for the Monroe County Department of Health, in upstate New York, as a Nurse Practitioner in their STD (sexually transmitted diseases) /infectious diseases program. He completed the interdisciplinary Leadership Education in Adolescent Health fellowship at the Golisano
Children’s Hospital, at the University of Rochester Medical Center. He is currently a Senior Teaching Associate at the University of Rochester, School of Nursing. Mr. Harris is a member of the Finger Lakes Chapter of the Association of Nurses in AIDS Care; a member of the board of directors for the National AIDS Education Services for Minorities (NAESM), and; the director for laboratory services for the Men of Color Health Awareness Project (MOCHA) Center in Rochester, NY.
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anything, as long as I remained focused. I will always remember you saying “learn how to say no.” That phrase, my friend, kept me focused on what was most important.
Abstract

Rates of the Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), and other sexually transmitted infections (STIs) are disproportionately high among young people living in the Caribbean, and particularly on the Island of Jamaica. The population of Jamaica consists of approximately 2.9 million people; with an annual growth rate of about 0.73%, and an adult HIV prevalence rate of 1.8% (UNAIDS, 2010). Thirty-eight percent of the HIV infections in Jamaica occur among men who have sex with other men (MSM) and the reported HIV infections cluster predominantly in two major metropolitan areas: Kingston (St. Andrew) and Montego Bay (St. James). Same-sex sexual behaviors are considered a criminal offense in Jamaica. Consequently, MSM in Jamaica experience high rates of verbal and physical violence, ranging from beatings, to brutal armed attacks, to murder. These forms of violence and discrimination are often viewed as socially acceptable. The purpose of this study was to describe the experiences and views of Jamaican men who have sex with men (JMSM) regarding their cultural and social environment and how that environment affects the options available to them to reduce HIV risk, or to remain healthy if they are HIV positive. Another purpose of this study was to explore strategies that JMSM have used to manage HIV risk in this environment.

A qualitative descriptive research design was used to study 30 JMSM predominantly from the Kingston and St. Andrew areas in Jamaica. Data were generated through semi-structured individual interviews (n = 20) and one focus group interview (n=10). Quantitative instruments were administered to gather basic demographic
information and to assess HIV knowledge. JMSM were recruited from a local community-based organization, through peer referrals, and on the grounds of a local university. Participants had a mean age of 22 years, demonstrated a mean HIV knowledge score of 78%, and frequently engaged in sexual activities that ranged from low, medium, to high risk for HIV transmission.

Findings from this study indicated that the experiences of JMSM were intertwined with relationships with their families, communities, and the larger society. JMSM collective experiences included being abandoned or disowned by their biological families and neglected by many state agencies. Many factors were identified that made it difficult for JMSM to be productive citizens: homelessness, disruptions in formal education, and their social and economic status. Despite this, many JMSM developed effective strategies to moderate those factors. A large number provided each other with effective strategies to disguise their sexual orientation and educate each other about issues related to HIV transmission and prevention. Additionally, surrogate family units were created to provide for basic life necessities.

These findings demonstrated that the JMSM experience is complex and is influenced by several factors that were beyond study participants’ control. Policy can best assist JMSM by addressing the systemic barriers that inhibit access to relevant resources within the society and encouraging discussions about tolerance and acceptance. Clinical providers, when delivering HIV prevention services, must build on the strengths of JMSM and collaborate with them as partners.
Contributors and Funding Sources

This dissertation was conducted under the supervisions of Professors Jane Tuttle (advisor) and Craig R. Sellers of the School of Nursing and Professor Ann Dozier in the Department of Public Health Sciences. Professor Leith Dunn from the University of the West Indies (Mona Unit), Institute for Gender Studies, a resident expert within Jamaica, provided consultation and support. All work for this dissertation was completed independently by the investigator.

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CHAPTER I: Problem and Significance

**Background**

Many rivers to cross and it's only my will that keeps me alive. I've been licked, washed up for years, and I merely survive because of my pride. This loneliness won't leave me alone. It's such a drag to be on my own.

Jimmy Cliff, OM

Rates of human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), and other sexually transmitted infections (STIs) are disproportionately high among young people living in the Caribbean and particularly on the island of Jamaica (Geary et al., 2008; Genrich & Brathwaite, 2005; Hutchinson et al., 2007; Ministry of Health 2005; Robinson, Thompson, & Bain, 2001). The prevalence rate of HIV in the Caribbean region is second only to those rates reported within sub-Saharan Africa (Anderson et al., 2008; UNAIDS, 2006; Voelker, 2001). The population of Jamaica consists of approximately 2.9 million people with an annual growth rate of about 0.73%, and an adult HIV prevalence rate of 1.8% (UNAIDS, 2010).

Approximately 32,000-41,000 people in Jamaica are living with HIV/AIDS (Hutchinson et al., 2007; Ministry of Health, 2008), of whom two thirds are unaware of their status (Foster, 2009). Thirty-two percent of the HIV infections in Jamaica occur among men (Figueroa, 2008; UNAIDS & WHO, 2008), and the HIV infections reported cluster predominantly within two major metropolitan areas, Kingston (St. Andrew) and Montego Bay (St. James; Ministry of Health, 2005). In 2009, the Jamaican Ministry of Health estimated there were over 1,200 AIDS deaths on the island, of which 45% was comprised of individuals below the age of 30 years (Ministry of Health. 2010; Olukoga, 2004).
Multiple sexual partners is a risk factor for HIV and a concern for public health practitioners (Ministry of Health, 2005). According to a Jamaican national survey of sexual activity among young people between the ages of 15-25, a significant number of males and females reported having multiple sexual partners. Additionally, inconsistent condom use is reported to be a major problem among this young adult population. Transactional sex was and still is a major concern on the island (Pruitt & LaFont, 1994). Due to high rates of poverty (1 in 5 Jamaicans are living below the poverty level) and desperation, a significant number of youths, more specifically young men who have sex with men (MSM), are trading sex for goods or money (Hutchinson et al., 2007; Ministry of Health, 2005; Norman & Uche, 2000).

Young MSM living in Jamaica (JMSM) experience a multitude of challenges that place them at risk for HIV infection (Gayle, 2002). These challenges include pressures for boys to prove their “manhood” by having sex at an early age (<14 years), outside influences that lead young men to become commercial sex workers, and the stigma associated with not adhering to traditional gender norms (Hutchinson et. al., 2007). Risk factors for HIV among JMSM include inconsistent condom use, involvement with multiple sexual partners, substance abuse, and unemployment (Norman, Carr, & Jimenez, 2006). Same-sex sexual behavior is a criminal offense in Jamaica. Consequently, MSM in Jamaica experience high rates of verbal and physical violence, ranging from beatings, to brutal armed attacks, to murder. For many, there is no sanctuary from such abuse (Human Rights Watch, 2004). This form of violence and discrimination is often viewed as socially acceptable and is often supported by families, neighbors, community leaders,
and police officers. MSM are often driven from their homes, forcing them to abandon their belongings and leaving many homeless (Human Rights Watch, 2004).

Considerable research has been conducted that documents HIV/AIDS stigma and discrimination within the Caribbean region (Carr, 2003; Foster, 2009; Norman, Carr, & Jimenez, 2006; Norman & Uche, 2000; White & Carr, 2005). Compared to the United States, Canada, and the United Kingdom, HIV/AIDS stigma and discrimination have led to the loss of life, property, and social support systems for MSM in Jamaica (Norman, Carr, & Jimenez, 2006; Norman & Uche, 2000). Due to a culture of discrimination and violence towards MSM living in Jamaica, HIV prevention interventions are not reaching MSMs, the population that is most severally impacted by the epidemic (Norman, Carr, & Jimenez, 2006).

A Culture of Violence Towards MSM

Homophobic violence is widespread in Jamaica. Over the years, there have been many instances in which lesbian, gay, bisexual, and transgender (LGBT) individuals were attacked by large mobs. A 2004 report by the Human Rights Watch characterized the island of Jamaica as “the most homophobic place on earth” (Human Rights Watch, 2004, p. 2). The attacks on MSM range from minor beatings and stabbings to murders. MSM live in a state of unrelenting fear because of frequent threats to their safety. Many MSM have been intimidated, bullied, and terrorized by their employers, community members, law enforcement, and family members.

Although violence towards MSM is widespread in Jamaica, perpetrators of these attacks are rarely brought to face the courts by the police (Human Rights Watch, 2004).
Police officers infrequently document these crimes that are fueled by hate, thus, contributing to the scarcity of evidence regarding crimes against sexually marginalized individuals (Human Rights Watch, 2004). Despite the failure by law enforcement to document these incidents of violence, other non-government based organizations such as members of the media, human rights groups, and community based organizations (CBOs) that provide services to sexually marginalized individuals do document these acts of violence in an effort to make them known to the international community. Some of these cases include:

1. The fatal shooting of a man in a Baptist church in the parish of St. Andrew in April of 2000. The man was cornered, jeered by a mob, and was shot and killed. His body was found near the alter, with several 9 millimeter shells surrounding his body. According to reports received by the local newspaper, *Jamaica Gleaner*, he was accused of being homosexual then chased by a group of individuals who later took his life (*Jamaica Gleaner*, 2004, Online).

2. In February 2004, at a local high school in Kingston, a 16-year-old male was attacked and beaten by a group of students after his father reportedly accused him of being gay. The student’s father repeatedly encouraged the students to attack his son because he found a nude picture of a man among his son’s belongings. The police responded to the scene and removed the student from school grounds. However, none of the student’s attackers were charged (*Jamaica Observer*, 2004, Online).
3. Brian Williamson, one of Jamaica’s leading LGBT rights activist was stabbed to death in his own home in June of 2004. Mr. Williamson was co-founder of the Jamaica Forum for Lesbians, All-Sexuals, and Gays (J-FLAG). The Jamaica Constabulary Force (JCF) investigated his case as a burglary. Two men were later charged in connection with this crime (Human Rights Watch, 2004, p. 31).

4. Victor Jarrett, a young man from the Montego Bay area, was stabbed and chopped (with machetes) to death by residents within his community in June of 2004. It was alleged that Victor was caught staring at a young man on the beach in the community; as a result, he was set upon by an angry mob who chanted anti-gay epithets at him while they stoned and stabbed him. Some witnesses reported to the Human Rights Watch that several members of the JCF joined in the stoning of Mr. Jarrett. One witness stated, “Where are you supposed to turn when even the police won’t protect you? Our society tells us there’s nothing worse than being gay” (Human Rights Watch, 2004, p. 18).

5. In November of 2005, Steve Harvey, an HIV/AIDS activist, was gunned down by four armed men who broke into his home and shot him to death. He was the leader of Jamaica AIDS Support, another CBO for LGBT and individuals affected by and living with HIV/AIDS (Human Rights Watch, 2005, December 1).
Human rights and community health outreach workers have been victims of violence and some have lost their lives as a result of their work (Oumano, 2005). Members of the police force and community members often accost safe-sex activists while they are engaged in outreach activities in the community (Human Rights Watch, 2004). In one example, a group of young men were walking along a major thoroughfare in the heart of Kingston to conduct outreach work when the police stopped them. After interrogating them at gunpoint and finding several condoms on their persons, they were taken to a local police station and were told that they would be charged for loitering. They were placed in public view in the police station and pointed out and labeled by police officers as battymen (a colloquial derogatory Jamaican term used to identify MSM) as patrons entered and exited the station. After several hours of waiting in the station, they were released without charge (Human Rights Watch, 2004). To avoid risking violence if presumed to be gay, community safe-sex workers are often counseled by their organizations about ways to amplify their masculinity when engaging with the larger community.

Although as an organization they have been one of the leading forces behind rampant homophobic violence within the community, a few members of the Jamaica Constabulary Force have also been victims of violence due to their own sexual orientation (Lacey, 2008). Several officers have reported threats, intimidation, and physical abuse from their colleagues as a result of affirming their sexual orientation as lesbian, gay, or bisexual. In 2008, an American newspaper covered a story of a young police officer whose life was threatened by his colleagues after he reported that he was
Gay (Lacey, 2008). As a result, the officer was forced to leave his job, went into hiding, and was later granted asylum in a foreign country. Police officers in the Jamaica Constabulary Force have to choose between being a police officer and accepting their gay identity. For some, being gay and an officer of the law is a contradiction, especially since these same officers are charged with the responsibility of enforcing Jamaica’s buggery (anti-sodomy) law.

There are several human rights groups in Jamaica that are currently advocating for the rights of LGBT individuals and people living with or affected by HIV/AIDS. These organizations include Family Against Terrorism, the Independent Jamaica Council for Human Rights, Jamaica AIDS Support, the Jamaica Forum for Lesbians, and All-sexuals, and Gays (J-FLAG). Due to the high probability of violence, many of these organizations are currently operating through post office box addresses. Financial support for these organizations comes mostly from international groups. Moreover, as noted above, members of these organizations are not exempt from falling victim to acts of violence (Human Rights Watch, 2004).

**Discrimination Toward MSM Under Law**

Discrimination against MSM in Jamaica is sanctioned by law. Currently, same-sex sexual behaviors are outlawed. This is referenced under the Offences Against the Person Act (OAPA). The OAPA is based on antiquated British colonial law of the late 1800s. The United Kingdom repealed their Buggery law in 1967, five years after Jamaica was granted its independence. Articles 76, 77, 78, and 79 of the OAPA addresses the issue of same-sex sexual behaviors; particularly, male-to-male sexual
behaviors. Articles 76-79 speak directly to the issues of “unnatural offences,” proof of “carnal knowledge,” and “outrages on decency.” The term buggery, which was mentioned under the OAPA, is a British word similar in meaning to the term sodomy (oral or anal coitus with a member of the same sex). Under Jamaican law, the crime of buggery includes any sexual acts between men or with any animal. It is considered to be an abomination, which is punishable by ten years in prison, with or without hard labor (Neufville, 2008). Under the OAPA, proof of “carnal knowledge” does not necessarily involve actual emission of seminal fluids; however, one is guilty of such offense if it is determined that actual penetration occurred during the sexual encounter. “Outrages on decency” is a charge specifically applied to any male who attempts to, or was found to have had any same-sex encounter (“gross indecency”) with another male (e.g., kissing or penetrative sex), whether in public or in private. Men in this situation could potentially be charged with a misdemeanor and face imprisonment of up to two years, with or without hard labor (Offence Against the Persons Act, 1969). The OAPA has been primarily applied to males.

Jamaican men who are charged with breaching the OAPA are forced to leave their homes, communities, employment/career, and possessions behind because of the potential for violent attacks on their person. Members of the constabulary force (JCF) often use this tactic to single out a particular individual in the community. Many MSM have reported being harassed by members of the JCF because of their physical appearance. They have reported being beaten by the police on numerous occasions. Human Rights Watch has documented many cases of blackmail, intimidation, and
extortion towards MSM from members of the police force (Human Rights Watch, 2004). For example, in 2007, a senior police officer was accused of forcing an adolescent male to perform oral sex on him (Whyte, 2007). The security forces have used blackmail and intimidation in order to extort money and other personal property from MSM. MSM who fail to give into extortion risk having the police come to their communities and make accusations related to their suspected sexual orientation.

Pressures from local and international groups to repeal the buggery law are currently at an all-time high (Hamilton, 2011). The Ministry of Health (MOH) in Jamaica has suggested that the repeal of the buggery law should be a major public health strategy used to decrease the rates of new HIV infections in Jamaica (Ministry of Health, 2008). Additionally, many local advocacy groups have called on the government to enact legislation that protects the rights of vulnerable communities such as LGBT individuals. As a strategic human rights effort, the president of the United States, Barack Obama, and the Prime Minister of Great Britain, David Cameron, have both pledged to withhold aid from any country that does not enact legislation that protects the rights of LGBT individuals. These pledges have been a source of controversy in Jamaica (Brown, 2011).

In the 2011 Jamaican general elections debate between then Prime Minister, Andrew Holness, and Leader of the Opposition, Portia Simpson-Miller, a question was asked as to whether or not a government formed by them would consider repealing the buggery law. Prime Minister Holness suggested that his views reflected those of the Jamaican people and that his administration would not revisit the law because he perceived that the majority of Jamaicans did not see the need for the law to be repealed.
Opposition Leader Simpson-Miller indicated that a new government formed by her would revisit the law and place it before parliament for members to vote their conscience on the matter (Hamilton, 2011; Wignall, 2011), and that she would welcome any person (homosexual or heterosexual) to serve in her cabinet as long as they were competent. Ms. Simpson-Miller’s party won the election with an overwhelming majority (42-21 seats in Parliament). Her ascension to the Prime Minister’s office was regarded as progress towards an inclusive Jamaica and the repeal of the buggery law (Hamilton, 2011; Wignall, 2011).

**Homophobia in Dancehall Music**

Homophobia within the dancehall music industry has contributed to HIV stigma and discrimination in Jamaica (Alleyne, 2006; Oumano, 2005). Dancehall music is a sub-genre of reggae music, which originated in Jamaica in the early 1970s (Davis, 2004; Oumano, 2005). It is often characterized by “slackness” (meaning vulgarity in Caribbean culture), along with sexist and violent lyrics (Stanley-Niaah, 2006).

The dancehall music fraternity is seen as a way out of poverty for many inner-city youth in Jamaica. Most of the entertainers who have had very successful careers came from garrison communities in which poverty, crime, and violence are heavily concentrated. Artists who write and perform homophobic lyrics often cite some form of religion (Christianity, Rastafarianism, etc.) as inspiration for writing songs that incite violence towards homosexuals (Bakare-Yusuf, 2006; Gunter, & Hue, 2000; Pinnock, 2007). In fact, this form of discrimination moves far beyond Christianity. Artists have
professed that they write these songs because it sells their music and it is popular among
the people (Davis, 2004; Oumano, 2005; Williams, 2005).

In recent years, several human rights groups have brought media attention to the
homophobic and violent lyrics within the dancehall music industry. As a result, a number
of artists have seen their overseas concerts cancelled. Moreover, a number of
multinational corporations have taken a stand against violent anti-gay lyrics within the
dancehall music industry. Some companies have gone as far as discontinuing corporate
sponsorships of artists who promote violence of any kind (Neufville, 2008).

Despite many efforts to combat the homophobia expressed in dancehall music,
ordinary citizens have taken these lyrical words as commands to carry out violent attacks
against suspected gay and lesbian individuals in Jamaica, the Afro-Caribbean Diaspora,
and other American and European communities. In 2004, several Jamaican dancehall
reggae artists including Buju Banton, Beenie Man, Elephant Man, Vybz Kartel, Capleton,
and Bounty Killer were all investigated by Scotland Yard, United Kingdom, after it was
believed that their musical lyrics led to the killing of a citizen in England. The victim,
David Morley, a 37-year-old man of a central London address, was attacked and beaten
to death by a group of teenagers who were believed to be acting in response to violent
homophobic dancehall lyrics (Oumano, 2005).

Politicians have used popular homophobic dancehall music for campaign theme
songs in order to energize their bases and to disrespect their opponents. During the 2002
general elections, then Prime Minister PJ Patterson (leader of the People’s National
Party) had to defend himself against anti-gay lyrics directed towards him by Edward
Seaga, the leader of the opposition Jamaica Labour Party. Mr. Seaga used a popular controversial dancehall song (“Chi-Chi man,” a derogatory Jamaican term used to refer to gay men) in reference to the Prime Minister. Mr. Patterson retaliated by asserting his heterosexuality and pledged to be a fierce supporter of Jamaica’s buggery law (Oumano, 2005). Mr. Patterson won reelection that year. Several years later, the Jamaica Labour Party, under the leadership of Mr. Bruce Golden, won the 2007 general elections. His campaign theme song was also a popular controversial anti-gay song. Following the elections, Prime Minister Golden expressed in a BBC interview that homosexuals would find no place in any cabinet formed by him (Davis, 2004; Oumano, 2005).

In recent years dancehall reggae music has become popular worldwide and, as a result, Jamaica’s homophobic dancehall lyrics have become a concern for both domestic and international human and gay rights organizations. Many dancehall artists and Christian conservative groups in Jamaica have made claims regarding Jamaica’s cultural sovereignty. Many artists view the efforts of these groups as an attack on Jamaican culture and free speech (Oumano, 2005). This very claim gives credence to the notion that homophobia is culturally acceptable in Jamaica. Fortunately, in Jamaica, which resides in a global community, cultural sovereignty and basic human rights are not mutually exclusive. Dancehall artists in Jamaica choose to focus on same-gender loving individuals because they are easy to target, given the homophobic culture. Anti-gay lyrics move partygoers in similar fashion to the “call and response” approach seen in black churches in the United States. This call and response approach may move partygoers to commit crimes of violence against sexual minorities.
Jamaican MSM and Healthcare

Homophobia drives MSM underground away from effective HIV/AIDS prevention services (Watson, 2010). MSM often cite stigma and discrimination as two of the major reasons for not seeking prevention services from the Jamaican healthcare system (Foster, 2009). When seeking healthcare services in Jamaica, MSM often rely on peer-to-peer referrals of “MSM friendly providers.” MSM are afraid to seek services in the community in which they live due to the potential for the breach of confidential medical information. Currently, there are no Jamaican laws that explicitly protect confidential private health information (Human Rights Watch, 2004).

The Ministry of Health has reported that there is a difference in the HIV and STD testing practices for men and women in Jamaica (Foster, 2009). Data from the Ministry of Health suggested that women were more likely than men to seek testing for HIV and other STDs (Foster, 2009; Norman & Gebre, 2005). Additionally, women reported less discrimination from healthcare workers and that their homosexual identity was less negatively perceived, while MSM reported higher levels of discrimination from doctors, nurses, and other health providers. Health educators and outreach workers have reported that interacting with MSM posed a major risk to their own safety due to discrimination and violence (Foster, 2009; Francis, 2009; Lisa, Carr, & Jimenez, 2006). These barriers make it difficult for MSM to benefit from HIV prevention-related services. Many MSM have later forgone HIV testing and treatment services as a result of the structural barriers that are present. MSM who delay testing and treatment often present to tertiary care
institutions much later in the disease course and receive an AIDS diagnosis, a progressive state of the HIV infection (Crawford, Gardner, & McGrowder, 2008; Davis, 2001).

A barrier to seeking health care services that is cited by MSM is the island’s buggery law (anti-sodomy). As discussed above, the buggery law prohibits same-sex sexual behaviors. MSM are less likely to report to their medical provider that they are a person who is having sexual intercourse with another person of the same sex due to the possibility of the provider reporting them to law enforcement or discriminating against them (Brown, 2011; Foster, 2009; Francis, 2009). Caribbean islands that have repealed similar laws have experienced significant decreases in HIV prevalence among MSM (Brown, 2011). Caribbean countries without buggery laws, such the Commonwealth of the Bahamas, Haiti, and Suriname, have HIV prevalence rates less than 10% (Brown, 2011).

Condoms and water-based lubricants are essential components needed for effective HIV prevention. Despite this information, the purchasing of condoms and other personal sexual materials is difficult for MSM because they are often placed in the view of other customers and behind the counter of drug stores and supermarkets. This creates an unsafe environment where MSM may feel uncomfortable asking someone for these products (Human Rights Watch, 2004).

Summary

HIV/AIDS and STIs are disproportionately high among MSM living in Jamaica. Several factors contribute to these high rates of infections among this population. Some of these factors include a culture of violence towards MSM and; discrimination under the
law, where MSM are often intimidated, blackmailed, and imprisoned for their same-sex sexual behaviors. Other issues include anti-homosexual dancehall lyrics that are deeply rooted in Jamaican popular culture. These lyrics are often vulgar, sexist, and violent in nature. Practitioners of dancehall music often recite lyrics that call for beating and killing of MSM. Due to these instances of homophobia and subsequent discrimination, MSM often go underground, so HIV/STI testing, treatment, and prevention services become inaccessible.
CHAPTER II: Background and Orientation to the Problem

Introduction

To date, a significant amount of the literature on Jamaican MSM has been primarily focused on HIV stigma and discrimination. Many of those writings are from editorial opinions expressed in local and online newspapers within Jamaica. Research studies documenting the lives and lived experiences of Jamaican MSM are limited, however. Moreover, studies examining HIV/AIDS knowledge, attitudes, and behaviors as they relate to MSMs are also scarce. This void in the literature has been attributed, at least in part, to the current social and political climate around the issue of homosexuality in Jamaica (Brown, 2011; Hamilton, 2011; “Homos at Risk,” 2001; “Sexuality and the Law,” 2001; Wingnall, 2011). In light of the current social and cultural climate shaping the lives of MSM in Jamaica, research studies, especially those guided by theory, are needed in order to better understand the experiences of Jamaican MSM. This information could eventually help stem the tide of new HIV infections, as well as make it possible for those already infected to gain access to treatment and regular medical care.

Research has shown that prevention interventions that are guided by theories are often proven to be effective in facilitating positive behavior change (Carey, Morrison-Beedy, & Johnson, 1997; Fisher & Fisher, 2000; Fisher, Williams, Fisher, & Malloy 1999; Kalichman, Picciano, & Roffman, 2008). For example, smoking cessation interventions have consistently employed the use of the Stages of Change theory to assess an individual’s readiness to discontinue smoking (Prochaska, DiClemente, & Norcross, 1992); the same was also seen in women and their perception of mammogram screening
for breast cancer with the use of the Health Belief Model (Rosenstock, 1974). With successful outcomes among populations with addictive behaviors and effective screenings for preventive illnesses, such as breast cancer, researchers have demonstrated that theory is valuable to guide behavioral change intervention research.

Due to the climate of homophobia, violence, and discrimination, MSM are often said to be hard to reach. This may be particularly true in Jamaica. Therefore, an understanding of the social and cultural environment is critical to confronting the high incidence of HIV/AIDS among MSM in Jamaica. Based on Bronfenbrenner’s social ecological framework (Figure 1), the following sections provide a synthesis of studies conducted to date that investigate the present issue.

**Theoretical Application**

The ecological model was first introduced by Urie Bronfenbrenner in the 1970s to provide a greater understanding of human development through the field of psychology (Bronfenbrenner, 1977). Since the introduction of his work, the ecological model has been adapted and used in a variety of fields and disciplines. Most notably, it has been used in child psychology, economics, risk behavior research (DiClemente, Salazar & Crosby, 2007), community and public health (HIV/AIDS risk behavior) research (Folke, 2006; Hosek, Haper, Lemos, & Martinez, 2008; Latkin, Weeks, Glasman, Galletly & Albarracin, 2010; Liebow et al., 1995; Lounsbury & Mitchell, 2009; McLaren & Hawe, 2005; Ostrom, 2007). The ecological model provides a blueprint for exploring complex problems that may affect an individual’s successful development. Using a multi-layered approach, the ecological model (see Figure 1) addresses several systems with which
individuals interface within their environments, some of which are beyond their immediate control (Bronfenbrenner, 1977; Bronfenbrenner, 1994). In his 1977 work,
Figure 1. Social-ecological model and HIV risk among Jamaican men who have sex with men (MSM) as adopted from Bronfenbrenner’s (1994) Ecological Models of Human Development.
Bronfenbrenner noted that, “in order to understand human development, one must consider the entire ecological system in which growth occurs” (p. 514).

Bronfenbrenner (1994) proposed that his theoretical perspective explains how the systems surrounding an individual are layered within each other and that these systems have bi-directional feedback between and within each other. The four interacting systems proposed by Bronfenbrenner are the microsystem, mesosystem, exosystem, and macrosystem (Bronfenbrenner, 1977; Bronfenbrenner, 1994).

The microsystem refers to the individual’s immediate situation. This is characterized by a pattern of activities, physical structure, social environment, and family. Additionally, how the system is designed or structured could shape the development of the individual (Bronfenbrenner, 1994). The second system, or the mesosystem, deals with the linkage of existence between two microsystems. For example, in the context of MSMs’ existence within their home and work environment, the individual is a participant. The third system proposed by Bronfenbrenner is the exosystem, where the linkages and processes take place between multiple settings. However, one of the settings may not directly affect individuals but may indirectly affect their ability to function within the setting. For example, community organizations and social institutions, such as schools, religious institutions, and health care, may have policies and procedures in place that may indirectly affect MSM, hence, hindering their ability to develop in the same way as heterosexuals. The final system in Bronfenbrenner’s model is the macrosystem. The macrosystem is all-encompassing of the micro-, meso-, and exosystems. This system is most distant from the individual. It holds the traditions, customs, beliefs, and political
processes of any society. Bronfenbrenner (1994) stated, “the macrosystem can be thought of as the societal blueprint for a particular culture” (p. 40). In this instance, the macrosystem involves key participants from within the society. They include governmental representatives, social elites from the ruling class, and policy makers.

This study explored the unique challenges of the social and cultural drivers of HIV risk behaviors in Jamaican MSMs. In the context of the Jamaican experience, the socio-ecological model was used as a theoretical framework in order to shift the focus beyond the individual, allowing exploration of other environmental factors that may be beyond the individual’s immediate control. This theoretical perspective offered an organizational framework within which these multilayered factors could be organized.

The several sections of discussion that follow, focus on building a case for all four parts of the theory (micro-, meso-, exo-, and macrosytems; Bronfenbrenner, 1994) as they relate to MSMs living in Jamaica (see Figure 1). This is followed by several sections reviewing the Caribbean region, providing an overview of Jamaica; Jamaican masculinity and dancehall popular culture; HIV prevalence data in Jamaica, and factors driving the epidemic; homosexuality and homophobia; stigma and discrimination; health care access and the national HIV policy; and, finally, HIV prevention knowledge in Jamaica.
Caribbean Region

Overview of the Caribbean Region

The Caribbean region is located in the Americas. Surrounded by a large body of water, the Caribbean Sea, the Caribbean is one of the most diverse territories in the world with a vast majority of its inhabitants with lineage to African ancestry. The Caribbean region is comprised of several islands. These islands are classified (based on their land mass) as small, midsized, and large. Islands within the Caribbean include Belize in Central America as well as, Guyana and Suriname in South America. Other independent territories include The Bahamas, Barbados, Cuba, Dominican Republic, Haiti, Jamaica, Trinidad and Tobago, Anguilla, Antigua and Barbuda, Aruba, Bermuda, Bonaire, Curacao, Dominica, French Guyana, Grenada, Guadalupe, Martinique, Montserrat, Saba, Saint Kitts and Nevis, Saint Lucia, St. Marten, St. Maarten, St. Vincent and the Grenadines, Statia, and the Turks and Caicos Islands. Though under colonial control, the commonwealth of Puerto Rico, U.S. Virgin Islands, Cayman Islands, and the British Virgin Islands are also considered to be part of the Caribbean. Contributing to the diversity within the Caribbean is the vast array of spoken languages, including Spanish, English, French, and Dutch. Moreover, each island does have variations of locally spoken Creole languages. Although a majority of the islands share a similar African ancestry, one island is not the same as another in terms of its culture and values (Blum et al., 2003; Camara et al., 2003; Figueroa, 2008; “The HIV/AIDS Epidemic in the Caribbean,” 2007; Voelker, 2001). On the other hand, traditional views of masculinity,
homophobia, and religiosity are common across the islands (Anderson et al., 2008; Castro & Farmer, 2005; Genrich & Brathwaite, 2005; Rutledge & Abell, 2005).

**HIV/AIDS Prevalence in the Caribbean**

The prevalence of HIV/AIDS in the Caribbean is second only to that reported in Sub-Saharan Africa (Caribbean Epidemiology Centre, 2007; Figueroa, 2008; Voelker, 2001). Since its emergence in the Caribbean in 1982, the region’s estimated prevalence is 1.2%, while Sub-Saharan Africa has a prevalence of 5.9% (Caribbean Epidemiology Centre, 2007; Voelker, 2001). In the Caribbean, HIV/AIDS is still the leading cause of death among adults 20-59 years of age (for males, the rate is 15.7%, and for females, 14.5%). Among young and middle-aged adults between the ages of 15 to 49, the island of Haiti is said to have the largest prevalence of HIV/AIDS (5.17%), while the island of Cuba has the lowest (0.1%) (Figueroa, 2008; Voelker, 2001). The HIV/AIDS prevalence for populations residing on neighboring islands is as follows: Jamaica, 1.6%; Trinidad and Tobago, 1.5%; Dominican Republic, 1.1%; Belize, 2.1%; Suriname, 2.4%; Guyana, 2.5%; Barbados, 1.2%; and the Bahamas, 3.0%. In a 2001 report released by the United Nations program on AIDS (UNAIDS), it was stated that of the 12 countries in the Americas with the highest HIV prevalence rates, nine of those countries are in the Caribbean (Figueroa, 2008; Voelker, 2001). These alarming statistics provide strong evidence for the importance and significance of this issue to the rest of the Caribbean and the United States.

Countries such as Jamaica, and Trinidad and Tobago (a twin island republic) are reported to have concentrated HIV/AIDS prevalence; meaning, only individuals who
engaged in high-risk behaviors (i.e., unprotected vaginal and anal intercourse, sharing of needles, substance use, and multiple sexual partnerships) are affected by HIV (Camara, 2001; Camara et al., 2003; Figueroa, 2008; Voelker, 2001). The island of Cuba, the country in the Caribbean with the lowest HIV prevalence rate, is unique in that persons with HIV in Cuba were subjected to mandatory, although now voluntary, commitment to sanitariums (Camara, 2001; Camara et al., 2003; Figueroa, 2008; Voelker, 2001).

A significant contributor to gross domestic product (GDP) in the Caribbean is tourism. Countries with tourism-dependent economies are disproportionately affected in terms of HIV seroprevalence and AIDS reported incidence. These islands include the Bahamas, Barbados, Bermuda, the Dominican Republic, Turks and Caicos, St. Maarten, St. Martin, and Jamaica (Montego Bay and Kingston; Camara, 2001; Camara et al., 2003; Figueroa, 2008; Voelker, 2001). The related concept of sex tourism will be discussed in greater detail in a subsequent section. Individuals who engage in the commercial sex trade are disproportionately affected by the STD/HIV/AIDS epidemic. Moreover, due to the relationship of poverty and other social drivers to acquisition of HIV infection, several other groups are also at increased risk of exposure and contagion.

At-risk Groups in the Caribbean

Adolescents, MSM, commercial sex workers, and prisoners are among the groups of individuals who are disproportionately at risk for HIV infection (Advocates for Youth, 2010; Camara, 2001; Camara et al., 2003; Figueroa, 2008; The HIV/AIDS Epidemic in the Caribbean, 2007; Voelker, 2001). The group that seems to be especially affected by this epidemic is MSM. Men who have sex with men account for the majority of HIV
infections in at least six islands within the Caribbean. In Jamaica, where the national HIV prevalence is 1.8%, MSM account for approximately 38% of the infections. Similar prevalence variances are seen for Trinidad and Tobago (1.5% national, 20% MSM), Dominican Republic (1.10% national, 6% MSM), Suriname (2.4% national, 7% MSM), Guyana (2.50% national, 21% MSM), and the Bahamas (3.0% national, 8.20% MSM; Camara et al., 2003; Figueroa, 2008; Ministry of Health, 2012; The HIV/AIDS Epidemic in the Caribbean, 2007).

Like MSM, commercial sex workers contribute to a significant proportion of HIV incidence and prevalence in Jamaica. The primary mode of HIV transmission for this population is unprotected sex. Due to monetary gain, commercial sex workers in predominantly tourist areas may forgo condom use (Camara, 2001; Camara et al., 2003; Figueroa, 2008; The HIV/AIDS Epidemic in the Caribbean, 2007; Voelker, 2001).

As is true elsewhere, the prison population is also considered to be at particular risk for HIV infection. Behavioral risks such as tattooing, unprotected anal sex, and injection drug use are key contributors to the HIV transmission amongst the incarcerated population. The Caribbean Epidemiology Centre regarded prison settings to be reservoirs for HIV infections (Caribbean Epidemiology Centre, 2007).

The adolescent population in the Caribbean is also considered to be at high risk for HIV infection. It was suggested that 73% of the HIV cases diagnosed were among young people between the ages of 15 and 25 years of age (Caribbean Epidemiology Centre, 2007). Several behavioral factors place adolescents at risk for acquiring HIV, including early sexual initiation, illicit drug use (marijuana, heroin, and cocaine), and
alcohol use. Significant among this population is the issue of teenage pregnancy, which lends itself to the potential for maternal-fetal transmission of HIV infection. Males have reported initiating sex at a much earlier age than females, 13 and 15 years of age respectively (Advocates for Youth, 2010). It is unclear whether these sexual encounters are consensual or with whom these young boys are engaging in intercourse (Advocates for Youth, 2010; Blum et al., 2003). Physical and sexual abuse was also associated with early sexual intercourse among adolescents (Blum et al., 2003).

**Stigmatization and Discrimination of MSM in the Caribbean**

Religion is often cited as one of the main reasons for the hostility towards MSM and people living with HIV/AIDS. HIV/AIDS stigma and discrimination is confounded by a combination of fear of contamination (eating or drinking from utensils used by an infected person), homophobia, and ignorance (Castro & Farmer, 2005; White & Carr, 2005). MSM living in the Caribbean encounter physical violence and employment discrimination as a result of their sexual orientation (Anderson et al., 2008; Castro & Farmer, 2005; Genrich & Brathwaite, 2005; Rutledge & Abell, 2005). HIV/AIDS stigma and discrimination have many effects on the individual. Some of these effects include emotional and mental instability, financial hardships, physical dysfunction, and social isolation (Castro & Farmer, 2005; White & Carr, 2005). As a result of the stigma and discrimination towards homosexuals in the Caribbean, MSM are regarded as sexual deviants. Acquiring HIV is associated with “fault.” Men who have sex with men are described as promiscuous, reckless, and risk-takers (Anderson et al., 2008; Castro & Farmer, 2005; Genrich & Brathwaite, 2005; Rutledge & Abell, 2005). Stigma and
discrimination towards homosexuals are associated with the late diagnosis of HIV infection, which has led to increased AIDS mortality (Norman, Carr, & Jimenez, 2006).

In Caribbean islands where stigma and discrimination towards MSM are high, higher rates of AIDS diagnoses were recorded (Castro & Farmer, 2005; Genrich & Brathwaite, 2005; Rutledge & Abell, 2005).

**Criminalization of MSM**

Male-to-male sexual activity is illegal in several countries within the Caribbean region. Criminal penalties for convictions range from 10 years to life in prison.

Barbados and Guyana are two countries that provide the harshest penalty of life in prison for homosexual sexual behaviors. Other territories with penalties of up to 10 years in prison include Trinidad and Tobago (25 years in prison), Antigua and Barbuda (15 years in prison), Belize, Dominica, Grenada, Jamaica (10 years in prison), St. Lucia, St. Kitts and Nevis, and St. Vincent and the Grenadines (Anderson et al., 2008; Castro & Farmer, 2005; Genrich & Brathwaite, 2005; Rutledge & Abell, 2005). Many Caribbean island jurisdictions have considered repealing these laws. Of note, island nations such as the Bahamas and Cuba that do not have punitive penalties for homosexual sexual behaviors have lower HIV prevalence rates (Anderson et al., 2008; “Caribbean Laws Criminalizing Homosexuality,” 2008; Castro & Farmer, 2005; Genrich & Brathwaite, 2005; Rutledge & Abell, 2005).

**Drivers of the HIV Epidemic in the Caribbean**

There are many factors contributing to the HIV epidemic in the Caribbean. Two major factors complicating efforts to control the HIV epidemic within the Caribbean are a
lack of HIV related resources (such as targeted MSM prevention and treatment services) and antiquated colonial sodomy laws (The HIV/AIDS Epidemic in the Caribbean, 2007). Other factors include environmental, economic and developmental challenges (Camara, 2001; Camara et al., 2003), limited access to health care, stigmatization of people living with HIV and AIDS, and issues related to confidentiality of protected health information (Figueroa, 2008), early sexual activity, inadequate education around sex and sexuality, cultural and religious taboos, multiple partners, inconsistent condom use, commercial and survival sex, discriminatory policies, and substance use (Advocates for Youth, 2010; Voelker, 2001).

Apart from those drivers identified above, a few protective factors that have aided in stemming the tide of the epidemic have been identified. One study suggested that connectedness (to family, friends, community, and religious homes) and human bonds are protective factors for individuals living in the Caribbean (Blum et al., 2003).

The Island of Jamaica

Overview of Jamaica

Jamaica is a small island located in the Caribbean. In terms of proximity, Jamaica is only 90 miles south of the coast of Cuba and 180 miles south of the coast of Florida. Although it has close proximity to Cuba, the island of Jamaica is considered to be a part of the English-speaking Caribbean. Once colonized by the Spaniards, in 1655 a British expedition defeated the Spanish military and took control of the island. With this new occupation, indigenous people fled their homes and moved farther into the mountains of Jamaica. With the abundance of sun and farm land, sugar and other spices became
popular agricultural products that could be cultivated locally. Although the Spaniards initiated organized slave labor in Jamaica, British settlers began importing slaves from Africa to work on plantations (Bertram, 2006). This gave rise to the formation of a plantation-dependent economy in Jamaica, one dependent primarily on slave labor.

**Spoken Language in Jamaica.** Like Haiti, Jamaica has its own unique language often referred to as Patois, or Jamaican Creole. Slaves, who were brought from Africa, in revolt to their English masters, created this language. This form of language gave slaves an opportunity to communicate with each other without their masters’ knowledge of what was being communicated. While English is the predominant language, Patois is still commonly spoken among the different classes in Jamaica.

**Administrative Divide of the Island.** The island of Jamaica is divided into fourteen parishes: Hanover, Saint Elizabeth, Saint James, Trelawny, Westmoreland, Clarendon, Manchester, Saint Ann, Saint Catherine, Saint Mary, St. Andrew, Portland, Saint Thomas, and Kingston. There are two commonly known urbanized cities in Jamaica, Kingston and Montego Bay. Kingston is located within St. Andrew and Montego Bay is located in St. James. Governmentally, the island is further divided into three counties: Cornwall, Middlesex, and Surrey. To ensure adequate delivery of health care, the Ministry of Health (MOH) has divided the country into four regions (Wilks et al., 2007). The first Health Region, under the jurisdiction of the South East Regional Health Authority (SERHA) is comprised of Kingston, St. Andrew, St. Thomas, and St. Catherine. The second Health Region, the North East Regional Health Authority (NERHA), includes Portland, St. Mary, and St. Ann. The third region, the Western
Regional Health Authority (WRHA) includes Trelawny, St. James, Hanover, and Westmoreland. Finally, the fourth Health Region is the Southern Regional Health Authority (SRHA), which consists of St. Elizabeth, Manchester, and Clarendon (Wilks et al., 2007).

**The Jamaican People.** The island of Jamaica consists of 2.7 million people with an annual population growth rate of 0.714% (CIA World Factbook, 2012; Wilks et al., 2007). The majority of the inhabitants of the island live in areas that are highly populated; these areas include Kingston (with almost a million people), St. Andrew, and Montego Bay, St. James. According to the CIA World Fact Book (2012), the island’s inhabitants consist of 91% of people from African ancestry, 6.2% with other ancestry (i.e., White, Asians, and South Asians), and 2.6% whose race is unknown. The age distribution is also diverse. People below and up to 14 years of age comprise 30.1% of the population. Young people and middle-aged adults between the ages of 15-64 make up 62.3% of the population, while adults 65 years and older make up 7.6% of the population. The life expectancy for the average Jamaican is 73 years of age. This may be different for young Jamaican males due to the high levels of crime, violence, and automobile accidents.

**Religious and Spiritual Diversity.** Contributing to the diversity of the population in Jamaica are the different religions practiced and beliefs held by its people. Individuals of the Protestant faith, which includes Seventh-day Adventist, Pentecostals, Church of God, Baptist, New Testament Church of God, Church of God in Jamaica, Church of God of Prophecy, Anglican, and other Christian faith comprise 62.5% of the
general population. The Roman Catholic Faith comprises 2.6% of the population, while other beliefs such as Rastafarianism, make up 14.2%. A significant proportion of the population (20%) reports no specified religious affiliation (CIA World Factbook, 2012).

**Structure of the Government.** Jamaica was granted independence from Great Britain in 1962. The system of government, a constitutional parliamentary democracy, is based on the Westminster model. Although Jamaica is an independent nation, the island remains a commonwealth of Great Britain. As a commonwealth, Jamaica has retained a majority of its customs, beliefs, and traditions from the imperialist British model. Within this Westminster form of government, representatives are elected by residents living in their constituency to represent them in parliament. However, with the exception of local government, Kingston/St. Andrew combined have their own jurisdictional body known as the Kingston and St. Andrew Parish Council (KSAC; CIA World Factbook, 2012). Elected members are chosen to be a part of the Prime Minister’s cabinet.

Jamaica has a common law system based on the English model. The chief of state for the government is Queen Elizabeth II, a position in which she has served over 60 years. Her Governor General, Dr. Patrick Allen, represents her locally in Jamaica on matters related to government. Dr. Allen has the power, on recommendations from the Prime Minister, to dissolve parliament, call new elections, and accept resignations of government ministers.

**Political System.** There are three political parties in Jamaica. Peoples National Party, or PNP, is headed by Portia Simpson-Miller, the current Prime Minster. The Jamaica Labor Party, or JLP, is headed by Andrew Holness, the current leader of the
Opposition. In recent times, in response to dissatisfaction with the two parties, other parties have emerged as alternatives to the two main parties. One such party, known as the National Democratic Movement, or NDM, is headed by Michael Williams.

**Legislative Branch.** The legislative branch consists of the Senate and the House of Representatives. There are 21 members in the Senate. They are appointed by the Governor General on the recommendations of the Prime Minister and the Leader of the Opposition. The ruling party is allowed or allotted a majority of the seats. In the House of Representative, there are 63 seats available. Members of the House of Representatives are elected, based on the popular vote, to serve a term of no more than five years, a period in which elections are constitutionally due (CIA World Factbook, 2012). In the December, 2011, general elections, the PNP brought their party to victory by securing over 53% of the popular vote, which yielded 42 of 63 seats in the House of Representatives; Ms. Simpson-Miller, as head of the PNP, is the current Prime Minister of Jamaica. The JLP received 46% of the popular vote and holds 21 seats in the House of Representatives. The NDM did not win any seats in the last election.

**Judicial Branch.** The Supreme Court heads the judiciary branch of Jamaica. The Governor General, on the advice and recommendations of the Prime Minister, appoints judges to the Supreme Court. In keeping with customs and traditions, the final Court of Appeals for the Jamaican judiciary is the Privy Council in Great Britain. Within the past year, the current government has advocated for a complete detachment from the British monarch by amending the Jamaican constitution to form a republic with their own
indigenous president and making the Caribbean Court of Justice (CCJ) the final court of appeals (CIA World Factbook, 2012).

**Economy.** Jamaica has a service-dependent economy. The tourism capital of Montego, St. James, Jamaica’s “second city” has the highest rates of HIV infection, followed by Kingston, Westmoreland, and St. Ann (Figueroa et al., 2008). The service-dependent economy accounts for 65% of the gross domestic product, or GDP. Other industries contributing to the GDP are tourism, bauxite/aluminum production, agriculture, manufacture, rum, cement, and telecommunications. The labor forces by occupation consist of services (64%), industry (19%), and agriculture (17%). The country’s primary export partners include the US (37%), Canada (18.1%), Netherlands (7.3%), United Kingdom (5.4%), and Norway (4.3%; CIA World Factbook, 2012). Products made available for export include alumina, bauxite, sugar, rum, coffee, yams, beverages, and apparel. The landscape for Jamaica’s import partners is different from their export partners. Jamaica imports a significant amount of products from the United States (33.9%), Venezuela (15.5%), Trinidad and Tobago (14.6%), and China (6.6%).

Jamaica’s public debt is approximately 125.5% of their GDP (CIA World Factbook, 2012). This has contributed to an unbalanced tax burden on the poor and middle-class. The country originates 25.6% of its revenues from taxes. There are approximately 19% of individuals living below the poverty line (24% in rural areas), and the unemployment rate is nearly 13% (CIA World Factbook, 2012). The economy is profoundly dependent on foreign exchange from tourism and remittances from families and friends living and working abroad.
Jamaica’s economy depends on the tourism industry and tourism accounts for 10% of the country’s GDP. In some parts of the world, Jamaica is considered a sex tourism destination. In regions of the country, where the local economy is tourist-dependent, local men and women often engage in “romance” or sex tourism (Pruitt & LaFont, 1994; Wedderburn, Amon & Figueroa, 1998). For many local men, a way out of their immediate poor economic situations is engagement in sex work, or relationships with Euro-American women. At times, tourist women engaging in these relationships will enter into marriages and petition for their local Jamaican husband to join them in their home countries. This is where the term “rent a dread” was created. On the other hand, same-sex romance tourism has a different objective. Oftentimes, foreign male partners maintain the relationship through frequent visits to the island, sending goods and money to their partners locally (Wedderburn et al., 1998).

**Masculinity in Jamaica**

**Colonial Jamaica.** Understanding masculinity within the Jamaican cultural context, first requires understanding the historical perspectives that aided in the formation of the Jamaican male identity since the British colonial occupation ended in 1965.

Masculinity in Jamaica has taken many forms related to race, gender, economic status, religious affiliation, and cultural factors (Chevannes, 1999, 2001; LaFont, 2001; Tafari-Ama, 2006). During British colonial rule, Afro-Jamaican male sexuality was perceived as animalistic, with men deemed incapable of love, and their copulation was seen as a way of expanding the slave labor force (Crooms, 2007). Male slaves were not given the
opportunity to love or form meaningful unions with female slaves. Marriage or fatherhood was not part of the colonizer’s plan for the Afro-Jamaican man and woman:

The Negroes in the West Indies, both men and women, would consider it as the greatest exertion of tyranny, and the most cruel of all hardships, to be compelled to confine themselves to a single connection with the other sex; and I am persuaded that any attempt to restrain their present licentious and dissolute manners, by introducing the marriage ceremony among them, as is strenuously recommended by many persons in Great Britain, would be utterly impracticable to any good purpose. (Edwards 1793, reprinted in LaFont, 2001, p. 7)

This statement by Edwards validated the crown’s attitudes towards any formal ceremonial bond between Afro-Jamaican men and women.

The perception that Jamaican men are incapable of love or sexual discipline has continued on in Jamaican society, today even after the abolition of slavery in 1834 and over 50 years of independence from British rule (Brown-Glaude, 2006; Crooms, 2007; LaFont, 2001; Roberts, Reddocks, Douglas, & Reid, 2009; Tafari-Ama, 2006). Over time and post-colonial rule, this attitude towards the Jamaican man has moved on to only include mostly inner-city men; these men are perceived by many social elites as sexually irresponsible, uneducated, and proponents of violence (Chevannes, 1999). Additionally, it is also perceived that these men escape the responsibility of fatherhood, leaving their children to be raised by single mothers (Chevannes, 1999). Within the Jamaican society, masculinity is defined by the number of children a man has. It is important to note that these perceptions are not held by all Jamaicans—such as persons with power or those
from middle- to upper-income. What is clear by this stance is that these perceptions stem from centuries of racial psychological trauma. Since Afro-Jamaican slave men were perceived as incapable of love, any sexual relationship between them and the Afro-Jamaican woman was viewed as unchristian or ungodly (LaFont, 2001). LaFont further noted:

The passion therefore to which (dignified by the name of love) is ascribed the power of softening all the miseries of slavery, is mere animal desire, implanted by the great Author of all things for the preservation of all species. This the Negroes, without doubt, possess in common with the rest of the animal creation, and they indulge it, as inclination prompts, in an almost promiscuous intercourse with the other sex; or at least in temporary connection, which they form without ceremony, and dissolve without reluctance. (Edwards 1793, reprinted in LaFont, 2001)

Here, Edwards suggested that the sexual relations between the Afro-Jamaican male and female were similar to those seen among animals and that these unions were only necessary for the procreation of future slave offspring, as intended by God.

**Post Slavery.** After the Emancipation Proclamation (1834) was passed, which gave slaves their freedom, the roles of Afro-Jamaican males changed. With the continuation of the sugar industry and the end of slave labor, many jobs were available on sugar plantations of postcolonial Jamaica. Many free men worked hard, cultivating the fields in an effort to provide for themselves and family. Many other free men were able to farm and raise cattle, most of which were used for consumption or to be sold in local markets (Chevannes, 2001). With the increase of many of these small agro communities,
the demand for labor increased and as a result, young boys participated in agricultural activities like their fathers and older male siblings. On the other hand, young girls were settled into domestic roles like their mothers (Chevannes, 2001). These gender socializations are present in Jamaican society today. Chevannes lamented that masculine gender socialization within the inner cities are similar to those of postcolonial Jamaica (1999). For example, once a young boy has reached the age of puberty, he is allowed to hang on the streets with other boys within his peer group; this is done in an effort to enhance his manhood instead of him being emasculated (or having his manhood stripped from him). This, in turn, creates what Croom (2009) labeled as hyper-masculinity.

With the absence of a father or primary breadwinner in the home, education is often considered to be least important for young Jamaican inner-city boys (Chevannes, 2001; Crooms, 2007). Instead, boys in the inner city are forced to abandon school for economic reasons such as providing for their families, while young girls abandon school due to early pregnancies (Brown-Glaude, 2006; Roberts et al., 2009; Tafari-Ama, 2006). Moreover, due to economic hardship, mothers are left to decide which of their children they can afford to send to school. Girls are often chosen over boys because of their perceived inability to bring financial resources into the home (Chevannes, 1999). Young boys are then left “to make life, juggle, or hustle” the streets to provide for their families (Chevannes, 1999, p. 28). Frequently, these activities are often illegal.

**Post-Independence.** Young men engaging in criminal activities tend to cling to traditional forms of gender behavior in order to mask the potential of being labeled as homosexual or effeminate (Chevannes, 2001; Crooms, 2009; LaFont, 2001; Roberts et al.,
In the inner city, masculinity is synonymous with violence. Male masculinity was believed to be measured based on the size of their guns. This new male behavior personified the “rude boy” attitude (Tafari-Ama, 2006). A rude boy in the Jamaican context is any male who perceives himself to be an outlaw; he is often hyper-masculine, hypersexual, and prone to resolving conflicts with violence. Violence and the rude boy persona are considered by many Jamaicans to be the true embodiment of maleness and masculinity. According to Tafari-Ama, the rude boy persona emerged in the 1960s, in the newly independent Jamaica. These rude boys in the 1960s were powerful in terms of their violent nature—as a result, they were feared by many (Tafari-Ama, 2006). The political climate in Jamaica has also contributed tremendously to the rise of the rude boy culture. During the infancy of the newly independent Jamaica, the two political parties provided a significant group of young men with weapons in order for them to secure the votes needed to win the election. The 1980s election was said to be one of the bloodiest in Jamaica’s history (Tafari-Ama, 2006).

Rude boys in Jamaican society today have transcended from the partisan garrison (ghetto) politics; instead, they are now known as posse, yardie, or shottas, all of which are linked to profound gang-related violence, extortions, rape, lottery scams, robberies, and murder (Tafari-Ama, 2006). Also, violence against women, homosexuals, and male-on-male violence provides legitimate evidence of their masculinity. With this new culture of violence and hyper-heterosexual masculinity, the rude boy persona has now been culturally normalized and anyone that falls outside of this narrowed definition of maleness and masculinity is rejected (Crooms, 2007; Tafari-Ama, 2006). To that end,
MSM in Jamaica are perceived to be less than men and, as such, they are seen as un-Jamaican. To differentiate them from other men with the society, JMSM are labeled and identified as *batty man* or *Chi-Chi men* (derogatory colloquial terms used to label homosexuals). This new labeling of the Jamaican homosexual is reinforced through the anti-gay dancehall culture in Jamaica (Tafari-Ama, 2006).

**Dancehall Culture in Jamaica**

Within the Jamaican cultural context, dancehall was used as a space for celebration, entertainment, and socialization (Stanley-Niah, 2004). The music that emerges out of dancehall is different from that produced by Bob Marley and other reggae artists. Dancehall Music is faster in pace and its lyrics are characterized as “slackness,” which is defined in popular Caribbean culture as vulgar, sexually explicit, or unruly (Hope, 2006; 2010). Moreover, it is also often derogatory towards women and violent towards homosexuals (Alleyne, 2006; Bakare-Yusuf, 2006; Bornstein, 2001; Stanley-Niah, 2006; Stanley-Niah, 2010).

Originally, dancehall emerged in the 1950s, before Jamaica gained independence from Great Britain. The term *halls* refer to the spaces in which dance events were held (Stanley-Niah, 2004). With limited access to economic opportunities, dancehall venues provided spaces for people to gather and share their stories of survival (Hope, 2010; Jennings, 2004; Pinnock, 2007; Saunders, 2003; Stanley-Niah, 2010); hence, “dancehall concerns with corporeality, gender, sex, sexuality, and political consciousness” (Pinnock, 2007, p. 52). Dancehall is the quintessential representation of Jamaica’s popular culture. As such, politicians use it to reach poor inner-city constituencies. The battle for society’s
morals is constantly being fought between inner-city and upper-middle class individuals (Hope, 2006; Jennings, 2004; Stanley-Niah, 2010). The celebrations of dancehall are often scheduled in the middle of the workweek, and the entertainment continues from sun down to sun up.

In today’s society, dancehall is viewed as the workplace, church, and classroom of the poor and lower class (Stanley-Niah, 2010). It is the place where women and men meet to work (exchange sex for money or other favors); a place of worship, where the male body is worshiped and the female body is sacrificed (figuratively); and the classroom where sexual education around socially taboo topics and political discourse are shared (Stanley-Niah, 2004). Over time, the locations of these celebrations have moved from the limited small halls to that of open spaces in some of Jamaica’s poorest urbanized communities and streets. A space that was once created to provide support against institutional oppression is now a space used to degrade women and oppress sexual minorities (Hope, 2010; Pinnock, 2007; Stanley-Niah, 2010).

As described in the previous section on masculinity in Jamaican society, the dancehall space, which today is seen as a source of oppression against sexual minorities such as homosexuals, is also a space of male-on-male violence. In this space the struggles of the ghetto are transformed into lyrics that are violent in nature. Practitioners of dancehall music are often poor inner-city individuals who look towards “artistic” musical recordings as a way out of their current economic conditions (Hope, 2010; Tafari-Ama, 2006). Additionally, these violent lyrical themes are seen to contribute to the masculine rude boy or badman personality (Hope, 2010; Pinnock, 2007; Stanley-Niah,
In this space, conflict is not settled peacefully but by dangerously violent, sometimes deadly, means, often times with a weapon (i.e., gun). In dancehall, the gun and the penis are equated (Pinnock, 2007). Dancehall dominates the conversation around Jamaican masculinity. Performers within the dancehall community strive to be successful at their craft. A successful dancehall artist can make it out of the inner-city/ghetto through the use of his artistic talents. Although most of these performers leave the inner-city, their songs are often in conflict with the morals of the larger Jamaica society (Hope, 2010; Pinnock, 2007). To this end, a culture of slackness (sexually explicit and often derogatory lyrics) is created and accepted by inner-city communities, however, rejected by society’s social elites.

Slackness, contributes to the hetero-normative discourse in Jamaica’s dancehall. The male’s reproductive organ is a valued part of dancehall’s masculine culture. The larger the male phallus (penis), the more effective it is in conquering the female’s anatomy (Hope, 2010; Pinnock, 2007; Stanley-Niah, 2006). In this space, gender identity and gender roles are defined by hyper-heterosexual men. Therefore, hyper-masculine men control the reproductive conversation around women’s health while rejecting the presence of the homosexual male (Hope, 2010; Pinnock, 2007; Tafari-Ama, 2006). Since inner-city men dominate the conversations around masculinity in Jamaica’s popular culture, men define the type of sex acts performed. For example, vaginal coitus is the only acceptable form of sex in Jamaican society. Fellatio and anal intercourse are contested, but fellatio, performed by the female to her male partner would often be socially acceptable among men. However, if the act was performed by the male to his
female partner, he would be rejected and embarrassed by his peers. Performing oral sex on his heterosexual female partner is perceived as emasculating for the Jamaican male, hence relinquishing power to the female. On the other hand, anal sex is perceived as a homosexual act, regardless of the gender of the sex partner.

In the context of the dancehall space, inner-city youth are perceived to be the envy of middle- or upper-income men. The perception of inner-city men is that they are the only ones who possess the ability to sexually fulfill (with their endowed penis and sexual stamina) all women (Pinnock, 2007). This form of gender and sexuality politics lends itself to a resentment of middle- and upper-income men by inner-city men and sexual violence towards women (Pinnock, 2007). The definition of a “real man” in the Jamaican popular culture is a man from the inner-city. Consequently, men outside of the inner-city (middle-class men) are perceived as incapable of satisfying their partners sexually. They are emasculated, which creates the avenue for the rude boy to eliminate the competition so they may have nuff gal (multiple female partners; Stanley-Niah, 2006).

Correspondingly, since homosexual men cannot fulfill women and their type of sex act (anal sex) is seen as un-Jamaican, demands for their termination from society are seen as justifiable. Here, in this space, the homosexual does not have to self-identify as such. Any form of effeminate attitudes or appearance is enough to render judgment. According to Hope (2010), the anti-homosexual discourse represented in dancehall is perceived as a male-to-male conflict, which demonstrates the apprehensive attitude of the heterosexual male. An example of homophobic dancehall lyrics is represented in the
2000 hit song of a popular dancehall group, T.O.K., called “Chi-Chi Man” (Clark, Davidson, McCalla, & Thompson, 2001, track 3).

1. My crew (my crew);
2. My dogs (my dogs);
3. Set rules (set rules);
4. Set laws (set laws);
5. We represent for the lords of yards;
6. A gyal alone a feel up my balls;

[Chorus:]

7. From them a par inna chi chi man car;
8. Blaze the fire make me bun them (Bun them!!!);
9. From them a drink inna chi chi man bar;
10. Blaze the fire make we dun them (Dun them!!!);

[Verse 1]

11. So mi go so, do you see weh I see?;
12. Niggas when ya doin' that;
13. Nuff a them a freak them a carry all them dutty act;
14. Thug niggas wannabees nuff a them a lick it back;
15. It them bring it to we, hold on nuff a cop a shot;
16. Cop a shot rise up every calico go rat ta tat, rat ta tat;
17. Every chi chi man them haffi get flat, get flat;
18. Me and my niggas ago make a pack;
19. Chi chi man fi dead that's a fact.

[Author’s translation]

5. We are presenting for the duns of yards;
6. Only women can play with my scrotum;
7. If they are riding in a homosexual’s car;
8. Use fire and burn them;
9. If they are drinking in bars owned by homosexuals;
10. Use fire and burn them;
11. So I say, do you see what I see?
12. Guys when you doing that;
13. They are freaks; look at the type of disgusting acts they are engaging in;
14. They are acting like rude boy but engaging in oral sex with men;
15. If they try to bring these acts to you, use your gun and shoot them;
16. Raise you gun and go bam bam;
17. Me and my friends are going to make a packed;
18. Every homosexual should die and that is a fact.

HIV/AIDS Incidence and Prevalence in Jamaica

HIV Incidence. Jamaica’s HIV epidemic has shifted from high-risk groups to the general population (Olukoga, 2004). Since 1997, Jamaica has had the largest increase in the rate of HIV infection compared to any other nation within the Caribbean (Olukoga, 2004; Wilks et al., 2007). HIV continues to be the second leading cause of death for Jamaicans. Jamaica’s HIV/AIDS epidemic has disproportionately affected youths and
young adults (Vickers, Alveranga, & Smikle, 2005). Reports from the Ministry of Health suggest that adolescent females (10-19 years old) were three times more likely to be infected with HIV than adolescent males in the same age group (Figueroa et al., 2008; Hutton-Rose, Blythe, Ogbonna, & McGrowder, 2008; Losina et al., 2008). This disparity was said to be due to the increased number of females engaging in sexual activity with age discordant partners (Olukoga, 2004; Wedderburn et al., 1998). According to the Ministry of Health, new cases of HIV infections among adolescents doubled each year since 1995 (Ministry of Health, 2005). A 2010 report exemplifies the impact of the current HIV epidemic in Jamaica, where the incidence is shifting in more recent years with adolescent females accounting for more of the newly reported HIV infections, compared to adolescent males (Ministry of Health, 2012).

**HIV Prevalence.** The HIV epidemic appears to be heavily concentrated in two highly urbanized areas: Kingston/St. Andrew and Montego Bay, St. James (Ministry of Health, 2010). These two urbanized areas accounted for almost 70% of all Jamaicans living with AIDS (Ministry of Health, 2010). The number of cumulative HIV cases for Kingston/St. Andrew is 1494 per 100,000 people, while the cumulative cases for St. James are 1956 per 100,000. Additionally, since Jamaica has a tourist-dependent economy, areas heavily dependent on tourism have some of the highest rates of HIV compared to anywhere else on the Island (Ministry of Health, 2010). Following Montego Bay, St. Ann (1089.6 cases per 100,000), Westmoreland (966.7 per 100,000), Hanover (957.3 per 100,000), and Trelawny (912.9 per 100,000) all have high rates of HIV prevalence (Ministry of Health, 2010). As mentioned previously, the Jamaican health
care system is divided into four regions; as such, the four parishes with these cumulative cases are all located within the western region. Even though the numbers for other parishes, such as Manchester, Clarendon, and St. Elizabeth are smaller, all had similar increases in reported HIV and AIDS cases in 2010 (Ministry of Health, 2010).

**Maternal-Fetal Transmission.** Unlike other developed nations in the Caribbean that have eradicated maternal-fetal transmission of HIV, Jamaica has not. In fact, currently in Jamaica, for every one thousand pregnant women, 16 are infected with HIV (Ministry of Health, 2005; Hutton-Rose et al., 2008). Additionally, it is also estimated that two or three HIV-infected children are born every week in Jamaica (Olukoga, 2004). This has contributed to a growing epidemic among children and adolescents. Since their parents are infected and treatment is not consistently available, children are becoming orphans in higher numbers than in other places. In 2003, it was estimated that over 120 children under the age of 18 were made orphans as a result of losing one or both parents to AIDS (Hutton-Rose et al., 2008). In Jamaica, AIDS is the second leading cause of death among children between the ages of one to four years (Figueroa et al., 2008; Gibbison, 2006; Hutton-Rose et al., 2008). Over the past decade, the Ministry of Health and other partner groups, both local and international, are working to eradicate maternal-fetal transmission. The country has experienced a dramatic 20% decrease in the rate of maternal-fetal transmission (UNAIDS, 2010). As a result of these efforts a significant number of pregnant women are now receiving antiretroviral medication.

**AIDS Cases.** Since the epidemic began in 1982, Jamaica has seen a cumulative number of 15,289 cases of AIDS (Ministry of Health, 2010). A significant majority of
these individuals presented to tertiary care centers with advanced stages of the infection. A vast majority of the reported AIDS cases (86%) in Jamaica are among people between the ages of 20-60 years (Duncan, Beckford, & Harvey, 2010; Ministry of Health, 2010). In 2005, the island had identified over 9,600 individuals who were living with AIDS, with a significant proportion of those individuals being male (61%; Ministry of Health, 2010).

**Persons Living with AIDS.** AIDS cases are higher among men than women in Jamaica. This is likely due to the many different high-risk sexual behaviors in which men engage. Men are more likely to be involved with multiple sexual partnerships and less likely to initiate condom use (Duncan et al., 2010; Figueroa et al., 2008; Pruitt & LaFont, 1994; Wilks et al., 2007). Heterosexual contact continues to be the predominant mode for HIV transmission, accounting for over 61% of the cumulative reported AIDS cases (Ministry of Health of Jamaica, 2010). Men attending sexually transmitted disease (STD) clinics have been found to have more sexual partners and many more risk factors for HIV than women (Duncan et al., 2010; USAID, 2008). The lives of those living with AIDS in Jamaica significantly improved since the government made antiretroviral therapy (ART) available. This in turn led to a twofold decrease (down from 333 in 2010 compared to 665 in 2004) in the number of AIDS related deaths (Ministry of Health, 2010). There continues to be gender disparity regarding persons living with AIDS, where men continue to bear the brunt of the epidemic. Males between the ages of 30 and 79 account for the largest proportion of reported AIDS cases (Ministry of Health, 2010).
**AIDS Mortality.** Compared to other islands within the Caribbean, Jamaica has the second highest rate of active AIDS cases and AIDS mortality (Ministry of Health, 2007; Ogbonna, & McGrowder, 2008; Olukoga, 2004). Annually, over 600 Jamaicans die secondary to AIDS. In 2010, the Ministry of Health reported that over 8105 persons have died from AIDS since the epidemic began in 1982 (Ministry of Health, 2010). In the early parts of the 2000s, the AIDS fatality rate in Jamaica was over 61% (Hutton-Rose et al., 2008). Persons who reported to tertiary centers in the later stages of the AIDS infection were more likely to die from the infection (Losina et al., 2008; Ministry of Health, 2007). Often times, their clinical presentation included muscle wasting, cough, shortness of breath, and oral candidiasis (Losina et al., 2008; Ministry of Health, 2007). Since the initiation of ART therapy in Jamaica, persons who are diagnosed with HIV and are placed on ART therapy, saw their prognosis improve exponentially (Losina et al., 2008). In Jamaica, there is also a large age disparity in terms of persons presenting to tertiary centers for care and receiving an AIDS diagnosis. Individuals are often diagnosed with AIDS within their middle adult years, and the majority of those are former commercial sex workers, drug users, and others with unspecified risk factors (Losina et al., 2008).

**Risk Behaviors of Persons Living with HIV.** Several high-risk behaviors are commonly reported among persons diagnosed and living with HIV. Approximately 80% of Jamaican individuals diagnosed with HIV reported having multiple sexual partners (Gibbison, 2006; Figueroa et al., 2008; Ministry of Health, 2008; Wedderburn et al., 1998). Other risk behaviors reported include commercial sex, past history of sexually
transmitted diseases, and injection drug use. A significant proportion of HIV infected individuals reported no obvious risk (20%). Of note, males in Jamaica who have been diagnosed with HIV are less likely to report homosexual or bisexual activity (Ministry of Health, 2008). Moreover, 85% of the HIV cases happen among individuals who are considered to be within their prime productive years, which the Ministry of Health considered to be between the ages of 20 to 59 (Ministry of Health, 2008; Gibbison, 2006).

**Jamaica’s Response to the HIV Epidemic.** Over the years, Jamaica’s response to the HIV epidemic has improved. Testing and treatment programs are becoming more available, improving early diagnosis of HIV infection. This, in turn, reduces the morbidity and mortality associated with the HIV infection (Duncan et al., 2010). Additionally, the number of people accessing antiretroviral treatment (ART) increased, with over 5000 individuals accessing ART therapy over the past 10 years (Duncan et al., 2010). Unfortunately, despite these gains, reaching MSM to screen and or treat them continues to pose many challenges for public health officials. The proportion of men diagnosed with HIV and AIDS who are classified as homosexual or bisexual (14%) is considered to be an underestimation (Figueroa et al., 2008). A true estimation of actual HIV and AIDS cases among MSM is likely closer to 20% (Figueroa et al., 2008; Ministry of Health, 2008). Due to stigma and discrimination against MSM in Jamaica, many men do not admit to having sexual relationships with other men, therefore, making access to prevention and treatment services difficult (Figueroa et al., 2008).
Factors Driving the Epidemic in Jamaica

Several factors drive the HIV epidemic in Jamaica. These factors are behavioral, economic, socio-cultural, and environmental (Olukoga, 2004; UNAIDS, 2010). More specifically, drivers of the epidemic in Jamaica include: early sexual activity, inconsistent condom use, inconsistency between knowledge and behavior regarding HIV prevention, the presence of other sexually transmitted infections, discrimination and stigmatization around HIV/AIDS, inadequate attention to HIV in the Health and Family Life Education curriculum (an educational instructional manual for students in secondary institutions), slow economic growth, unemployment, prostitution, masculinity, and gender inequality (UNAIDS, 2006, 2010; USAID, 2008). Of particular concern in Jamaica (as it is in other places) is the issue of multiple sexual partnerships. Culturally, multiple sexual partnerships are socially acceptable among young people between the ages of 20 and 29 years (Figueroa et al., 2008; Gibbison, 2006; Hutton-Rose et al., 2008; Ministry of Health, 2008). Due to high rates of unemployment for both men and women (13%) and a significant number of individuals living below the poverty line (16.5%), engagement in commercial sex work becomes appealing as a way to make a living (Hutton-Rose et al., 2008). The high rates of unemployment and poverty in Jamaica also contribute to a high incidence of heterosexual and homosexual intergenerational sex, where young boys and girls are having sex with older women and men for goods or money. This behavior increases the vulnerability of an individual to become infected with HIV (Figueroa et al., 2008; Hutton-Rose et al., 2008).
Commercial Sex Workers. Commercial sex work in Jamaica, though illegal, has grown over the years. Both urban and rural communities have experienced an increase in establishments that promote exotic live shows where sexual intercourse happens on stage (Figueroa et al., 2008). With the emergence of these exotic “business” establishments, commercial sex workers are not limited to the traditional street corners. Sex for money, goods, or services is not limited to adolescent girls and young women, but also includes young boys. More specifically boys from impoverished inner-city communities and those living on the streets are also engaging in survival sex with older men who are willing to pay (Figueroa et al., 2008; Wedderburn et al., 1998). With the increased unemployment and poverty rates, young women and young men find the commercial sex trade more lucrative than actual traditional employment. In a study conducted by the Ministry of Health, in 2005, 19.4% of all HIV/AIDS cases were linked to commercial sex work.

Adolescents. For the majority of adolescents, sexual initiation was reported between the ages 12-15 years (Baumgartner, Geary, Tucker, & Wedderburn, 2009; Geary et al., 2008). Young boys, for many reasons, tend to initiate sex at an earlier age compared to girls within the same age group (Baumgartner et al., 2009; Geary et al., 2008; Figueroa et al., 2008). Many adolescent males are engaging in sexual intercourse with more than one partner (Forbes, 2010). Age discordant relationships are of major concern for young adolescent males and their sexual partners. The sexual partners for adolescent males are often within their peer group or five or more years older (Baumgartner et al., 2009; Wood, Hutchinson, Kahwa, Hewitt, & Waldron, 2011).
Adolescent males are socialized by a culture that promotes multiple sexual partnerships (Crawford & McGrowder, 2008; Eggleston, Jackson, & Hardee, 1999; Eggleston, Leitch, & Jackson, 2000 Smith et al., 2003). Young adolescent males are expected to prove their masculinity and virility through early sexual activity, multiple sexual partnerships, and fatherhood (Gayle, 2002; Hutchinson et al., 2007). These types of behaviors protect and promote the promiscuous adolescent male from being labeled as homosexual (battyman, chi-chi man, and fish—derogatory, colloquial Jamaican terms used to label homosexuals; Crawford & McGrowder, 2008; Gayle, 2002; Hutchinson et al., 2007; Robilland, 2001; Smith et al., 2003). Additionally, having multiple children with several different women or girls is seen as a testament to their manhood (Hope, 2010; Stanley-Niah, 2010).

Young adolescent males and females often receive mixed messages regarding gender norms about what are considered to be socially acceptable forms of sex acts and sexuality (Eggleston et al., 1999; Forbes, 2010; Norman & Uche, 2001). Young adolescent females are expected to be sexually reserved and, if sexually active, to be with only one partner. Age discordant relationships between adolescent females and older male partners are common (Forbes, 2010; Wood et al., 2011). These types of relationships are often encouraged by maternal figures in the adolescents’ lives. It is seen as a way out of their current economic situation, which often involves exchange of goods, money, and other resources for sex. Like the adolescent female, young boys also engage in this form of arrangement with older men and women (Crawford & McGrowder, 2008;
Hutchinson et al., 2007); however, the prevalence of this is unknown (Robillard, 2001; Smith et al., 2003).

According to Gayle, young boys who engage in commercial sex work are often introduced to the lifestyle due to their current economic situation (2002). One author emphasized that boys who live in the inner city are forced to assist their families (most often a single mother with multiple children) economically, defend themselves and family from violence, and demonstrate their masculinity. Though they may not self-identify as homosexual, younger adolescent boys may engage in commercial and survival sexual activity with both male and female clients. This also places them at risk for violence on the streets of Jamaica (Crawford & McGrowder, 2008; Gayle, 2002; Robinson, Thompson, & Bain 2001).

Sexual violence is among the atrocities experienced by adolescent males and females in Jamaica (Baumgartner et al., 2009; Geary, Wedderburn, McCarraher, Cuthertson, & Pottinger, 2006; Geary et al., 2008). Sexual coercion during the first sexual experience also is a common occurrence (Geary et al., 2006; Geary et al., 2008), and both males and females have reported being forced to have sex at some point in their lives (Geary et al., 2008). A close family member or friend of the family was often identified as the culprit of the sexual coercion experienced by young adolescents (Geary et al., 2008). Children and adolescents who report these instances of abuse or coercion to a parent, family member, or the authorities are often neglected or told that their experiences/stories were fabricated (Geary et al., 2006). Of note, studies in the United
States established a link between childhood sexual abuse, early sexual initiation, and risk taking behaviors with HIV infection (Crawford et al., 2008; Geary et al., 2006).

Inconsistent condom use is common for sexually naive adolescents (Norman & Gebre, 2005; Robillard, 2001). While condoms are readily available to the general adult population, adolescents and MSM face many challenges in obtaining them. Some adolescents may be embarrassed to ask adults for condoms, while MSM may experience stigma and perhaps discrimination from local store clerks, shopkeepers, or pharmacy personnel. Business personnel may have negative attitudes towards supplying condoms to adolescents or MSM—this reservation may be due in part to a moral code which is rooted in a strong religious background (Figueroa et al., 2008).

**Homosexuality and Homophobia in Jamaica**

Homosexuals account for a small portion of the population in Jamaica; however, they account for a significant proportion of individuals living with HIV/AIDS. The term homosexual is often used to refer to individuals who self-identify as gay, bisexual, or lesbian. The public health term of MSM (men who have sex with men) is used to identify males who engage in sexual activities with other men but do not necessarily consider themselves gay or bisexual. As quiet as it is kept, Jamaica has a small, but vibrant MSM community (White & Carr, 2005; Williams, 2005). Estimates of the homosexual population in Jamaica range from 9,000 to 27,000 individuals (Ministry of Health, 2008). The HIV prevalence rate for MSM is 38%, with half being unaware of their HIV positive status (Figueroa et al., 2008; Hutton-Rose et al., 2008). Moreover, adequate/accurate
surveillance data are sparse due to the many structural challenges that inhibit access to this population.

A significant structural challenge that has inhibited access to populations of MSMs in Jamaica is discrimination. Men who have sex with men in Jamaica are often targets of verbal and physical abuse by members of the security force and work colleagues, members of their community, and their families. Additionally, many individuals have lost their lives or have been rendered homeless as a result of mob attacks on their person by members within their own community (Figueroa, Dolan, Dale, Hileman, & Weir, 2007; Lacey, 2008; White & Carr, 2005; Williams, 2005). In an interview conducted by a staff reporter for the New York Times, a senior police officer made a clear statement regarding the visibility of homosexuals in Jamaica. The senior officer insisted that an openly gay person could not survive in Jamaica (Lacey, 2008). Lacy reported that this senior officer lamented to the homosexual community that they should, “hold your corners, because it may provoke a violent breach of the peace” (p. 4), immediately after, several armed men invaded a home they suspected was occupied by homosexuals. MSM are often blamed for attacks on other persons. Most notably, public officials, such as politicians and the island’s public defender, have noted that if homosexuals were less flamboyant, the violence they experience would decrease (Lacey, 2008; White & Carr, 2005).

The Human Rights Watch (HRW) has documented many instances of violence and abuse towards MSM individuals in Jamaica (2004). Many have been denied basic services that are offered within the society. Some have expressed concerns over denial of
access to transportation. One gentleman reported to the HRW that he was denied access
to public transportation or taxi services because he was effeminate. Another gentleman
reported being physically assaulted and thrown off a public bus because he fell asleep on
the shoulder of a passenger (2004). Similar stories have also been documented by the
HRW regarding unlawful evictions of perceived homosexuals. The HRW reported:

Right now, I’m not living in my house because people thought I was gay…. 
About two weeks ago, I got a call at work that there were twenty-five men
surrounding the house because they understood we were gay and wanted us to
leave because they didn't want any gay men in the area. [I was told] that the men
had machetes. I didn't go home for two days because I was scared. (Human
Rights Watch, 2004, p. 53)

Another gentleman who spoke to the HRW also shared his experience with
sexuality-based violence and community mob evictions. This 38-year-old homosexual
man lamented:

Because [a person is] gay in Jamaica, it’s hard for us to live anywhere.
Those that can afford [to]; [sic] they can rent an apartment and not be
molested. But we cannot afford it. Some might attempt to rent a little
house. But within days, or it doesn't last for a month, they have to run
away, leave everything that they have. (Human Rights Watch, 2004, p.
52)
The above experience underscores a point made earlier. The story explained by this gentleman documents the issue of social class in Jamaica. Middle class homosexual men who can afford to move into a “safe” or less threatening area may do so because of their resources.

Sexuality-based oppression is engraved into some of Jamaica’s institutions, lending itself to institutionalized discrimination through the legal and health care systems, popular media, and culture (“Battybwoys affi dead,” 2004; Carr, 2003; Human Rights Watch, 2004, Lacey, 2008; White & Carr, 2005). This form of oppression creates limited spaces for MSM to socialize or meet for safe consensual relationships (Carr, 2003; Figueroa et al., 2007; White & Carr, 2005). Gender-based inequality and homophobia have also played a role in Jamaica’s politics. In 2002, one of Jamaica’s political parties used anti-gay lyrics, Chi-Chi man by T.O.K, as part of their party platform message (Clark et al., 2001; White & Carr, 2005). To avoid detection, MSM in Jamaica socialize at secret venues and practice their faith in movable churches (Lacey, 2008). These limitations on MSM’s socialization have created small-intertwined sexual networks. The public health literature has suggested that when HIV is concentrated within a particular subgroup, the risk for HIV transmission increases (Carr, 2003; Figueroa et al., 2007; Hope, 2010; White & Carr, 2005).

Like other high-risk groups in Jamaica, multiple sexual partnerships are also common among MSM. Some men reported up to 12 partners within a calendar year (Browning & Scott, 2002), contributing to the high prevalence of HIV within this population. In a study conducted by Hassad (1994) on homosexuals in Jamaica, a
significant proportion of the men in the study endorsed condom use. However, a group of men within the study reported feeling uncomfortable or afraid of requesting that their partner use a condom. Additionally, those men who reported feeling uncomfortable or afraid were less likely to have used condoms (Hassad, 1994). Although knowledge of HIV transmission may be high among these individuals, it appears self-efficacy around effective condom negotiation is lacking. Hassad suggested that programs geared towards MSM should develop and enhance skills and self-esteem. To date, no research interventions have been developed to address these issues.

**HIV/AIDS Stigma and Discrimination in Jamaica**

Despite adequate knowledge about HIV transmission, HIV stigma and discrimination continues to be a source of concern among people living with HIV/AIDS. In the early 1980s in the United States, HIV was associated with homosexuality (Andrinopoulos, Kerrigan, Figueroa, Reese, & Ellen, 2010; Norman, Carr, & Uche, 2006). Jamaicans also made the same association and, as such, discriminated against those who were currently living with the virus (Andrinopoulos, Kerrigan, Figueroa, Reese, & Elle, 2010 White & Carr, 2005). Since then, a growing number of people living in Jamaica have yet to recognize that this association between homosexuality and HIV has been debunked by extensive research both in Jamaica and internationally. Moreover, this conflation between HIV and homosexuality by people living in Jamaica has left many with a sense of invincibility to the virus. On the other hand, due to the association of homosexuality and HIV, MSM and other populations at risk avoid seeking HIV testing
and treatment services (Figueroa et al., 2008; Ministry of Health, 2001; Ministry of Health, 2008).

The perception and attitudes of the populace in Jamaica have been ones of scorn or hatred for people who are identified as homosexual, or sex workers who are living with HIV (Norman, Carr, & Jimenez, 2006). In a study of university students in Jamaica, a majority of individuals reported little or no sympathy towards homosexuals living with HIV. Instead, students were more apt to express sympathetic attitudes towards heterosexual men and women who were living with HIV (Norman, Carr, & Uche, 2006). Also, attitudes and levels of stigma and discrimination vary based on gender among Jamaicans. Males are less likely to express sympathy towards homosexuals living with HIV than females (Andrinopoulos et al., 2010; Norman, Carr, & Uche, 2006; White & Carr, 2005).

The HIV incidence for men within the incarcerated population is steadily growing (Andrinopoulos et al., 2010). Jamaica’s prisons are subdivided into multiple sections, which include the general population, the labor section, the medical section, and the “homosexual section” (Andrinopoulos et al., 2010). Andrinopoulos et al. reported a high prevalence of HIV infection (25%) within the homosexual section in the island’s largest prison, compared to the general prison population, which had a prevalence rate of 3.3% (2010). In 1997, to combat this growing epidemic among the incarcerated population, prison officials proposed providing inmates with condoms. Immediately after this proposal was made, both the general public and the incarcerated population protested against the policy (Andrinopoulos et al., 2010; White & Carr, 2005). The inmates in one
of the prisons rioted, which resulted in the deaths of 16 inmates who were believed to be homosexuals (LaFont, 2001). It was later theorized that the riot was linked to the association between condoms and homosexual activity.

Despite the stigma associated with condoms and homosexual activity in Jamaica’s prisons, Andrinopoulos and colleagues reported that inmates with high self-efficacy, and low HIV testing stigma were more likely to seek HIV prevention services (2010). Additionally, high levels of HIV testing among inmates were also strongly correlated with low internal and external stigma, high levels of social support, and having the requisite knowledge regarding HIV transmission and prevention (Andrinopoulos et al., 2010).

HIV/AIDS stigma and discrimination is one of many drivers of the HIV epidemic in Jamaica. As indicated by researchers and public health officials, and as perceived by MSM, Jamaica’s buggery laws also contribute to this problem of stigma and discrimination (White & Carr, 2005). The Offence Against the Person Act of the Jamaican Criminal Code provides the courts with the power to impose lengthy prison sentences on individuals who engage in homosexual sexual activity. With a 38% prevalence rate of HIV among MSM, public health officials in Jamaica and other advocacy groups have called for the law to be repealed. A repeal of the buggery law will aid in clearing many of the structural barriers that inhibit effective HIV prevention intervention from reaching vulnerable populations.

Classism and skin color also contribute to HIV stigma and discrimination in Jamaica (White & Carr, 2005). The high levels of HIV stigma and discrimination
directly impact people who are living below the poverty line. These indigent individuals have limited access to health care and other resources needed to live healthy lives. In many inner-city communities, those residing in these areas indicated that they are able to tell if someone had AIDS based on appearance (Robinson et al., 2001). This is partly due to the presence of skin lesions and possible presence of opportunistic infections. Both White and Carr have also indicated that HIV/AIDS was directly linked to social-economic class and as such “paints a picture of the public face of poverty in Jamaica” (2005, p. 8). Middle-and upper-income individuals have more resources and are able to travel off the island if needed to seek HIV treatment services.

In Jamaica, there is a clear distinction between the income classes. Lighter or fair skinned persons are perceived to be more economically affluent than those who are of a much darker complexion. In some communities, it is believed that fair skinned persons were more likely to be homosexual. However, research in the Jamaican context has shown that skin color was associated more with class than it was with homosexuality or HIV (White & Carr, 2005).

**Educational Institutions and Homosexuality**

In recent years, there have been significant reports of homosexual behaviors in secondary schools in Jamaica. A majority of these reports were highlighted on public television and in the media. One of these reports, published in a local newspaper, the *Jamaica Gleaner*, suggested that homosexual activities in secondary institutions have risen to such a level that it is considered to be one of the major behavioral problems confronting educators (Grindley, 2012). These reports prompted parents to be selective
about the schools to which they send their children. For example, it was suggested that
one factor in the selection process which parents have to consider is whether or not the
school is same gender (boys or girls only) or a mixed gender school (Grindley, 2012).

In addition to the careful selection process of educational institutions by parents,
school officials added to the controversy by conflating the behavioral issues of male and
female students (school bullying) with those of homosexuality. The president of the
Jamaica Association of Principals of Secondary Schools, Sharon Reid, suggested that
school officials be vigilant in identifying homosexual behaviors as it is commonly seen in
schools across the country, which, she stated, poses many behavioral problems (Grindley,
2012). Though it is not clear what those behavioral problems are, Ms. Reid provided an
explanation for the increased visibility of homosexuality in secondary institutions: She
suggested that external factors, such as pressures from the gay community (both local and
international), and current events taking place around the world as two key factors
contributing to the emergence of homosexual activity locally. As a senior administrator,
Ms. Reid also suggested that the role of guidance counselors was to report those youths
engaging in “deviant” (by which she means/meant homosexual) behaviors to their parents.
Given that homosexual behaviors in these youths are perceived by the educators to be
negative, these actions are intended to be corrective by combating the issue of
homosexual behaviors in secondary schools (Grindley, 2012).

Within the past few years, the Ministry of Education along with local and
international partners, such as the Global Fund, the United Nations Population Fund, and
the United Nations Children’s Fund, worked towards implementing an effective and
constructive sexual health and family planning curriculum in secondary institutions (Reid, 2012). The proposed Health and Family Life Educational Curriculum and text were created for young people between the ages of 13-15 years of age (grades 7-9; Reid, 2012). The intent of the curriculum was to engage students in teacher-led conversations around human sexuality, sexual behaviors, and safe and healthy family planning (Reid, 2012). For example, some of the questions asked in the curriculum are: Have you ever had sexual intercourse? Have you ever had anal sex without a condom? What caused you to be a heterosexual? However, following an uproar from parents, the Jamaican Ministry was forced to pull the curriculum from secondary educational institutions because of perceived supportive homosexual contents and age-inappropriate sexual content (Reid, 2012). Additionally, the Ministry of Education also ordered all such books, with similar text, to be removed from schools (Reid, 2012).

Unsatisfied with just the recall of the Health and Family Life Educational Curriculum, many parents and local religious advocates then called for action to be taken against the individuals at the Ministry who had approved the text to be used in schools. They also spoke out against the involvement of the outside groups noted above. Parents and other local leaders considered these groups’ involvement as a strategy to enhance and forward the local homosexual agenda (Reid, 2012). Minister Holness, Education Minister for the ruling government at the time, subsequently ordered the removal of all text and curriculum related to sexuality and sexual health (Reid, 2012).

Although homosexuality has been perceived as deviant behavior in schools, due to the issue of HIV/AIDS and the vulnerability of children and adolescents, the Ministry
of Education, Youth and Culture has created a national policy for HIV/AIDS management in schools (Eggleston et al., 2000; Ministry of Education Youth and Culture, 2004). The policy’s aim is to focus on prevention, dissemination of information, and education, and to promote positive behavior change. Additionally, the policy aims to provide confidentiality and protection of HIV/AIDS related information, and to ensure the dignity of students and staff in educational institutions across Jamaica (Eggleston et al., 2000; Ministry of Education Youth and Culture, 2004). The overall responsibility for the implementation of the nation’s HIV policy in educational institutions rests solely on the Ministry of Education, Youth and Culture. However, the Ministry encourages all educational institutions to create their own action plans on handling students or staff within their institution who are infected with HIV. Of note, the Ministry of Education also identified behavioral issues that may place students at risk for HIV. They suggested that HIV exists within the context of early sexual activities and high levels of unprotected sex among older students (Eggleston et al., 2000). Even with this affirmation, the Ministry of Education, Youth and Culture failed to implement a family life and sexuality curriculum geared towards all students within Jamaica’s secondary institutions.

Health Care Services and Homophobia

Jamaica has a well established public health service system. Since the 1970’s, the primary health care approach has been the island’s way of disseminating health care to the general public. This approach has led to achievements in reducing malnutrition and infant mortality, increasing immunization coverage, eliminating polio and measles, and improving sanitation status (Ministry of Health, 1999, 2005; UNAID, 2006; USAID,
There are over 300 primary care facilities on the island, providing basic to complex services, consisting of maternal and child health, dental, STD, and mental healthcare. Since Jamaica has a public health services system, public hospitals provide 95% of care for the island (Ministry of Health, 2005). Disease surveillance is conducted through collaboration with public and private entities. Health information is gathered from public and private primary care facilities, hospitals, and laboratories (Ministry of Health, 2005; UNAIDS, 2006; USAIDS, 2008). Jamaica’s HIV/AIDS surveillance is conducted via case-finding and active and passive surveillance. The Ministry of Health is responsible for contacting laboratories, hospitals, hospices, and public and private physicians.

The general infrastructure for public health sexually transmitted disease services in Jamaica is comparable to that of other nations. Consumers seeking services at any of the island’s health facilities, more specifically, STD testing and treatment centers, will find that they are capable of addressing their immediate health needs. However, previous research suggested that staff located at some of these health centers may require additional training around adequate sexual history taking, tailoring specific individualized behavioral counseling, prevention education, cultural competence when working with sexual minority populations, and the appropriate treatment for the various sexually transmitted diseases (Bryce et al., 1994; Human Rights Watch, 2004). Although condoms were readily available at a majority of the centers providing STD services, Bryce and colleagues suggested that there was a significant discrepancy in the number of people seen and the number of condoms distributed. This meant that while condoms
were available not many people were taking advantage of the services offered at these centers.

Although Jamaica has a well-established health care system, many sexual minorities and marginalized individuals are afraid to interface with the health care system because of fear of stigma and discrimination (Andrinopoulos et al., 2010; Norman, Carr, & Jimenez, 2006; White & Carr, 2005). Many individuals reported instances where they were either ill treated by nurses and other members of the health care team or denied services altogether (Human Rights Watch, 2004). Symptomatic homosexual men are afraid to seek or may delay treatment services depending on the type or location of symptoms. In a report to the Human Rights Watch, a staff nurse at Jamaica AIDS Support, an organization that provides medical services reported:

Most of the gay men that I talk to don't even want to go to the hospital at all. They come to me one-on-one and say, Can you get this for me, can you get this medicine. Sometimes ordinary medicines, nothing to do with HIV. But they are afraid to go to a doctor or hospital even with a common cold or flu because they [hospital health care staff] will ask them questions or call them names. (Human Rights Watch, 2004, p. 46)

A 24-year-old gentleman also lamented the need for culturally appropriate services for homosexual men in Jamaica. He, too, recounted an instance in which he felt uncomfortable going to see a medical provider regarding a health concern.

I try to keep myself healthy because if you go to the hospital, they won’t take care of you. If you got a bruise on your anus, that would make it worse. To be honest,
if anything should happen to me, I am not going to the public hospital. I would buy over-the-counter medication or speak to my friends. I know that I am at risk but just to keep myself safe I cannot go to the hospital. Because if something should happen to me, I cannot go to the police because they will not help me.

(Human Rights Watch, 2004, p. 47)

Another issue highlighted by HRW is the issue of confidential health services. Many homosexual men, due to prior experiences or the perceptions of others, have a general mistrust of the health care system. It is often reported that homosexual men are afraid that medical staff may breach their confidentiality by leaking their medical information to unauthorized individuals within the community (Human Rights Watch, 2004). A 22-year-old gentleman told HRW about an experience he had that made him skeptical of seeking STD services.

One time, I caught gonorrhea. I was so scared of it, to go to the doctor. At first I said, this will go away. I started to see it [penis discharge] getting yellow, and it started to run [from my penis], then it started to turn green, so I put a diaper there because it was running really hard and painful…. Some of my friends won’t go to the doctors. They don't want the word spread around, and they say what they don't know won't hurt them. (Human Rights Watch, 2004, p. 46)
HIV Prevention through Popular Culture

In contrast to previous discussions about the negative aspects of dancehall, some dancehall artists used their music to disseminate HIV prevention messages. Some of these messages were done through lyrical performances, while others’ messages were disseminated through drama and live theatrical performances. Dancehall artists such as Mark Myrie (AKA Buju Banton), Shabba Ranks, Lady Saw, and Yellow Man have led the promotion charge in HIV prevention through dancehall music. Buju Banton is most notable with his hit lyrical HIV prevention song, Willy.

Chorus
1. Raggamuffin don't be silly put some rubbers pon uno willy;
2. AIDS ah go round and we doh wha catch it;
3. Rude bwoy don't be silly put some rubbers pon uno willy;
4. AIDS ah go round and we doh wha catch it.

[Author’s translation]
1. Guys don't be silly, put a condom on your penis;
2. AIDS is spreading and you don't want to catch it;
3. Guys I am telling you, don't be silly, use a condom;
4. AIDS is going around and you don't want to catch it.

Verse 1
1. Life is precious when yuh have it fi live, mek sure yuh nuh HIV positive;
2. A aware B prepare C constructive;
3. Don't yuh nay say you no care nar you no business;
4. Dis is not ah soap opera nor ah miniseries;
5. One life de Father give yuh one life yuh gotta;
6. Live to de world me ah talk whether yuh small or yuh big.

[Author’s translation]

1. Life is very precious, live your life, just make sure you are not HIV positive;
2. A is for aware, B prepare, and C constructive;
3. Don't say you don't really care or it is not your business;
4. This is not a soap opera or a miniseries;
5. God gave you one life;
6. Enjoy it while you can.

Though he has faced much criticism from the international community over his controversial songs calling for the killing of homosexual men (which he still currently performs), Mr. Banton nonetheless was the first artist to lead the charge of a lyrical HIV prevention campaign (Figueroa et al., 2008).

Other artists, such as Frisco Kid, also contributed to HIV prevention in his song, Rubbers, which was aimed at heterosexual community.

1. Mi want a jook offa Jacqueline;
2. But mi haffi draw for my rubbers, for my rubbers;
3. Sex nice but the AIDS ting;
4. Wi mek yuh die like flowers, die out like flowers;
5. When mi stop an mi look inna mi crystal ball;
6. Mi get fi find out say, no man a nuh wall;
7. An most pretty gal yuh caan trust dem at all;
8. At all, at all Hey.

[Author’s translation]:
1. I want to have sex with Jacqueline;
2. But first I am going to reach for my condoms;
3. Sex is great, but that AIDS thing;
4. It will make you die like flowers;
5. When I look into my magic ball;
6. I understood that men are not invincible;
7. Most beautiful women you cannot trust them;
8. At all.

**Jamaica National HIV/AIDS Policy**

In 2005, the Jamaican Ministry of Health drafted and established the island’s first national HIV/AIDS policy. The Ministry of Health has identified that HIV/AIDS is more than a health problem that affects the individual, but a developmental problem that affects the society, culture, and the economic stability of the nation (Ministry of Health, 2005). The national policy aims to: prevent new infections, establish effective treatment and care programs, provide support to those infected and affected by the epidemic, reduce the impact of the epidemic, and reduce sigma and discrimination against people living with the HIV virus. While the government of Jamaica has been identified as having the lead
role for implementation of the National HIV policy, there are many organizational partners who are key to implementation of the policy. These other partners include the National AIDS Committee (NAC), trade unions, private sector employers, non-government organizations (NGOs), and faith-based organizations (Ministry of Health, 2005).

Despite having a national policy, there are several obstacles that hinder its full implementation. For example, the government suggested that, due to limited access to voluntary counseling and testing, specialty care, and antiretroviral drugs, individuals without the virus have not been able to adopt frequent testing behaviors, and those with the virus are unable to receive the care and services needed to remain healthy (Ministry of Health, 2005). To combat these issues, according to the Ministry of Health, financial resources and legislation from the government were to be allocated and enacted to affirm the rights of persons living with and affected by HIV/AIDS and the rights of those most vulnerable to HIV/AIDS. The limited financial resources allocated by the government are expected to mitigate the socioeconomic impact of HIV/AIDS on individuals, families, communities, and the nation (Ministry of Health, 2005).

General HIV Knowledge

One of the main prevention strategies used to decrease HIV transmission is knowledge. Both the Ministry of Health and the Ministry of Education identified the need for increased education and awareness around HIV transmission (Ministry of Health, 2008; UNAID, 2006; USAID, 2008). Despite this acknowledgement and efforts by the two above-named ministries, misinformation among the general public about HIV
transmission has remained. For example, in a Knowledge, Attitudes, Behavior, and Practices (KABP) survey of the general population (conducted frequently by the Ministry of Health), a significant number of individuals believed that one can become HIV infected if bitten by mosquitoes (Garrett, Tint, Fogo, & Jolly, 2004; Robinson, Thompson, & Bain, 2001). Additionally, only 36% of young men and 40% of young women correctly identified safe ways of preventing the sexual transmission of HIV (Ministry of Health, 2008).

A study of street boys (N= 35) in Kingston, Jamaica, conducted by Robinson, Thompson, and Bain (2001) suggested that the age of first sexual activity was as early as seven years, with female partners who were older, and with limited HIV prevention knowledge. Many of those youths reported that no one had taught them how to use a condom. Some even admitted that using condoms for sex is for older men and not young boys like themselves (Robinson et al., 2001). Additionally, the young men in the study also shared the belief that one could identify a person who is HIV positive or living with AIDS by looking at them. Robinson and colleagues (2001) noted that the young men in their sample were under the erroneous impression that HIV feeds on blood vessels, mosquitoes are carriers, and that a male with HIV may experience necrosis and loss of his penis as a result of being HIV positive (Robinson et al., 2001). It was also apparent that these young boys were getting their HIV education information from unreliable sources. Television, after-hours sex shows, and friends were some of the places identified by these youths as their source of HIV prevention knowledge and information (Robinson, Thompson, & Bain, 2001).
Conclusion

HIV incidence in the Caribbean is exceptionally high and the prevalence rates are second to those reported in Sub-Saharan Africa. Moreover, smaller Caribbean islands, such as Jamaica, that have a tourist-dependent economy, have experienced the impact of the HIV epidemic. In Jamaica, the epidemic affected groups include adolescents, MSM, commercial sex workers, and incarcerated men. Rates of HIV and STI infections are disproportionately highest among MSM. Several key factors contribute to the HIV epidemic among MSM, including violence towards MSM; discrimination through popular culture, educational and health care access, and economic instability; HIV stigma; issues around masculinity and the need to profess one’s manhood through multiple sexual partnerships; and criminalization of male-to-male sexual activity.

Although many of the reasons for delayed testing and treatment are clear; there are several other significant factors that are less well understood. These factors include the protective and survival practices, the lived experiences, and current sexual behaviors and HIV knowledge of JMSM. Little is known about transactional sex among young MSM (Hutchinson et al., 2007; Morrison & Chen, 2004; UNAIDS & WHO, 2008). Additionally, little is known about resources such as social support systems, subcultures of MSM (rich, middle-class, and poor), relationship dynamics (romantic and familial), and community factors available to MSM. In an effort to address some of these gaps in the literature, the purpose of this study was to describe the experiences and views of JMSM regarding their cultural and social environment and how that environment affects the options available to them to reduce HIV risk or to remain healthy if they are HIV
positive. Another purpose of this study was to explore strategies that JMSM have used to manage HIV risk in this environment. Since limited data are available on the protective and survival practices of MSM, current state of HIV knowledge, systems of social support, or their interactions with systems within Jamaican society, the following research questions were the focus of this study.

**Research Questions**

This study addressed the following research questions:

1. What are sexual behaviors and current levels of HIV knowledge among JMSM?
2. How do MSM describe their experiences of living in Jamaica?
3. What are the protective factors and strategies used by JMSM to mitigate or prevent physical harm to themselves and their risk for HIV infection?
CHAPTER III: METHODS

Study Design

A review of the literature on HIV and MSM in Jamaica revealed that protective and survival practices, HIV knowledge, social support systems, and MSM risk navigation around HIV remain largely unexamined. It was the purpose of this study to address these voids in the literature. The specific aims of the present study were to: (a) describe the experiences of MSM as they pertain to being MSM and living in Jamaica, (b) assess the current state of HIV knowledge among JMSM, and (c) identify protective factors and strategies JMSM use to navigate HIV risk.

The design of this study was qualitative description with some quantitative measures. Data were collected through one-on-one, semi-structured interviews, self-report questionnaires, and a focus group. The qualitative descriptive research design was appropriate for this inquiry as the intent was to describe the experiences of MSM participants living within the Jamaican cultural context (Sandelowski, 2000). Moreover, qualitative description allowed the researcher to remain close to the data while gathering rich in-depth description of the different perspectives of the experiences of the young men, and garnering a better understanding of the meanings, traditions, and interpretations of the culture being studied (Portney & Watkins, 2009; Streubert-Speziale & Carpenter, 2003). The researcher remained close to the data and took advantage of all opportunities for observations of events, in order to achieve the most accurate possible portrayal of the participants’ experiences of navigating or interacting with the different social systems within Jamaican society (Sandelowski, 2000).
Prior to data collection, an in depth cultural assessment was conducted, which proved to be essential before the researcher engaged in any activities with participants selected for the study. Culture is a collection of beliefs and behavioral patterns that shape community identity and include values, attitudes, beliefs, and morals (Patton, 2002). The researcher met with and spoke to representatives from several key community agencies (JFLAG and JASL), educators, medical practitioners, religious leaders, and community members prior to creating all study materials. Additionally, a systematic review of cultural artifacts, such as local newspapers, were obtained and reviewed. A complete analysis of the findings will be presented in Chapter Four. In qualitative research, the terms *emic* and *etic* are often used. The term *emic* refers to the language and categories used by people in a particular culture. The term *etic* refers to categories and themes created by the researcher based on his or her analysis of that culture. These two terms are used to describe the insider (emic) and outsider (etic) perspectives. To this end, it was the researcher’s goal to grasp the emic view while retaining the perspectives of his own etic views and biases (Patton, 2002; Portney & Watkins, 2009; Streubert-Speziale & Carpenter, 2003).

To accurately capture the emic prospective of the culture and the people being studied, the researcher moved to the island of Jamaica, were he lived for a period of 10 months. During this period, he immersed himself in the culture and society and also used his training as a public health expert to formulate a multifaceted insider perspective. In addition to moving to the island, through the United States Embassy in Kingston, the researcher was able to affiliate with the Institute for Gender and Developmental Studies
Unit at the University of the West Indies (UWI), Mona Campus, in Kingston, Jamaica. Dr. Leith Dunn, a key expert at the university, served in the capacity of local supervisor, providing guidance and support to the researcher. She serves as a senior lecturer and department chair for the Institute for Gender Studies. Dr. Dunn’s research expertise and interests include gender-based violence, gender, sexuality, reproductive rights, and HIV/AIDS.

Quantitative data were collected from all participants in the study prior to their participation in the in-depth, one-on-one semi structured interviews or the focus group interviews. The quantitative data were used to provide the researcher with demographic data and an accurate description of the participants, which enhanced interpretations of the qualitative findings (Sandelowski, 2000). A paper and pencil demographic/sexual behavior survey along with the HIV Knowledge Questionnaire for Young MSM of Color (HIVKQ; Fields, 2005) was administered to each participant to provide supplemental descriptive data for research question #1.

**Sampling**

**Inclusion and Exclusion Criteria.** This study included thirty men from across the island who: (a) were between the ages of 18 to 30 years of age,(b) identified as male with supporting self-reported biological genitalia, (c) were Jamaican born, (d) self-identified as a man who has sex with other men, (e) was sexually active with another man within the past 12 months prior to enrollment in the study, and (f) had the capacity to give consent. Capacity was established if the participant did not appear to be intoxicated, was able to understand the research materials, and did not have any mental limitations as
recognized by the researcher. The researcher was in a position to determine capacity as he is a certified family nurse practitioner.

Participant age was limited to between 18 and 30 years of age. This range was not arbitrarily selected. Due to the homophobic climate in Jamaica, participation in the study by persons younger than 18 years of age posed many risks to the participant. A major example of this risk included the potential of “outing”/exposing the minor’s sexual orientation to his parents. Additionally, persons over the age of 18 may have reached several psychological and sexual developmental milestones that persons younger than 18 years may not have achieved. The rationale for the limitations on the upper limit of 30 years of age was based on information derived from the literature. It has been less than three decades since the emergence of the HIV/AIDS epidemic. Men over the age of 30 may have a different perspective on HIV since they have been alive since before the crisis began. Additionally, including those over 30 could add unnecessary heterogeneity to the sample and complicate the interpretation of the findings (Hallett, Gregson, Lewis, Lopman, & Garnett, 2007).

Since a participant’s gender identity may be different from his biological sex, the researcher was able to inquire by asking each participant questions regarding his gender identity and if his self-reported gender identification was congruent with his biological sex. For example, some participants might be a biological male based on his genitalia; however, he might identify as female and not have supporting female genitalia. In the general sense, sex is usually assigned at birth (i.e., male, female, or intersex), and is usually based on the genitalia of the newborn (Gainor, 2000). Questions such as (1) how
do you define your gender (i.e., male, female, or transgender) and (2) are you
circumcised were added. Though question #2 was asked for the purpose of ascertaining
HIV related health risk, it also served as a tool to screen for sex/male genitalia. Men who
identified as female or transgender were considered to be ineligible to participate in the
study (see Appendix A).

Study participation was limited to men who were Jamaican born. Since Jamaica
is a member of the Caribbean Community (CARICOM), an agreement signed by various
island nations which allows free movement of citizens from one Caribbean island to
another, it was possible that non-Jamaican citizens were living in Jamaica and or
attending Universities on the island. This limitation was established to capture the unique
experiences of those men who were native to Jamaica. Questions to ascertain this
included (a) were you born in Jamaica and (b) in what parish are you currently living in?
Also, Jamaica is an English-speaking island; therefore, all participants were expected to
speak English. Some participants felt more comfortable conversing in the local Creole
(patois) language; they were not excluded, however, as the researcher is able to read and
understand patois.

For some individuals, their sexual behaviors might be incongruent with their self-
identified sexual orientation. Since sexual orientation is fluid, a person might self-
identify as heterosexual yet engage in sexual activity with partners from the same sex, as
a homosexual (Klein, 1993; Peplau & Garnets, 2000). Sexual orientation often refers to
the physical and romantic attraction of one person to another (Klien, 1993). It is often
viewed through three categories: 1) heterosexuality—defined as an attraction to members
of the opposite sex; 2) homosexuality—defined as an attraction to members of the same sex; and 3) bisexuality—an attraction to members of both sexes (Peplau & Garnets, 2000). Though these categories have been used widely in the literature, in public health, new challenges have arisen for practitioners who have encountered a subset of individuals within the population who were engaging in same-sex sexual activities, though not identifying as homosexual (Young & Meyer, 2005). Therefore, new terms such as men who have sex with men (MSM), women who have sex with women (WSW), and men who have sex with women and men (MSWM) were developed to capture this subset of the population (Young & Meyer, 2005). MSM is not to be mistaken as a category of sexual orientation, rather as a term to delineate sexual behaviors. Use of this term leaves open the possibility that men who are labeled as MSM may also be having or engaging in sexual activities with women. Within the context of the present study, inquiries about the sexual activity of each participant were made. Participants who were identified as gay, bisexual, or MSM were deemed eligible and were enrolled in the study. Additionally, eligible participants were required to have had sexual activity with another man within the past 12 months. Men who only had sex with women or who were sexually inactive were ineligible.

The primary objective of the study was to describe the protective and survival practices and the experiences of JMSM. Therefore, participants who reported that they were HIV positive were not excluded from participating in the study. As a result, three participants who self-reported as HIV positive were included. Because it may be cost
prohibitive for participants to seek HIV testing, documentation of HIV status was not necessary for participation.

Along with the other study inclusion criteria, capacity to give consent was of significant importance. The researcher is a family nurse practitioner, and was able to determine capacity based on interactions with participants. However, as suggested by the Ethics Committee at the UWI-Mona, the Mini-Mental Status Examination (MMSE) to evaluate cognitive functioning was available for use. A score of 25 to 30 was considered normal. Men with scores of 25 and higher were deemed eligible to participate in the study. All scores were over 25.

The researcher had originally planned to conduct two small focus groups. This decision was based, in part, on the possibility that there might be challenges in recruiting young MSM who were living in a homophobic climate to participate in an open group with other men like themselves. The researcher anticipated encountering internalized homophobic stigma. However, this proved not to be a factor, and there were no difficulties in recruiting multiple persons for participation in a single focus group. Ultimately, the researcher was able to organize one focus group with 10 participants, all of whom felt comfortable with each other. The inclusion and exclusion criteria for the individual interviews were the same for those who participated in the focus group.

**Sample Size.** Unlike quantitative design that relies heavily on effect size and establishment of statistical power, qualitative research designs focus on saturation of the information being collected (Lincoln & Guba, 1985; Portney & Watkins, 2009). Saturation refers to redundancy of the information obtained in a study. This is the point
at which no new information is elicited. For qualitative researchers, saturation of data is achieved when no new categories or themes can be generated from the analysis (Lincoln & Guba, 1985). In qualitative research, strict focus on large numbers for statistical significance is not necessary (Miles & Huberman, 1994). Qualitative researchers require an adequate, often small, sample of persons who are “nested in their context and are studied in-depth” (Miles & Huberman, 1994, p. 27). According to Patton (2002), “there are no set rules for sample size in qualitative inquiry” (p. 244). The decision in selecting a sample size in qualitative research should be based on the phenomenon being studied and the reason for the inquiry (Patton, 2002). Qualitative research designs that employ the use of in-depth interviews do not typically require large sample sizes (Patton, 2002; Streubert-Speziale & Carpenter, 2003), as large sample sizes may provide more breadth but less depth and may not be useful.

The principal sources for data collection in this study were individual, semi-structured, in-depth interviews. The focus group served as a form of post-hoc member checking of themes and ideas generated from the individual interviews (Patton, 2002). Because the primary purpose of the focus group was to check-in with participants not previously interviewed regarding the themes and ideas generated from the individual interviews, the sample size for this group of men was kept purposefully small. However, this does not negate the possibility of gathering new insight into the phenomenon being studied. Though there has been no consensus in the literature on what is considered to be an adequate focus group size, qualitative investigators have suggested using smaller manageable groups. McLafferty (2004) has suggested that “the fewer people there are in
the group, the greater the likelihood that they will interact” (p. 190). A manageable group is considered to be a group consisting between four and eight individuals (Kitzinger, 1995). Albeit groups consisting of four to eight persons were considered to be a manageable sample size for a focus group, the research team interviewed a larger group, consisting of 13 persons. The larger group provided more insight into the phenomenon and new ideas which also led to new themes.

Thirty-four young JMSM were screened for participation in the study. All participants satisfied screening criteria except for four persons. The individuals who did not meet criteria were deemed ineligible due to their age. On screening, they reported that they were 17 years of age. Thirty young JMSM in total were enrolled in this study, and all were included in the final analysis. A total of 20 participants completed individual interviews and 10 participated in a focus group.

**Sampling Strategies**

Purposeful sampling, using maximum variation sampling technique, was used to recruit the participants for this study (Patton, 2002). The purpose of maximum variation sampling is to identify a wide array of common patterns and to document variation (Marshall & Rossman, 2006; Miles & Huberman, 1994). Maximum variation sampling allows the researcher to identify and document important patterns across a diverse sample (Miles & Huberman, 1994; Patton, 2002) Because little is known about the phenomenon of interest, the researcher employed maximum variation techniques in an attempt to capture the variations (younger vs. older, socioeconomic status, educational attainment, and geographical location) of the experiences of potential participants. Because the
primary interview sites were based in Kingston, this also involved purposeful recruiting of rural and suburban young men. Maximum variation sampling also allowed for participation of variation within the JMSM community. This meant that all men were able to participate in the study regardless of their sexual risk factors, sexual identity, and levels of masculinity. A process of snowball sampling was also employed for the recruitment of study participants (Patton, 2002). Both eligible and ineligible participants shared their experiences with peers and referred them to the researcher. A total of 15 individuals were referred to the study through snowball sampling.

**Negotiating Entry**

The investigator had not lived in Jamaica for over a decade. Therefore, developing better insight into the culture and society was paramount to the success of the research project. The investigator began his fellowship by negotiating and maintaining entry into the culture and society upon arrival in Jamaica. This involved attending classes on gender and sexuality within the Caribbean at the University of the West Indies. This course allowed the researcher to learn more about the Caribbean, more specifically, Jamaican culture. In addition, the investigator attended student group meetings on campus. Some of these groups discussed issues related to JMSM lives and experiences. Interestingly, one particular group was exclusively created to provide resources, advocacy, and support to young LGBT professionals. Other activities included attending social events within the community, such as intimate social gatherings, which are known locally as limes. These social gatherings provided the investigator with the unique opportunity to meet a wide range of young, professional, university-educated, and
middle-income men. In order to broaden his experience with different sub-communities of JMSM, the investigator sought out and attended several local outings (out-door night clubs) catering towards MSM. These events further broadened the exposure and the possibility of meeting young men from different income and educational backgrounds. Finally, through the professional contacts provided by Dr. Dunn’s office, the investigator was able to connect with officials from Jamaica Theological College and the National Family Planning Board, a subsidiary of the Jamaica Ministry of Health, with whom he engaged in meaningful conversation regarding the plight of MSM in Jamaica. This process of integration and negotiation of entry continued throughout the data collection and analysis phases of the study.

**Settings**

The parishes of Kingston and St. Andrew were the primary sites for study recruitment. Throughout the literature, much of the research on JMSM has been concentrated in tourist dependant areas such as Ocho Rios, Montego Bay, and Negril. Participants from these areas might share experiences unique to persons living in those areas and thus, might not be expected to provide a broad range of insights into the lived experiences of other YJMSM. Additionally, since Kingston is the largest city on the island, many MSM have migrated there from rural parishes in order to seek better economic and educational opportunities.

At the study conception phase, two community-based organizations (CBOs) that work specifically with JMSM were targeted as primary venues for recruitment: Jamaica AIDS Support for Life (JASL) and the Jamaica Forum for Lesbians, All-Sexuals, and
Gays (J-FLAG). JFLAG was later identified as an advocacy organization for the LGBT community in Jamaica that did not provide direct or indirect clinical services to individuals. Although the site was not used for recruitment, with their verbal permission, posters were still made available to the site and staff were able to refer participants to the study. Ancillary venues included the campus grounds of the University of the West Indies (i.e., outdoor areas, the chapel, and an office space in the Institute of Gender and Development Studies) and the Emancipation Park in New Kingston.

Participants who were screened and deemed eligible for participation in the study chose where they would like their interview to be conducted. In order to provide convenience and safety, the researcher made two choices available. These were the University of the West Indies (UWI) or an exam room in the clinic of JAS. Due to unforeseen circumstances a month after initiating data collection, JAS was no longer a viable site for study interviews. The staff notified the investigator that they were leaving the property and did not have a new location. On the day of becoming aware of this change an interview was to be conducted at the JAS clinic. Without notice, this interruption forced the investigator to conduct one of the interviews at a local park, Emancipation Park. Though the park was a safe space for the interview, winds and pedestrian foot traffic were distractions. No other interviews took place at that location. Due to the sensitivity and complexity of the topic the balance of the formal interviews of participants were conducted in a safe space at the University of the West Indies. This guaranteed the safety of both the participants and the researcher. Additionally, a Jamaica
Constabulary Force (police) substation on the university campus was available to provide assistance if there was a need.

**Recruitment Strategies**

Both the University of Rochester Research Subjects Review Board (RSRB) and the University of the West Indies Ethics Committee granted approval to recruit participants in the following ways: 1) Ethics Committee and RSRB approved posters and business cards, 2) direct/in-person recruitment from the University of the West Indies community and a local CBO, JASL; and 3) peer referrals.

The poster for the study was titled “Understanding the Sexual Health of Jamaican Men” (see Appendix B). This title was chosen as it made the study seem more general than it was. It was the investigator’s goal to go into details after interested participants contacted him for more information. Not mentioning that the study was specifically designed for MSM was a protective measure to avoid inadvertent disclosure. Additionally, the level of homophobia in Jamaica would have ensured that the posters would have been vandalized (torn down; defaced). The poster included a brief study description, what was expected of study participants, and the email and phone number of the study contact person (see Appendix I). Flyers were posted at JASL, JFLAG, Institute for Gender Development Studies (IGDS), and the UWI health center.

Direct recruitment of participants was undertaken in multiple ways. First, the investigator attended several social events frequented by JMSM. During these social events, he introduced himself as a doctoral candidate at the University of Rochester, School of Nursing, and a visiting Fulbright scholar at the University of the West Indies.
Institute for Gender Studies. He discussed the research by explaining the purpose, design and methods of data collection, and principles of informed consent, and answered questions raised by expressing interest in the project. Business cards bearing the contact information (including the study phone number) of the investigator were distributed to interested individuals. Those who were not interested were thanked for their time. This process yielded a significant number of interested persons and over 50 business cards were distributed. The second part of direct recruitment involved giving business cards to acquaintances, key informants, and community leaders from JASL (such as CBO team leaders). When interested participants contacted the study phone number they were asked how they became aware of the study. The final phase of direct recruitment involved attending and recruiting potential participants from Jamaica Red Cross sponsored HIV testing sites. Interested participants were provided with additional information, screened, and, if eligible, offered to schedule a time for participation in the study. They were also given two to three business cards along with a study flyer to share with their peers. No compensation was provided for referrals made. Through this process a significant number of interested persons contacted the study phone number for screening.

**Eligibility Screening**

Interested participants were instructed to contact the investigator using the study phone number to complete the screening process. Some participants completed this through direct face to face contact with the investigator (e.g., the JAS clinic). Those persons who were screened onsite and were deemed eligible were given the opportunity
to be interviewed immediately or at a later date. The study screening form was created to
standardize the eligibility process (see Appendix A). Each section of the screening form
had a script which was read to potential participants. Eligible participants were assured
that participation in the study was voluntary and that they could withdraw at any time
without fear of reprisal. Ineligible participants were told to contact the investigator if
anything changed for them in terms of the inclusion criteria (i.e., after their 18th birthday
or becoming sexually active with another man).

**Remuneration**

All participants were given an honorarium of $1,800 Jamaican dollars (the
equivalent of $20.00 US) for completing the one-on-one interview and all survey
materials. Those who participated in the focus group were remunerated an equal amount
of $1,800J for completion of the focus group discussion and individual survey
instruments. These figures were based on the current exchange rate at the time of
recruitment. Fluctuation of the exchange rate throughout the data collection period was
minimal and, thus, revision in the amount of the honorarium was not required. This small
remuneration was given to each participant for their time and for transportation to the
interview location. After receiving these funds, all participants were asked to sign a two-
page carbon copy receipt. This receipt included the full name and signature of each
participant. All receipts collected were stored in a locked cabinet at the University of the
West Indies Institute for Gender Development Studies Unit. They were later destroyed
upon the investigator’s return to the United States.
Reciprocity/Community Service

As reciprocity for the assistance and support received from the various entities within the Jamaican community, the researcher provided technical assistance and capacity-building training to the community-based organization, Jamaica AIDS Support. The investigator conducted a one-day life skills course for persons newly diagnosed with HIV and those who are at risk of HIV transmission. The information provided in this one-day course was general and covered topics such as HIV (CD4, viral load, and treatment), STDs (primary, secondary, and tertiary prevention), Hepatitis (A, B, and C), Healthy Living, Life Skills, and planning for the future. In continued work with the organization, the investigator attended and participated in field outreach work with members of the JAS staff. This work involved driving around the streets of Kingston delivering condoms and safe sex messages to commercial sex workers, and attending local exotic night clubs to provide pelvic exams, pap smears, and condoms to dancers within those establishments. The investigator continued his engagement with this organization and assisted as new needs arose. This collaboration allowed the investigator to forge a sustained relationship with the organization while gaining access to participants for the study.

In addition to working with non-governmental organizations, connections were made with the Gender and MSM coordinator at the Ministry of Health. Though the investigator was not able to volunteer with the Ministry, the research project and opportunities for dissemination of study findings were discussed.
Protection of Human Subjects

The study was reviewed and approved by two independent institutional Human Subjects Review Boards, The RSRB of the University of Rochester and the Ethics Committee of the University of the West Indies, Mona Campus Unit (see Appendix C). The RSRB of the University of Rochester classified the study as minimal risk of harm. The UWI Mona Ethics Committee classified the study as moderate risk of harm, due in part to their concerns over the topics to be discussed with participants during the interview (see Appendix D). These concerns were addressed by adding additional support (psychologist through JAS) for those participants who manifested or presented signs of emotional distress.

Loss of Confidentiality and Distress. There were several risk factors identified as areas of potential concern. Potential risks for participating were: (a) breach of confidentiality for participants, (b) a lengthy interview process that might result in participants becoming fatigued, (c) the potential for the participant’s sexuality to be exposed as a result of associating with the investigator or participating in the project, and (d) emotional distress, brought on by evocation of feelings, thoughts, and experiences around JMSM culture, sexuality, HIV stigma, and discrimination.

Mitigation of Risk. An investigator is always charged with the responsibility of protecting the participants in a study. As a result, several measures were used to minimize any potential risk of participating in this research project. To reduce the risks identified above, the investigator offered several options for interview locations to participants. Participants had the options to be interviewed at the following locations: (a)
a private clinic on the grounds of Jamaica AIDS Support for Life, (b) a private office space in the Institute of Gender and Development Studies on the UWI campus, and (c) a private office space in the library (if they were a current student at the university) or on the grounds of the UWI campus. After a month of initial interviews, all subsequent interviews took place on the campus of the UWI. These spaces provided privacy to all interview participants.

The issue of confidentiality was a major concern for both the researcher and the participant, as a breach of confidentiality could result in dire consequences. Confidentiality was safeguarded through each step of the research process. The investigator had sole responsibility for the collection and storage of data, which included participants’ contact information, audio-taped interviews, transcription and transcripts of interviews, and field-notes generated by the investigator.

To reduce the risk of breach of confidentiality, the investigator was the sole person who determined how interview transcripts were handled. A transcription service offered through the Department of Government at UWI was employed to transcribe several of the interviews. As it was made clear to the investigator that some employees of the transcription service were current university students, no interviews involving current students were referred to that service; instead the investigator transcribed those interviews. Audio recordings of each interview were de-identified and encrypted to minimize disclosure prior to releasing them for transcription.

All study materials were kept in a separate secured location at the University of the West Indies, in a locked file cabinet. Only the investigator had access to this cabinet.
Personal contact information (such as name, address, and phone numbers) and signed consent forms were also kept in a secured location and locked file cabinet separate from study materials. All these materials were packaged and shipped via FedEx back to the United States upon completion of the study. After returning to the United States, this information was kept in a locked space in the investigator’s office. As per the RSRB protocol, they will be kept for a period of three years after completion of the dissertation project. Participants were made aware of all these safeguards to confidentiality during the informed consent process and after each interview.

Before deciding to participate in the study and as part of the screening process, participants were informed that participation in the study consisted of the completion of two survey instruments and an interview lasting up to two hours. At the beginning of the session, survey instruments were administered first, followed by the semi-structured interviews. To reduce fatigue, breaks were offered to each participant.

Though there were concerns around disclosure of participants’ sexuality by being associated with the project or the investigator, safeguards were put in place. When a research participant arrived on the campus of the university he was given the option of having the investigator meet him at the transportation center to escort him to the interview location or be given directions directly to the interview site. This safeguard allowed the participant to decide whether or not he wanted to be seen with the investigator in public.

Because of the sensitive nature of the topics discussed during each interview, the investigator was aware that some participants might demonstrate or exhibit some form of
emotional distress during the interview. For some, the interview was the first time that they were sharing this aspect of their lives. All participants demonstrated eagerness in sharing stories about violence from members of society, alienation from their family members, and instances where they had experienced stigma and discrimination, which could have brought on mild emotional distress (i.e., crying). Rather than causing emotional distress, however, the interviews appeared to be cathartic and were welcomed as a source of release. Even though no participants reported, nor did the investigator observe any discomfort, breaks were offered during each interview. Moreover, participants were reminded throughout the interview that participation was voluntary and that they could withdraw at any time from the study.

The investigator is a licensed Registered Professional Nurse with six years of experience and a Family Nurse Practitioner with over three years of experience working with and diagnosing MSM with HIV and other STDs in the United States. During his training, he completed several rotations that included mental health and infectious disease experience. In addition, he also completed a year-long fellowship in adolescent health and medicine. A significant portion of his clinical responsibilities included providing emotional support to individuals after receiving uncomfortable news. As already described, no participants became visibly upset during the interviews; however, if they had done so, the investigator was well equipped to provide emotional support. If the emotional support offered was deemed adequate, the investigator then would have asked for the interviewee’s permission to move forward. If the emotional support offered by
the investigator was deemed inadequate by the interviewee, the investigator would have provided referrals for clinical support, a resource which was already in place at JASL.

**Informed Consent.** The University of Rochester Human Subjects Review Board (RSRB) and the University of the West Indies Ethics Committee approved the interview consent forms used in the study (see Appendix D). Per the Ethics Committee’s request, a separate consent form was created for those recruited for the focus group (see Appendix E). Most participants’ screening took place over the phone. Participants who met study eligibility criteria were subsequently consented on the day of their interview with the investigator. They were given an opportunity to read the consent form. However, not making assumptions as to the literacy levels of the participants, the investigator also read the contents of the form aloud before asking the participants to sign. This increased the likelihood that all aspects of the consent form were understood and that each participant was aware of his rights as a study participant. Two copies of the consent form were given to each participant for their signature. One copy was issued to the participant and another copy was retained by the investigator. Some participants refused to keep their copy because of the content on the form; they were afraid that persons might intercept or see the form and openly discriminate against them. These fears were alleviated by allowing them to at least have available the contact information (i.e., cellular phone number and email address) of the investigator.

**Resource Guide.** Because many MSM may be unaware of the resources available within their own communities, the investigator developed a resource guide which was distributed to all persons (usually at their initial eligibility screening)
regardless of their participation in the study. The resource guide included information on locations on the island that offered free or low-cost STD/HIV testing and treatment, identified “MSM friendly” medical providers and members of the clergy who were MSM friendly, and law enforcement (victims’ rights advocates). The guide also included information on men’s health maintenance issues such as self-administered testicular examination, genital, and anal health (see Appendix F).

**Instruments and Surveys**

A questionnaire packet was created to collect general information from each participant (see Appendix G). This packet included two survey instruments: (a) demographic/behavioral (sexual) survey (Wharton, 2013), and (b) the HIV Knowledge Questionnaire for Young Men of Color who have Sex with Men (Fields, 2005). All questionnaire materials were self-administered using paper and pencil. They were reviewed for missed items after completion by the participant. Surveys with missed items were returned to participants for their completion.

**Demographic and Behavior Survey.** Developed by Wharton (2013), the demographic and behavioral survey addressed four topic domains: (a) General Demographic Information, (b) Education and Income, (c) Sexual Identity, and (d) Relationship and Sexual History (see Appendix G). General Information contained five areas including the age of the participant, the parish in which he was born, place of current residence, religious or spiritual background, and hobbies or extra-curricular activities. The Education and Income section included questions about levels of education completed, current enrollment in school, and sources of primary and secondary
income. The Sexual Identity section asked participants to describe their sexual identity in their own words; mark on a visual analog scale with an X to rate their biological sex, gender identity, gender expression, and sexual orientation. These questions allowed the participant to indicate whether he identified as male or female, expressed his gender as masculine or feminine, was attracted to women or men, and if he was currently having sex with men or women. The Relationship and Sexual History domain included questions about age of first sexual experience, types of relationships and current relationship status; sexual behaviors, frequency of each behavior (last sexual encounter, past 30 days, 3 months, and 12 months). This domain also included questions about condom use history, types of condom used, history of forced intercourse and sexually transmitted infection history.

**HIV-Knowledge Questionnaire.** The HIV Knowledge Questionnaire (HIV-KQ) was developed as a self-administered tool to assess knowledge regarding HIV/AIDS in populations with low literacy skills regardless of their age, gender, sexual orientation, or level of education (Carey, Morrison-Beedy, & Johnson, 1997). The HIV-KQ is a 45-question instrument. Respondents answered each item using the following options: “true,” “false,” and “I don’t know.” Responses that were “true” were scored as correct, while “false” and “I don’t know” responses were scored as incorrect. The internal consistency of the original instrument had a Cronbach’s alpha of .91 and was stable at 1, 2, and 12 week intervals (Carey, Morrison-Beedy, & Johnson, 1997). In addition, the instrument had been tested across many social groups (i.e. African American women, young adolescent girls, and illicit drug use populations) and was deemed valid (Carey,
Morrison-Beedy, & Johnson, 1997; Volpe, Nelson, Kraus, & Morrison-Beedy, 2007). The 45-item instrument was later adapted for use among Young Men of Color who have Sex with Men (Fields, 2005).

**Adaptation of the HIVKQ-45 for Young MSM.** Fields’ (2005) adaptation of the HIV-KQ for YMCSM used a sample of two diverse focus groups to elicit HIV knowledge (see Appendix H). Items specific to female gender were eliminated. Items that were added included: (a) “men who only practice ‘topping’ cannot get HIV,” (b) “a person can get HIV from ‘rimming/tossing salad’ (inserting your tongue into or licking another’s anus),” (c) “getting fisted (having a person’s hand inserted into your anus) increases your risk of getting infected with HIV,” and (d) “men who only practice ‘bottoming’ (having a penis inserted into your anus) cannot get HIV.” The aim of these new items was to capture potential gaps or myths around HIV knowledge among young men of color who have sex with men (Fields, 2005). Due to the small sample size, as reported by Fields, reliability and validity analyses were not conducted. Content validity was established by use of the focus groups (Fields, 2005). Due to its limited psychometric testing, Fields noted that use of this instrument to other cultures/subcultures of YMCSM should be undertaken with caution (Fields, 2005). Evidence of reliability and validity is paramount in assessing the usefulness of any instrument. This caution is important and relevant to researchers who are conducting research with ethnic minorities, more specifically Jamaican MSM. Due to the complexities of colloquial language, words and phrases may be misinterpreted, which may interfere with an accurate interpretation of survey items and erroneous scoring or results. For this study, the adapted instrument for
YMCSM was used. It was used because it was the only instrument available that assesses specific HIV knowledge of young MSM of color.

**Interview Guides**

Interviews were the primary sources of data for this study. Two interview guides were developed to fulfill the study’s main objectives, one for use in the individual interviews and the other for use in the focus group interview (see Appendix I and J). The interview guides provided structure, ensuring that the investigator adhered to the main objectives of the study and that all participants were interviewed in a consistent manner.

The individual interview guide (Appendix I) began with an introductory script, which was read to every participant before they were asked initial questions. Following the script were fifteen sections with multiple questions: (a) Warm-up Questions- Getting to Know You, (b) Sexual Identity Development, (c) Experience in Educational Institutions, (d) Maleness and Masculinity, (e) Cultural Influences around Sex and Sexuality-Based Violence, (f) Religion, Faith, Spirituality, and Attitudes towards MSM, (g) Music and Attitudes toward MSM, (h) Sexual History and Sexual Practices of MSM, (I) Self-maintenance and HIV Testing Practices of JMSM, (j) Protective Factors of MSM and Strategies against HIV Risk, (k) Interactions with and Perceptions of HIV Positivity (Stigma and Discrimination), (l) Health Care Systems Utilization, (m) MSM Experience with Law Enforcement, (n) Community Environment and Personal Safety, and (o) Final Thoughts. Initial questions were broad and focused on less sensitive, general topics and issues. This allowed the investigator to build rapport with the participant prior to asking
more intrusive questions. For example, a general question, such as, “How are you doing?” or “What’s going on with you today?” was followed by more targeted questions, such as, “Tell me more about what it is like to be MSM living in Jamaica?” Through this approach the participants’ perspectives were elicited on what it is like to be MSM living in Jamaica and how that has influenced their decisions surrounding their sexual practices.

After completion of the individual interviews, a focus group interview guide (see Appendix J) was developed. The creation of this guide was based on themes and ideas generated from the individual interviews. The purpose of the focus group was to confirm preliminary findings, clarify conflicts, explore unresolved concepts from the individual interviews, as well as to gather new information regarding current developments that occurred post individual interview sessions. The focus group guide had twelve sections: (a) Relationship with Family and Community, (b) Experiences in Educational Institutions, (c) Religious, Faith, Spirituality, and Attitudes towards MSM, (d) Music and Attitudes towards MSM, (e) Keeping Safe in Jamaica, (f) Use of Social Media, (g) Terms used to Identify MSM, (h) Role Models, (i) Health Care Systems Utilization and Mental Health, (j) MSM Experience with Law Enforcement, (k) Wanting to leave Jamaica, and (l) Final Thoughts.

Process of Data Collection

Along with demographic information, the researcher used the following methods of data collection: participant observation of JMSM in their social spaces, participation in the research setting, analysis of documents and materials within the culture (Streubert-Speziale & Carpenter, 2003; Portney & Watkins, 2009).
In an effort to maintain consistency, a detailed process for data collection was employed by the investigator. The process applied to both individual and focus group participants. To determine eligibility, every potential participant was first screened. Screening was conducted by having the potential participants call the study cellular number or by meeting in person with the investigator. For those participants who were screened over the phone and deemed eligible, an appointment was made for them to meet with the investigator to complete the study materials. For those who were screened in person by the investigator, study materials were presented shortly after. The consent form was presented first to the participant. It was read, reviewed, and signed by both the investigator and the participant. Prior to receiving the quantitative instruments, a four digit identification code was assigned to each individual survey instrument. For example, a code of 0001, which denoted the first participant, was used for identification instead of his name or any other identifier. This was followed by the completion of the demographic and behavioral survey, using paper and pencil. Then the HIV-KQ for YMCSM was presented for completion. While the participant was completing the HIV-KQ the investigator reviewed the demographic and behavioral instrument for missed items. If missed items were noted the investigator asked the participant to complete the forms. This process of review by the investigator ensured that there were no missing items. The individual interviews and focus group discussions began shortly after all study paperwork was completed. Each interview and focus group discussion was audio recorded. At the conclusion of the interviews and focus group, participants received the honorarium and signed a receipt. At the completion of each participant encounter, the
investigator recorded his impressions in the form of field notes. These field notes captured his immediate impressions and reactions to each interview.

Digital audio recordings of interviews were uploaded to the investigator’s computer. Ten interviews were transcribed by the investigator; the remaining were transcribed by a transcription service and were later reviewed by the investigator. Interviews were transcribed within 24-48 hours after completion. This allowed the investigator to cycle back and forth in the data in order to identify themes while creating strategies for collecting new information from future interviews. This iterative process assisted the investigator in revising the interview guide for future interviews. Interviews were transcribed verbatim and “cleaned”/checked for accuracy. Transcriptions that were done by someone else rather than the investigator were checked for accuracy. Field notes, which included the investigator’s impressions, notes about the environment, and non-verbal communications, were recorded after each interview and were kept with the interviewer (Lee, 1995; Sanjek, 1990).

Observational Milieu

The investigator arrived in Jamaica in September, 2012, as a United States Fulbright Fellow. The purpose of the fellowship was to conduct a research project while promoting mutual cultural understanding between the two nations, the United States and the Island of Jamaica. The purpose and context of the cultural exchange was up to the investigator and was not prescribed by the U.S. government. Upon arrival on the island, the investigator attended a debriefing session at the U.S. Embassy in Kingston. During this session he was made aware of several security concerns and provided with a
mechanism for ensuring his safety. He was also presented with the emergency contact information of key Embassy officials.

Following his visit to the U.S. Embassy in Kingston, the investigator met with his Fulbright sponsor and local supervisor, Dr. Leith Dunn, the Head of the Gender and Development Studies Unit at the University of the West Indies, Mona Unit. The Investigator had sought and obtained Dr. Dunn’s patronage over the year prior to his arrival. He had visited the university on many occasions over a period of 2 years in order to establish a collaborative partnership. Dr. Dunn’s office connected the investigator to the relevant offices on campus, such as the ID office, housing office, library services, and International Students Office. These offices assisted the investigator in settling into the environment.

Although the option of residing on campus was presented to the investigator by the International Students Office, the investigator declined and chose to live off campus. By living in the community, the investigator was able to meet and interact with a more diverse set of persons. This allowed for a better appraisal and appreciation of the culture. In addition, this allowed for the researcher to fulfill his commitment to mutual cultural understanding (learning about the Jamaican culture while sharing his American culture with key informants) as suggested by the Fulbright scholars program. The investigator was also able to be within walking distance of the community agency, Jamaica AIDS Support.

Observation involves the systematic noting and recording of events, behaviors, and artifacts in the social setting (Streubert-Speziale & Carpenter, 2003; Patton, 2002;
Participant observation is when the researcher spends a considerable amount of time within the setting to learn what it is like to live in the culture of interest (Marshall & Rossman, 2006; Patton, 2002; Portney & Watkins, 2009; Spradley, 1980). By living in the community the investigator established friendships with local MSM, received invitations to social events hosted by MSM, and volunteered at a local AIDS service organization. Continuous immersion in the culture allowed the investigator to learn what it was like to live in Jamaica and to also learn from his own experiences of being in the culture. The investigator became close companions with key informants and as a result continued to receive invitations to social events and places frequented by MSMs. The goal was to observe a wide range of events, so no predetermined checklist or categories were created (Marshall & Rossman, 2006).

Preliminary observations of these events informed all aspects of the research investigation. Upon generating the interview guides, feedback was solicited from Dr. Dunn, staff from JAS, key informants, other members within the community, and the dissertation committee. Once finalized, the interview guide was submitted in January 2013 along with other study materials to the Ethics Committee for members’ approval. Interviews began shortly after receiving confirmation of approval from the RSRB and the Ethics Committee.

Young JMSM were interviewed over a period of four months, from March, 2013, to June, 2013. A majority of the study participant referrals were from prior participants. The investigator received feedback regarding length of time, structure of the interview, and the personal nature of some of the questions asked during the interview from
participants. Several persons expressed concerns that perhaps the one to two hour time commitment was too long. Others noted that they liked the structure and personal nature of the interview and interview setting. Although a few personal questions were asked, participants did not express major objections to them. In fact, they all expressed gratitude and thanked the researcher for asking those questions, as for some this was their first time expressing their sexual behavior risk to anyone.

Throughout the interviews, the investigator allowed participants to express themselves freely without reservations. For example, if they wanted to curse or use swear words, this was allowed. This also provided further comfort to participants knowing that it was a judgment-free environment. To most, it was a cathartic experience. At the end of the interview, participants were asked for their final thoughts or if there were other things they wanted to share that the investigator may have missed. At this point, two-thirds of the sample inquired about the sexual orientation of the investigator. With further probing it was determined that their curiosity stemmed from a level of comfort. Some stated that perhaps they would not have participated if they did not feel comfortable or if the investigator did not look like them. The fact that the investigator could have related to them in patois made them even more relaxed. This proved to be useful as there were three to four individuals who found it difficult to communicate in Standard English.

The living/life situation for many of the participants varied across the sample. Homelessness, unemployment, dependency on family or friends, and survival and transactional sex was common for some; however, others had stable homes. In addition
many participants disclosed histories of suicidal ideation, depression, anxiety disorders, and self-mutilating behaviors (e.g., cutting). In fact, one participant explained that he engaged in cutting to relieve the pain from the discrimination he faced within the society. He also presented his arms to the investigator to give evidence of this behavior. As the investigator is a Nurse Practitioner in the State of New York, an assessment was made as to whether further intervention was needed. The participant reported the behavior was in the past. Although he was offered information for a mental health specialist at JAS, further intervention was declined.

Data Analysis

Quantitative Data. Since participants completed the survey instruments using paper and pencil, each instrument had to be checked by the investigator for missing information before discharging the participant. Each file was kept in a secure location to be shipped via FedEx back to the United States at the end of data collection in Jamaica. Upon arrival in the United States, the investigator again checked each item for missing data before they were entered into the Statistical Package for the Social Sciences (SPSS) version 19 used for quantitative analysis. Descriptive statistics (frequency, mean, and standard deviation) were calculated for the demographic and behavioral survey items. The HIV-KQ was scored by the investigator and the data were entered into SPSS and analyzed using descriptive statistics.

Qualitative Data. As mentioned above, almost half of the twenty interviews were transcribed by the investigator. The remaining interviews were sourced out to a transcription service at the UWI to individuals who were trained in confidentiality and
human subjects protection concerns in research. A majority of the transcripts sent to the transcription service were from participants who felt comfortable speaking patois during their interview. Audio recordings were encrypted prior to being released for transcription. Since each interview was to be transcribed verbatim, the investigator determined that it was best to have those interviews transcribed by persons who could speak and write patois. Those transcripts were later reviewed along with the audio recording by the investigator for missed or inaccurate information. Inaudible sections of the interviews were highlighted with yellow and marked with a question mark (“?”). Interview transcripts were de-identified; however, they were labeled with the four digit identification assigned to each participant at the initial study encounter. Only the investigator knew the significance of the four digit number holder.

**Codes Extraction.** The computer program, ATLAS.ti (version 6.2; Scientific Software, Inc., Berlin) was used for qualitative analysis, which assisted creating, managing, and comparing codes across all interview transcripts. The program was installed on the investigator’s study computer and kept in a secure location at the University of Rochester. Code development was an iterative process and involved frequent consultation with dissertation committee members and other qualitative experts and persons who were familiar with the analysis software. Coding may be defined as tagging or assigning labels to words or phrases that represent an idea within the data, which may then give meaning or allow the investigator to draw inferences from the data (Patton, 2002). Codes that were generated with the first set of interviews were continuously evaluated as the analysis proceeded in order to ensure a rich and full
description of the codes. The initial step in code development was open coding. Open coding involves reviewing each transcript, selecting sections of text, and assigning a code to that text. A clear descriptor was assigned to each code after they were created. This process was continuous and occurred throughout the data collection process. The process yielded over seven iterations of coding and 168 codes. Codes were later compared for similarities; similar codes were redefined or combined with existing codes. Some codes were eliminated if they were redundant or had no clear meaning. A final open code list consisting of 100 items was retained. Additionally, the investigator continued to record his thoughts, impressions, and reactions to the data by writing field notes and recorded questions that emerged as memos (Sanjek, 1990).

**Theme Development.** Qualitative content analysis was used to identify themes and patterns in the data. This involved reading and re-reading the data, noting questions and impressions, making decisions about additional information that was needed and writing memos or analytical notes (Miles & Huberman, 1994).

After codes were identified and named, the investigator created categories for clusters of codes. These were called code families. Code families were reviewed for similarities and interconnectedness. This process yielded a total of seventeen code families. This list was later refined by reviewing each family for similarities and interrelationships. Redefined code families were later expressed as thematic statements. Seven thematic statements were ultimately created, supported by exemplar quotations. Throughout this process, qualitative experts were sought out for feedback and insight
regarding the created themes. The categories and themes used in the study were not predetermined.

A descriptive comparative matrix (see Table 3.1) was used to display the study’s findings, support a search for patterns, and build a logical chain of evidence supporting the interpretations (Miles & Huberman, 1994). By displaying the data in cells, the investigator was able to examine each case individually, making comparisons across cases for differences and similarities and assessing for trends. Miles and Huberman (1994) suggested using a case-ordered descriptive matrix in order to develop a substantive understanding of the themes across the different cases. Table 3.1 illustrates selected cases and examples. It does not include all cases.
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Sexuality</th>
<th>Who is important in your life</th>
<th>When I realized my sexuality</th>
<th>Experienced sexuality-based violence</th>
<th>Relationship with parents (bio)</th>
<th>Forced to have sex (ever) and with who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andre</td>
<td>29</td>
<td>Gay</td>
<td>Myself and God</td>
<td>4 years old (believed this was due to molestation)</td>
<td>Faced discrimination in public when with other feminine friends</td>
<td>Father passed on and mother lives in the states. Lived with other family members</td>
<td>Molested at 4, 8, and 12 years of age by older male cousin and aunt</td>
</tr>
<tr>
<td>Oshane</td>
<td>18</td>
<td>Gay</td>
<td>My grandmother</td>
<td>9-10 years of age after “ramping”/playing childhood games with a male cousin</td>
<td>Was mobbed attacked at the age of 16 while on his way home by older men in the community</td>
<td>Does not have a relationship with his father even though the father have a presence in the community…mother is present.</td>
<td>Never been forced to have sex</td>
</tr>
<tr>
<td>Steve</td>
<td>25</td>
<td>Gay</td>
<td>“Myself right now”… “I have no one else to look out for me”</td>
<td>7 years of age after “experimenting” with his male cousins</td>
<td>Had to leave his community multiple times due to his feminine behavior -sexually assaulted by multiple men on his way home from school</td>
<td>-Relationship with family is improving -went on the streets at the age of 15 due to the turbulent relationship with his parents</td>
<td>At the age of 14 he was a victim of an indecent assault. Was attacked at knifepoint by 4 men in a car (posing as a taxi). No arrest was made in the matter</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Where to meet potential partners to have sex</td>
<td>History with HIV testing and experienced with HIV+ persons</td>
<td>Interactions with Law Enforcement</td>
<td>Experiences with navigating health care services</td>
<td>How do you protect yourself in your community?</td>
<td></td>
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<tr>
<td>Andre</td>
<td>Through social media and male seeking male sites…often at their home</td>
<td>-First time getting tested was at 27y.o.</td>
<td>Negative interactions with law enforcement. Was openly discriminated against by an officer</td>
<td>Does have a personal doctor but “hates” him because he is often sexually inappropriate with him</td>
<td>Not hang out with openly gay men or those who are too “real” (feminine).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(29)</td>
<td>-Gay</td>
<td>-Does not like being around persons who are positive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oshane</td>
<td>Met partners through chat rooms on his phone and through social media</td>
<td>-First time getting tested was at the 17y.o.</td>
<td>Believed that the police was close by when he was being attacked and did not come to his aid</td>
<td>Does not have a regular medical practitioner…Only seek medical care when he wants to be tested for HIV</td>
<td>-Avoid large crowds -Not hanging with “real” men in public -Walk in large groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(18)</td>
<td>-Gay</td>
<td>-knew one person who is positive but does not have a relationship with him anymore</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Steve</td>
<td>-Engage in commercial sex work</td>
<td>Received his + results at the age of 15</td>
<td>Negative and positive. Police was helpful when he was the victim of an indecent assault. Faced discrimination as a sex worker</td>
<td>Faced no discrimination. Able to articulate his medical needs to staff. Is open about his orientation with medical team.</td>
<td>-Been living on the streets since age 15 -fled his community to avoid being attacked -refrain from wearing female attire in day light</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(25)</td>
<td>-Gay</td>
<td>-Meet potential partners on the streets</td>
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<td></td>
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</table>
Rigor

There are many perspectives and terms that are used to describe rigor and validity in qualitative research. Lincoln and Guba (1985) developed alternative terms as qualitative equivalents of traditional quantitative approaches to validation which researchers continue to use to describe how they addressed these issues. Thus, the measures used to enhance rigor in this research will be discussed in relation to these authors’ four criteria of trustworthiness: credibility (paralleling internal validity), transferability (paralleling external validity), confirmability (paralleling objectivity), and dependability (paralleling reliability).

Credibility

Credibility refers to the accuracy or truth value of study findings and their ability to provide evidence in support of the researcher’s interpretation of study results. In this study, credibility was assured by prolonged engagement in the field, persistent observation of the lives of JMSM, peer debriefing, reflective journaling, triangulation of data sources, and member checking (Creswell, 2007).

Prolonged Engagement and Persistent Observation involved establishing rapport with the study participants, understanding their culture and living environment, and building relationships with trusted community members. Steady and consistent immersion in the culture was essential to maintaining prolonged engagement. The investigator had been traveling to the island of Jamaica for a period of five years prior to the beginning of data collection. The investigator was also on the island for a period of ten months as a U.S. Fulbright Fellow to conduct the research study and also to promote
mutual cultural understanding between him and the people of Jamaica. He attended several community events, volunteered at an HIV/AIDS service organization, led MSM support group meetings at JAS, and participated in an HIV testing initiative sponsored by the Jamaica Red Cross. Through these exposures, the investigator was able to engage with multiple segments of the population (including subcultures of MSM). The investigator visited and explored locations across the island (Kingston, Montego Bay, Negril, Ocho Rios, and Portland) that are known to be frequented by MSM. During this time he interacted with the population of interest and participated in cultural events and celebrations while documenting his observations in the form of field notes. Observations were recorded before, during, and after each interaction.

**Peer Debriefing** involves presenting study findings to others in an effort to clarify inferences that have been made and to invite other viewpoints beyond those of the investigator. Allowing for scrutiny of findings by the investigator’s peers “provides an external check of the research process” (Creswell, 2007, p. 205). Peer debriefing was initiated in Jamaica from the moment data collection began. Twice per month, the researcher would teleconference through a web-based application, Skype, to a peer led “Qualitative Methods Discussion Group” (QMDG) in the School of Nursing at the University of Rochester. This group is headed by a senior qualitative faculty member and is comprised predominantly of doctoral students in various levels of their program. The group meets on a weekly basis throughout the semester including the summer months. Each week, doctoral students take turns presenting their projects, findings from their research, or manuscript ideas to the larger group. This environment provides an
opportunity for true debriefing with the investigator’s peer colleagues. The investigator has been a member of this group since 2010. Initial codes, categories, themes, and other ideas were presented to this group by the investigator throughout the year of data collection and analysis. In addition to the QMDG, the investigator also participated in routine meetings with the members of his research team.

**Reflective Journaling** was used to address the issue of researcher bias. This was one of the most challenging issues for the investigator, as the country of interest was also his native country. The investigator’s preconceived thoughts and feelings regarding the population of interest provided some insight into the phenomenon; however, this did not inhibit his ability to remain objective. Although difficult, it was important for the investigator to bracket his assumptions so he could view the data objectively. Therefore, identifying and addressing issues of bias was a constant focus. The investigator attempted to mitigate his biases by: (a) engaging in frequent reflexive exercises, (b) consulting consistently with his local supervisor and other members of the research team for clarifications, (c) and acknowledging his personal experiences and connection to the population. Additionally, because in-depth interviews were the primary mode of data collection, the researcher attempted to not interrupt the participant with his own personal experience. This is was the opportunity for participants to share their experiences and for the investigator to listen. The investigator validated their experiences by demonstrating empathy and creating a supportive environment.
**Triangulation of Data Sources** was built into the design of the study. In data triangulation, the researcher employs the use of multiple sources of data in order to provide a clear and accurate representation of the phenomenon (Creswell, 2007). In this study, information was obtained from individual participants, field observations, a focus group interview, and informal discussions with key informants. Additionally, data were collected through surveys, semi-structured interviews, and field notes. Survey data provided demographic information, HIV knowledge, and the current sexual behaviors of the sample. Interview data provided content-rich information regarding the experiences of each participant. Participants were able to express their thoughts, feelings, and perceptions in their own words. Field notes were generated as an outlet for the investigator to express his thoughts and ideas as well as a way to record and keep track of events that occurred throughout the data collection phase. Focus group discussions allowed the investigator to re-present study findings to participating members of the population in order to corroborate study findings. The investigator underwent tremendous scrutiny from members of his research team, from the inception of the research to its conclusion. Throughout the design process, feedback and suggestions for improvement were offered and inferences made throughout, data collected also received thorough examination by members of the investigator’s dissertation committee, peers, QMDG, and young JMSM. Suggested changes were reviewed and incorporated into the analysis.

**Member Checking** involved taking study findings or interpretations of the data back to the original group, stakeholders, and community members for confirmation of
accuracy and plausibility (Polit & Beck, 2008). This process allowed for corrections and often provided new insights. Members of a focus group, which consisted of a total of ten not previously interviewed MSM between the ages of 18 to 25, were asked to offer insights about presented study findings and provide new information, if necessary.

**Transferability**

Transferability involves providing sufficient information that will allow readers of study findings to determine the extent to which the knowledge is applicable to similar human situations. According to Lincoln and Guba (1985), “the naturalist cannot specify the external validity of an inquiry; he or she can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility” (p. 316). It is the duty of the researcher to provide rich descriptions which allow the reader to decide if the study findings are generalizable to other similar populations of interest (Creswell, 2007). In this study, transferability was enhanced by in-depth field notes, data saturation, and vivid descriptions (Lincoln & Guba, 1985; Polit & Beck, 2008). Specifically, comprehensive field notes containing extensive descriptions of participants and the study setting enabled the investigator to track and validate his thoughts and observations over the course of the study. Data collection continued until no new information was obtained and the code categories were judged to be saturated. The investigator also conducted negative case analysis, which involved seeking and reviewing cases in which the views of some participants were different from the majority. These measures ensured that the collected
information fully described the phenomenon of interest and that data quality would be able to support vivid, detailed description.

**Confirmability**

Confirmability, paralleling objectivity is demonstrated by providing evidence that reported findings and interpretations are grounded in the data. Throughout the research, safeguards were put in place to control for bias and personal opinions on the part of the investigator and to ensure that participants’ perspectives were expressed as they were presented (Polit & Beck, 2008). Meticulous documentation (i.e., an audit trail) further ensured confirmation of auditability of the research process from the inception to the end of the study.

**Dependability**

Dependability (paralleling reliability) refers to the ability of the researcher to account for changing conditions in the phenomenon of interest (Lincoln & Guba, 1985). In this research, dependability was demonstrated by careful maintenance of an audit trail that included retention of all the materials produced for this study. Materials retained include: (a) literature search articles, (b) study protocol, (c) interview guides, (d) consent forms, (e) receipts, (f) eligibility screening forms, (g) instruments used in the study, (h) all notes and written feedback received during the QMDG meetings, (i) field notes, (j) memos, and (k) audio recordings of all interviews and their corresponding transcripts.

**Study Timeline**

The first three Chapters of the dissertation were completed and submitted to the three member committee in November of 2012. The dissertation proposal was
successfully defended on December 6th, 2012. Study materials such as the study protocol, consent forms, and interview guide were submitted to the both the University of Rochester Research Subjects Review Board and the Ethics Committee of the University of the West Indies in January of 2013. While the RSRB at the University of Rochester granted approval after three weeks of submission, the Ethics Committee took several months and requested further revisions before the study was approved. The study was approved by the Ethics Committee in March of 2013. Recruitment and data collection were initiated in March of 2013, shortly after Ethics Committee approval was granted. Individual interviews continued for four months, from March 2013 to June 2013. The focus group was conducted on June 20th, 2013 shortly after the completion of all individual interviews. This concluded data collection. Data analysis began immediately after the conclusion of the first interview, continued through the fall of 2013, and was concluded with the preparation of this document. A total of one year was required for data collection, analysis, and preparation of this manuscript.

**Summary**

In conclusion, rigor in qualitative research is established through an attempt by the investigator to truthfully describe the findings as presented by the participants and to put safeguards in place that demonstrate credibility, transferability, confirmability, and dependability. However, he or she is not responsible for how the reported research findings are received. To this end, potential readers also have the responsibility to judge for themselves the credibility or plausibility of qualitative findings (Creswell, 2007;
Lincoln & Guba, 1985; Streubert-Speziale & Carpenter, 2003). Interpretations of research findings are always open to criticism by the consumers of such reports.

The investigator has another obligation, though, to those who, through their assistance and cooperation, have made it possible for the research to be conducted. At the completion of the dissertation project, the investigator will make plans to share the study findings with key stakeholders in Jamaica. During data collection, participants expressed interest in hearing about the results after the study is complete. On numerous occasions, several participants expressed concerns and discontentment with foreign-based researchers who had visited the island, asked them for their participation but never returned to share the results with the community. The investigator assured them that this was not his intention and that he was planning to visit Jamaica to share the results of the study. In addition to honoring the request of the participants, sharing the results will also allow for further feedback about the study findings prior to presenting the data at academic meetings.

It is the intention of the investigator to share the results of this study in the form of a poster or podium presentation at small and large scale academic meetings throughout the United States and the Caribbean. Thus far, the following scientific meetings have been identified as possible places for dissemination: the International AIDS conference to be held summer of 2014 in Melbourne, Australia, and the Caribbean HIV Conference, date to be determined. The researcher attended these two conferences in the past and found that they are suitable for dissemination of study findings as they are well attended by JMSM, members of the Jamaican community, and health care providers in Jamaica.
Other conferences of interest include the National African American MSM Leadership Conference on HIV/AIDS and other Health Disparities and the Center for AIDS Research at the University of Rochester. Manuscripts will also be submitted to peer-reviewed journals with audiences both in the United States and the Caribbean.
CHAPTER IV: Findings

The purposes of this study were to: (a) describe the sexual practices and behaviors of JMSM and their current level of knowledge about HIV, (b) describe their perspectives about what it is like to be MSM (gay, bisexual, or non-label affirming same-gender loving individuals) and living in Jamaica, and (c) to describe the protective factors and strategies used by JMSM to mitigate physical harm to their person and HIV risk.

The findings of this study, while based on the specific aims described above will be presented in three parts. The first part will focus on young Jamaican MSM knowledge about HIV. The second part will focus on the unique sexual behaviors of JMSM. The final section will describe the social and cultural context of the lives of young JMSM.

Demographic Characteristics

The study included 30 young Jamaican men who have sex with other men (JMSM). The demographic information for the participants is summarized in Table 4.1. The young men in the study ranged from 18 to 29 years of age, with a mean age of 22 (SD =2.8) years. Participants represented each year in that age group except for persons 28 years old. A majority of the sample (53%) were between the ages of 21 and 24 years. Parish of residency varied among the sample. Individuals who participated in the study were primarily from Kingston, St. Andrew, but also represented St. James, St. Catherine, and St. Thomas parishes. Consistent with the larger Jamaican society, a significant proportion of the sample reported Christianity (87%) as their religious affiliation. One participant did not indicate a religious affiliation, while some participants reported that they were either “spiritual” or atheist.
The sample was representative of individuals with varying levels of education: grade school, high school, college, graduate school, and vocational training. While a little more than half of the sample \( (n = 17/30; 57\%) \) reported completing some college, the remaining half reported current enrollment in a degree (Bachelors or Master’s) or certificate-granting program. Participants reported various documented and undocumented sources for their primary income. Some of these sources included: parents, panhandling (“begging”), legitimate employment (receipt of a paycheck), commercial sex work, and self-employment (web and fashion designing, dance instructor, and consultant). Income levels ranged from less than $15,000 to greater than $70,000 Jamaican per year. Some participants did not identify a primary source of employment \((n = 8; 26\% )\) or reported having no personal source of income at the time of the present study \((n = 6; 20\% )\). Of note, some of these primary income-generating activities may potentially place persons at risk for the acquisition of HIV infection.
## Table 4.1

**Demographic Characteristics of the Sample (N=30)**

<table>
<thead>
<tr>
<th>Variables</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (mean = 22.40 yrs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-20 yrs</td>
<td>8</td>
<td>26.7%</td>
</tr>
<tr>
<td>21-24 yrs</td>
<td>16</td>
<td>53.4%</td>
</tr>
<tr>
<td>25-29 yrs</td>
<td>6</td>
<td>19.9%</td>
</tr>
<tr>
<td><strong>Parish of Residency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. James</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>St. Catherine</td>
<td>7</td>
<td>23.3%</td>
</tr>
<tr>
<td>St. Andrew</td>
<td>5</td>
<td>16.7%</td>
</tr>
<tr>
<td>St. Thomas</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Kingston</td>
<td>16</td>
<td>53.3%</td>
</tr>
<tr>
<td><strong>Religion/Spirituality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>26</td>
<td>86.7%</td>
</tr>
<tr>
<td>“Spiritual”</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Atheist</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Levels of Education Completed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade School</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Some High School</td>
<td>8</td>
<td>26.7%</td>
</tr>
<tr>
<td>High School Diploma/GED</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td>Some College</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>Associates Degree</td>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>5</td>
<td>16.7%</td>
</tr>
<tr>
<td><strong>Primary Source of Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>26.4%</td>
</tr>
<tr>
<td>Parents/ Family</td>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>Panhandling ( “beg”)</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Employment (Receive a paycheck)</td>
<td>11</td>
<td>36.3%</td>
</tr>
<tr>
<td>Commercial Sex Worker</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>*Self-Employed</td>
<td>6</td>
<td>19.8%</td>
</tr>
<tr>
<td><strong>Income (in JA dollars) per year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than $15,000</td>
<td>8</td>
<td>26.7%</td>
</tr>
<tr>
<td>$15,000-$20,000</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>$20,001-$30,000</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td>$40,001-$50,000</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>$50,001-$60,000</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>&gt;$70,000</td>
<td>8</td>
<td>26.7%</td>
</tr>
<tr>
<td>No personal income at this time</td>
<td>6</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Note. Self-employment included persons who were independent consultants, dance teacher, hairdressers, web and fashion designer."
A visual analog scale was employed to assess five dimensions of gender and gender identity, sexuality, and sexual behavioral practices of JMSM. JMSM were given an opportunity to visually rate their biological sex (“their biological anatomy and hormones”), gender identity (“your sense of self”), gender expression (“how you present yourself”), sexual orientation (“your erotic attractions”), and sexual behavior (“who you have sex with”). These questions were relevant in understanding JMSM’s views of self and sexuality within the context of Jamaica’s patriarchal hyper-male masculinities. The averages and the ranges for each of these areas are listed in Figure 2.
Figure 2. Variations of Identity Development and Sexual Behavior of Young JMSM
Part I: HIV-Knowledge Questionnaire

Levels of HIV Knowledge

One aim of this research project was to describe the levels of HIV knowledge among this unique sample of young JMSM. General HIV knowledge may be attained by any individual, awareness of current HIV sero-status was not a factor reported for participation in the assessment of such knowledge. The knowledge assessment instrument used in this sample of JMSM was the adapted version of the HIV-KQ for young men of color (Fields, 2005). The mean score on the HIV-KQ for young JMSM was 77.6% correct (SD = 9.354, range = 42% to 91%). Accurate HIV knowledge clustered around general information regarding transmission and prevention. However, assessment of knowledge about specific sexual behavioral practices for MSM scored slightly lower, which may indicate a knowledge deficit when it comes to particular sexual behaviors (anal insertive and anal receptive sexual intercourse) of JMSM. Participants were aware of HIV symptomatology and that it is not possible to identify someone with HIV infection based on physical appearance. Respondents were also aware that HIV and AIDS were the same thing and rejected myths about HIV transmission (i.e., mosquito bites, sharing a glass of water, or sharing a hot tub with someone who is infected). Of the 45-item questionnaire, a total of nine questions had a correct response rate of ≥ 97% (see Table 4.2).
Table 4.2

<table>
<thead>
<tr>
<th>% Correct</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>3. A person can get HIV from a toilet seat.</td>
</tr>
<tr>
<td>100%</td>
<td>7. A person can get HIV by sharing a glass of water with someone who has HIV.</td>
</tr>
<tr>
<td>100%</td>
<td>22. Men who only practice “topping” (inserting their penis into another man’s anus) cannot get HIV.</td>
</tr>
<tr>
<td>100%</td>
<td>33. Having sex with more than one partner can increase a person’s chance of being infected with HIV.</td>
</tr>
<tr>
<td>100%</td>
<td>35. A person can get HIV by sitting in a hot tub or swimming in a pool with a person who has HIV.</td>
</tr>
<tr>
<td>97%</td>
<td>1. HIV and AIDS are the same thing.</td>
</tr>
<tr>
<td>97%</td>
<td>13. Showering, or washing one’s genitals or private parts, after sex keeps a person from getting HIV.</td>
</tr>
<tr>
<td>97%</td>
<td>29. You can usually tell if someone has HIV by looking at them.</td>
</tr>
<tr>
<td>97%</td>
<td>42. A woman can get HIV if she has vaginal sex with a man who has HIV.</td>
</tr>
</tbody>
</table>

Several items on the HIV-KQ had a correct rate of ≤ 50% (see Table 4.3). These items included knowledge deficits regarding conventional HIV prevention methods, vaginal intercourse, analingus (oral-anal intercourse), and treatment for AIDS. Participants’ performance on questions 8, 21, 25, 27, 32, 37, and 39 were poor. For question #8, which assessed whether “HIV was killed by bleach,” all participants in the study failed to answer this question correctly (n=30; 0%). Although questions about male latex condoms and vaginal condoms had some correct responses, question #25, which assessed knowledge about the use of a lambskin condom for protection against HIV, was answered correctly by only 47%. Knowledge about the use of lambskin condoms may be low for several reasons. For example, lambskin condoms may not be available in Jamaica for purchase or there might be a generational disconnect where older
persons may have had experiences using them. On several occasions, participants in the study asked the researcher to further explain what a lambskin condom was. When asked about the types of condoms they used, participants listed a wide variety, including Trojan, Lifestyle, Rough Rider, Slam, Intense, Durex, and Magnums. Although some participants elected to purchase their own condoms from pharmacies, supermarkets, and gas stations, other sources of condoms included community based organizations (CBOs), non-government organizations (NGOs), and government-operated health centers were listed as places to obtain free condoms and lubricants.

Question #39, “if a person tests positive for HIV, the test site will have to tell all of his or her partners,” was answered correctly only by 17% of participants. This indicated that the men in the study were unaware of the public health procedural implications of partner notification. This may also indicate that participants may be unwilling to seek testing due to the fear of their partners becoming aware of their diagnosis. Also of importance is the procedural process of blood donation. A total of 77% of participants believed that “a person can get HIV from giving blood.” The responses to these questions shed some light into the potential areas of educational improvement and remediation regarding current HIV knowledge deficits for young JMSM. These implications will be discussed in Chapter 5.
Table 4.3

<table>
<thead>
<tr>
<th>% Correct</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>47%</td>
<td>25. Using a lambskin condom is the best protection against HIV.</td>
</tr>
<tr>
<td>33%</td>
<td>37. A person can get HIV from the wetness from a women’s vagina.</td>
</tr>
<tr>
<td>23%</td>
<td>27. A person can get HIV from giving blood.</td>
</tr>
<tr>
<td>23%</td>
<td>21. Some drugs have been made for the treatment of AIDS.</td>
</tr>
<tr>
<td>17%</td>
<td>39. If a person tests positive for HIV, the test site will have to tell</td>
</tr>
<tr>
<td></td>
<td>all of his or her partners.</td>
</tr>
<tr>
<td>13%</td>
<td>32. A person can get HIV from “Rimming/Tossing Salad” (inserting your</td>
</tr>
<tr>
<td></td>
<td>tongue into or licking another’s anus).</td>
</tr>
<tr>
<td>0%</td>
<td>8. HIV is killed by bleach.</td>
</tr>
</tbody>
</table>

Part II: Sexual Practices of Young JMSM

Partner Types and Sexual History

Participants were asked to describe their own sexual identity. This free-text approach allowed participants to describe their sexual orientation in their own words. The majority of young JMSM (n = 18; 60%) identified themselves as “gay.” The remaining participants (n = 12; 40%) self-identified as “bisexual.” No other forms of sexual orientation were offered by the participants. These responses were recorded on the demographic and behavior survey also discussed in Chapter 3. During the individual interviews, the researcher further explored the participants’ understanding of “bisexuality.” Of note, most of these men had never had a physical sexual relationship with a woman at any point in their lives. For some, admitting to being bisexual was, in their mind, “safer” than self-identifying as “gay” or homosexual.

The age of first sexual experience varied for individuals within the sample (see Table 4.4). The reported mean age of sexarche (initial onset of sexual intercourse) for participants was 15.73 years of age (SD = 3.723; range = 7 - 24 years). For a majority of
the men in the study, their first sexual experience was with another male \((n = 26; 86.7\%)\). Often, first sexual partners were likely to be seven to ten years older, were a male family member (although one participant reported his first sexual experience with a female family member), close friend of the family, or someone they met through a social media platform. About a third of the sample of JMSM \((n = 9, 30\%)\) reported \textit{ever} having been forced to have sex with a male family member or close friend of the family.

Table 4.4

<table>
<thead>
<tr>
<th>Age of First Sexual Experience for JMSM</th>
<th>Frequency</th>
<th>Percent %</th>
<th>Cumulative Percent %</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old were you when you had your First Sexual Experience?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>3.3</td>
<td>6.7</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>3.3</td>
<td>10.0</td>
</tr>
<tr>
<td>12</td>
<td>2</td>
<td>6.7</td>
<td>16.7</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>3.3</td>
<td>20.0</td>
</tr>
<tr>
<td>14</td>
<td>6</td>
<td>20</td>
<td>40.0</td>
</tr>
<tr>
<td>15</td>
<td>2</td>
<td>6.7</td>
<td>46.7</td>
</tr>
<tr>
<td>16</td>
<td>3</td>
<td>10</td>
<td>56.7</td>
</tr>
<tr>
<td>17</td>
<td>4</td>
<td>13.3</td>
<td>70.0</td>
</tr>
<tr>
<td>18</td>
<td>3</td>
<td>10</td>
<td>80.0</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>3.3</td>
<td>83.3</td>
</tr>
<tr>
<td>20</td>
<td>2</td>
<td>6.7</td>
<td>90.0</td>
</tr>
<tr>
<td>21</td>
<td>2</td>
<td>6.7</td>
<td>96.0</td>
</tr>
<tr>
<td>24</td>
<td>1</td>
<td>3.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Participants reported a wide variety of relationship statuses (see Table 4.5). Of the 30 participants in the study, 53\% reported being “single” \((n = 16)\); among the balance, responses ranged from “dating a few people” \((n = 5)\), to having a “boyfriend or steady male partners” \((n = 12)\), or having a “girlfriend or steady female partner” \((n = 1)\). On average, JMSM’s sexual relationships typically lasted five months or longer \((n=17; 56.7\%)\). The mean number of sexual relationships for the past 3 and 12 months for
JMSM was 2.47 and 4.67, respectively. Possibly due to the high rates of unemployment and the growing need to engage in survival or transactional sex, a few participants \( (n=2) \) listed 10 or more partners at 3 and 12 months with a number of these partners being visitors or tourists to the island. Additionally, sexual partners were more likely to be male, although a few identified female partners.

Table 4.5

<table>
<thead>
<tr>
<th>Intervals</th>
<th>Total Partners</th>
<th>Male Partners</th>
<th>*Overseas/Tourist Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past 3 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>( n )</td>
<td>Frequency</td>
<td>( n )</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td><strong>Mean</strong> (2.47)</td>
<td>( (2.37) )</td>
<td>( (2.30) )</td>
<td></td>
</tr>
</tbody>
</table>

| **Past 12 months** |                |               |                            |
|--------------------|                |               |                            |
|                    | \( n \)        | Frequency     | \( n \) | Frequency | \( n \) | Frequency |
| 1                  | 1              | 8             | 0 | 2 | 0 | 23 |
| 2                  | 2              | 8             | 1 | 7 | 1 | 5 |
| 3                  | 3              | 2             | 2 | 7 | 10 | 1 |
| 4                  | 4              | 3             | 3 | 3 | 15 | 1 |
| 5                  | 5              | 1             | 4 | 3 | | |
| 6                  | 6              | 1             | 6 | 1 | | |
| 10                 | 10             | 3             | 10 | 4 | | |
| 11                 | 11             | 1             | 11 | 1 | | |
| 12                 | 1              | 14            | 14 | 1 | | |

*Note. Majority of the participants reported having fewer foreign-based partners except for those who engaged in sex work.*
Assessment of Sexual Practices and Behaviors

A description of the types of sexual activities engaged in by JMSM and the use (and frequency) of HIV prevention methods over the course of 3 and 12 months are detailed in Tables 4.6 and 4.7. Participants reported a wide range of sexual activities, including: masturbation (n=28), mutual masturbation (n=26), fellatio (n=26), receptive analingus (n=22), insertive analigus (n=11), anal insertive (n=19) and receptive intercourse (n=27), douching with a feminine product to prepare for anal sex (n=7), and consumption of alcohol or recreational drugs before or during sexual intercourse (n=5). Of the activities listed above, it appears that JMSM have engaged with high frequency in the act of masturbation, an activity that carries no risk of HIV transmission.

The majority of participants (83%) reported participating in high frequencies of anal receptive intercourse during the past year. Similarly, there was also a high degree of participation in anal insertive intercourse (63%). Despite a high knowledge of the potential risk of engaging in unprotected anal intercourse, as demonstrated by 100% correct responses on the HIV-KQ (question #22), JMSM reported participating in unprotected anal intercourse.

Condom use among the participants in this sample was inconsistent. Almost half of the JMSM who participated in anal insertive intercourse reported they did not use condoms consistently (46.7%) during their last sexual encounter. Reported condom use was higher among participants who engaged in anal receptive sex within the last 30 days (66.7%). This is consistent with JMSM reporting condom-negotiating activities with their partners. When asked, “who initiates condom use when you have sex,” a majority
of participants (83%) reported that they did. Among participants (n=26) who reported performing fellatio within the past 30 days, only 3% reported using a condom during the last time they performed this activity.

In addition to inconsistent condom use, 10% of individuals reported using alcohol or recreational drugs before or during their last sexual encounter. “Douching,” an act of preparing or cleaning the anal canal with a feminine hygiene product or enema before anal insertive sex, was reported with little or no frequency (within the past 30 days or at the time of last intercourse).

Of significance for this population of JMSM are the rates of disease within the sample. JMSM contained in the sample (n = 5) reported that at some point in their lives they were diagnosed with a form of sexually transmitted disease. The diagnoses reported were: infection with gonorrhea (n = 1), human papilloma virus or genital warts (n = 1), syphilis (n = 1), and HIV (n = 3). For these men, their experience with a sexually transmitted infection began during their early adolescent years. The three JMSM who identified their HIV sero-positive status reported receiving their individual diagnoses as early as 14, 15, and 16 years, respectively. Additionally, one participant, who was diagnosed with syphilis, reported receiving this diagnosis during his early adolescent years. Consistent with Jamaican culture, circumcision was uncommon for JMSM. Of the 30 participants in the study, 73% reported not being circumcised.
Table 4.6

*Occurrences of Common Sexual Acts, Behaviors, and Condom use of JMSM*

<table>
<thead>
<tr>
<th>Frequent Sexual Acts and Behaviors of JMSM</th>
<th>Participants who have ever engaged in this activity (n)</th>
<th>How many times in the past 3 months</th>
<th>How many MEN have you done this within the past YEAR?*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Masturbated</strong> (by yourself)</td>
<td>28</td>
<td>98.13</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Kissed a man</strong></td>
<td>29</td>
<td>2.47</td>
<td>7.00</td>
</tr>
<tr>
<td><strong>Masturbated someone</strong> (gave someone a hand-job)</td>
<td>26</td>
<td>1.67</td>
<td>4.07</td>
</tr>
<tr>
<td><strong>Given oral sex</strong></td>
<td>26</td>
<td>1.90</td>
<td>3.07</td>
</tr>
<tr>
<td>(your mouth on someone’s penis or vagina)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rimmed</strong> (licked someone’s ass)</td>
<td>11</td>
<td>.27</td>
<td>.47</td>
</tr>
<tr>
<td><strong>Been rimmed</strong> (someone lick your ass)</td>
<td>22</td>
<td>.93</td>
<td>1.77</td>
</tr>
<tr>
<td><strong>Penetrated someone</strong> (your penis in their ass or vagina)</td>
<td>19</td>
<td>1.27</td>
<td>2.50</td>
</tr>
<tr>
<td><strong>Been penetrated</strong> (someone put their penis in my ass)</td>
<td>27</td>
<td>1.53</td>
<td>3.67</td>
</tr>
<tr>
<td><strong>Douched before anal sex</strong> (cleaned your ass with a feminine wash or enema)</td>
<td>7</td>
<td>1.30</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Used alcohol or recreational drugs before or during sex.</strong></td>
<td>5</td>
<td>.37</td>
<td>.60</td>
</tr>
</tbody>
</table>

*Note. * = numbers represent the average number of times these activities were performed over the past year*
Table 4.6 continued

*Occurrences of Common Sexual Acts, Behaviors, and Condom use of JMSM*

<table>
<thead>
<tr>
<th>Frequent Sexual Acts and Behaviors of JMSM</th>
<th>How many times in the past 30 days?</th>
<th>How many times you used a condom when doing this in the past 30 days?</th>
<th>Did you use a condom the last time you did this?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Masturbated</strong> (by yourself)</td>
<td>22.77</td>
<td>.03</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Kissed a man</strong></td>
<td>1.13</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Masturbated someone</strong> (gave someone a hand-job)</td>
<td>1.00</td>
<td>.07</td>
<td>3.3% (1 out of 30)</td>
</tr>
<tr>
<td><strong>Given oral sex</strong> (your mouth on someone’s penis or vagina)</td>
<td>.90</td>
<td>.07</td>
<td>3.3% (1 out of 30)</td>
</tr>
<tr>
<td><strong>Rimmed</strong> (licked someone’s ass)</td>
<td>.27</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Been rimmed</strong> (someone lick your ass)</td>
<td>.50</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Penetrated someone</strong> (your penis in their ass or vagina)</td>
<td>.93</td>
<td>1.93</td>
<td>46.7% (14 out of 30)</td>
</tr>
<tr>
<td><strong>Been penetrated</strong> (someone put their penis in my ass)</td>
<td>1.47</td>
<td>1.70</td>
<td>66.7% (20 out of 30)</td>
</tr>
<tr>
<td><strong>Douched before anal sex</strong> (cleaned your ass with a feminine wash or enema)</td>
<td>.20</td>
<td>.00</td>
<td>0% (0 out of 30)</td>
</tr>
<tr>
<td><strong>Used alcohol or recreational drugs before or during sex.</strong></td>
<td>.10</td>
<td>.07</td>
<td>10% (3 out of 30)</td>
</tr>
</tbody>
</table>
Table 4.7

*Frequency of Anal Insertive and Receptive Intercourse*

<table>
<thead>
<tr>
<th>Number of times participated in anal insertive intercourse</th>
<th>Frequency</th>
<th>Percent %</th>
<th>Cumulative Percent %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>11</td>
<td>36.7</td>
<td>36.7</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>23.3</td>
<td>60</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>16.7</td>
<td>76.7</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>6.7</td>
<td>83.3</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>6.7</td>
<td>90</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>3.3</td>
<td>93.3</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>3.3</td>
<td>96.7</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>3.3</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of times participated in anal receptive intercourse</th>
<th>Frequency</th>
<th>Percent %</th>
<th>Cumulative Percent %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>5</td>
<td>16.7</td>
<td>16.7</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>23.3</td>
<td>40.0</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>20.0</td>
<td>60.0</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>16.7</td>
<td>76.7</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>10.0</td>
<td>86.7</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>3.30</td>
<td>90.0</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>3.30</td>
<td>93.3</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>3.30</td>
<td>96.7</td>
</tr>
<tr>
<td>37</td>
<td>1</td>
<td>3.30</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Part III: Social and Cultural Climate

In part three of this Chapter, a description of this study’s participants experiences of what it is like to be a MSM living in Jamaica is presented. To this end, seven thematic statements derived from the data, which illustrated the current social and cultural climate as it pertains to young Jamaican MSM, are described throughout this Chapter. The thematic and sub-thematic statements described by JMSM are presented in the Table 4.8. Each thematic and sub-thematic statement will be described in further detail along with supporting quotations.
Table 4.8

*Thematic Representations of the Social and Cultural Experiences of JMSM*

<table>
<thead>
<tr>
<th>Thematic Statements</th>
<th>Exemplar Quotations</th>
</tr>
</thead>
</table>
| Theme 1: Societal views of maleness, masculinity, and the rejection of gender nonconforming males have created a hostile living environment for young Jamaican men who have sex with other men. | • “They treat gay people worse than how they treat dogs.”  
• “Show me your company and I tell you who you are.”  |
| Theme 2: Educational, religious, and other governmental institutions reinforce socially and culturally acceptable norms against JMSM through a process of stigma, discrimination, and neglect. | • “The last high school I went to the guys wanted to jump me because I was too feminine for the school.”  
• “The Bible based on what I see is used as a tool to drive homophobia in the society.”  
• “Dancehall encourages hatred and violence towards homosexuals in their songs.”  |
| Theme 3: JMSM’s sexual identity development is viewed through the microcosm of having a dual identity: For JMSM, developing an orientation that is contrary to what is socially and culturally acceptable is perceived as un-Jamaican. | • “When I was young I didn’t understand what it was that I was feeling.”  |
### Table 4.8 continued

**Thematic Representation of the Social and Cultural Experiences of JMSM**

<table>
<thead>
<tr>
<th>Thematic Statements</th>
<th>Exemplar Quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 4:</strong> Persistent homophobia and homophobic violence from members of the Jamaican society towards MSM have contributed to various levels of maladaptive behaviors, physical abuse, and psychological trauma.</td>
<td>• “I tried to kill myself once because I didn’t want to deal with this lifestyle anymore.”</td>
</tr>
</tbody>
</table>
| **Theme 5:** JMSM’s interpersonal relationships with friends, intimate partners, neighbors, and family members can either be a source of support around having a sense of belonging or be associated with rejection and social isolation. | • “My boyfriend had my back. I felt loved.”  
• “When it comes to support from civil society we don’t get a lot of support.” |
| **Theme 6:** For some JMSM, their experiences with HIV have been directly linked to their present social and economic situations—however, access to and navigation of the relevant health care systems within the island presents various forms of challenges. | • “I was dating this one guy who was HIV positive and I didn’t know at the time.” |
| **Theme 7:** There are several situations that compromise JMSM’s safety which also places them at risk for infection with HIV—however, young JMSM were reasonably skilled at developing strategies that are useful in mitigating or modifying these risks. | • “He said I had to sleep with him if I wanted to stay in his house, at that point I had no choice but to sleep with him.”  
• “I try to act masculine in public to create an edgy version of myself around others who I know are against homosexuals.” |
Jamaican Society and the Social Environments of JMSM

Theme 1: Societal views of maleness, masculinity, and the rejection of gender nonconforming males have created a hostile living environment for Jamaican MSM. “They treat gay people worse than how they treat dogs.”

The Jamaican society is a microcosm of complex forms of cultural expressions, ideologies, and moral expectations. Within this microcosm, written and unwritten rules are made available to govern expressions and behaviors that are deemed culturally and socially acceptable. Many of these acceptable behaviors and expressions are enshrined in old colonial laws handed down from British colonial rule. Throughout the island’s history, Jamaicans developed a reputation for leveling their grievances with their government when they disagree or have been unjustly disenfranchised. Within the last decade, the country has undergone a transition on issues related to sexual minorities, more specifically men who have sex with men.

Various views are held by many within the Jamaican society about homosexuality. A majority of these views are based solely on religious pedagogies. From a very young age, Jamaican youths are educated on the “devious” behaviors of homosexuality during Sunday school services, indirect education within their respective communities, and through socialization with each other. These views are reinforced through various means. Within the home, parents and other members of the family reinforce these negative views regarding homosexuality with threats of disownment or abandonment. Additionally, threats of homelessness or cessation of financial support are also common within these families. In the larger society, reinforcement of an anti-
homosexual agenda is expressed through fear and intimidation. For homosexual men, it is well understood that their sexual identity is contrary to what is expected of men living in Jamaica and, as a result, any behaviors pertaining to such identity must be kept private.

The quotations that follow were provided by the men who participated in this study. Participants were asked to provide pseudonyms in place of their names to further protect their identity. Acknowledgments (i.e., pseudonym and participant’s age) follow each quotation.

You know that we are living in a very homophobic country and as a child you are still aware of it. So you would never want to tell your mother or your sister because you are scared. *Mark (age 23)*

JMSM have the perception that they live in a country that does not support their existence. With the constant reminders of the Jamaican society’s attitudes and beliefs regarding homosexual behaviors, JMSM expressed fears and concerns regarding their safety and security. JMSM perceived that homophobic attitudes seen in the society are a result of neglect from the state and the failure of the state to educate the nation on tolerance and acceptance of MSM. Images seen on television and printed media, in addition to the attitudes seen within the society, reinforced those beliefs held by JMSM.

JMSM were acutely aware of how homosexuals are treated. One JMSM in the study explained his awareness of how the society treats homosexuals. He reported:

They treat gay people worse than how they treat dogs. They treat gay people bad. If it comes to it, they will come and tell you that they would light you and burn you in the middle of the road—I know they would do it. *Zack (age 21)*

As a result of being acutely aware of the treatment of homosexuals within the society, JMSM have accepted the secrecy of their behaviors. They believe that in order
to remain safe in this environment their same-sex behaviors are to be kept private. There have been many instances where men were caught engaging in same-sex sexual behaviors (that the society disapproves of). These men who were caught in those situations subsequently became victims of various acts of discrimination. Some were victims of mob attacks, while others who were not able to escape faced death. Another participant in the study talked about his experience with the Jamaican society’s disapproval of homosexuality.

Homosexuality is frowned upon here. No one wants to be associated with that.... So unless you know someone who is willing to try it out, then no. Everything that is done in homosexuality is done in the dark. You never see it. If you would see a man walking in the street hugging and kissing another man, they must be foreign because that is strange. It is in the music and the culture. It is what you hear when you are growing up. Society tells you it is wrong. Your parents, the church, and the television all tell you that it is wrong. Omar (age 23)

JMSM are exposed to anti-homosexual attitudes during their early years. Some recounted direct and indirect messages from their parents about homosexuality. Although a majority of those messages were codified around religious pedagogy, many were reflections of the parents’ personal views. This anti-homosexual socialization led to internal conflicts within the MSM and left the MSM to reconcile the moral teachings of their parents, and pedagogies of their religion with their own intrinsic attitudes and feelings about themselves. One MSM recounted his thoughts about being raised by his parents and his same-sex attractions. He stated:

I grew up in a Christian home, right! So not practicing what the church says, that a man should be with a woman, is not good.... They would all preach that you should not be with a man because it is wrong and it is not a part of the kingdom of God. So listening to that and then me now finding or accepting something that they are having a problem with.... If I am having these feelings, how can it be
wrong? I didn’t force myself to have them. That simply means that maybe it was the way I was born. *Mark (age 23)*

For other JMSM, exposure to anti-homosexual attitudes led them to suppress their same-sex attractions. JMSM who experienced these negative attitudes from their parents and communities learned from an early age that their desires were wrong and could potentially bring them harm. The pre- and early adolescent years for many of these JMSM often caused tumultuous family relationships. JMSM reported that during their early years, before becoming an adolescent, they began experiencing an attraction towards other young men their age. With limited exposure or outlets to explore their desires, they were left confused, not having an appropriate label or way to express their attraction.

At that point I never knew what was happening to me…. I thought it was an experience and I was young and almost a teen and stuff like that… but when I realized how the Jamaican society was at the age of fourteen… I couldn’t express it. I mean it does not work like that here and though I had a good relationship with my mother she would say that “I can’t be this way and that it is not of God. It’s ungodly and you will go to hell.” So I made the decision to keep it to myself. *Barry (age 22)*

*“Show me your company and I tell you who you are.”*

In Jamaica, it is widely accepted for persons to discriminate against homosexuals. While both heterosexual men and women discriminate against homosexual men, a majority of the acts of violence towards MSM in Jamaican society are at the hands of heterosexual men. Persons who are identified as homosexuals often live in hiding. They are condemned by all aspects of the society. Because of the disdain for the homosexual male, heterosexual individuals refuse to associate themselves with homosexuals. In addition, referring to a heterosexual man as a *battyman* (homosexual male), is perceived
as the ultimate insult. For heterosexual men, this label is an affront to their maleness and masculinity. To this end, labels such as battymen, battyboys, fish, and number two are terms that are exclusively used towards homosexuals.

Same-gender loving individuals, more specifically MSM, are stigmatized as a result of their sexual orientation. To be labeled as a homosexual in Jamaica can lead to loss of housing and employment. Generally, once one’s sexuality is revealed it is expected that one will lose one’s heterosexual male friends due to their fear of being associated with homosexual sexual orientation.

They all condemned homosexuality. Persons might not want them to be around so they disassociate themselves from them. *Mark (age 23)*

Many heterosexual men avoid the company of homosexual men. They do not avoid the company of these individuals because of their own personal fear of being homosexual; instead, they avoid the company of homosexuals because of the stigma that society associates with the orientation. Avoiding the “gay contagion” is paramount to upholding the family’s reputation.

Jamaicans in general tend to say “show me your company and I tell you who you are.” They would say “if he is hanging with that battyman then he must be one too. You see who him a talk with?” There is nothing you can say to refute the claims of homosexuality. *Garry (age 26)*

Straight men avoid being our friends because of the stigma that is attached to homosexuality. If you are homosexual and you have a male friend persons usually be like, “that’s another gay person.” So usually when they see a homosexual one they have recognized or identified as homosexual usually they automatically say that person is gay as well. In Jamaica they don’t believe that persons who are homosexuals can have heterosexual friends. In the society in which we live, why would you be seen with a homosexual person in public if you weren’t like them? So usually persons attach the stigma to you once you are seen with a homosexual… that you are also homosexual. *Barry (age 22)*
**Current Discourse within the Society.** Jamaica’s social and cultural transitioning has taken many forms. Within the past decade, lyrical expressions that were once permitted to be aired on Jamaica’s public radio and television stations are now governed by the Jamaica Broadcasting Corporation. Limitations were placed on the types of vulgar language, or slackness, which were previously allowed to be aired. In addition to the censoring of sexually explicit content, music that incites violence of any kind, including violence towards MSM, was banned. Moreover, under Jamaica’s new Charter of Fundamental Rights and Freedom (2011), citizens have the opportunity to petition their government if their rights are unjustly violated. The rights of sexual minorities were not included as part of this charter. However, that has not inhibited sexual minority groups from bringing legal challenges to the Country’s Charter of Fundamental Rights to the highest court on the island. For example, there were two cases that were brought to the Jamaican Supreme Court challenging the existing Charter. The first case dealt with the refusal to air a “gay tolerance” advertisement by local media houses. The second case was brought by a homosexual activist who is challenging the island’s anti-buggery law as it is applied to sexual acts between two consenting adults. On the first case, a decision was made, in 2013. The court found in favor of the media house’s refusal to air the tolerance advertisement. The court announced that they will hear oral arguments in the second case in summer of 2014.

The treatment of MSM in Jamaica is evidence of the society’s negative attitudes towards homosexuality. This evidence is portrayed on television, printed media, and through other cultural expressions. Content depicting the homosexual lifestyle are
censored on television. In 2014, the Grammys, a United States based music award show featured the wedding ceremony of several same-and opposite-sex couples. One of the television stations on the island acquired the exclusive rights to broadcast the show. However, during the segment that featured the ceremony, the broadcast was stopped, thus preventing a Jamaican audience from viewing the wedding ceremonies of same-sex couples.

In printed media, MSM are portrayed as vulgar, promiscuous, and violent. One particular newspaper on the island not only depicted homosexuals in a negative light, but often published news related to homosexual behaviors on the front page along with derogatory headlines. Some of these headlines included: *Freaky gays harassing New Kingston residents*, *Residents fed up with homosexuals soliciting sex*, *Death of a faggot*, *Vicious gays–homosexual men stone supermarket and threaten staff*, *Gays wreak havoc–cops say homosexuals too much to handle in South East St. Andrew*, *Rowdy gays upset JFLAG*, and *Rowdy gays strike: JFLAG abandons raucous homosexuals misbehaving in New Kingston*.

**Laws around Homosexuality.** The decision to bring the anti-buggery case to the Jamaican Supreme Court has been met with mixed opinions both from members of the sexual minority community and other members of the broader society. The discourse among members of the broader society suggests that, with removal of the buggery law, homosexual men will engage in inappropriate sexual relationship with children and other young men. It is also assumed that a passive approval of homosexual behavior will lead
to other challenges such as the pursuit of marriage equality (same-sex marriages). These assumptions are the main drivers against the repeal of the island’s buggery law.

During her campaign for office, the Prime Minister of Jamaica indicated her willingness to repeal the buggery law. Although her promises have not lead to policy change, many MSM advocates within the society viewed her words as a major step forward. The Minister of Justice, under this Prime Minister’s leadership, announced, in 2013, that a review of the law would come. While these promises were made on several different occasions to the people of Jamaica, JMMSM have expressed concerns about the inaction of the government in removing the law.

I don’t think anything has been done to reduce the stress on the community and even with the last election that they had, the promises that were made by the Prime Minister, bold promises…. People had certain level of expectations and she never came through at all. I mean even though people are becoming more liberal about the issue and in their thinking, the government still holds on to what some insignificant people have to say. Roy (age 20)

Instead of waiting on the review promised by the Prime Minster, MSM advocates have taken their plight to Jamaica’s Constitutional Court.

Sexual minority groups, more specifically MSM, expressed their views supporting the removal of the buggery law for sexual behaviors between two consenting adults. According to MSM advocates, the law provides a legal avenue for persons within the society who disapprove of homosexuality to openly discriminate against homosexual men. One participant in this study expressed his concern about the law and the implications for homosexual men within the society. In his opinion, by the government refusing to remove the buggery law, they are sanctioning discrimination against homosexuals. He stated:
One of the things in Jamaica that we have to look at is our laws. We cannot have discriminatory laws. You cannot have a group in any country to be subjected to discrimination or stigma because of their class or sexual orientation. Again, I think our laws should reflect our motto which is “Out of Many, One people.” If we stick to that then I think we wouldn’t have what I like to call legalized discrimination. That’s certainly something that I’d like to know…. Another thing, the laws are not the end of everything we face… you can change the laws but you can’t change the culture or the people…. *Ken (age 24)*

Although many MSM within the society view the buggery law as a detriment to their progress and personal freedom within the society and advocate for its removal, other MSM expressed their concerns over the removal of the law. During the focus group discussion, the participants engaged in an in-depth conversation about reasons to keep or remove the law. For many of the participants, changing the law would be a great step forward in achieving equal recognition under the law. For others, their perception was that it will lead to open revolt, continued discrimination, and possible attacks against homosexuals. The discord between these two groups provided some context into the current debate over the law.

**Discrimination at the Community Level.** Communities in Jamaica are diverse. Based on the parish in which an individual lives, their community may be divided based on social class. Rural communities are more homogeneous than dense urbanized areas. In many urbanized areas like Kingston and Montego Bay, communities are divided into middle-class and high poverty areas. Middle class communities in Kingston are referred to as uptown areas, while high poverty areas are regarded as inner-city (garrison) communities. Inner-city communities are often aligned with one of the two major political parties on the island. In addition, inner-city communities are often areas with high crime rates.
The economic situations for persons living in many inner-city communities are linked to educational and financial deficits. While there are persons living in these communities who are college prepared, the current economic situation does not afford them the opportunity to utilize their skills. For those with limited educational attainment, employment as domestic helpers, gardeners, and security guards are common. Men with a trade, such as a barber, mechanic, or construction worker, are able to use their skills through employment or entrepreneurships. A majority of the children in inner-city communities are raised in single-parent homes. Half of the sample of JMSM interviewed indicated that their mothers became pregnant during their adolescent years. For this sample of JMSM, their adolescent mothers raised them without the presence or participation of their fathers. As such, in these communities (inner-city), women are some of the major power brokers.

As major power brokers within these communities, women groom their young boys to become strong men according to their Christian traditions. According to some JMSM, boys were expected to be “tough,” “rough,” and “strong.” When young men reach adolescence, they are expected to assist their mothers in taking care of the home and their siblings. Additionally, due to the nature of the community and the economic climate, adolescent boys often become members of gangs and engage in criminal activities. Membership in gangs and participation in criminal activities help to define maleness and masculinity. Males are groomed to not be acquiescent or subservient to women. These are expectations that are reinforced at the community level.
In Jamaica, most garrison communities are the epicenters of Jamaica’s hostility towards homosexuals. Homophobic violence is concentrated in highly urbanized and rural areas. Inner city and rural communities are often areas where homophobic violence is rampant. JMSM highlighted instances of anti-homosexual sentiments from an early age. JMSM in the inner city are exposed to anti-homosexual rhetoric and sometime witnessed the judgment rendered towards homosexual men.

When I was living in [X] community there was one particular guy they found out he was like that [gay]. They shoot him and chop off him head and put it on a stick in the middle of the square. On the news they didn’t talk about it as the person being gay. They only say that three men was found in a bedroom and one dead and the other two escaped something like that. I lived in that community and I had to leave from up there and find somewhere else because community men come down to the house where I was living and told me that I was acting too effeminate to be in the community and they said to me “you don’t know what went on here?” I said what happen here, “them say listen to me go back in the history of the area and find out.” I asked the lady next door what happened and she told me. So when I heard it I did not let them go any further. I just pack up the same day when she told me the history that was up there, I did not want to be the next history. Again I did not want to go down that road. I took note of it, so I just left. [Author’s translation: So when I heard it I did not let them go any further. I just packed up my stuff the same day when she told me the history that was up there, I did not want to be the next history. Again I did not want to go down that road. I took note of it, so I just left]. Steve (Age 25)

Recently, I don't think this has been on the news but my friends were telling me, I think a day or two ago that in Mandeville they shot this man because they thought he was gay and then they burnt his house down with him inside. I think it was last year apparently there were two boys that drowned or they found them dead and there was some talks about them being molested and then there was this one man in the community everyone thought was gay and they beat him because they thought he was the one that did it. So people are really angry towards homosexuals here in Jamaica and so this intolerance has always been there…. I have friends who are scared, very scared to go to this one community because every time he goes there somebody comes at him. Larry (Age 24)

The incident highlighted above by Larry occurred during the first weeks of the investigator being on the island. The incident took place in Zion near Falmouth,
Trelawny. The investigator recalled reading the news story in the local papers and following the coverage on local television stations. Initially, the incident sparked outrage and disapproval from various parts of civil society. A major point brought out in the news reports suggesting that the two boys were sexually molested angered the residents within the community. While the police were conducting their investigation, the community took actions into their own hands by attacking the home and personal property of a community member who they suspected to be gay. They destroyed the property, wounded his sister, and took the life of his father during the process. It was later revealed that the young man did not have any connection to the young boys. A post-mortem analysis later determined that the two young boys were not sexually molested and that the cause of death was due to accidental drowning (Plunkett, 2012; Silvera, 2012). On observing the discourse taking place in this Jamaican, the investigator had a clearer understanding of the anti-homosexual sentiment within its society.

**Employment Discrimination.** For some JMSM, discrimination in the workplace because of their sexuality is a common occurrence. Recently, the government has instituted a workplace policy making it illegal for an employer to terminate the employment of an employee due to their HIV status (Ministry of Health, 2005); however the policy did not include any protection for individuals who were identified as homosexuals. JMSM reported losing their employment once the employer became aware of their sexual orientation. Some left their jobs voluntarily due to pressures in the workplace from other employees.

Sometimes I am sorry that I am gay. I would not lose so many jobs because of the constant moving up and down. It makes it hard to find a stable place to sleep
at night. If I cannot work to pay for my apartment. If persons find out that you are gay, they segregate themselves from you…  

*Frank (age 26)*

When the investigator first met Frank he reported that he was living in a shelter at the time. When asked about why he was living in the shelter, he reported that where he had been living, the neighbors mobbed his house; a neighbor noticed what was occurring and notified the police. Upon arriving on the scene, the police participated in the attack, arrested him and charged him with using indecent language. At the time of his arrest he was wearing his work uniform. After finding out where he worked, the police officer called his place of employment in order to notify them that they had a “battyman” working for them. The employer later terminated his employment and as a result he lost his housing. Frank kept in contact with the investigator for a few more months following his initial interview. He was later employed with a new company where he worked part-time. This new employment afforded him temporary housing. However, his employment was later terminated again after his employer received word from other employees stating that they saw Frank hanging out in a park with a group of homosexual men. Stories like these are common for many JMSM. Another JMSM recounted a similar experience with his employer.

Like I can give you an example…. I was working at this company before the one I’m at now and the boss actually called me into his office and told me that the other employees were saying things in relations to my sexuality…. They were asking if I was gay and stuff like that. That had gotten me really upset…. I admitted to him that I was gay even though their reasons for thinking that was nothing concrete… you know… they didn’t [sic] caught me in the act nor did I admitted to them anything [sic]. It was just because of who they saw me with…. So I admitted to him that yes I hang out with these people, simply because I like their company and I am like that in fact and I did nothing differently afterwards.  

*Larry (age 24)*
Although many JMSM shared similar experiences of discrimination in the workplace, there were a few men who had satisfying relationships with their employer and other employees. JMSM in this sample whose employers were women shared positive working relationships compared to those whose employers were men.

Well basically the whole of them kind of suspect me, probably because they were all women…. One girl name Sarah, she’s like, she is like…. She came to me and said, “Oshane can I ask you a something? Are you gay”…. So I said, No girl…. What makes you think that? So she said, “It’s nothing if you are gay.” I could tell her if I was. She said she was ok with it if I was. So I told her that I wasn’t gay. Then a few days later she came out and told me that she is bisexual and I was like wow…. Really? You know, I honestly didn’t know if she was testing me so I waited a few days before I told her that I was gay. We became very close after that. **Oshane (age 18)**

I wasn’t worried about losing my job because at my former workplace, the cashiers know I am gay. I gave them lots of jokes…. So they love my vibes. **Sean (age 20)**

**Rules Defining Maleness and Masculinity.** Based on the statements reported to the investigator by JMSM within this sample, it is determined that within the Jamaican society, there are unwritten rules that govern perceptions of maleness and masculinity. In this context, maleness and masculinity are defined by young inner-city men, religious ideology and pedagogical structures, and the selective spaces created by popular culture. For JMSM within this sample, their ability to express themselves freely was restricted and limited to their geo-economical (areas of concentrated poverty), political, and social environments. Some JMSM in the study, being expressively effeminate and living in an inner-city community may directly impact their personal safety. Those participants who were enrolled in an institution of higher learning (college or university) suggested that
residing on campus provided them with an opportunity to express themselves more freely than if they were still living in their respective communities.

I think university is more tolerant than in high school. It is more tolerated, you see persons who are open who don't care really about what you think about them. Usually, some university students are more educated about it and accepted it more. I think persons who accept homosexuals are intelligent persons and persons who don't accept homosexuality are not intelligent. *Barry (age 22)*

Navigation of hyper-masculine spaces often present challenges for feminine JMSM in this sample. For example, JMSM who are gender non-conforming, attending a *Passa-Passa, Dutty Tuesdays, or Horny Fridays* (themed social events that are often held on the streets of inner-city communities), where the disc jockey frequently calls for the open elimination of *battyboys* (gay and bisexual men), have been the victim of physical attacks and the loss of lives. For many JMSM who participated in this study, this was a common occurrence with some having firsthand experience of violent attacks on their person.

Well my father always says that you must be a man and talk like a man. I can remember like two days ago, he said to me, “I know you don’t like it here (garrison community) and you don’t like hard life. You love the soft and gentle life, you love to be pampered, but you need to grow up and act like a man and do things like a man.” [Laughter]…. So I asked him, Why would you say that? Am I not doing things like a man? I might not be doing things like what others do, but yeah, I have been doing what men do. He doesn’t see me going around flaunting like a female? So you can’t say that. That’s his view anyway. A man is someone that has a penis and a woman has a vagina. So now how do we define a man? We Jamaicans define a man to be someone that is very masculine or macho, which I don’t believe. You know why I don’t believe that? Nothing can change the fact that I have a penis. So I will always be a man. No matter my sexuality. *Mark (age 23)*

There was an incident when I was in third form and this was the second semester in school…I realized the woodwork thing ain’t going to work… and this was in woodwork because we were going to do woodwork for one year… then after that you go into the sciences and the arts and I remember my form teacher and she was
like… “I noticed your grades for woodwork last semester and I don’t like it.” The theory aspect I would pass but the practical aspect I didn’t like it. I always mess up. She was like don’t worry, don’t worry, I will make you do home economics; it was compulsory to do it as a guy. The girls go over to home economics. I remember when we were going to assemble and we normally walk in different directions- when the teacher called for girls to go on one side and the guys on the other side, I went over to the girl’s side and the boys were like- I don’t understand, you a girl now? *Garry (age 26)*

One particular gentleman noted that because he was unable to navigate the hyper-masculine spaces created by men within his community and because of fear of what might happen to him if he attempted to navigate those spaces, he decided to spend his time with the females within the community.

Alright…. If a group of men out there hanging out… and you know when they hangout, they drink and smoke, and thing. As feminine as I am, I can’t go there and drink with them…. I don’t want them to kill me…. I can’t go there and drink with them because they would say, “Batty bwoy” [faggot], don’t come around me.” You understand? I know my space so I won’t really go there to hang out. You understand? I would probably hang out more with the girls, so if the girls them drinking, me and them will drink and everything [sic]. *Zack (age 21)*

**Expectations for Men within the Community.** Within this narrow view of maleness and masculinity, Jamaican men were confronted with the realities of their individual communities. These realities manifested themselves through their interactions with each other and their female partners. For many Jamaican males, expectations imposed by their families, friends, and communities in order for them to prove their manhood inadvertently promote promiscuity and violence. JMSM suggested that they themselves faced many instances of discrimination because they failed to adhere to the Jamaican society’s inflexible definition of masculinity. JMSM in this study reported being encouraged or forced to engage in sexual relationships with females often their age or older.
To be a Jamaican man, there is a song that says man must have ‘nuff gyal inna bungle—gyal from Rema and gal from Jungle” [Author’s translation: having a lot of female partners preferably from these two inner-city communities]. So you have to have a lot of women to prove your virility to fuck all of them and have a lot of children, if you are attracted to a man you are not seen as a man. You see, straight men have a lot of women, they hate the notion of homosexuality; you will hear them say “bun a battyman” [burn faggots]…. Those are the messages that I have seen in high school and if you weren’t one of these men then you are probably something else. Being a man you have to be physically tough…. **Omar (age 23)**

In the Jamaican context you have to be macho, rough, tough, have a rough voice, you cannot be soft, be rougher on the edges you cannot be too polished. Anything that is too polished might be questioned, even though there have been some shift. Because 10 years ago, even some of the ways, the culture shifting the way men dressed now a days, the whole metro-sexual vibe, looking much more polished and doing something that could not have been done back in the days but there is still a perception as to who the males should be and how the males should look, and how they should act. **Ken (age 24)**

Straight guys in our society can have sex with ten different women or have sex with a lot of women; they can have lots of feelings towards a woman. But gay guys on the other hand are not allowed to have sex with men at all…. **Focus group participant**

Jamaican MSM who failed to adhere to society’s expectations of maleness and masculinity were concerned about possible attacks on their person, family, and property. Some MSM perceived having what they referred to as “gay tendencies” as barriers in negotiating entry into the larger society. These tendencies were often characterized as behaviors or mannerisms that are incongruent with what is socially and culturally acceptable.

Umm, living here sometimes does not make me feel safe. If they find out that I am gay or that I have gay tendencies… I know I having [sic] feelings for men and the society I live in is telling me that if they find out that you love a man or that you are in a relationship with a man, they will kill you or they will beat you until you change. If you can’t change, then they will kill you. **Frank (age 26)**
Acceptance or Rejection of Feminine Men. Although having or portraying mannerisms that are incongruent with what is socially and culturally acceptable within the Jamaican society, many JMSM reported having certain privileges that may not be afforded to other JMSM. Though some JMSM faced homophobic stigma and discrimination within their communities because of their perceived fractured manhood or masculine ineptness, others, who were born and raised in inner-city areas, where they were familiar to members within the community, enjoyed the freedom to live and move freely throughout the community, without fear of discrimination. Oftentimes their sexuality was unknown to members of the community. However, their gender non-conforming attitudes and behaviors were overlooked.

If you were born and grow in that community they [are] not going to trouble you… but if you [are] new there and they see you move [a] certain way they might tease you and probably try to beat you up. **Sean (age 20)**

Persons in my community, they know of my background in terms of me working my way up, high school and they know my family. My father is a well-known figure so there is this general acceptance there to say alright he speaks well whatever… whatever versus if I should go into another area that probably have a similar background.... Mi affi guh drop in some patois in deh [Author’s translation: I have to speak patois] and act thuggy-thuggy [act like a thug]…. So I mean that is understandable but you have to adapt based on the context because growing up in another community, similar demography and background they might see me as a *fish* [faggot], so you have to adapt based on where you are. Come to think about it, there have been several instances while growing up and so forth. There is this particular gay guy that lives around from where my grandmother lives, I don’t talk to him or anything…. I think what saved him is the fact that he grew up there; he’s not an outsider. Perhaps if he was an outsider they would have attacked him but they know his mother and they have been there for years. He has had confrontations within the community but they have not put him out and I think there have been physical fights but they have not asked him to leave per say; then again, leave and go where? **Ken (age 24)**
Even though there were instances where some JMSM were allowed to continue to live in their community, regardless of their sexuality or familial status, many individuals were acutely aware that the expression of their same-sex attractions were to be kept private and not in full view of the society.

We are aware and cognizant of our surroundings, so we are not going to present ourselves so loud to people and say that we gay…. So some of us will try our best to not put it out there. We will try and retain what we can. I remember there was one guy in our community who people found out was gay because they caught him with another gay…. They stoned him so he had to leave the community… This happened when I was in primary school…. So it was then that I realized that you have to know your surroundings and know what folks in that community believe in. We know that we are not supposed to present it [your sexuality] in their faces. You must try and do what is best by only presenting it to persons you knows will accept it. **Mark (age 23)**

One boy in my community is named John. Before him started the lotto scam. There was a tape with a lot of gay people on it, including him…. Someone carried it down there for the community to see, so they beat it. I think it was a gay tape… cause he went to a gay party and him [sic] carry the tape down there and a talk a lot of things. So they beat him and deal with him bad. Only water alone could come to my eyes, but I couldn't bawl and let everyone see. **Zack (age 21)**

If, however, they chose to express themselves freely, they risked the potential ejection of themselves or their entire family from the community. For some JMSM, if their communities became aware of or were suspicious of their sexual orientation they were rejected by the community and often had to leave their belongings behind.

Additionally, families engaged in acts of abandoning their homosexual relative. Some rejected their homosexual family member by choice while others rejected them at the behest of community members through threats and intimidation.

I think the society is somewhat open[ed] up, or maybe that was not the term to use. It is more tolerant and understanding where men having sex with men was concerned. But it is still taboo with the man-to-man or thinking about a man
having sex with another man… “They should be put to death you know”… I think because of our culture I don't think my mother would be depressed about it [if she found out I was gay]…. Although, I think because of my community they would probably force her to disown me. They would literally force her to have me leave the house and community… they would come with a brawl or crowd and create excitement and she wouldn't want that…. She would ask me to leave.

Garry (age 26)

I was asked to leave my apartments on more than one occasion. Because my spouse comes over for the night or weekend or week or whatever… I have to move because my landlord doesn't want gay persons in the area because it contributes to violence. Because if people in the community hear that there is a battyman [faggot] living in the area, they would come and burn down the house. The fear of them mobbing you, ganging you and beating you at any given time let you not feel safe in the community. Man! Sometime this year, early this year I was mobbed…. My neighbors found out that I was gay and created a scene at the house. They came to my house asking who is the man I have locked up in my house… and if you a battyman you cannot stay here… I was living at my aunt’s house in [X] city and they called police on me complaining that too many men were frequenting the property…. There were a few guys staying with me because they were homeless too as well…. They called my aunt overseas and tell [sic] her that me a battyman and that if I don't leave the house they are going to burn it down. Frank (age 26)

Life in Kingston is very rough…. Hard… Especially growing up with a mother who is very poor and the father can’t make ends meet. It's very challenging also being who I am which is gay and some form of effeminate way show up [sic], community members really don’t accept me so it was [sic]…have a really rough childhood days growing up… because of the discrimination and the stigma…. At one point the community because of the stigma they attached to me forced my mother to really go against me and so I [took] the initiative to leave the house at the tender age of 15. Steve (age 25)

When I was young, I left the country and came to Kingston to live with me mother. During that time, with me living with her now in Kingston and going to school, there was an issue with the community members and… constant teasing, calling me names, like fish, deuces, you know those words that they use to classify gay men…. I just couldn't understand the community and I couldn't tolerate it so I decide [sic] to run away…. I came back and was attacked when I was coming home from school. Coming home at night late from school when I was going to [X] high school and walking from a distance to go to my home, my yard… you would find some idlers on the street and I’ll get attacked. They rushed out on me with a big stone throw it on my shoulder…. I didn't fight back but I was able to escape from it and sound an alarm at the police station. When
my mom and I reported the incident to the police... the officer told me why my mom [doesn't] look somewhere to put me... you know... rent somewhere and put me. I guess I was too feminine to live there... so then my mom and siblings told me to cut down on my femininity and man up in terms of my facial, I love my make up you know... so somebody [sent] word to my mother that their safety was in jeopardy... so because I didn't want their safety to be out of control you know... that's my mom house and I don't want them to destroy it.... I want them to live there peacefully, so I left.... I was 15 years old. Arron (age 24)

**Stages of Suspicion of “Questionable” Men.** With the threats of physical violence looming over their heads on a daily basis, many JMSM identified a system or condition under which these attacks against their person would often take place. Some have suggested that a homosexual man living in the inner-city who is gender non-conforming faces extreme scrutiny, where everything that he does is viewed with suspicion. Moreover, innocuous activities such as having visits by male friends have led to mob-type attacks against the occupant of the dwelling and their guest. The participants in this study identified a stepwise process of community suspicion and aggression. The four-stage process of possible mob or violent attacks towards JMSM by community members included: (a) initial suspicions of members of the community (i.e., physical appearance, gesticulations, soft spoken, or any other feminine characteristics), (b) the initiation of an unofficial investigation (i.e., gossiping with other community members, examination of text messages and social media accounts), (c) confirmation by community members’ own investigation or the “slip-ups” of the MSM, and (d) persistent verbal assaults and harassment which often escalate to physical confrontation.

I don't have feelings for women. I have feelings for men. I have a boyfriend. I would love for my boyfriend and I to live together. But under Jamaican society, that can’t happen. If you live with a man, people will start saying, “two faggots live over there.” Then they will start calling you names. First they will start segregating themselves from you. If you go to their shops or whatever, they will
give you attitude. “What do you want?” After you tell them, they will say they
don’t have it even if they do. They are pretty much calling you names, throwing
words, when you walk past, they see the need to say at that time to “burn out
battyman.” They may not say it to you directly but they are just throwing out
their words. That fear of them mobbing you, gangling you, and beating you at any
given time; let you not feel safe to be around them. Frank (age 26)

Well I don’t feel safe in my own country that’s for one. If someone hears or has
an idea that you are homosexual in most cases they’ll try to find out if it’s true or
not and they’ll try one or make attempts to beat you for it. My own community is
a little bit too violent for my own taste. It is terrifying because if you don’t fit
into society you’re going to have to watch your back everyday cause you never
know when someone could decide that they’ve had enough and decide say it’s
time to make a move at you for you to change your ways or just leave the
community or where you live. Kevin (age 21)

To avoid any confrontation with members of their community, some JMSM

refrained from or limited having male company visit their homes.

In order to keep myself safe, I do not have men coming over much.... Only
female friends would come by. I try not to hang out much either. I go from work
to home, work to home. Nobody knows when I am coming home. I could stop
by my family and don’t come home for days. These are the mechanism I use to
divert attention from myself. Andre (29)

The perception held by some JMSM study participants was that this sort of

community anti-homosexual sentiment was not widespread across the island. One

participant suggested that gay men who lived in suburban areas enjoy the love and

support of their community.

Let me tell you a little bit about my lifestyle. I don't feel comfortable to go
everywhere with it. As I tell you again, garrison [inner-city community] is
different. Alright, you see if you go live in the uptown area like Cherry Garden
and them gardens, them [sic] people will be more sensible and would be more
understanding… and say it is your life and your choice… and I have to love you
[the] same way… but in the ghetto…. NOOO! Zack (age 21)

Another participant, while walking down a major intersection on the streets of

Kingston on his way to his interview with the investigator, echoed these same sentiments.
He explained that he himself had experienced many instances of violent attacks on his person as a result of his sexual orientation. His thought was that he if had lived in an upper-class neighborhood his experience would have been different. This adds to the widely held perception by many JMSM who participated in the study that living in inner city communities poses threats to JMSM’s safety and prosperity.

**Law Enforcement.** JMSM have had interactions with the police at some point. Overwhelmingly, a majority of the MSM who were interviewed reported that these interactions with law enforcement were negative, explaining that often when they are the victims of violence and are in need of protection, the police officers who respond to the incident also participate in the attack upon their arrival. JMSM reported being both verbally and physically assaulted while in the custody of the police, while others reported various levels of police harassment. Those JMSM who have challenged the negative treatment promulgated by the police have been arrested and charged with minor criminal offenses such as use of indecent language. One young man recounted such an incident, tears streaming down his face.

I was mobbed sometime last year because persons found out about my sexuality and came to my house to kill me and my friends. The neighbor called the police to come help us. The neighbor who called the police to help me came in the house when the police got there and gave me a bottle of water. She told then that the mob wanted to kill us because we are gay. So she begged them to take us out the area and protect us…. Unfortunately, they forgot that part. When they came and got us they beat us in the van on the way to the police station. One of them hit my boyfriend in the stomach because he was too feminine saying that he was acting like a girl. So I spoke up and told him to stop treating him like that…. He then hit me several times all over my body including my head with his baton then put me in handcuff, saying he was going to lock me up…. They had me handcuffed to a bench at the station when we got there…. I wanted to know why
they were locking me up so they told me I was being locked up for using a curse word. My boyfriend wasn’t there when they were beating me at the station. If he was, I would have killed myself…. I couldn’t have him see that… I got some rawtid [damn] lick from them… while they were hitting me they kept yelling… “battyman must die.” “Any faggot who comes to this parish must die.” That was exactly what they said…. Word for word… The neighbor who called the police to come help us called the station all night to check on me to see how I was doing. I spent the night handcuffed to that bench and they released me the next day without charge. Apparently they did not know what to charge me with…. Even though they really wanted to charge me I know they couldn’t because I did use the bad word…. But it was in my house…. Not in public… and according to the law… that was ok. You can curse on your property but not in public spaces.

Frank (age 26)

Like this respondent, JMSM who reported similar negative treatment by the police indicated that they often refrained from reporting the abuse to the officer’s command due to fear of police reprisal. Many indicated an inherent mistrust and had a general feeling that such matters would not be investigated. When asked why he did not report his experience of abuse by the police, one JMSM explained:

After he ill-treated me I asked him to apologize. He never apologized. So I made it clear to him that I was going to file a report… and I said that this is verbal abuse. So he came up to my face and said, “What did you just say?” He was speaking to me in a voice that was threatening to me. It was as if he was trying to intimidate me. I ended not reporting it because I don’t trust the police here. I think they are all in collusion with each other. I was worried that after reporting it they might call me an informer and come to hurt me. Roy (age 20)

Another participant recounted a similar encounter with an officer from his community.

He stated:

I had a nasty encounter with a police officer at a station in my community. My mother was with me at the time…. I said to him that I was going to write a letter and put it out there in the papers to show people how the police system is in this country…. So then he said that it was my business and I should do whatever I want to do…. “We don’t want any battyman around here”…. He told me that he
was the Chief of Command so I can’t do anything to him. *Focus group participant*

Some JMSM who were victims of abuse or assault by members within their community expressed concerns that law enforcement officers refused to take their reports because they were unwilling to “taint their logs with homosexual language.” This may offer some explanation into the sparse statistical data on crimes that were committed towards homosexuals because of their sexuality.

I remember the police was called in for an incident that involved me and a relative. I remember going down to the station and they asked what happened… Of course you know this was going to be the bit of the week or the embarrassment of the moment. So I said to the officer that I had just came home from school and reading an assignment that I had coming up… [and] he came into my room and was cursing and started to call me *battyman* and *fish*. The officer then said,” Stop. What did you said he called you?”…. So I repeated it again. So he told me to stop again…. Then he said we don’t really want those things in our report book…. So [I] told the officer that the family member accused me of something and violently attacked me so why was it that he was refusing to take the report. I asked him if he was refusing to take the report because of my sexual orientation and then he said…”You are in Jamaica; why are you talking about sexual orientation?” So then he asked if I was gay. I refused to answer him. He never took the report. *Garry (age 26)*

**Finding an Escape.** JMSM expressed concerns about living in the society and reconciling their sexual identity (and orientation). For some JMSM, finding an escape from the homophobic attitudes of members of the society was the only way for them to be comfortable with their identified sexual orientation. JMSM interested in getting married, starting a family, or dressing in female clothing all expressed a desire to live outside of Jamaica.

If tomorrow morning comes and someone tells me that I can leave the island, I don’t know where I would go, but I would leave Jamaica in a heartbeat. Leaving here would make me feel more comfortable being gay. *Zack (age 21)*
There are many legal ways for JMSM to leave Jamaica. Those fortunate to acquire a visitor’s visa from either the embassies of the United States, Canada, and United Kingdom were able to leave the island legally. While some sought asylum immediately after arriving in one of these countries, others declined to return home by overstaying their visa, which then automatically rendered them with undocumented status.

I got the opportunity to leave the other day but when it came to it I just couldn’t go through with it. The preparation was not enough in terms of what will I do or who will I live with when I got there. I got the opportunity to go to a conference overseas. I wanted to just run-off when I got there. But the organization that I was working for told me not to do it. I guess if I had done it I would have been homeless in a foreign country… but you know when I came back to Jamaica after attending the conference my gay friends were saying that I was a fool. I have a friend who went to the same conference last year and they didn’t come back to Jamaica. So I guess I learned my lesson. Next time I will make preparations ahead of time so when I leave; I would never come back to this place. *Arron (age 24)*

Overall, a common theme emerged for persons wanting to leave the island. For these JMSM, comfort in expressing their sexuality without fear of discrimination was the common reason for wanting to leave the island. This was common across education and income levels for the JMSM that were interviewed.

In the society in which we live, homosexuality is not tolerated, so persons usually seek asylum. So you have these persons who are well educated that are thinking of leaving because of them not being able to express themselves the way they want to. They can’t express their lifestyle in ways that are comfortable for them. So persons usually seek asylum. Leave the country… You know… to get away from family, etc… to be themselves. So you never asked me if I wanted to leave the country someday. My answer to that question if you had asked would have been yes. *Barry (age 22)*

Many countries were identified by JMSM as potential places for relocation. The countries identified were in the Caribbean, Europe, and North America. JMSM specifically identified the United States, United Kingdom, Canada, The Netherlands,
France, and Trinidad and Tobago as potential places where they could relocate. These locations were chosen by JMSM because of their acceptance of homosexuality, freedom of expression, and same-sex marriages. Other reasons for leaving included the need for better educational and financial opportunities.

A few years ago I was able to leave the island to study abroad in Trinidad and Tobago. It was fun. I enjoyed it to the fullest. It was my first time away from my parents, my church, and Jamaica. I felt liberated.... You know, I think Trinis are ignorant as Jamaicans.... But they are far more accepting of homosexuals than they are here. They don’t care about how you dress like they do here.... They are not afraid to be your friend even though they know you are gay.... Unlike Jamaica were they would say, “Birds of a feather flock together” .... When I was in Trinidad [I] would go out and mingle and stuff like that.... But here I don’t do it because I don’t want anyone to know my sexuality. 

Roy (age 20)

I would leave here for two reasons because of my sexual orientation and to further my studies. I want to leave here to further my studies and to also make some real money. I have been considering going to the U.S. but I have a few people telling me that I should try Canada too. I have friends and family in the U.S. and Canada. I like where they are in terms of the Human Development Index, you know, quality of life and stuff like that. 

Ken (age 24)

Oh lord.... If somebody could just buy me a ticket to go like Amsterdam or Canada I would just take it and run. Right now I am trying to start a project and as soon as I am finished and everything, I would take my money and run. There is no room for me to improve here in Jamaica....

Focus group participant

Experiences in Navigating Social Institutions within the Society

Theme 2: Educational, religious, and other social institutions reinforce socially and culturally acceptable norms against JMSM through a process of stigma, discrimination, and neglect.

Educational Institutions

“The last high school I went to the guys wanted to jump me because I was too feminine for the school.”
Jamaican MSM in this study participated in different components of the education system. Their experiences ranged from traditional to technical high schools. In Jamaica individuals who score exceptionally high on state-issued exams could select from any of the prestigious traditional high schools on the island. Those with lower scores were placed in community technical high schools. Although many attended public schools, a few young men indicated that they also participated in private schools as well. While many attended mixed gender institutions, others attended single gender (all male) schools. Mixed gender schools were found to provide support for MSM who were exploring their sexual identity. For many, they were able to explore their affections with girls their age, while they came to terms with their homosexual attraction.

At that time in high school I was a *gallis* [a man with multiple women] so to speak…. I can remember I got enough money to take care of myself so I would go and buy lunch for the girls…. I was very popular in high school…. I [used] to sing in concerts and stuff…. High school as it relates to gay life, there was no gay life in high school for me…. Even though there were gays in the school. At that time, I wasn’t associated with that kind of life…. As I said, during high school, I was more of a *gallis*. In terms interacting, I interacted with a whole bunch of girls.

*Frank (age 26)*

JMSM described primary school as a place where they experienced the least amount of discrimination. While the general student population may have been cognizant of colloquial terms used to describe homosexuals and the anti-homosexual attitudes held by many in the society, the JMSM in this study experienced only instances of verbal abuse from their schoolmates in primary school. They did not report physical assault by students. For some participants, primary school was seen as a place for feminine boys to express themselves freely (despite the verbal assaults). However, they were also conscious of the fact that they might have to conform to societal rules around
maleness and masculinity if they wanted to survive in a secondary educational institution (high school).

When you are younger, person don’t pay so much attention to your lifestyle. But as you grow older it becomes more, you get more attention. So I would say when I started high school, I usually hang out with most of the girls, not so much the boys and persons will call you a sissy and stuff. So it’s basically in high school that it starts. First year of high school, grade 7 through 9… usually someone [would] have something to say about the way you would act, or the way you would speak and stuff like that. *Barry (age 22)*

Primary school was easy. It was a breeze until I went to high school. In primary school, you don’t think about who you are. People don’t really mess with you that much. For me it was all about playing video games, watching TV… Dragon Ball Z was my favorite cartoon at the time. I remember loving pop culture…. You know Britney Spears…. *Omar (age 23)*

Primary school was good. I was always active. I think there was a point in primary school when I was out there… meaning that I wasn’t afraid to play with the girls and stuff like that. Because I chose to play with the girls and not the guys I got a bad rap for that…. I was more feminine in primary school too…. But when it was time for me to go to high school I was like, I got to cut that out…. I did not want the other boys to tease me because I was hanging out with the girls…. So it was something that I definitely had to cut out in high school. For the first part of high school everyone thought I was this horrible serious person… but it was me trying to cut out that feminine part of me…. I didn’t flash my hands, nothing like that…. I was cleansing all of it, bringing it to a minimum, and it worked. *Wade (age 20)*

Adolescent males who were expressively effeminate recalled discrimination during their high school years. They were often the victims of both verbal and physical abuse. For many JMSM this was their first direct encounter with physical homophobic reactions. Many attributed the discrimination (by students, faculty, and staff) to the attitudes and beliefs held by adults within the society. For a majority of the JMSM participants school bullying was a result of how others perceived sexuality, similarly to earlier descriptions about community responses to homosexual adults. Although they had
not disclosed their sexual orientation, many were labeled as homosexuals because of their mannerisms or the company that they kept. They were teased, called names (i.e., *battyman, faggot, and fish*), and often attacked, even on school property.

I think it was in 9th grade I remember going to the wood workshop and I was backed up in a corner by a group of 12th grade boys who attacked me. There were girls there too and they participated in the attack. At the end of it I was told that I did something and said something to some girl that I didn’t like…. But I later found out that I was because I am gay. It felt awful. I felt like I did not want to go back to that school anymore. I felt betrayed…. I was really upset because it was all over the school…. Everyone started calling me gay. **Garry (age 26)**

When I was in the 7th grade everything was good and mellow; it was one of the brightest schools so everybody was soft even though they say the *douncer* [less intelligent] boys were always rough around the edges…. But everybody was soft so some people were coming from a very rich home…. But at the end of grade 7 when some boys started mixing with the guys from the 8th and 9th grade, they try to man up now so they will start calling me faggot and stuff. What was interesting is that if you are masculine and you do the gayest things persons wouldn’t make much comment about it… they would just laugh it off…. But if you are effeminate [then] the slightest thing you do they make a big deal out of it…. I guess for them it was just guys being guys. For us feminine guys, we would get some beating from them. **Roy (age 20)**

Educators who were not complicit in the discrimination against young JMSM students often did little or nothing to address issues of bullying (in and out of the classroom). This fostered an environment where young MSM were afraid to report the abuse or seek assistance from persons in authority. Some students elected to leave the institution due to reoccurring re-victimization.

There was this one time when I was in high school, I was homeless at the time, and you know jumping from one guy’s house to the next. I was on one of the sports teams at my school… I was pretty good actually. I held the record there…. One of my friends thought he was helping me out by coming up to the school to tell my coach that I was sleeping on the road and sometimes sleeping at the houses of older men…. The coach told the team I was a *battyman*. Later that afternoon I went to practice and I was attacked by the guys on the team. My own team attacked me. They hit me with a stick and a piece of board among other
things…. The coach stood outside while this was going on and did nothing. He didn’t help me or tell them to stop. I think they did that to me because they knew I was vulnerable. I was living on the street and I wasn’t living with my mother. I told my mom about it though. We went to an organization for help and they took us to the police station. But after hear about the process like pressing charges and going to court and stuff… another thing is that my mother was so knowledgeable about those things we just dropped it and moved on. I gave up my scholarship that I had gotten accepted to go to that school and went to a technical high school. The way I see it, it was a school for low achievers. I finished the school but didn’t get any subjects. Arron (age 24)

JMSM caught engaging in simple displays of affection with members of the same sex were asked to leave the institution and their parents were notified. The activities were often characterized by respondents as being caught in a “compromising position.”

There was this one time in high school were someone was beaten up because of rumors, even though it was true. These two guys were in the bathroom fooling around and they got caught. One of the guys was chased by other students. He had to run to the principal’s office for rescue. After the incident he had to have a teacher escort him to and from his classes. He was allowed to leave school early during the day. For example, if school let out at 230 PM they allowed him to leave around 215 PM to avoid the rush by students. Within three months it stopped, it blew over. I guess people forgot about it. Knowing how the society is I felt that was really reckless on their part. Something good came out of it though. It reminded me to always be on guard…. I was extra defensive, absolutely no slip ups. Wade (age 20)

After graduating from primary school, I went to one of the highest high school here. It was an all male school…. Just one of the best…. Everything was going real well until something happened…. I realized there were a lot of guys there who I thought was gay but at the time I didn’t know how to react to them. So later I met a guy on the school compound. We started to flirt with each other until we decided to engage in our first sexual experience. We started making out in an empty classroom. I always hear about students being caught doing stuff in the bathroom so I made up my mind that I wasn’t going into any bathroom. We got caught in the classroom. A security guard was walking by and caught us. He brought us to the principal’s office for the principal to speak to us. I was 14 and scared. He kept saying that we were bringing down the school by engaging in such activities on the property. He told us that people already had it to say that only battyman goes to this school. He just kept cursing expletives upon expletives at us. He called our parents in and told them what happened. I was scared to my wits…. I didn’t know how daddy would react. He would be so
embarrassed and devastated. The principal expelled us. I bounced around from one technical high school to the next because daddy refused to spend the money to send me to another good high school. **Boe (age 19)**

The pervasiveness of the homophobia experienced by many JMSM in this study led some to even abandon their education. The lack of support and protection from educators within the institution made it difficult for them to complete their studies. Other JMSM who were victims of school based bullying reported not receiving any support from persons such as school guidance counselors. Some chose to not even talk to their guidance counselors due to mistrust.

The last high school I went to the guys wanted to jump me because I was too feminine for the school. They plotted something thinking that they could beat me but I retaliated and stabbed them. I tried reporting it to the dean of discipline and he did nothing. He told me that if I was actually gay he would get rid of me off the school compound at the snap of the finger. Man… I honestly wish I could have reported that school. I felt so powerless…. I gave up totally. I really couldn’t take it anymore. It was damaging me psychologically. I was afraid to talk to the guidance counselor because I was sure how she would react to my sexual orientation. I really think the Ministry of Education should put safe security systems in these school to protect people like me…. I was tired of it all honestly, man. I couldn’t take it anymore. I would go back to that school over and over again and nothing would change. It was like the same thing over and over again. Constant name calling…. So I dropped out of school. **Boe (age 19)**

You might go to a guidance counselor for help and not really get it. There is no solution…. So if I do go to the guidance counselor they will tell me what I already know basically. They don’t really give you any solutions even if it is about your sexuality and you fighting because you are being teased at school. If I go to the guidance counselor and say these guys are teasing me and so forth the guidance counselor would just say, Why don’t you avoid them? Or that I need to avoid them…. So she is telling me stuff I already know. It’s pointless. **Focus group participant**

I am just afraid of people. Let me tell you something; this is how I feel. What I noticed is that I have to study people. I am not that bright but I try to use my head and study people so you can be safe. You have to know the teachers who you can talk to. You have to know who will sit down and talk things through with you, and even with that you have to try and use your head. You will find that a lot of
gay kids here lie a lot about the life that they live… that is because you have to lie all the time so people won’t suspect you. You share your story with them and then they turn around and tell the other teachers what you told them…. I don’t want that to happen to me. So for me to go and share what is going on in my life with the guidance counselor I just won’t feel comfortable with that. **Zack (age 21)**

In Jamaican schools male students were typically prohibited from participating in vocational activities that were specifically geared towards female students. JMSM interested in vocational activities such as cooking, sewing, and home economics, were forced into other trades such as carpentry. Two participants recounted this experience and expressed that they were only allowed to do the vocational training that they desired, home economics, after personally approaching their teachers. One had a favorable experience and his grades improved, while the other abandoned his training as a result of bullying and homophobic actions.

When I was in 9th grade I was assigned to the woodwork shop to learn carpentering. This was wood work so I was going to be assigned to this for one year. After that you go to the sciences and the arts. I remember my form teacher and she was like, “I noticed your grades for woodwork last semester and I don’t like it.” The theory aspect of woodwork I would pass but the practical piece, I didn’t like it. I always mess up. She was like, don’t worry, don’t worry, I will make you do home economics. It was compulsory to do home economic as a guy. The girls go over to home economics…. It was fun. It worked out for me because the girls were willing to assist. It was fun and my grades skyrocketed. It wasn’t until three years later that they integrated the whole thing by allowing you to choose where you wanted to go. **Garry (age 26)**

When I was in school I was doing business because I wanted to get into fashion. I was very good at it. I was good at sketching and designing clothes. They had that in home economics; it is called clothing and textile. I wanted to do it because I went to a place to start the training in sewing so I thought high school could help. Trust me I didn’t even do it because sometimes when I do thing like make baby booties and all those things…. The guys teased me and call me girl…. So I gave it up. **Steve (age 25)**
Homophobic experiences extended to university campuses as well. For some JMSM in this study bullying and negative attitudes towards homosexuals are common occurrences on local university campuses. While some JMSM have experienced the occasional teasing or name calling while traversing through public spaces on the university campus, others were victims of physical assault. Young men caught engaging in private intimate contact with another male were beaten and harassed by students and other members of the university community. The homophobia experienced by some JMSM also extended to their residential dormitories on campus. Heterosexual males have physically removed JMSM students from their hall if their homosexuality was revealed.

I can remember once on hall this Trinidadian person had some gay porn on his laptop and apparently he left it on and went to the bathroom. Persons were passing by and they heard the sex songs and everything and they kicked his door down and they went in and they destroyed the laptop. He had to move from off the hall and they tried to put him on another hall but the guys on that hall were aware of what had happened and they refused to allow him to stay on their block as well. He had to move to the female hall and stay with a female who was willing to have him as a roommate. I was disheartened about the whole situation because that could have been me. He was a friend of mine so I was affected by it somewhat and all the negative things people had to say about him. The names they called him [were] horrible. For awhile he couldn’t be seen in public. Person would throw things at him. So I was really disheartened by the whole thing. Roy (age 20)

Sex Education. Many of the JMSM in the sample reported receiving some form of sexual education from their parents. Some reported that their parents sat with them and discussed safe sex, while others reported being handed some form of material about the subject. Most of the sex education received by JMSM was taught by their mothers (not surprising when many were in female headed households). Fathers did not talk
about sex; however, they provided their sons with condoms as an attempt to introduce the topic of sex. There were no messages or education around sexuality, in general and more specifically, about homosexuality.

Well I learn about sex from my mother you know. She is not afraid to talk about sex in the home because she believes that all of her children should know about it rather than go out there and seek it from someone else. So she would tell me about it. She would tell you that it is good but you should know when and how as a child you shouldn’t run into it and not to listen to people. *Mark (age 23)*

My mom spoke to me about sex. It wasn’t really much. It was more of the typical things. You know! Like when you have sex use a condom and that there was stuff out there that you can get. You know…. Take care of yourself and stuff like that. *Garry (age 26)*

Funny enough my parents made a sad attempt. They were like go read this book. I was like twelve and I think they were saying that it was about that time. I think the book is called “The Complete Tween.” So they were like, go read this book. There was no explanation or anything. Just read the book. *Wade (age 20)*

These JMSM became aware of homosexual sex through various means. While they did not receive homosexual sexual education from their parents, information sources included other homosexuals, cable television, community workshops, and the Internet. Friends provided information on different sexual positions and ways of preventing HIV transmission. Gay themed cable television shows and movies provided JMSM exposure to multiple forms of homosexual relationships and sexual practices. Many JMSM also recounted their experience of attending homosexual content specific workshops sponsored by the Ministry of Health. At the end of each workshop participants were also able to take advantage of free HIV testing in a non-judgmental environment. The Internet provided several participants with privately accessible detailed information about different types of sexual practices of gay and bisexual men.
For the most part, I would listen to my friends and watch TV. I would watch all the channels that I wasn’t suppose to watch, and then go on the internet for more information.  **Focus group participant**

So I have two close friends and we talk to each other about these things. If I tell them that I just had sex they would ask me if I had used a condom…. If I say no, they will talk to me about HIV and that I can get it from unprotected sex. So they told me to go get an HIV test. So now I know what I am doing because of HIV. You understand?  **Zack (age 21)**

I remember I went to this gay workshop on Mary Road. I went there and learned a lot. I learn how to put on a condom and about anal sex. At the end of the presentation they gave us a certificate. We were also able to get an HIV test done.  **Sean (age 20)**

While many JMSM reported learning about homosexual sex through their friends, Internet, and cable television, some reported learning about sex from firsthand experience. These experiences included experimentation with a close friend or family member, often at an early age.

The stuff I know about gay sex… I learn about it hands on…. I didn’t use any Internet or anything. Mine was through experience. I just fit the puzzle together. When I was younger, me and my cousins would kiss [sic], then we wonder if our penis could go in other places so then we experimented and that was how we knew it could work.  **Steve (age 25)**

Learning about the birds and bees from my parents wasn’t enough. For me I learn about gay sex from the Internet, porn, and then actually doing it myself…. When I actually got into homosexual intercourse I had the internet and the Internet had videos that gave you the juicy details. So the internet gave me an idea as to what to expect.  **Kevin (age 21)**

I learned a lot of things about sex on TV. I observe a lot, analyzed and figure things out. If someone shows me something I try to figure it out myself after.  **Nick (age 23)**

Secondary schools were the primary source of some form of formal sex education for a few JMSM. This content specific sex education was hetero-normative, covering themes such as safe sex, abstinence, and no sex before marriage.
I did receive some sex education in high school from the guidance counselor. Homosexuality was never mentioned though. The only thing they talked about was how to protect ourselves, use a condom, and wait until we are married. That is all they really talk about.  **Roy (age 20)**

Our guidance counselor spoke to us about sex back in high school. The main message we got from that was that we should practice safe sex or abstain from sex really. They also said that there were different challenges that can come with you not abstaining like getting an STI, pregnant, stuff like that. They didn’t get into what you should do when you have sex. The main messages were to abstain or if you are going to have sex use prophylactics.  **Barry (age 22)**

With the limited content around sex education in secondary schools, efforts by the Ministry of Education to reform the curriculum was met with strong opposition. JMSM in school at the time of the public debate welcomed the proposed curriculum change. Due to strong opposition from parents, religious, and other special interest groups, the proposed curriculum change was later rescinded. For some JMSM the opposition was expected. They attributed this to the Jamaican culture and pervasive homophobia within the society.

School didn’t offer anything, they still don’t. They were trying to make some attempt to bring some kind of sensible sex education in the school but that was met with some controversies. People did not like the content that was in the books. There was some homosexual content in the book…. It’s Jamaica, people were behaving like it does not exist, and I was like “ignorance is not bliss” so let the people know—so that they can make their healthy decisions. Basically, there was no set sex education from authorities. What you know is what you found out on your own, or you can do rubbish or the good stuff that your friends would tell you.  **Wade (age 20)**

“The Bible based on what I see is used as a tool to drive homophobia in the society.”

**Religious Institutions**

For many JMSM, their religious milieu was identified as another source of socialization. The church was the place where they acquired their moral and ethical
beliefs. Although the church was viewed as a good place for socialization, many expected more from their church. While desiring the presence of the church in their life, many wrestled with internal conflicts. Reconciling their homosexual identity with the religious teachings of the church created many challenges for JMSM in this study.

The church was important for me growing up. It played a good role in my life. It was the main source of socialization, which taught me my morals and ethics. I think for me and most people in general, we hope that the church would not be so bashful as they are. I also want them to be more understanding. They should recognize that the world is not so black and white. There are some gray areas. They should dictate to people what they want. They are using the Bible to ensure that people adhere to the rules of the church. I just think these things are made up by them.  

Garry (age 26)

I grew up in the church. I went to a Christian Pentecostal church. Growing up in the church was extremely fun. I was actually excited to go to church. I was well involved. I did everything I could in the church, like dance, sang, and signed language. The people at church were fun because they were a lot of young people in Youth in Action. I liked going to church.  

Wade (age 20)

Although some fought to reconcile their homosexual identity with their religious teaching, others used the teachings of the church to help them process their internal feelings. Additionally, the fear of “going to hell” as a result of committing suicide brought one particular JMSM closer to his religion.

I think religion saved me. It kept me from going to the deep end actually. Religion actually saved me through getting rid of the thoughts of suicide. So like during the period where I thought about suicide and so forth. I think when it reached the peak of the thoughts—there were couple of Bible phrases and talks that I end up occasionally [stumbling] up on right especially the one that said persons who do suicides go to hell. My fear of hell kind of brought me back to reality and made me realize that killing myself won’t solve anything and it’s just a quick escape from internal torture on earth cause if I die I am going to hell. If I kill myself, I am going to hell.  

Kevin (age 21)

The church’s interpretations of the Bible caused mixed emotions for some of these JMSM. It was the perception of the MSM that the interpretation of the biblical
scriptures by some ministers were made intentionally to fulfill a hidden agenda by the church. Some saw these inaccurate interpretations as a way for the religious community to reinforce their anti-homosexuality agenda.

Where I have a challenge though is where Jamaicans speak of religion in terms of Christianity and whatever. The Bible based on what I see is used a tool to drive homophobia in the society…. Everyone have their own interpretation of what is said in the Bible you know…. All of it is subjective though…. I would really love for [a] person to explain to me how the Bible gives them the authority to discriminate or stigmatize any group or any person. I know the Bible didn’t say you should go out there and chop, kill, murder, and cause mayhem. I don’t see that anywhere in the Bible…. So again interpretations become subjective and it’s driving homophobia. These are persons who have their own agenda. Ken (age 24)

I really don’t think about what persons have to say because usually the thing a church person has is the Bible. They always say that Leviticus thirteen, man should not have sex with men. That’s not the only thing Leviticus 13 says, it say a lot of things that persons who are basing out at homosexual engage in. So I think it’s just a high level of hypocrisy. Someone who is doing something and bashing out against gay people are still sinners too. People shouldn’t judge another person because they are gay. This is why I pay a small amount of attention to what persons have to say. But for your own safety you just have to make sure that they don’t know about your sexuality. Barry (age 22)

Through interpretation of the Bible and other messages received from the church about homosexuality, many JMSM felt they were not welcomed by their church. For some, their perceptions were based on prior experiences with direct anti-homosexual attitudes directed towards men in the church. Many viewed the church’s stance on homosexuality as being “hypocritical” around the issue. Some JMSM expressed that they would prefer for their church to provide support on issues such as HIV and promoting tolerance and acceptance in the society.

You know what I want the church to do? I want them to stop being hypocrites. Stop saying that being homosexual is a sin. When you do infidelity… what are the others? I don’t even know. But when you do those there is like an acceptance
to it. They basically say you can go to God and beg him forgiveness. But then if you are homosexual they would say that this is wrong and you should not be a part of the church. I have heard of a lot of situations like that. They would just bash you because they don’t want you to be a part of the church. I think that should be changed. As Christians, [the church practice] should be: the persons that are homosexuals can go and ask for help if they need it. You should be there for persons, not bring them down. *Mark (age 23)*

I heard that heterosexual men, those that live the right way according to the Bible, which I observe to be a phony…. I am sorry that is just my view and if you live the heterosexual lifestyle you will live a long life because you are living in God’s eyes. What God expects of you as a gay man is just plain and simple; if you have sex with another man you are condemned and should be put to death. At one time I thought that I needed to change because I didn’t want to go to hell. But looking back at it, I realized that I am needed to live my life because it’s mine…. So why should I let anyone tell me how to live my life?…. It is mine…. So I was like, if I am going to hell, I am going to go in style. I am going to walk down the devil’s Broadway in my drag and I am going to shake his hand and say hi. *Boe (age 19)*

Some JMSM found themselves selecting churches that were supportive of them regardless of their sexuality. Although anti-homosexual teachings were common in those churches, JMSM reported feeling welcomed because they did not perceive the messages as being directed towards them. Others who were in need of the church’s assistance due to their homelessness and poverty situation also endured negative attitudes promulgated by members of the church.

The thing is that we go to the church but we don’t really tell them that we are gay. We don’t say we are gay and we are sitting here. No! We go there and sit down as normal people. But sometimes the pastor will pick it up and then come to us and talk to us about our lifestyle and we will share it with him and then sometimes he will go the pulpit and preach about homosexuality. They will preach about it and say that it is wrong but they won’t go up there to say that John in the audience is gay and he needs to repent in front of the church. No they won’t do that. But I guess you put up with it because you really need the help. *Steve (age 25)*

Living in the shadows was a protective factor for some JMSM who desired to feel welcomed in their church. Many of these MSM played an active role in the church.
Some were in leadership positions like directing the choir, youth ministry leader, or Sunday school teachers. They were able to remain in these positions only as long as their sexuality was unknown.

My church family loves me. They really do love me. I am active in the church. I am one of the few young men who are so active in the church. I was away studying abroad a few years ago and when I came back things weren’t the way they were before I had left. People were glad that I came back so things could get back to the standard that was there before I left and they thought I could do that. They welcome me though as long as they don’t know that I am gay. *Ray (age 20)*

JMSM who are feminine were often sexually assaulted by older members within their religious communities. Some experienced unwanted touching, ranging from a slight hand on the shoulders or legs to aggressive sexual assault. These incidences often go unreported due to the fear of being labeled and rejected by their church.

Something happened to me one time when I was young and attending Sabbath day classes. This deacon came and sat beside me and I felt his hand touching my pants. I just moved to another seat. I was so frightened because I wasn’t expecting anything like that at all. *Nick (age 23)*

I was about 11 or 12 at the time. There was this dude in the church and as young as I was I noticed he was looking at me. I didn’t really put anything to it. One Sunday I took myself up and went to the bathroom to urinate. It was kind of a secluded place… So as I was urinating I heard someone walked into the bathroom. As I was walking out he held on to my hand. I remember him saying, “How you do” and I said, Yeah I am good, as I was trying to make my way out. I realized the door was locked from the inside and he then grabbed on to my hand and my neck with his other hand. He then told me not to scream… “Yuh nah f* scream, just tek it easy” [Author’s translation: You don’t have to scream, just take it easy]. So then he started drawing my shirt out of my pants and he started to unbuckle my pants. Mi did lickle and mawga dem time deh [Author’s translation: I was little and slim at the time]. I was also a little feminine too… I wanted to scream so badly but I was worried about what might have happened to me. Luckily my grandmother who I had went to church with started worrying about me. She came to the bathroom asking me what was taking so long. She knocked on the door and he realized and said answer… So I fixed myself. My grandmother wasn’t stupid; when I walked out I had to tell her what happened. She was asking why a 40 something year old man doing being locked up in a
bathroom with an 11 year old kid…. Then she threatened him. She told him if
she ever saw him in the community again he wasn’t going to like it. From that
incident she held on to me and hugged me. From that incident he left, he didn’t
stay and I have never seen him again. Ken (age 24)

Some JMSM had firsthand experience with homophobic behaviors in their church
homes. Some witnessed the removal of church members whose sexuality was questioned
by other members in the church. Men who once held leadership positions in their
religious communities often had to leave their post and the church if their sexuality
became public.

There was a member of the church, a brother; someone accused him of making
some sort of sexual advances towards him. The dude who accused him went to
the senior pastor to report it. The pastor called a meeting…. The accused was
very active in the church…. They asked him to leave the choir and not to take
part in anything else in the church…. So eventually he left the church. They
probably felt that the tendencies are still there and they he may affect the young
people in the church. I was upset about the whole thing. He was very involved.
He was the choir director, led conventions, and read public announcements. So I
thought if they could take such [a] drastic measure like taking all those things
away from him, I wondered what they would do to me. They would probably
throw some hot water on me or something. Garry (age 26)

Some JMSM who grew up in the church engaged in the practice of “praying the
gay away.” For those who were unsuccessful at changing their sexual orientation, they
felt as if they were living a lie when attending church. As a result, many of the
participants in this study made a conscious decision to leave the church completely, while
some left the church when they were older and could make the decision to attend church
based on their own free will, instead of the insistence of their parents.

I can say that the church definitely pushed me closer to accepting who I am. I
have never been comfortable in any church because of their teaching. I left the
church when I was young because of the fear of rejection. If someone in the
church had found out about me or that I had these thoughts they would certainly
tell me to leave. All I could think about is them telling me to leave. **Larry (age 24)**

I did feel like I was living a lie that is why I stopped going to church. I try to be as honest as possible. I never felt any connection with being in the church…. I am not going to be the one who goes to church and be condemned. So basically from I was 17 or 18 I stopped going to church and my parents noticed. When I am here at school I don’t go to church but when I go home I go to church just to please my parents. When I go I don’t even pray or anything and it disturbs me when a lot of people are strongly in church and they are gay… but I guess they have different way of reasoning it but to me I don’t think it can work so I gave up on the whole thing. **Wade (age 20)**

**“Dancehall encourages hatred and violence towards homosexuals in their songs.”**

**Dancehall Culture as an Institution**

Dancehall spaces are arguably the quintessential representation of Jamaica’s popular culture. Many JMSMs, however, rejected the messages espoused by dancehall artists around maleness and masculinity. Generally, the JMSM in this study believed that dancehall music promotes and reinforces negative distorted morals and values. Men are reminded of their responsibility and rules are set in terms of how they are expected to behave as men. If those rules and expectations are not followed, one is labeled and identified as a homosexual.

There is one particular comedian that we have in Jamaica whose name is Shebada. He is very effeminate. Just really out there. So they would always sing in their song that they don’t want youths to behave like him. So we are always hearing that we should not act like Shebada because he tends to dance and act like a girl. So they always use him as a reference in their songs. So we know not to act like him because he is a battyman…. You know the funniest thing about dancehall is that you have all these rules that you have to follow…. They sing that men is[ sic] not suppose[d] to wear tight pants and then you turn around and see the same dancehall artist in the same tight pants…. So there is some double standard to it. They tell you not to pierce your ears or tongue but they do it. So it’s confusing…. They say if you do these things you are not considered a man and you are not living up to what a man should be. **Garry (age 26)**
Sometimes dancehall music is too much in a sense that it is always about women and sex. And if you don’t have a woman you are not a man, you are a *battyman*. Stuff like that. It gives youths a sense that if you don’t have four or five girls you are on the borderline. Your sexuality is questionable. Sometimes dancehall is too much and if you follow everything you will be all over the place sometimes.…. 

*Focus group participant*

Many of the JMSM in this study were able to identify numerous songs that spoke out against homosexuality. As result of the lyrical homophobic content evident in dancehall music, many participants disassociated themselves from it and refrained from recognizing it as a representation of their culture.

In the music they preach that if you are gay you must die. Society should hang you, string you up alive, and stone you. If you are gay you can’t come around and hang with us straight people. Run them out of your house, yard, and stuff like that. Artist like Capleton and Buju Banton are famous for songs like that. *Frank (age 26)*

I don’t listen to dancehall music because it is totally against my culture. They hate me so I turned away from them completely. Their beliefs are not my beliefs so no one can push me or tell what to do…. Dancehall preaches about homosexuals being wrong in every song. It encourages hatred and violence towards them. Mostly all dancehall music encourages that kind of behavior. *Barry (age 19)*

JMSMs who continued to recognize dancehall music as part of their culture, regardless of its hostility towards homosexuals, enjoyed taking part in the space created by dancehall through a process of filtration. JMSM reported enjoying the music; however, they tried not to listen to the songs that speak directly about homosexuality. Some participated in the anti-homosexual chants as a way of protecting themselves in these spaces. For other JMSM, dancehall music allowed them to embrace their culture, dance, and feel a sense of cultural, if not homosexual pride.

I was never drawn to dancehall music. Maybe it was because I never went out much. I use[d] to hear it but not listen to it much. But I listen to it now because I
hear it a lot when I go out to parties. It’s funny to dance to in that sense. I like it now. However, I am annoyed by some of the anti-gay lyrics that they produce. When those songs are playing I would be silent or when a DJ wants to big himself up by saying “Who say battyman fi dead” [Author’s translation: Who agree that gays must die] raise your hand, I would just stand there and say, Good luck with that. Wade (age 20)

Dancehall does not influence me much at all. It has no influence but I love listening to my dancehall. Why? Because it gives me a groove of being entertained. I can listen to it and be happy. But then I don’t listen to the lyrics and use it play a part of my daily life…. They might bash gay men and all that…. I don’t see a problem with that because it is their society, that’s all they know. So they need to keep up an image…. I don’t take it on my head to have a problem with what they are saying. I just enjoy the music itself. Even some of the songs that bashes gay people I listen to those too. Mark (age 23)

I never used to listen to dancehall prior to leaving Jamaica. I would hear it but never really listen to it, you know. But then I went to this other Caribbean island and I saw how they loved dancehall, how they embraced it so I felt bad. That’s when I started listening to it…. Then I found it intriguing to listen to so I listened more. It’s kinda [sic] fun, fast beat. I even listen to the burn out battyman songs because I find them funny anytime I heard them. I think it is more of an appreciation of Jamaican culture than anything else. Roy (age 20)

Other JMSMs who were at venues where homophobic dancehall music was being played found themselves filtering songs that speak directly against homosexuality.

However, some participated in the homophobic chants at these events as a way to obscure their identity.

When I am at straight parties sometimes and the DJ would play those anti-gay songs I often just stand there and pretend that I am enjoying it…. I would think to myself, What am I going to do? Am I going to follow them and burn out the gays too? I am not going to do that because I would be living a lie if I did. So I just stand there. Mark (age 23)

I like dancehall music because it gets me going. I don’t really pay attention to the homophobic part. Like for example, if I am listening to a song and it says don’t wine, wine, and if you are winning you are a battyman. I am not going to pause and not dance to the song anymore. I will just continue dancing. Oshane (age 18)
Jamaican MSM who were marginalized and alienated by Jamaica’s dancehall culture often turned to soca music (i.e., Bacchanal/carnival events) and the space it creates. Soca is a form of Caribbean music that originated in Trinidad and Tobago; it is infused with calypso to create a fast pace and upbeat tempo. In Jamaica, soca music, through carnival-type events, created safe places for JMSM to dance or wine (gyration of the hips and waist as seen in many West Indian cultures). These soca events afforded them the opportunity to express themselves freely and provided them with a sense of belonging in a society that viewed them as foreign.

I like to dance and soca is dancing music. The lyrics are clean and sweet. I really liked it when I went away to that other Caribbean island. They have a subtle way of expressing what dancehall would say like really raw. You don’t hear them singing about burning gays. It is all about drinking alcohol and dancing up and down. Roy (age 20)

Soca is one those genres of music that I think offers freedom, unmitigated freedom. I don’t think it is the music, it’s more the event. Usually at certain events you probably would have heard about it. At certain soca [bacchanal] events gay people are just free to enjoy and be themselves. You just hear persons talk about how they were behaving badly at those events…. [Laughter]…They pretty much let loose. Larry (age 24)

I like the up tempo beat in the songs. It’s one of the few times where as part of the community I go out into an open space and mingle with other people. Just wine and get on bad. There are no restrictions as to how you are suppose to behave per say. You just wind and have a good time. There are usually a lot of [Bacchanal] events going on leading up to carnival. There are so many gay people there it is unbelievable. They are just there having a good time and enjoying themselves and just letting go. Ken (age 23)

The investigator had an opportunity to attend several soca (Bacchanal) and dancehall events. At a typical dancehall event, men were observed either hanging out with a group of other men smoking cigarettes or marijuana, drinking, and sometimes dancing alone or with a female in front of them. The investigator also observed that
periodically the disc jockey would utter phrases such as “battyman fi dead” (gays must be killed) and “who don’t like battyman put unnuh hands up in a di air” (if you don’t like gays put your hands up in the air). These phrases often evoked praises from mostly men in the audience. The key participants who accompanied the investigator to these events, who also identified as MSM, participated with similar responses. When asked later as to why they participated in the homophobic chants, they all reported that it did not bother them and that if they had not participated perhaps the other patrons would have noticed and created a scene.

Attendance at various soca/carnival events by the investigator provided new insights into why this space was seen as more supportive of MSM, regardless of whether or not they were masculine or feminine. On immediate observation, it appeared these events allowed for men and women to dance in provocative ways that would not have been allowed in the dancehall area. Men were seen gyrating their hips in close proximity to each other. Some were observed dancing with females. As the night progressed, it was not uncommon to see some men dancing with each other. These spaces are usually closed off to general public and a fee is required for entry into the venue. Based on the investigator’s observations at many of these events, it appeared that these soca events allowed for MSM to consume alcohol, dance, and let go temporarily of the stigma and discrimination promulgated towards homosexuals. Although heterosexual persons were in attendance at these soca events, they knew that negative behaviors (i.e., personal attacks against LBGT individuals) were not allowed and that if they expressed these behaviors the organizers would ask them to leave.
One day while at a local barber in Kingston the investigator asked the barbers and other patrons if they have ever been to a soca or carnival event. Overwhelmingly, the men responded that they refused to attend those events because many homosexuals frequent them. With the observations made and statements noted by many JMSM, it appeared that soca (via carnival) created safe spaces for JMSM to temporarily be themselves in the larger societal context. Many JMSM reported that regardless of social class, economic standing, or levels of education, soca/carnival season was Jamaica’s unofficial gay pride.

Although many of the soca events on the island created a safe environment for JMSM to express themselves freely, some met resistance (verbal assaults) from other patrons who disapproved of their flamboyant behavior. For example, an individual dancing by himself may not pose much of a threat; however, once he begins dancing with another male in a public setting, he is met with negative reaction.

A few months ago at this year’s national road march for carnival there was an incident. I wasn’t there but it came in the papers and on the news that they [gay men] were dancing on each other and that got the crowd upset so they started to throw stones and bottles and shots were fired. But I think in that particular incident the winning on each other got people ticked off because generally you will see one person dancing by himself and people don’t really care. They would just say look at him enjoying himself. I think it is the winning on each other that people that made them upset. That went a bit too far. Larry (age 24)

Sexual Identity Development

Theme 3: JMSM sexual identity development is viewed through the microcosm of having a dual identity. For JMSM, developing an orientation that is contrary to what is socially and culturally acceptable is perceived as un-Jamaican.

“When I was young I didn’t understand what it was that I was feeling.”
The JMSM in this study became aware of their sexual orientation or same-sex attraction during their early childhood and adolescent years. Childhood games, such as “dolly house,” “hide-and-seek,” or “purple touch” provided these JMSM with an avenue to explore sexual thoughts and feelings with their peers. Childhood games such as “dolly house” helped JMSM mirror relationship dynamics seen in adult heterosexual relationships. Those dynamics often facilitated their curiosity with sex and assisted in sexual exploration with peers. Playmates took on the role of “mother,” “father,” and “children.” Initial sexual experimentation began here between the two playmates that had taken on roles as parents. “Hide-and-seek” and “purple touch” (described in the quotes below) are games that are played in private, sometimes in bushes or enclosed, secluded areas. They provided the JMSM with the opportunity to explore the body’s of their playmates in a non-judgmental way. However, with an early understanding of the culture and the risk associated with being caught in a compromising situation with another male, young JMSM engaged in sexual exploration in secret and often in public places (schools, churches, and public bathrooms) that were considered dangerous.

I realized that I was gay when I was 4 years old. I had some friends that usually come over the house…. We usually play together…. And we found ourselves playing with each other in a sexual way…. We played like hide and go seek, dolly house, stuff like that…. At that age I [knew] I was different. Mark (age 23)

When I was in sixth grade I remember there was this guy…. He was half Jamaican and half British. He was here for school at the time. I didn’t take the feelings I was having for anything really. I figured it was just me being a child. You know you always play dolly house and stuff like that. So in sixth grade me and him [sic] sat together in class on a bench that could seat three persons. While we were in class he rubbed all over my legs and stuff. I honestly didn’t stop him. So eventually when it continued I realized that I like him. Then we began moving closer together. Later he left the island to go back home. I went to high school and started checking out other guys. Garry (age 26)
The first time I had sex with a guy was when I was 12 years old. He was 14 at the time and in a gang.… You know we are boys. No one was questioning our relationship at the time because we were kids. So he and I were always together. It happened that his father migrated overseas and left him with his own place. Fourteen years old, living on his own, you know. We started playing games like purple touch. You know it? In purple touch you have to have your hands a certain way when they call on you and if your hands are not in that position, the person can touch you on your private. We use to kiss and hug each other, then sex. It was the first time I saw cum. I didn’t understand what was going on. At first when I saw it I was shocked and trying to figure out what it was…. Lord Jesus, you understand. **Zack (age 21)**

Although some JMSM satisfied their own curiosity about homosexuality by exploring their sexuality at an early age with their peers, other JMSM were pressured into having sex with a female at the behest of their family members in order to prove their manhood or heterosexuality.

I moved to live with my step-mother where I was physically abused around 8 years old…. I began to become confused with my own sexuality. So then I left and went to the country and I was forced to have sex with a girl down there because I didn’t seem to fit the ghetto or masculine enough type. So I left and went to live with a female who helped me out. I went off to college where I decided I was going to change my life. I fought the situation where I came across men who wanted to give me money or anything I wanted just so they could sleep with me. I wasn’t about that at all. **Andre (age 29)**

Some JMSM were coerced into sexual activity with boys who were not their playmates and who often were older than they were.

I had an interesting experience with someone when I was 8 years old. We were playing dolly house. There was no intercourse or anything…. Let me explain the scenario. It was like we were a family. You had mommy and daddy and us kids. Mom left one day and went out so it was daddy and me at the house together. We were using another friend’s house to play dolly house. So I was on the bed with daddy, he asked me to give him a blow job and so that’s where it happened. He was a little older than me. I did it that one time. Another time we were playing again and he asked me to do it and I told him no. He got really upset and said that if I didn’t do it he was going to tell everyone that I gave him a blow job while he was asleep and that I was nasty. I refused. Because I refused he went and told his
cousin. So news got to my father and I got some good beating and he never spoke to me after that. Everyone in the community knew…. It was so embarrassing. Nothing happened to him because he said he was asleep and I was the one who did that to him. Deep down I knew my father was angry at me. I felt it with every blow that I got. I was really ashamed.  *Roy (age 20)*

It all started when I was a little child because my brother’s friend would come over our house. That was my first time seeing another male’s genitals. He came by the house one day and you know this kind of feelings came on and I said to him I want to see so then he showed it to me. And it continued from there…. I was around 7 years old and he was 15. We had an outside bathroom and whenever he came over we would shower together and stuff. One day while we were in the shower together he asked me to touch his genitals. When he slept over he would pull me on top of him in the bed. I think he got his kicks off from that. He made a statement one day when me, him [sic], my brother, and cousin were playing. He came into the room and took out his penis. It was hard. He then told me to come and sit on it. So I told him no. I wanted to get away from him because I was afraid. He stood there saying come on, come on, then after he left the room.  *Alex (age 26)*

Some young JMSM experimented with female partners during their early years. For some, this experimenting provided the opportunity to explore heterosexuality before rejecting it.

Yes. It make [sic] me get frustrated, real frustrated…. Because I don’t have anybody to talk to and everything full up in my heart now…. I need somebody to release it to and I don’t have nobody [sic]. I went to one doctor and I told him that I want to get out [of] this gay life…. I asked him if there were any pills that I can take that will well me develop feelings for women…. I told him that I did not have any feelings for women…. None at all…. All I feel is for men…. He told me no…. So I went to a whore house to see if maybe that would help…. I end up go [sic] whore…. Go [to a] fuck shop and I go buy a whore to see if I can feel it with a woman…. I bought some pill that said it will make you last long. I tried it and that didn’t work any at all…. I never feel say [sic] the pill can work on your mind you know….  *Zack (age 22)*

While many recognized that they were attracted to males only, some were attracted to both sexes and later accepted a bisexual identity. Moreover, close female friends or
previous female partners provided cover (against homosexual suspicions) and protection for JMSM.

I realized I was gay when I was around 12 years old. I realized it because at the time when I looked at girls and at that age they want to have sex with you, you understand…. You will try one little time [sic] and not really like it. So from there, you find out having sex with men must be the way to go… so you must be gay. **Zack (age 21)**

I remember my best friend approached me on the matter of my sexuality. She was like, Dude when were you going to tell me. I told her when I was in the 11th grade; I was like 16 years old. I figured she knew but she was just wasn’t going to say it. She never mentioned it for years and I was like, let me tell her and she had all her exciting questions… she was cool with it…. Before, even though we’re best friend[s], I had to delay that side but once we talked about it, I am a little more open about my sexuality with her…. **Wade (age 20)**

At one point I remember when I was around twelve or maybe thirteen. I remember my mother saying to me, You don’t have a girlfriend yet? I was like, No not really. So she was like, What happen to that girl that I saw you with? So because of my mother I got closer to the girl. She was just a friend. I guess I did it more so for my mother than myself. **Garry (age 26)**

Childhood sexual experimentation and exploration for some JMSM occurred between the JMSM and a male family member. Most often, the exploration involved experimenting with a male cousin their age or older. Of the JMSM who reported experimenting with their male cousins, none of them reported being forced into the act. Exploring their sexuality with their cousins ended before they reached adolescence.

Well when I was younger I don’t remember what age exactly…. I was around probably 9 going on ten, maybe…. I didn’t understand what it was that I was feeling. So me and my cousin [sic] would always ramp up and down [play around]…. You know we will like play and stuff and more time we play in other ways. So I would touch him in places that I shouldn’t touch him. He was older than me, maybe like three years older. It was fun. He didn’t tell anyone that I did that to him…. Thank God. **Oshane (age 18)**

It was a tender enough age like 11 years old that I realized I had these feelings for guys. But I think it really, really, really started with my cousin. He’s two years
older than me \textit{sic}. He is 24 going on 25 next month. When we were kids, he
use to come spend summer at our house so would spend a lot of time together.
We were always playing with each other. We used to bathe together and I think
somewhere along the line some feeling started to develop…. I guess it was an
experiment and one thing led to another. We never had intercourse but there was
some touch, kissing, and some oral. \textit{Ken (age 24)}

I was around 7 and it was with my cousin. We didn’t know anything basically.
We were like experimenting and we just started off with kissing until touching.
We just masturbated each other until one day, you know, my cousin push[ed] his
finger in my anus and then we were like, oh something can go in there too. And
then we try it out and it worked. We start[ed] to like it and then we all do it… and
then had another cousin who came down to the house to visit, came with
knowledge about these things and shared it with us, then we did it again. \textit{Steve
(age 25)}

The Internet, communications with trusted friends, social media, and cable
television shows, such as \textit{Queer as Folk}, served as a catalyst for young JMSM to research,
explore, and ultimately accept their sexual orientation. The Internet provided JMSM a
mechanism to find other young people who were going through the same issues, while
television shows, such as MTV’s \textit{True Life} and \textit{Queer as Folk}, allowed for JMSM to
model same-sex relationships.

I wasn’t exposed to a lot of details about homosexuality when I was younger. So
I was basically doing my research back in high school about the topic. Now I
know and fully understand that it is perfectly normal. So now I don’t have a
problem being me anymore. I don’t let the church or society dictate how I should
think and feel about myself. \textit{Barry (age 22)}

I have always liked the male physique. When I was 11 I remember I danced with
a group and I remembered seeing an older guy changing. He is a year older than
me and I was just watching him change. I wasn’t sure I understood what it meant
at the time but probably in the 8th grade when the whole sexual identity thing
stated to play in my head. I started watching \textit{Queer as Folk} and I liked to see the
relationships the guys had, the nakedness, their skin, and just how Brian made
Justin felt safe and loved and special. How they smiled. I wanted that for me
too…. Just to feel safe and loved. You know…. Special! \textit{Omar (age 23)}
There are many factors that inhibit JMSM from accepting a homosexual identity.

Due to their socialization, JMSM rejected their homosexuality at an early age and discriminated against those who publicly embraced it. The decision to remain invisible (secretively engaging in homosexual behaviors) was viewed as a way of protecting themselves from any potential negative reaction to their identity. This often led to tumultuous internal conflict when self-affirming such an identity.

You know it is a funny question you ask. Because when I was growing up I didn’t think what we were doing was wrong. I just thought we were just kids and having fun. You knew it was wrong. It’s not like you were going to get killed as a kid. It was just fun. *Garry (age 26)*

I had to pretend and try to be someone that I am not going growing up. Furthermore, pretending for me does not work. I had to pretend for sometime of my life. I was living in a ghetto and I did most of those street parties and so on. I had to behave and develop a character that is not me. So it was very uncomfortable. The think that I love though was that I was living with a girl and she know about my sexuality *[sic]*. So it wasn’t a problem. When you go to these street parties you find a lot of homosexuals there. However, they try very hard to show persons that they are not like that. *Mark (age 23)*

I am now comfortable with my sexuality you know. Even though I am still having conflicts… but I don’t think I have escaped the conflicts even today…. I am still wondering if I should be this way or if I should fight it because of my Christian influence…. But it is really hard…. I’m thinking if I was in another society where it wasn’t as an abominable sin as here, I wouldn’t be focused on it…. I would be more free to accept myself but because of the influence of the church and my family. I remember my father saying if he finds out that I am gay he is going to kill me himself. *Roy (age 20)*

While many JMSM began exploring their sexual orientation during their pre-pubescent years, coming to terms with their sexual orientation typically only occurred during adolescence. For some, realization of a same-sex attraction was viewed as normal. For others, rejecting cars, bikes, or other toys that were assigned to the male gender, were seen as confirmation of a homosexual identity.
When I was a child, around 7 years old, when it came to games and so forth I always wanted to, you know, like childhood games; I wanted to play the female role. I always wanted to do the cooking; I always wanted to be the mother. You know, even though girls were around… I didn’t care. But I always want to be the mother…. I was aware that I had feelings for guys. I gravitated to them especially when it came to the bedtime. I gravitated to the boys’ room [rather] than the girls’ room. When it came on the other stuff like cars and bikes and so forth, I was never interested in those. I was more interested in dolls and other stuff like that.  

Steve (age 25)

From an early age I can remember having thoughts about men. Let me see, about grade three. When you are young, like you know four or five, I did basically all the female stuff. At that point you didn’t have like a sexual preference, you know, you’re still a child…. But as you grew older, your approaching puberty, your body starts to change at that point, and you come to realize as to which one you prefer most. So I basically fantasized about men and stuff, on TV and in the music videos. That’s the age I can remember actually thinking about men.  

Barry (age 22)

With an awareness of the impact of negative homophobia, some JMSM in this study created ways to protect themselves. Protecting oneself from homophobia involved developing creative stories or “fake” personalities. Some of these JMSM reported that overtly lying to protect themselves was a stressful process. However, they saw lying as necessary and took every opportunity to remain consistent with their stories. Having to lie about who they really were was reported as the number one reason why JMSM despised their homosexual orientation.

The one thing I hate about this life is the lies that you have to tell. I am generally a planner, every step of the way. There is a lot of hiding and lying and pretending that you have to do to prevent people from knowing who you really are. For me it just worked but I have friends that would have some slip ups and their parents would go to some extremes like kicking them out of the house and stuff like that. I had a best friend that that had happened to while we were in 10th grade in high school. That experience made me more careful. It was emotionally draining. We were so young and having to figure out how to help our friend.  

Wade (age 20)
Parents or family members who were aware of their child’s sexual orientation reacted in different ways. Some offered support, while others adhered to dogmatic societal ideologies and rejected or abandoned their child. Therefore, decisions to “come out” were contingent on whether the JMSM thought they would be supported or rejected. JMSM in this study often “came out” first to a close female friend or family member.

I am very close with my mom. We talk about everything. Because we are close I would talk to her about my boyfriend. When I first told her she said she already know [sic]. I guess it is right when they say that moms are always the first to know. I guess mothers always see things but don’t say anything. Nick (age 23)

For some JMSM in this study, having an opportunity to safely “come out” was disrupted when a parent caught them engaging in sexual behaviors with a male partner.

My mom found out that I was gay because a friend of mine came to the house and we were playing around…. You know, like sexual contact. We took off our clothes and she came in and saw both of us naked…. I was like 15 years old. Everything went downhill from there. I had to move out of the house because they didn’t want me there anymore. So I left and went on the street. That’s when I started doing sex work. Steve (age 25)

One day my mom caught me having sex with some guy in my room. I gave her some bullshit story that he came to look at the computer and I was naked in the room because I was doing push-ups and she didn’t believe me. She called my aunt, called my brother, my daddy, my pastor, and then she called her sister, and then her girlfriend and told them that she came home and saw me with a man. She made a big fuss of it. Anytime we have an argument she would call me names like battyman, faggot, and so on. She told me to leave her house, that I am a piece of shit. It has been hell for me. She calls my phone and leaves voice messages, send[s] me text[s] saying that I was going to get AIDS and die. She said I should kill myself, no one wants me. I am worthless, I am a piece of shit, and I am crap. She says the worst things just to hurt me. Omar (age 23)
Psychological Impact of Homophobia

Theme 4: Persistent homophobia and homophobic violence from members of the Jamaican society towards MSM has contributed to various levels of maladaptive behaviors and psychological trauma.

“I tried to kill myself once because I didn’t want to deal with this lifestyle anymore.”

The JMSM in this study experienced a wide range of life circumstances during adolescence and early adult years. Often, these circumstances caused major disruptions with the individual’s identity and sexual development. Development of caring, loving, and meaningful relationships was sometimes delayed because of the fear of others or the self-hate of their own identity.

After my mom found out that I was gay I felt as if she should poison my food. She said she does not want to eat from me because I am a faggot. It’s been so confusing and hellish. I have cried a lot and it’s very emotional for me to be there and I don’t want to live with her anymore. We live in an apartment where the walls are paper thin and she has called me a lot of negative names and our neighbors heard her and they are talking about it. She has been verbally, physically, and emotionally abusive. We are always fighting…. She gave me a black eye once…. I didn’t report the abuse because what I would get is a mother in jail and the whole country will know why she gave me the black eye, so I just let it ride and use her words as building blocks to get over things. **Omar (age 23)**

Some JMSM attempting to cope with the stigma and discrimination of having a homosexual identity experienced various self-diagnosed mental health disorders.

I stopped cutting myself now over a year ago. However, sometimes I get anxiety…. I didn’t know it was called depression…. It’s a good thing when you love to read…. I was actually reading a book and there I came across everything that I was going through…. Everything was in the book…. So that’s how I found out that I was depressed…. Just about the whole lifestyle and how people treat me when I am on the road. **Nick (age 23)**
Suicidal ideation and other self-mutilating behaviors (i.e., cutting) were engaged in to cope with the issues of stigma and discrimination. Lacking loving and supportive relationships were identified as some of the main reasons why these JMSM engaged in self-destructive behaviors.

Well you know when you hear comments like boom bye bye [gun shots] in a battyman head and battyman must die, you know stuff like that…. You don’t feel any sense of belonging. You don’t feel like you should live. Then put all of that together with your parents being disappointed in you. Those are the major reasons why you really want to kill yourself… but sometimes I feel like I really should not live. Roy (age 20)

I tried to kill myself once because I didn’t want to deal with this lifestyle anymore…. Well not to kill myself really but just to take the pain away…. I don’t know if I should be telling you this. I tried it once. I use to cut myself. I was dealing with a bad depression when I was 16… I cut myself when I get stressed or anxiety and I don’t know what to do, I just cut. You can see the marks because I used a razor. Nick (age 23)

My aunt found out that I was also interested in guys and told everyone around me about it. She even told my girl friend at the time. She told her to be careful around me because I am gay and a whole lot of things. All of last year, I got very depressed. As you see me now my original weight was 182 lbs and I now presently weigh 157 lbs. A lot of stuff was spread through my community about me. It was really unsafe. I just didn’t have anywhere to go but stay…. So I started to get scared. I got worried and it dragged me into a deep mode of depression. I had suicidal thoughts and I just wanted everything to go away…. Alex (age 26)

While some of these JMSM struggled with accepting their sexual orientation, others embraced it as part of their overall identity. Making the decision to “come out of the shadows” (or the “closet”) was seen as a conscious choice, free of blackmail or intimidation. It also appeared that, in order for some JMSM to accept their homosexual identity, several internal and external battles had to be fought.

I have tried to kill myself numerous times. I have taken pills, tried to hang myself, and I used to slit my wrist with a razor. At time[s] I am drawn to hurting myself
but then I look into it and just say it is not worth it. I am not sure what stopped me really. I think it’s growing up and saying yes I am finally an adult; live up to your responsibility and stop hiding your sexuality. Boe (age 19)

I have came to terms with my sexuality at about age 14 that was after a lot of internal stigma and a whole lot of grappling with who I am and what was happening to me. So yeah around 14 after recognizing a whole heap of internal issues I came to the conclusion. The harder I tried fighting to be who I am not, the more depressed and suicidal I got. So I felt that it was time to be me. I am glad I chose that course. Everything is not perfect but I don’t question who I am anymore. I accepted me. I am gay…. Ken (age 24)

Traversing local streets within the society on a daily basis was a difficult task for some of the participants in this study. Being teased or bullied was perceived as an unavoidable consequence of one’s physical appearance and sexual orientation.

I have been teased because of how I look and even speak…. It happened to me this morning while on my way coming here to see you. This morning a guy was driving past and he just stopped his car. I was on the phone and I wasn’t really paying much attention as to what was going on or to him…. He pulled down the window and took a cup of ice water and threw it out at me and yelled “battyman.” I couldn’t do anything because he drove off shortly after he did that…. I hate having to deal with this every single day. It just gets to me sometimes. Made me want to just stay home sometimes and curl up in a ball just to be by myself. Boe (age 19)

Persistent homophobia led to disruptions in the lives of these JMSM, as it related to their housing, employment, and education. Often times, derogatory words such as “battyman” were used to incite mob-type situations, which in turn dissuaded others from coming to the aid of the victim.

They treat guys really bad here in Jamaica…. If they see a group of guys together who look feminine they would like try to chop you up, throw bottles at you, or you would hear them say gun shot in your head. Some would want to come up to you and beat you up and create a lot of excitement. When they use the word battyman no one would come and rescue you from their beating. So using the word is really a great way of starting a mob attack really. One of my friends in my area got beat up on New York Ave [a discrete place; this name does not represent the actual location]. He and his friend were walking to the bus stop and
some men suspected them of being gay…. They chased them, beat them, and threw bottles at them. One of them escaped while the other one was beaten so bad he had to be rushed to the hospital. He spent several days in there. **Sean (age 20)**

I remember me and some of my friends were walking heading to the bus stop and a group of guys started following us…. They started calling us names…. I didn’t do or say anything because I was minding my own business. You know, walking, going where I am going because it was kinda [sic] late, around 11 PM or so. So my friends said, Let’s run, I was like, Run for what? I didn’t do anything. So they took off left me. So they ran over to me and cornered me. They asked me where I was going. I told them I was going to the bus park. They grabbed my expensive phone out of my hand. I asked them for it back… they refused. One of them hit me cross the face, then the others started punching and hitting me. I took off running asking for help…” Someone help me please, someone help me please, call the police,” and stuff like that. While I was running they kept yelling out “battyman! Battyman! Kill him. You guys don’t help him.” So this woman came over to me while they were beating on me saying, “Oh God, don’t kill him”…. She was begging for my life… They chopped me in my face, the back of my head, and broke my finger. Can you see the scar? I ended up in the hospital for several days. You know the sad part about all of that was? I heard one of the women who came to help me saying that the police was right around the corner and saw everything that was going on and they did nothing. They later came and took me to the hospital. No one was arrested…. I was 17 at the time of the attack. **Oshane (age 18)**

To cope with the psychological impact of homophobia, some JMSM engaged in different forms of internalized homophobia. Although they did not express hatred towards themselves specifically, many opted to be in the company of friends who were overtly masculine and discriminated against those who are effeminate by not wanting to be seen or associated with them in public.

I try not to go out in public spaces with those feminine kinds. I will hang out with them at time because persons just can’t really see who you are hanging out with or whatever. So will go and hang out at least at Emancipation Park or Devon House with them. But only at night. You are not going to find me hanging out with them during the day. **Frank (age 26)**

Some of these gays are just too loud. They display their personality [sexuality] in such a way that I don’t like being around them. I don’t try to seek the out the
feminine ones…. I prefer the persons that are more masculine…. I love [laughter] a masculine person. I love to look at them…. I don’t believe in being with or hanging out with feminine guys at all.  

**Focus group participant**

The decision to not be seen in public with men whose masculinity was questionable was made out of concern for the safety of the JMSM. Having or being associated with hyper-masculine men was perceived as providing a protective cover.

When I am out in public person would stare at us probably because my friends are a bit loud [the way they look] at times. So because of how they look they would tell their story. The clothing that they would wear, you know. So persons would stare a lot. But I think it is very impolite. They will sometimes they would make a few nasty offensive remarks. So sometimes I don’t like hanging with them because I am thinking about my safety. I have seen where persons have been attacked before and I wouldn’t want to be in that situation. The whole negative views don’t bother me as much. It is that fact that you could get attacked because of your sexuality… that is the only thing that I think about when I hang out with these people. **Barry (age 22)**

**Relationships and Support Systems**

**Theme 5: JMSM interpersonal relationships with friends, intimate partners, neighbors, and family members can be a source for support around having a sense of belonging or rejection and social isolation.**

“**My boyfriend had my back. I felt loved.**”

In a predominately male machismo environment, that is often unsupportive and unsympathetic to the plight of JMSM, matriarchal or strong female figures within JMSM’s social networks were sources of strength, support, and protection. JMSM were more likely to discuss their sexual orientation with a female figure. Some of the men in this study relied on women for support on issues related to their sexuality, and for protection.
I was afraid to tell anyone about my sexuality when I was younger… at that point I never knew what was happening to me…. I thought it was a phase you know… because I was young and almost a teen… but then I realized how the Jamaican society was so I couldn’t express it…. So I was like, I will keep it to myself but then eventually I told my friend, my girlfriend…. I probably told her because I was questioning her sexuality too…. I think I knew she was somewhat curious or at least interested in women you know. She wasn’t really a hoe [whore] or anything like that…. I was drawn to her for a lot of reasons.  

Garry (age 26)

I think my older and younger brothers surmised that I am gay because of what happened recently…. I went to meet a friend at a party and he didn’t tell me that the guys there were kind of gay…. So when I got there somebody from the neighborhood saw me. I had to run and hide in the car. I told my grandmother what had happened because she knew about me. So when the talking started she dismissed [it] and told them that I was with her. After that the rumors stopped…. She said, You know it is not safe for people to know [a] story like that…. Just be careful.  

Andre (age 29)

My aunt knows I am gay… she accepted it. When I was younger I use[d] to behave like how I am behaving now: feminine. Yeah and most of the time my mother would be like, “Stop behaving like that,” and everybody else would say the same thing, that I was behaving like a girl…. My auntie now, she did always just accept me for who I am…. She always like say, “Yeah you are my nephew and I love you.” She always say [sic] things that made me feel comfortable…. She hasn’t said anything negative to me that would make me say, “Oh God, not you too,” you know?!  

Oshane (age 18)

Many JMSM identified their mother as the most important person in their lives whether she did or did not know about their homosexual identity. Mothers were important because of their continued involvement in the lives of young JMSM. For some JMSM, their mothers were a source of emotional and financial support. Although some JMSM reported that they were able to look to their mothers for support, many feared that if their mother became aware of their sexuality, the support they were receiving would cease.

My mother is the most important person in my life right now…. She is important because she is always there for me. Anything I want to talk about I would call me mother….  

Focus group participant
To tell you the truth, my mother is the most important person in my life. She is always there for me. I can communicate very easily with her. She understands me well. She doesn’t give me a hard time. I can basically confide in her, tell her what I am feeling and she doesn’t get upset with me. She still treats me like a baby…. I get annoyed with her at times but I don’t mind it. I know she loves me and she is only doing it because she cares…. I know if she found out that I was gay it would really change our relationship…. I am not sure if we would still be this close to her, you know…. So it is always in your head as to what you should expect. **Barry (age 22)**

While mothers were a major source of support for many JMSM, other participants reported that their father was the most important person in their lives. For at least two JMSM, their fathers were a major contradiction of what is expected from a “typical” Jamaican father. At some point these fathers were single parents, raising their sons. The presence of the father provided them with a model for fatherhood and offered emotional and financial support. It was also clear to the MSM that if they wanted the support to continue they had to keep their sexuality hidden. Unlike mothers, disclosure was not an option.

If I could pick that one person to say that they are the most important person in my life, it would be my father. I think my father contradicts everything that they say about Jamaican dads. He has actually been a father. I don’t know why he ended up with me at a month old. I don’t know why a woman would give up their child, but he stuck with it and I can always count on him and stuff. He is very peppy and always want[s] to converse with me. **Wade (age 20)**

Right now my dad is the most important person in my life. He is important because he provides for me and looks out for me. The more I get to understand him is the more I see that he really loves me and work hard and put out a lot of effort to ensure that I am ok and [every]thing. He is supportive…. If I have children I would want to be like my dad. He is just always there…. My father always wanted to help and give me advice even when you don’t want his help. He is just a normal father…. **Roy (age 20)**
In addition to mothers and fathers, some JMSM received support from their friends who also identified as gay or bisexual. They supported each other on issues related to homophobia, HIV prevention, safe sex education, and, whenever possible, financial assistance was provided. Older JMSM provided advice to young MSM on the potential implications of having partners who were older. They were also seen as extensions of the JMSM’s family. In some instances, due to being abandoned or neglected by their families, some JMSM created their own (non-biological) family structure. Within this new family structure older MSM took on the role of parents, and as such, provided emotional support and shelter.

Me [sic] talk to my friends you know and me [sic] tell them you know…. Me [sic] tell them, say when you use a condom, pinch the tip, leave an inch, and roll…. They are young you know and they don’t know these things…. See when you are younger you find that older men are more interested in you. See for me, they wouldn’t try to date me because they know that I am more sensible… only if they were desperate then they would look at me. It’s probably because they know they can’t get over on me because I am a veteran in this lifestyle. But the younger guys now, these older men use them and later refuse them. They give you what they feel like giving you…. I told one of my friends this the other day. I said, “[Peter] you are young, you’re slim, and attractive. A lot of older men are going to be after you.” If you and I should go on the street together, they would be more likely to call to you… because I am a veteran…. **Zack (age 22)**

Both in schools and within the larger community, gay and bisexual men provided protection for each other. JMSM who congregated together in large numbers perceived this as a strength, not a deficit. While some avoided hanging out with other MSM in public, others preferred doing so because their large numbers protected them from being attacked. In addition to protection, older MSM also gave suggestions on how younger MSM can maximize their safety, often by instructing them about how to disguise their
sexual orientation. This was viewed as an important way to modify their risk of community aggression.

I think gay youths are happy that somebody is like them, you know…. I think gay people on a whole like and respect other gay people, you know… they look out for each other and stuff…. So when you go and talk to them, they would basically show you love and appreciate you and give you advice and stuff on how to like manipulate your sexuality so you don’t make it too obvious…. *Barry (age 22)*

When we were in school we supported each other…. I went to an all-boys school and there was a lot of other gay dudes there. We found each other and formed sort of an alliance. Other persons in the school started calling us names… they called us fag five… [and] it was annoying but it wasn’t intense. Nothing physical! There was no intense mocking, maybe because we were so bold. You know what the best thing was? We had strength in numbers. I mean, they would try to put you down but if you seem like it has no effect on you, it got lame after and they just leave you alone. *Wade (age 20)*

For some JMSM, intimate partners were a source of love and validation as opposed to just simply sexual gratification. They also provided emotional and financial support to each other. When JMSM in this sample were in an age-concordant relationship, power dynamics were usually equal.

At the time when I was going through my whole depression and crazy thoughts, the guy I am talking to now, he is a thug—gangsta youth, he was the kind of person who guided me through it all. If it wasn’t for him I am not sure if I would have made [it]. *Alex (age 26)*

My boyfriend had my back. He would check up on me. Always wanted to know where I was at, what I was doing, where I was going, how I was feeling, or if I needed anything. If I did he would get it for me… I felt loved. I had just came back from Christmas break and this guy walked up to me and called me by my name, I didn’t know who he was and I asked him who he was. I asked him who he was and he said it didn’t matter and we exchanged contacts and had a lot of conversations. It all stemmed from there. We went on dates and to the movies. I just remember holding his hands, and holding his hands, and not wanting to let go. He meant a lot to me. We kissed a lot. We never had sex or anything until we were around 20 years old. *Omar (age 23)*
On the other hand, age discordant relationships were common for several of the participants. The reasons for entering into these partnerships varied. Many JMSM participated in these relationships because of their love and affection for the older partner; others entered these relationships because of their economic situation. Age-discordant partners provided support for school, housing, food, and other major life necessities.

Well this guy was my track and field coach…. I was in 11th grade at the time…. I think he was 34 years old… What had happen[ed] was as I said before, I was active in school…. So we always see [sic] each other around. He was always at my practice. I think he knew what was happening, you know, about me being gay…. We exchange [sic] numbers and we spoke over the phone…. at times things would come up in that regard and I would say to myself, “It seems like he knows what I am about.” Until it happened once he told me that he liked me…. I love being chased…. It was my choice to sleep with him. I called him actually and I told him that I was ready. So he said really… then we did it. **Mark (age 23)**

I am very skeptical of how I meet other guys. It is not just any and any one that I let into my life. We will keep it at friend level until we get to know each other a bit better…. I mostly date older guys because they are more mature. The oldest I have dated was over 50 years old…. I was 18 at the time. I have always been attracted to older men. I guess I am attracted to their level of maturity…. **Boe (age 19)**

As Boe noted, the age difference between partners could vary quite a bit. The average age difference between young MSM and their current age-discordant partners was fifteen to twenty years of age. These relationships created imbalanced power dynamics; some younger MSM were forced into complicated and dangerous situations.

The guy I was with was married. He was the one who had the money. He was much older than I was…. He was like in his 40s. I felt like I was being over-powered. I wasn’t forced or anything…. But I was always reminded that he was the one with the money…. So it wasn’t a good situation at all…. **Garry (age 26)**

Have you heard of Lemon Road [not the actual area]? I met someone who lived up there and I went up to his house. He met me at the park first, you know
because I didn’t trust him. He told me he liked me and that he wanted to hang out with me some more…. So I went up to his house and relaxed with him. So he is asking me about sex and if I had ever let anyone do me before. Then I asked him why he was bringing up these arguments to me. Apparently I didn’t know that was what he wanted. I refused to do it with him. He held me down and I had to fight him off of me. He didn’t want to let me go. I almost called the police on him…. I was young, around 17 years old. Because I fought him off, he didn’t get to rape me. However, I had to give him oral sex before he allowed me to leave. He locked me in the room and he held me down in the bed telling me that I had to suck him off…. I told him I didn’t want to do it and he forced my mouth open, so I just did it just to get it over with. **Sean (age 20)**

JMSM who were interested in establishing relationships (and sometimes one-time sexual encounters) met their partners through different avenues. Meeting partners through Internet-based platforms that did not allow for them to see images of the potential partner was perceived as dangerous. Social media and other Internet sites, where photographs were exchanged, were used to connect with each other for relationships or intimacy. Overall, JMSM preferred to meet their potential partners via social media sites, such as Facebook, Adam4Adam, Smutvibes, and Twitter. These sites allowed JMSM to not only view images of the potential partner; it also allowed them to interact with them in real time. In general, JMSM usually engaged in numerous sessions of online conversations before meeting the individual in person. After a decision was made to meet, the locations chosen were always public, which provided them with additional security. JMSM in this sample reported that these protective measures were put in place because of the deceptive practices of some heterosexual men in the Jamaican community.

Sometimes I meet partners from walking down the street. I just walk to New Kingston and guys would call out to me…. You have to be careful though because right now you have too many imposters out there…. Persons pretending like they are gay and they are really not. They will attack you and stab you up….
So you have to develop a code system…. You know, only use terms that other gay people would know…. Only meet them in public until you can trust them…. 

*Steve (age 25)*

We met through Facebook…. He started to talk to me and I started to talk back…. I asked him to put up or send me a picture…. I didn’t know that he sent me pictures of someone else…. Afterwards, we exchanged numbers on Facebook and he called me once to hear my voice…. I was worried though… because I didn’t really trust him…. It is really scary out there…. I always hear stories about people being raped and killed and persons say that some person could pose as gay and try to trap you. So I am always worrying so what I try to do is always meet them at a really public place in the day and not too late at night even at a police station…. *Roy (age 20)*

I meet them mostly on Facebook… and because it’s kinda [sic] dangerous…. So yeah, chat rooms aren’t good because you can’t see the person or anything and you don’t know if like some straight boy[s] are in there messing around. Then you go and meet them and then they attack you and stuff like that…. So from me [to] go in there and meet that one guy, I didn’t go back in there again…. I normally meet them on Facebook where I can see their pictures and faces and judge if he’s definitely gay. *Oshane (age 18)*

Sexual assaults and victimization were common for many of the JMSM in this study. These incidents were often perpetuated by older men within the community. The issue of sexual crimes against children was, however, not new to the Jamaican society. During the time that the investigator was on the island conducting research there were several news reports of children being sexually assaulted. One participant recounted his experience of being assaulted while on his way from school. During this interview, the participant became upset and tearful while recounting his near death, rape, and abduction experience. He began crying and was very emotional. It was clear that whatever happened to him was very traumatic. After offering to pause the interview, the investigator provided emotional support while allowing the participant to share his experience.
When I was fifteen I was forced to have sex with some guys. Well it was basically indecent assault…. The police called it rape…. I was going home from school and I stopped to take a taxi…. Normally taxis in Jamaica, they don’t have the word taxi on it all of them… so this one never had “Taxi” on it… and I took it heading home. So when I jumped in, there were two guys around the back and one in the front with the driver… so basically 4 other men in the car…. When I saw the driver turned off the street where he was suppose[d] to go, I questioned what he was doing and he told me that he was going to pick up another passenger…. I wasn’t in any rush so I didn’t make any fuss of it. But then it started to get dark and I got worried…. Moments later I felt a hand touching my leg… so I looked at the guy and said, Wah a gwan yah so? [What is going on here?]…. At the point we got to a dead end, they parked the car, then the person touched me and put a knife at my neck and threatened me…. The driver then came around and forced me to get out of the car…. They brought me down into a gully [and] forced me to perform oral sex on them…. At one point my mouth was very tired and I started crying… there was so much pain…. When it was time for them to penetrate me I figured that I would rather them kill me so I took off running…. I hid in the gully off [the street]…. I could hear them saying, “Look for the boy, where did he go? If we don’t catch him we will be in a whole lot of trouble…. Find him”…. I stayed hidden for a long time; the rain even came and wet me up…. I was so scared…. [Tears]…. If they found me I would have been killed. I eventually came out and reported to the police…. We went to go look for them but couldn’t find them…. **Steve (age 25)**

For some JMSM, the opportunity to improve their economic situation was perceived as the responsibility of the state. They expressed feeling neglected and unsupported not only by their family, but also from the government, communities, and non-governmental organizations.

I have observed it where more and more thug gangster youths are coming out from behind the shadows now and are displaying their true sexuality as being bisexual. These guys really need jobs…. I haven’t seen where organizations for people like us have stepped in to help us attain a steady 9-5 job so we can save and find good housing. There is nothing in place and I am wondering if it will continue this way or is it that the agency will now step in to assist. **Alex (age 26)**

Is just that when it comes on to support from civil society like those NGO’s that serve us we don’t get a lot of support… and if they do give support it is given to persons who don’t really need it…. It would be nice if they could offer us financial support or even help you start your own business. What about helping
those guys on the street… You know?! For me, it felt like they are not there for us… We are neglected… Focus group participant

Health Care Access and Experience with HIV

Theme 6: For some JMSM, their experiences with HIV have been directly linked to their present social and economic situation. However, access to and navigation of the relevant health care systems within the island presented many challenges.

“I was dating this one guy who was HIV positive and I didn’t know at the time.”

Despite the discrimination from the larger society that is faced by many young JMSM, developing a personal and professional relationship with their medical providers made it easier for them to disclose their sexual orientation. A level of trust was necessary for these JMSM to disclose their sexual orientation. Additionally, while some disclosed their orientation because they felt comfortable with the provider, others disclosed because they recognized that failure to disclose could potentially hinder them from receiving appropriate screening and treatment. Providers identified as friendly or sympathetic towards homosexuals were later referred by the JMSM to their peers.

Well, my doctor knows that I am gay…. I didn’t tell him…. He just figured it out…. [Laughed]…. I didn’t tell him that I was gay…. He found out because of what happened…. I was sick and I went…. I called him at my house…. He came there…. When he came there he stuck his finger up my butt and then he asked me if I ever had anal sex… so I said yes…. He said ok…. I didn’t mind telling him the truth because it was for my health… and once it was because of my health and it was my doctor that was asking, it was ok… so why hide from my doctor? His job is to help me to be healthy…. I later found out that he is gay…. I feel I can [tell the] truth [to] him too…. He is a very good doctor… and I would refer some of my gay friends to him… because he can be trusted…. Mark (age 23)

My person[al] doctor knows that I am gay because I told him. I had to tell him because recently I fucked 2 months ago and I don’t know what happened… but I got sick…. I had the flu and I took something to kill the flu which then caused
me to develop diarrhea…. I thought it was all because of the rough sex. We use a condom but he was rough, plus we didn’t use much lube. So I thought that it didn’t allow for me to keep regular bowel movements. So I told the doctor and he gave me some pills for the diarrhea…. He also asked me when my last HIV test was and I told him…. He didn’t ask me to do another one… He was really chill about my sexuality… and asked questions about it as it pertains to my health. He was very professional. **Omar (age 23)**

If it came up I would tell my doctor that I am gay…. I mean because at that point, I mean I would [tell the doctor because]… that information has the potential of guiding treatment…. Because I was… I have told one doctor. That’s not my regular though, because I had, I had sex with someone without a condom and apparently I picked up something…. He said it was E coli…. It was after I told him what I had done then he knew it was E coli and prescribed the relevant antibiotic…. He was going there at first… like trying to ask me about my sexuality…. But I was withholding that bit of information so he was like scurrying all over the place to… you know…. To put something together…. And when I told him what happened he was like, Oh yeah. So it does have the potential to guide treatment. He was cool after…. His expressions never changed one bit…. **Larry (age 24)**

The Ministry of Health, non-governmental organizations, and other public health settings were identified as the main source of support for confidential HIV testing services and health education for young JMSM who were unable to afford private care.

To this end, some MSM in this study identified the importance of working with providers who are supportive and culturally competent. The resources and education provided by the Ministry of Health were viewed as invaluable to JMSM who had little or no exposure to safe sex education that was specific for homosexuals. Workshops conducted by the Ministry of Health and community partner agencies were also ideal places for MSM to have safe and confidential HIV testing done.

With the Ministry of Health I learned the importance of getting tested… they had a program on sex education/peer education. It’s about homosexuals, about young homosexuals…. If we’re being safe or stupid and through that little program regardless if you’re having sex with a condom or not you should still do a HIV test every three months…. It was nerve wrecking…. It was my first and I didn’t
know what they’d ask or how the procedure goes. I knew it needed blood but I didn’t know how they would take the blood. Luckily it was my first time and I did a saliva swab instead of the blood and while there waiting… I was actually calm within myself; I knew that I was careful in all the cases so I had nothing to worry about….  

Kevin (age 24)

JMSM seeking healthcare from medical practitioners in public health clinics faced a wide range of discrimination from heterosexual patrons also receiving care in those settings. Some MSM were the victims of direct physical assault while others were victims of verbal abuse. A few of the comprehensive public clinics developed policies to handle these negative reactions from the public. The JMSM participants reported that in some settings, once the staff identified them as a MSM, they would expedite the visit. This practice minimized their interactions with other patrons in the waiting area. Clinical settings that did not have such a policy or practice were known by MSM as areas to avoid.

When I went to the comprehensive clinic for a checkup I told them that I was gay…. They didn’t discriminate me or anything like that…. They took care of me…. I felt the discrimination from the public…. Like from the other persons who were waiting in the waiting room…. They would look at you and call you battyman and stuff like that… the long waiting that you have to do when you go those places kinda give [sic] you up too…. It give them more time to really observe you and all of these things and they’re aware of the fact that battyman a come down there so they know. Basically they know how battyman look ….  

Steve (age 25)

I don’t go to anywhere specific… like a personal doctor or anything… because I can’t bother with the discrimination more time…. It’s like I ask my friends if they know anywhere and they say yeah…. More time when I see the Red Cross truck anywhere like passing through Cross Roads, Halfway Tree, or suppose it even over here at the university, I like go in line and take one….  

Oshane (age 18)

Many structural barriers inhibited JMSM from accessing personal sexual products. Protective materials, such as condoms, and lubricants were difficult to obtain because of the stigma and discrimination faced by the MSM during the procurement
process. Pharmacy and store clerks were the main source of the stigma and
discrimination directed towards MSM when purchasing condoms and lubricants.

I don’t go to the store to get lubricants and stuff…. They tend to look at you funny…. So like my KY [lubricant jelly brand name] and stuff I would have a female friend go and get it for me. I am not going to the pharmacy to buy KY because they would wonder why a dude [is] coming to buy that stuff…. My friend went in and bought it and didn’t have a problem…. If I can’t get lube I [would] rather improvise and use spit or lotion because you don’t know what these people [at the shops that sell lubricant] might do.  

Andre (age 29)

I have gone to the pharmacy before to buy lubes before…. I don’t like it… but I go anyway…. I don’t like it because it feels uncomfortable…. They look at you funny like why you need lubricant you know…. They don’t really say anything…. It’s just the looks they give you… It just makes me wonder what they are thinking and saying…. Wade (age 20)

Experience with HIV. Becoming infected with HIV for these JMSM was measured through a distal and proximal risk assessment. For MSM, proximal risk involved not being immediately concerned with HIV infection during intimate contact with their partners, while distal risk involved the possibility of being caught in a “compromising situation” with their sexual partners, or any other circumstances that might affect their personal safety. Early experiences with HIV for MSM included having a sexual partner who was living with the infection. Awareness of that partner’s status, however, was often revealed at the conclusion of the relationship.

I had met someone before and they had it… but they didn’t know… and I can remember we were talk, talking, talking until one night we were there making out and to tell you the truth, I didn't think about using a condom… so then he said let’s use a condom…. I said, Jesus I didn't even remember…. Seriously… I didn't remember so then we used the condom. Two weeks after we were hanging out and his phone rang…. I heard a woman over the phone saying, “Why you give my Pinckney [son] HIV?” I was at his house at the time when he got that phone call. To tell you the truth, I almost died…. I am telling you, that was a bad experience for me and to know that I was going to do something with him without a condom…. So there was a time in my life where I could have gotten the virus…
and now the person that he is currently with doesn't know that he is positive… so me [sic] and some other friends have to be covering the story for him.  *Mark (age 23)*

I was dating this one guy who was HIV positive and I didn’t know at the time... We met through another friend…. He didn’t tell me that he was HIV positive…. I just figured it out…. based on conversations that we were having…. I visited the person who had the friend that is HIV positive… and based on their actions the things they were saying, they didn't come out and say that the person is HIV positive but they must use a condom, we need to use a condom if they want to have sex. If no condom was there they would go out of their way to ensure that they get a condom?…. Things I don't think was [sic] normal…. I think, I brought it up to the person and they basically, they didn’t say at the time, they basically hid it but after a while they did confess and say he was indeed HIV positive. Which was the reason we have to use a condom every time we have sex, even though we are dating for so long…. I wasn’t shocked! I basically expected it. So I wasn’t shocked at the news, and I am aware of the ways in which you can become infected. So I wasn’t that timid to be around the person really.  *Barry (age 22)*

Despite adequate knowledge about the mechanism of HIV transmission and prevention, many of the JMSM in this study had unprotected sexual contact with persons who were HIV positive. Some reported that the decision to not use a condom was based on the trust that they had for the partner or because of their poor economic situation. Many of these JMSM found themselves in situations where they had to compromise their personal safety by engaging in unprotected sexual activity with someone who was HIV positive in order to have a safe place to sleep or have food to eat. For these men, protection from HIV was a secondary, or distal concern after their primary needs of personal protection, food, and shelter were met.

I guess I have been very lucky…. God damn lucky…. I remember doing it with a person I know... we only did it once though…. He migrated…. He was a businessman where I was living…. He is the one I told you about earlier…. I didn’t know that he had HIV…. I found out after we had sex…. His friend told me…. The friend asked me if I had sex with him and I told him yes… so he told me to go get checked because the man is HIV positive…. When we were in the
middle of sex… he refused to use a condom at the time… and I had trusted him then…. So the phone rang at the time…. He went to answer the phone and when he came back he said…. Ok let’s use a condom…. I trusted him because he was someone who would do things for me because he is financially stable. I didn’t question that one…. At the time, he was about 38 or 39… I was only 19. Frank (age 26)

While a majority of the participants in this study indicated that they were HIV negative, at least three participants reported being HIV positive. Acquisition of the HIV virus for these young men occurred during their early adolescent years. Common experiences reported by the individuals were homelessness at an early age, engaging in survival sex with age-discordant partners, poverty, and inadequate parental involvement. Community organizations, such as Jamaica AIDS Support for Life (JASL) were reported to be a major source of support for those who were HIV infected. Through this organization, young HIV-positive MSM were able to access support groups, food, medical care, and medication.

I have been HIV positive since 2005 when I was in high school….. I was maybe around 15 or 16 at the time…. I went to a community organization to get the test done….. I went because I was losing a lot of weight… wasn’t eating much and I had just felt sick…. My body features just changes so much that it was to be questioned…. I didn’t notice these changes when I was in the country…. It wasn’t until I came to Kingston most of these started happening…. I was very vulnerable… [I] was homeless at the time and bouncing from one place to the next…. I didn’t know AIDS or about taking the necessary precautions…. So you will find someone and they will say if you stay at my crib then you have to give me sex. I can recall one time the first person, the same incident when I say he didn’t use I had sex with him a few time[s] and didn’t know anything…. One day I went with a friend to an HIV support group and say the ex in the group…. So I thought if he is there then he must be positive too…. When I was staying at his house…. He forced himself on top of me at the time. Arron (age 24)

I think it was 16 and in high school when I found out that I was positive…. They told me that I was HIV positive…. I felt like I was going to die like three weeks’ time. I was crying I remember when I did it, when they said you need to go round to the doctor and talk to him…. They knew the results but they didn’t want to
give me… So they sent me to see the doctor… The doctor then told me that I was HIV positive… When he said that I jumped up and said, “Yayyyyy” and the doctor was like really… you know what this mean[s]? And I say, Yeah I know…. It means, “I don’t have it.” And he said, “No”…. After that my head felt numb… I started crying and he told me not to cry because when you go back out in the waiting room people are going to know that you are HIV positive…. So he asked me for mother and father [sic] number to call them so I gave him the wrong number because I didn’t want them to know and I was not living with them anyway…. When I step out of the office everybody was looking at me and I start smiling like nothing happened…. Then when I reached out on the road I cry and I walk from comprehensive clinic till I got to the K street… People were looking at me on the street because I still had my school uniform on. **Steve (age 25)**

For the JMSM in this study, knowledge about HIV prevention was predominantly centered on the use of a condom as a barrier method. These JMSM were aware that while homosexuals are at higher risk of acquiring HIV, it is not a disease that only affects MSM. Additionally, there was adequate knowledge about how to prevent HIV infection and, once diagnosed, the importance of medication adherence.

Well they say HIV is not the end of your life… it’s just something that when you know you have it [sic], you must take your medication and stuff like that and you cannot pass it around to other people like that… you must always use condom. Because you can still get re-infected if you have sex with a person if they have HIV… but as long as they are wearing a condom you should be ok… make sure the condoms are good and stuff like that… and that it didn’t expire…. Make sure you look for the expiration date…. **Oshane (age 18)**

Based on what I have heard, it is not a gay disease… I have been to seminars and they say that it isn’t a gay disease… but persons on the streets think that it is…. I read that if you don’t protect yourself you can catch the virus…. I heard also if it’s left untreated it can lead to AIDS… so you should get tested. **Garry (age 26)**

Well from [hearing] people on the street, it is a death sentence; you are going to die. Some people are really paranoid and think that you should scorn the person but I have good information so I know what to believe and what to block out. From the general public, they are still scared or think it’s some contagious disease. I think that’s a lot of people’s mindset…. It’s a gay disease. First I was just [sic] thought that men having sex with men were the ones who were transferring the disease. **Wade (age 20)**
Due to the high level of awareness of the impact of the HIV epidemic within the MSM community, some of the JMSM in this study engaged in acts of discrimination, such as sero-sorting with potential intimate partners. This meant that they were choosing to enter relationships with other men who they perceived to be HIV negative. While many chose not to engage in sexual activity with a person who was HIV positive, some remained close friends with infected individuals, and were sources of support for the person living with HIV infection.

I have a very close friend who is [HIV] positive. I empathize with him and talk with him about how he got it. He was the one who got gang raped…. He wanted to be in a relationship with me…. He didn’t tell me this before he got gang raped…. Funny enough I felt myself stepping backwards from him because I wasn’t too sure of what might happen between us…. Ideally I would like to be in a relationship with someone that does not have an STI but we are friends so we talked and I check up on him…. It is hypocritical, I know, in a sense that I won’t be in a relationship with someone with HIV…. If I had to be with one I would have to be careful and madly in love. He told me that he is now sick of the anti-viral drugs…. I am glad that he is on them though… [Because] they are making him health[y]. He has to move gingerly with his life. **Omar (age 23)**

It would be hard to be around persons who are HIV positive because I don’t like any mushy sad feeling; I don’t like pitying people or people pity me but I think I may have a tendency when people are sick to be over-caring, [and] I don’t want to be caught in that…. A lot of persons won’t want to be around you if they know, and to think about it, if someone has it and they tell me I might not want to be around them as much either…. I would be too scared… of catching it from them. I know you can’t catch it through general interactions and all of that but it’s just still kind of scary…. I would be scared but I wouldn’t discriminate or hate them or anything; I would just be really uneasy around the person. **Roy (age 20)**

**Navigation of Personal Safety and Mitigating Factors**

**Theme 7:** There are several situations that compromise MSM safety which also placed them at risk for infection with HIV. However, young JMSM were
reasonably skilled at developing strategies that were used to mitigate or modify these risks.

“He said I had to sleep with him if I wanted to stay in his house; at that point I had no choice but to sleep with him.”

**Situations that Compromise JMSM Safety.** There were several situations that compromised the safety of these JMSM. Some of these situations were as a result of the homophobia within the society, while others were direct results of the MSM’s actions and decisions. Several JMSM reported engaging in sexual activities with men who they perceived as heterosexuals. Often times, these heterosexual men had steady female partners and sometimes children of their own. It is unclear, however, if these heterosexual men were in fact bisexual, or if they were using the cover of heterosexuality as a protective factor against negative homophobic attitudes.

These straight guys are hypocrites because they say they straight and when you check behind the curtain they are not. That’s why you hear the dancehall DJ say, “What you a do behind curtain!” Some of these straight men say they won’t fuck with a guy but most of them that I have been with say them [*sic*] straight but still mess with me…. They must be bi then, right? I never mess with a guy that is just gay. I prefer straight men. Every man I messed with, I was the first guy he ever fucked with. All of them [are] always talking to a woman and they are with more than one woman. **Zack (age 21)**

Other JMSM engaged in practices that placed them at risk for reactionary violence. While the practice may be perceived as a form of self-deception on the part of the MSM, the desire to dress in female clothing for the purpose of commercial sex work was made out of necessity. Some JMSM transformed their gender by putting on female clothing, acrylic nails, artificial hair (i.e., wigs), and make-up. By transforming their
gender expression, they were able to broaden their client base. This practice placed them at risk of violence from the police and angry patrons.

Sometimes the high school guys when they come for the sport championships they come out on the streets looking for girls to buy sex from…. So because I cross-dress they don’t really know that I am a man…. I only offer oral sometimes and if they ask for anal I will do it… but if they ask for vagina sex I always tell them that I’m seeing my period…. Sometimes they don’t even know if it is a pussy or anus because trust me I lube up and you lube up well…. So we go in a dark corner and I bend over and they push it in… they don’t know…. They just push and they cum that’s it…. And most of the time I give them oral. I work with a team of cross dressers as well. What we do is find spots that it’s very sticky [small enclosed space], it’s a very sticky spot so if you go there it’s just for them to take out their penis, push it in, cum, and leave…. You understand me…. In these sticky spots you don’t have room to spread out. **Steve (age 25)**

One of the things I really love the most is that I can cross dress and no one knows that I’m a male…. I have pictures on Facebook of me cross-dressing; but I worry sometimes though because you hear them shooting a battyman…. So at nights you know you’re like, ok you’re talking to some guy and he thinks it’s a female he is talking to…. It is really nice because they carry you out to drink and all of these things. But they don’t know that you are a man. They don’t know that I am a man because I use good make-up like Revlon…. It is risky if you don’t apply it well. I mean you have to be a very good make-up artist you have to know what to wear how to set the hair, what hair fit your face, what garment would make you look sexy and look feminine…. You have some people that put on these things and they just look like a man still. What you do is go look in the mirror, if you look at yourself and you can recognize that it’s you, and then don’t go out on the street. **Focus group participant**

Sexual assault situations were common for some of the MSM in this study. While some of these situations occurred as a result of being in the right place at the wrong time (e.g., waiting for transportation to home from school), other situations occurred as a result of alcohol consumption. There were instances were young MSM were forced into unexpected sexual situations and were brutally raped or assaulted by persons at the venue. Often, a close friend would invite the unsuspecting victim to a private social event knowing the true intentions of the host and other patrons at the event.
I remember going to a party. I was with a friend, I got extremely drunk, and the friend allowed the men there to do a lot of stuff to me…. The party was off campus in a community called [Chocolate City]. When I went there, there were about 5 other guys that were there. It should have been a lime but it turned into a party. They peed on me. I can remember one guy saying, “You know how long I wanted for him to suck my dick…. From [when] he was at university.” I remembered him using his dick to slap me in the face… then I remembered someone peeing on me. I blacked out after that. I woke up the next morning and checked to see if I was raped. I guess they could have done stuff to me and I don’t feel it. I didn’t remember anything. I just remember when I woke up.

**Garry (age 26)**

Transnational sexual networks with North American and European men were established locally via social media and the Internet. Relationships with these visitors were often reciprocal, where the international partner would send goods and remittances to the local partner in exchange for sex.

I met this foreigner off Adam4Adam. We fucked a few times whenever he is on the island. So he used to send me money from time to time so I can help myself. It is not only him that I met from there you know. I have met a few more that I have been in relationships in and they help me out too…. When they come down I never take them to my house…. We go to their hotels to fuck…. When I am done, I go home and they stay where they are. That way everyone is good.

**Omar (age 23)**

Some JMSM engaged in undesired sexual activity with men who were able to provide them with a roof over their head. The experience was characterized as survival sex because it was performed out of need for food and shelter. In these situations, the risk of HIV exposure increased; however, the MSM were willing to compromise their health and personal safety as long as their immediate needs were met.

It was with the same person. He asked and I said no…. He said, “You must be joking.” I said, “No I am not joking; I am not in the mood.” He then said I had to sleep with him if I wanted to stay at his house…. So at that point I had no choice…. I stayed at his house for three days and every single time for those three days he wanted sex… but I didn’t…. On the second day he said either I do it or you leave…. So at that time I had to…. I left the third day; I told him that I
was leaving tomorrow… So I did not give him a chance for a third day…. My boyfriend doesn't even know about that situation. It was a time in my life where I had nowhere to stay and that was what I had to do in order to have a roof over my head…. It made me feel small in myself. I guess that’s just a part of being gay… being in somebody’s house that is gay and if they tell you that they want to have sex, then you have to have sex with them because you are in their house. So being gay, I think that is one of the pitfalls. Even for the young guys now, they may meet a guy that is willing to buy them clothes, food, and stuff like that…. It’s not because he is kind; he wants something. He wants to have sex with the guy…. So they would do anything and say anything just to get you to sleep with them…. I pick and choose who to have sex with. I am a top… so I won’t allow anyone else to fuck me unless I really have to…. Or if I am in a needy situation then I will let you penetrate me. I will only let my partner penetrate me and that’s like once in a blue moon…. In a situation where I am in need and an offer is made, I will see where they can fulfil the need. Frank (age 26)

I got to understand that when you’re living with somebody or “cotching” you tend to go through some stages of your life where you cannot do nothing more than you have to say yes and if you don’t say yes then you’ll be out again. So those are some of the experiences I have been facing. Focus group participant

While some MSM were in situations where they participated in undesired sexual activity with men who offered them a place to stay, others participated in this activity in order to financially provide for themselves. These men were commercial sex workers. They viewed commercial sex work as legitimate employment. Some offered “on-the-job” assistance to younger MSM who were new to this line of work. For some MSM, engaging in commercial sex work also provided needed income to pay for continued tertiary education.

Every single day two or three young boys come out on the street. Once they out there on the streets the older MSM catch them and start having unprotected sex with them. That’s the first thing they start to do with them, unprotected sex…. If you go out there you have a lot of them who are 14 or 15…. Some of them can’t read or write and they are out there. They don’t know how to negotiate anything at all… not even money. They may know money but they not even know the value. These are guys that will have sex for little or nothing and have also been abuse[d] by the same older MSM…. A person like me who is a veteran now the men who come to buy sex know they can’t give me any little thing because I
know the value of money. But the young one will do it because they are hungry. **Steve (age 25)**

I would say having this sexuality it would have brought more success to my life… meaning help and assistance…. I have tried so hard to gain these assistance through so many medium though politics, church, and nothing came through and I thought that with this kind of life style I would have been given the opportunity for help and assistance to pursue my studies without being bothered by the financial department of my institution… so I just hate the part of this lifestyle because the aid is at its low…. Well they say that in this lifestyle there are many persons of high standing and usually you would encounter persons who you can get some assistance from so that was my hope and intention that I could at least find that one person who could give some assistance with my schooling because that’s all I need… assistance with my schooling. **Alex (age 26)**

*“I try to act masculine in public to create an edgy version of myself around others who I know are against homosexuals.”*

**Protective Strategies.** With a clear understanding of the homophobic attitudes held by many within the society, the JMSM in this study created several strategies to navigate the society on a daily basis. Some JMSM who were interviewed for this project suggested that creating terms or names to use among each other while in public places provided them with additional protection. Early exposure to anti-homosexual sentiments was identified as the main reason for creating these names. Some of the terms identified included *sprint*, *blessed*, and *gum-drop*. The terms *sprint* and *gum-drop* are used to refer to any person the individual identified as homosexual. The term *blessed* refers to the male genitalia. So if two MSM were engaging in a conversation about a sexual experience one of them had with another male, he would use the term *blessed* to refer to the other man’s genitalia. One of the participants explained the term “*sprint*” below.

Now when you go to an athletic event in town that is where all the *sprints* go…. Let me tell you what *sprint* means…. *Sprint* means I can use it in public and not be scared…. When I say *sprint* in public nobody doesn’t [sic] really know what I
mean… you understand? When I use the word gay and battyman, everyone know, the whole of Jamaica knows what that mean. But when I say sprint or the child…. Nobody doesn’t [sic] really know what those terms mean. **Zack (age 21)**

In order to protect themselves on a daily basis from community aggression, these JMSM had perfected the strategy of knowing how to mask their identity so that they might pass as heterosexuals. When navigating unfamiliar areas, the MSM expressed or appeared to be more masculine than usual. Their feminine characteristics were suppressed while they were in unfamiliar environments.

One other thing I do is that you have to zoom in to your surroundings…. I call it zoom in, some people say transformation, to me zoom in is better. What I do if I’m coming on campus like now, you have to look different; there are different types of people here but yet it is still a more safe space…. But you don’t really let down your guard. Keep up your guard and try to fit in like everyone else and if you go to place like [Inner-City A] or [Inner-City B] you try to act more masculine. Don’t try to overdo it but you try to really zoom into the community, zoom into the people, zoom into your environment and try to fit in it like a camouflage… just try to do that. Is not everybody can do it [sic]…. But [it’s] so funny that is one of the things I can do. Anywhere I go I can just fit in and fit in normal…. They just don’t go there any at all. **Focus group Participant**

In most cases I would just try to act masculine in public I create a edgy version of myself in public and around others who I know are strictly safe and who are against homosexuals… so basically just act rough or toughen up myself more than the real-real me…. I’m never real unless I’m around good friends…. I dress, I dress more clean, nothing that draws too much attention to anyone just average…. The ones that blends [sic] well with society…. And they understand what it is to live in a country like this and persons who I know and are not just friends because of what you can do for them but mainly because we enjoy each other [sic] company and we roll good together. **Kevin (age 21)**

Development of unofficial family structures was viewed as a protective factor. Some older MSM took on the role of surrogate parents. The more effeminate male took on the role of mother, while the masculine male took on the role of father. Each of these units might have three or more children. The “parents” (i.e., older MSM) often engaged
in commercial sex work as a form of employment in order to provide food for their “children.” In some situations, the children were also encouraged to in engage in similar sexual activities in order to provide for the rest of the family. These family units appeared to serve dual purposes. They provided economic support for young and older MSM and they provided each family unit with protection from homophobic community aggression.

I think it’s a revolution I think it’s time now where a lot of parents are putting them out and they are grouping together…. Trust me… if you go out there and fling a stone after one, the whole entire group attack you…. So they are building like an army and they are not afraid of coming out and being on TV now…. They are behaving so outrageous and they don’t care. They want to come out and be gay…. Some of them were in their community getting bad treatment and they hear about the group out in New Kingston so them [sic] leave and joined them…. It is like a revolution. It is a big group but each group has a sub-group. They have their families like a gay mother and a gay father…. Those parents may have like 10 children that they are responsible for…. So there’s not really one big leader that lead the whole tribe…. So the parents try and get food and feed the lot…. The children may do sex work on their own and also when they do it on their own they want to give the parents money.  

Focus group participant

Some of the JMSM, who were homeless developed several survival strategies.

For example, they described elaborate plans for surviving unexpected weather situations, such as a hurricane. In other instances, having a keen understanding of local community resources, such as a church soup kitchen for food, and an abandoned area or open lot for shelter, was a part of their plan for survival. For homeless MSM in this study, the odds of surviving on the streets were extremely low. Their survival was contingent upon their relationships with the police, members of the community, and their ability to navigate the relevant resources.

At one point, yes, I tried to…. When I was doing the whole sex work I got robbed [and] run down by police.... I couldn’t eat for 3 to 4 days.... I was not
making enough money…. I wasn’t making enough money to even take myself off the street. I was still living on the street while doing it and it just come down to a point where I just thought to myself…. what am I living for? Is this my life? I’m like breathing under water; I just can’t take it anymore. I wake up in the morning trying to find a place to bathe and finding food. You know you have to sleep in the night air, rain come, storm come, you get wet. You know all of these things…. So what am I living for... might as well I just die.... When [a] hurricane comes they always talk about the shelters. I never really go to the shelters because…. One, as soon as they see you [act] effeminate and you start behaving and at the time I was doing sex work so I was always in the little tight shorts, tight blouse and all of these things…. So I couldn’t go there. For hurricanes and so forth I try to find sturdy places. There was a container at the Canadian embassy at the back… it’s not there anymore but that is one of the places that I went to…. Not just me alone but a few of my friends went there and we stayed in the container…. It is a big container. My support came from ending up doing sex work at one point. When I can’t hustle on the street, I go to [a Baptist Church] for food…. When you don’t make any money; sometimes you [sic] been robbed, you make money and get rob [sic] in the night from the same persons who came to buy sex… the imposters. Sometime I go up to [the Hill] to use the water that come[s] to the reservoir to shower, then at nights I jump over the fence and sleep by Hope Gardens. In the morning I’ll wake up make it to [a Baptist Church] or the [Adventist] church on Saturdays that issue meals. I try to have a mapping system so I know where to go for the free meals.... So I know what time they issue food and so forth so I try to wake up and go to those places.

Steve (age 25)

While many of the protective strategies mentioned by the JMSM were positive, some were extremely negative. These negative strategies were a direct response to the prevailing negative homophobic attitudes. Many of these negative homophobic attitudes had caused the MSM to sometimes respond violently.

I met another guy on the school compound and I found out that he was gay as well. So I drew closer to him. I found out that he was upset that he was gay and he couldn’t help it. The guy was suicidal and was willing to take his [own life], to kill himself on the school compound and I helped him out of that. Afterwards, because we were so close, people began saying that we were together, but that wasn’t so. We were just friends. I found out that he and another guy were together, which made him happy. Seeing them happy made me happy because I was like, yeah that could actually happen to me too. I was looking into myself and I was like, wow we were really like this. First it was good and then automatically it went form good to bad…. The straight guys at school plotted,
thinking they could beat us. I retaliated of course and stabbed them… with a pen. This dude thought that he could beat me with a belt. I was like, really. Boe (age 19)

JMSM who were in positions of authority at school, such as Head Boy, Prefect, or Class Monitors, were able to reduce their own vulnerabilities. The positions they occupied provided them with levels of protection that were not available to other MSM within the institution. Often, JMSM in these positions were also responsible for peer discipline and some had a zero tolerance policy for bullying of any kind.

I was protected because I was an outspoken child and anything that I am doing I have to be the leader…. So at no point in time I was [sic] ever bullied. Not even to this day…. Primary school was fun because when I was in primary school I never had these intentions to sleep with guys…. High school same covering up…. I had to live a double life in high school and at times I felt guilty… but it was just so nobody tried to bully me because I wore many badges…. I was prefect, class monitor and became deputy head boy. I was a very high-standing student in high school…. Alex (age 26)

Places to engage in sexual activities were often determined by the MSM. JMSM in this study who lived with their parents often chose to engage in sexual activities at their partner’s residence. In instances where the partner also lived with their family, hotels and guest house were seen as suitable alternatives. For others, parks, bathrooms, and other secluded yet public areas were used for sexual purposes. The decision to have sex in any of these vulnerable areas was not made because of the need for thrill but out of necessity.

It was at his house. At the time he basically lived alone…. His grandmother is away and he basically had the house to himself. So I would go there…. The way it works out usually is either my partner have their own place or if I have my own place my partner would come to me… but I have had exploring encounters where it could be in the back of the van or some other private secluded place…. I mean that is something, right? Sometimes it is a construction sites…. I have been open
to mangroves and stuff... it is like where the seas is... It is like a place with vegetation.... We took some risk, yea. **Kevin (age 21)**

I had sex one time in my partner’s office... He’s in a good job. Like a diplomat job.... He asked if I had sex before and I said yes.... He asked if I had sex with a guy before and I said no.... That time I was still in high school. So he asked me if it was with a girl so I said yes. So the question came up as to if I ever thought about having sex with a guy.... So I was like yeah... but not an old guy.... He asked me if I would try. So we did it in his office.... **Garry (age 26)**

**Summary**

For the Jamaican MSM in this study, their experiences of living in Jamaica and identifying as gay or bisexual were intertwined with their relationships with families, communities, and the larger society. Their collective experiences included being abandoned or disowned by their biological families and overt or covert neglect by many state agencies. In addition, they identified many factors that made it extremely challenging for them to become productive citizens. These included: (a) their knowledge about HIV and their inability to access preventative community resources, (b) their social and economic status, (c) their place of residence (i.e., in urban or rural areas), (d) disruptions in their formal education, and (e) homelessness. While there were legitimate concerns over the fear of being visible by projecting their gender nonconforming behaviors, many MSM developed effective strategies to mitigate those concerns. JMSM sought to protect themselves by learning from each other about ways to disguise their sexual orientation and educate each other about issues related to HIV transmission and prevention. Building new allies in the form of surrogate family units provided many life necessities, most importantly being protection from negative, and often violent,
homophobic community aggression. The surrogate family unit gave many JMSM in this study a social support structure that their biological families had failed to provide.
CHAPTER FIVE: Discussion

The objective of this study was to describe the social and cultural factors that impact the lives of young Jamaican Men who have Sex with Men (JMSM). Several thematic statements were identified (see Table 4.8). These statements provide insight into the perspectives of young JMSM. In addition to fulfilling the study’s primary objectives, additional insight was provided to explain the strategies used by the JMSM to protect themselves from becoming HIV infected, discrimination, and physical assault. These findings provide an intimate account of the past and current lives of JMSM who were predominantly from the parishes of Kingston and St. Andrew. The following sections of this Chapter include: comparisons of the present study’s results to existing literature; contribution of new knowledge to the literature and the current discourse within the Jamaican society; implications for practice and future research; limitations; and concluding thoughts.

Comparison to Existing Literature

**HIV Knowledge.** At the time of the writing, there were no published studies that examine the HIV knowledge of JMSM. The few previously conducted studies were on a small scale and only involved heterosexual “street boys” in Jamaica (Robinson et al., 2001). Robinson and colleagues (2001) noted that within their small sample of heterosexual “street boys,” HIV knowledge was limited. Additionally, the Knowledge, Attitudes, Behavior, and Practice (KABP) survey conducted routinely by the Ministry of Health in Jamaica does not capture the sexual practices that may place MSM at risk for HIV. For the present sample of JMSM, HIV knowledge was measured by utilizing the
45-item HIV-Knowledge Questionnaire (HIV-KQ) designed specifically for young men of color who have sex with men (YMCSM; Fields, 2005).

Thus far, the HIV-KQ for YMCSM has been used in three separate studies, two of which were conducted within the United States. The third, the present study, was conducted in Jamaica, West Indies. In comparison to the original study, JMSM in the present study had slightly lower HIV knowledge. In his research, Fields (2005) reported a correct response rate with a mean score of 83% (SD = 2.34; range = 40% - 90%) for a sample of 16 young MSM of color in the United States. In the second study, conducted by Wharton (2013), with a total of 31 young Black MSM from Western New York, a correct response rate with a mean score of 76% (SD = 16.17; range 31% - 96%) was reported. In the present study, with a total of 30 young JMSM, there was a correct response rate with a mean score of 77.6% (SD = 9.354; range = 42% - 91%). This study represented the first time the HIV-KQ for YMCSM was used outside of the United States and within the Caribbean.

In all three cohorts, two items consistently scored lower than other items. In Fields (2005), Wharton (2013), and the present study, question #8, “HIV is killed by bleach,” and #39, “If a person tests positive for HIV, the testing site will have to tell all of his or her partners,” both had low correct response rates. These lower correct scores suggested that young MSM of color in Western New York, and Jamaica are unaware of the clinical significance of using bleach to destroy the HIV virus outside of the human body and the procedural public health implications of partner notifications (Fields, 2005; Wharton, 2013). In both previous studies, 81% and 87% (respectively) of participants
answered question #8 incorrectly (Fields, 2005; Wharton, 2013). In the present study, no participant answered that question correctly.

Within this sample of young JMSM, there were also misconceptions about acquiring HIV and blood donation. Of the young men surveyed, 77% were under the mis-impression that a person can acquire HIV from giving blood. This may pose challenges for healthcare workers in hospitals and the local blood banks if the larger public is still under the impression that a person can acquire the virus through blood donation.

Consistent with other information in the literature, JMSM were aware of several myths about HIV acquisition. Of the 45-items, only five items were answered 100% correctly by all participants. These questions included: #3, “a person can get HIV from a toilet seat,” #7, “a person can get HIV by sharing a glass of water with someone who has HIV,” #22, “men who only practice ‘topping’ (inserting their penis into another man’s anus) cannot get HIV,” #33, “having sex with more than one partner can increase a person’s chance of being infected with HIV,” and #35, “a person can get HIV by sitting in a hot tub or swimming in a pool with a person who has HIV” (see Table 4.2). The high correct response rates to these questions suggested general awareness of how HIV is transmitted (Fields, 2005; Wharton, 2013).

Since the questions related to the sexual practices of MSM are not included on most HIV knowledge instruments, public health officials are neglecting to assess key domains of knowledge that are unique to sexual behaviors that place MSM at risk for HIV (Fields, 2005; Wharton, 2013). Although it is the first time that this instrument was
used in a unique sample of young JMSM, the instrument gave insight into the knowledge deficits of this population as it relates to their sexual behaviors. While JMSM were aware that “men who only practice ‘topping’ (inserting their penis into another man’s anus)” are also at risk of acquiring HIV, they were uncertain of their risk of acquiring HIV when performing analingus on their male partners; 87% of the sample answered this question incorrectly.

**Sexual Practices and Behaviors.** The general population in Jamaica are under the impression that MSM are the main contributors to the increase in HIV rates (Davis, 2001; 2004). There has, however, been limited research investigating the sexual behaviors and practices of JMSM. Moreover, no studies have compared the sexual behaviors of heterosexual men and MSM in Jamaica. When compared to the studies in the United States, the theory that Black MSM (BMSM) were engaging in more risky behaviors than other MSM has been debunked (Millett, Malebranche, Mason, & Spikes, 2005). Consistent with what had been reported in the United States, for this sample of JMSM, their sexual risk behaviors were no different.

The JMSM participants in this study reported engaging in a wide range of sexual activities. These activities ranged from low, medium, to high risk for HIV transmission. Overall, this sample of JMSM engaged more frequently in masturbation and mutual masturbation than any of the other sexual actives within the past three months. While both anal insertive and receptive sex were reported, JMSM engaged in those activities at a much lower rate. The subset of men in this study who engaged in commercial sex work,
however, reported higher rates of receptive unprotected anal intercourse and only 13% of those men reported using a condom at their last intercourse.

Although inconsistent, these JMSM were using condoms with most of their insertive and receptive male partners. During the last 30 days, men practicing receptive intercourse reported moderate rates of condom use (67%). This is consistent with JMSM overwhelmingly reporting that they were the initiator when deciding to use condoms. Intimate relationships and the “heat of the moment” were the reasons cited for inconsistent condom use with unprotected anal intercourse. The decision to cease using condoms for JMSM was contingent on how long they had been in their relationships. This is consistent with what has been previously reported in the United States (Wharton, 2013). For JMSM in this study, the “heat of moment” was described as being in a situation where sex was unplanned or unexpected.

In some instances, sexual partners were selected based on what they were able to provide to the young JMSM. Some of the men in the study were currently, or had previously been in, age-discordant relationships where they were the younger partner. Age-discordant relationships provided stability, economic support, validation, and love; these also provided the MSM with a sense of belonging. Usually, age-discordant partners were between 10 and 20 years older than the JMSM. These relationships may be more common in Jamaica due to the current economic climate, where the unemployment rate was 38% among young people between the ages 14 to 24 years (Statistical Institute of Jamaica, STATIN, 2013). Relationship dynamics as seen in heterosexual unions was also mirrored in this sample of young JMSM. JMSM in this study who had identified or
projected a more female gender expression reported practicing high rates of receptive anal intercourse. For young effeminate JMSM in this sample, older partners were considered to be the “man” in the relationship.

While many studies have documented the risk for HIV transmission among age-discordant relationships between adolescent girls and older male partners within the United States and Sub-Saharan Africa (Bruce, Harper, Fernandez, & Jamil, 2012), no research on this issue among age-discordant JMSM relationships has been conducted. One particular study conducted in the United States, however, provided some insight into these complex relationship dynamics and the implication for HIV risk. In their research, Bruce et al. (2012) reported that HIV risk was much higher for young MSM in age-concordant relationships than those in age-discordant relationships. They attributed this fact to the high prevalence of HIV among young MSM. However, in age-discordant relationships where the partner was older, the anal receptive partners were more likely to be younger (Bruce et al., 2012). This was true for the young JMSM in this study as well. As previously mentioned, the HIV prevalence rate for the JMSM community is 38% (Ministry of Health, 2012); therefore, the possibility of coming in contact with a partner who is HIV positive is higher compared to other sub-groups within the population (Outlaw et al., 2011).

Other Findings that Expand Current Knowledge

Identity Development. Many of the JMSM in this study began exploring and experimenting with homosexuality at a very young age. For some, their experimentation began during their school-age years. This is consistent with what has been documented
in the literature (Floyd & Stein, 2002). In their research project, Floyd and Stein (2002) reported that young people gave accounts of becoming aware of their same-gender attraction at a very early age. The mean age for their sample of young LGBT participants was 11 years (range = 3-18 years). While many became aware of their same-gender attraction at an early age, many delayed sexual intercourse with a same gender partner (mean = 17 years; Floyd & Stein, 2002). This, however, was dissimilar to what was reported by the JMSM in the present study.

In this small sample of JMSM, participants’ awareness of their same-sex attraction was closely followed by sexual experimentation and exploration, oftentimes with young boys within their peer group. Traditional Jamaican childhood games, such as “dolly house” and “hide-and-go-seek” provided the opportunity for these young JMSM to explore their sexual attraction in a non-judgmental and non-threatening manner. While studies have shown that young women and men at some point in their lives have explored same-sex attractions, men engaged in early sexual activity with each other at a much higher frequency (Dempsey, Hillier, & Harrison, 2001). The involvement in such sexual activities assisted in solidifying a homosexual identity.

Even though many of the men in this study became aware of their same-sex attraction and had experimented with same-sex activities at an early age, many also reported anxiety around developing a homosexual identity. For them, the thought of being perceived as different was more than enough reason to keep their sexuality hidden from persons who might do them harm. This form of anxiety has been reported as common among young MSM who are in various stages of their “coming out” process.
The JMSM in this study repeatedly expressed that, at a young age, more specifically, during their school age years, they remembered feeling different; however, they were unable to place a label on the feelings they had. Young men who were gender non-conforming or effeminate reported being teased by their peers as early as the primary school level. Teasing was not directly linked to any form of sexual practice. It was mostly related to school ground politics of maleness and masculinity.

As it pertained to their same-gender affirming identity, the JMSM in this study frequently negotiated public spaces within the society. Their peers questioned their masculinity at a young age. Derogatory terms were used as a way to diminish or invalidate the existence of gender non-conforming JMSM. Terms like *battyboy* and *fish* were used to disrespect and bully marginalized students. Plummer (2001) had similar findings in his report, where children in the UK used derogatory terms such as “*faggot*” and *poofier* as a form of insult; however, he noted that at the same time, these words had no sexual connotations or meaning when used (Plummer, 2001). While they may not have any meaning rooted in sexual practice for the children using the terms, the JMSM in this study reported feeling isolated and neglected.

It has been documented that early exposure to homophobic attitudes may contribute to maladaptive identity formation for young MSM (Plummer, 2001; White & Carr, 2005). Negotiating hyper-masculine educational spaces at times led to a wide range of psychological distress for many young JMSM. As a result of their failure to successfully negotiate these situations, some had attempted or contemplated suicide, and others engaged in the self-mutilating practice of cutting. McCready (2010) in his report
explained the psychological impact of masculine anxiety for young men who are gay or gender non-conforming. Although this is not a new phenomenon in Jamaica’s public school system (Grindley, 2012), further research is needed to explore the psychological impact of marginalization for young JMSM.

**Childhood Sexual Abuse.** Although it was not a major finding in the study, the issue of childhood sexual abuse (CSA) was reported by a small subset of the men in the present study. An older family member, neighbor, teacher, or religious leader perpetrated many of these instances of CSA. While mostly older males were reported as perpetrators of the abuse, older females were also implicated. For one participant, his experience with CSA occurred as early as four years of age. Both he and other JMSM who experienced CSA reported not being able to attach a label to what they were experiencing; however, they sensed that it was wrong. It was during the interview with the investigator that they then realized that the experiences that they had with these older individuals were, in fact, abuse.

JMSM in this study who were gender non-conforming were more likely to describe being victims of CSA. Their experience with CSA occurred on multiple occasions over several years. The psychological impact of CSA was evident with each victim blaming himself for the abuse. They rationalized the abuse by stating, “Maybe if I wasn’t effeminate or soft I wouldn’t have gone through all the stuff I went through.” Others attributed their same-sex attraction to their experience with CSA. Experiences with CSA have been linked to a wide range of later high-risk behaviors and mental health issues among MSM in the United States (Brennan, Hellerstedt, Ross, & Welles, 2007;
Fields, Malebranche, & Feist-Price, 2008). In three independent qualitative reports, a combined high prevalence of CSA (32%) was found among Black MSM within the United States (Fields et al., 2008). In that same report, the abuse was perpetrated by an older member of the family or person in authority over the child. In the study by Fields and colleagues, CSA was directly linked to mental health and HIV risk behaviors for Black MSM (2008). While Brennan and colleagues reported moderate prevalence of CSA within their sample of gay and bisexual men, high rates of HIV and other corresponding risk behaviors were reported (Brennan et al., 2007). This is consistent with what was observed among the JMSM in this study who reported a history of CSA. Of the nine individuals who reported a history of CSA, three indicated that they were HIV positive. Of note, two of those individuals also reported a history of homelessness and commercial sex work.

Instances of CSA often go unreported because the victims were threatened and felt that adults receiving the report would not believe them. The young men who reported having experienced CSA explained that they did not report the abuse because of the fear that they would be blamed or “get in trouble.” Conversely, reporting these sexual atrocities may be futile, as, under Jamaican law, the Sexual Offences Act of 2009, the rape and sexual assaults of men and boys are not recognized (Nelson, 2014). As the law is currently written, there are no protections for young men and boys who are also vulnerable. Although these self-reported experiences provided a snapshot of CSA among this vulnerable group of individuals, their collective experiences pose many unanswered questions. For example, what is the current prevalence of CSA among young JMSM?
And, are experiences with CSA directly linked to the increased HIV prevalence and high-risk behaviors as observed among Black MSM within the United States?

**Educational Institutions.** Primary, secondary, and tertiary educational institutions were a source of psychological trauma for many of the young JMSM in the current study. Appearances, gestures, soft-spoken voices, and unique and unconventional forms of grooming made many participants targets for harassment. Institutionalized attitudes towards homosexuality exist in the Jamaican heteronormative educational system that is rooted in religious pedagogies. For many participants, marginalization stemmed from them being effeminate or gender non-conforming. Effeminate and gender non-conforming JMSM were isolated, harassed, and sometimes physically abused by their peers and educators. Teasing, bullying, and *being taxed* (extortionist-type behaviors against students who were perceived as “weak” or gay) were all forms of harassment and victimization for JMSM. Oppressive educational environments such as these created an unsafe and unproductive environment for each and every student, more specifically marginalized individuals who are gay or gender non-conforming (McCready, 2004).

The JMSM in this study responded to various forms of oppression and harassment in different ways. Some responded violently, others avoided their tormentors (by making supportive spaces for themselves), and those who were unable to do either, voluntarily left the institution.

Violent responses to homophobic assaults were perceived as necessary to deter future attacks. The JMSM who were teased, bullied, or *taxed*, recounted reporting the incidents to school administrators. For the most part, their complaints went
uninvestigated. As a result, the harassment continued. When they responded to their assailants, school administrators blamed them for the altercations. This created a frustrating and vexing learning environment. While violence of any kind should not be condoned, educators, policy makers, and the Ministry of Education must implement policy geared towards addressing the issue of violence in Jamaican educational institutions.

Due to the lack of support from many school administrators and as a response to the frequent harassment and abuse, many JMSM in secondary institutions and universities were forced to create their own supportive spaces. These spaces were unofficial and neither sanctioned nor supported by school administrators. Gay and other gender non-conforming students met in small groups to discuss current issues within their school and the society and offered each other support around intimate relationships, family, and HIV prevention. By creating these supportive and caring spaces for themselves, marginalized students, more specifically young JMSM, were able to have their psychosocial needs met. Studies of gay and gender non-conforming African American students suggested that making spaces was one unique way of responding to institutional oppression and marginalization (Blackburn & McCready, 2009; Venzant-Chambers & McCready, 2011).

Some JMSM made spaces for themselves by becoming a part of the student leadership body. They became “head boys” (a senior student in the school that represents the institution in public and is responsible for student discipline), “prefects” (a student with limited authority over his or her fellow students), athletes, and members of debate
teams. As a result of holding these high level positions in their school, they received respect and protection not afforded to other non-student leaders. Venzant-Chambers and McCready (2011) referred to this as a political and institutional strategy used that is necessary as a response to perceived and actual marginalization.

The decision to abandon their education was never an easy one for many of the participants in this study. After frequent instances of torment and abuse, many young JMSM withdrew from school. Before this, however, many tried transferring from one school to another in order to find a place that was more accepting. The culture and politics of many prestigious single-gender schools (i.e., all-boys schools) allowed for anti-homosexual attitudes and behaviors to flourish. According to the JMSM participants in this study, school administrators perceived homosexual and gender non-conforming youths as threats and a “cancer” that needed to be eradicated. Moreover, anti-homophobic attitudes and behaviors were amplified when young JMSMs were caught engaging in simple homosexual activities (i.e., kissing a member of the same sex). When caught, the safety and security of those young men were compromised. Their sexuality was exposed to their parents and they were later asked to leave the institution in order to remove the notion that “only battyman go to that school.” Unable to secure acceptance into another prestigious same-gender school, many of the JMSM in this study transferred to technical and vocational high schools or withdrew altogether.

From the experiences of many young JMSM in this study, both teachers and school administrators were implicated in acts of marginalization and homophobic assaults. In instances where gender non-conforming students were assaulted by their peers,
teachers often ignored the bullying type behavior. In other cases, educators and administrators placed blame on the individual MSM for their circumstances. This type of neglect and approach lends itself to an oppressive knowledge production where students, based on the attitudes and behaviors of their educators, believed that their reactions to presence of homosexual students are normal (Brockenbrough, 2013). Adequate training and more public discourse are needed to assist educators at the institutional level to address or support students that are gender non-conforming or homosexual (Brockenbrough, 2013).

While Brockenbrough (2012) found mixed opinions among male educators playing the role of surrogate father for their male students, some reported deep emotional connections with male students that were reflective of father-son type relationships. Although many participants in the present study had their fathers or step-fathers in their lives, they reported not being able to have conversations around their sexual orientation and other safe sex messages. There is a clear indication that additional structural support is needed. As part of a programmatic approach, the Ministry of Education could increase the presence of male teachers and guidance counselors in the education system so they may serve as mentors. It must be made clear, however, that the role of male teachers is not meant to replace biological fathers, but to be a source of additional support for male students who are in need of guidance (Brockenbrough, 2012). The investigator of this report during his field observations spoke with several male teachers who also happened to be same-gender-loving, regarding their role as teachers and working with students within their institution. Overwhelmingly, many of the young male teachers that the
investigator spoke to mentioned that often they had to come to the aid of the gender non-conforming students within their schools. Some reported serving as a source of emotional support and offering guidance in navigating their JMSM students’ oppressive environments.

Instead of taking an apoplectic approach to the presence of homosexual youths in Jamaica’s educational institutions, the Ministry of Education and school administrators need to play a pivotal role in confronting the issues of homophobia and intolerance. Programs addressing these complex issues must be geared towards shifting the focus from the individual MSM level to a more general, across-the-board policy that expands its reach to all students from the primary to the tertiary level. By taking this approach, the Ministry of Education and other key stakeholders will ensure that the issue of intolerance and homophobia is not handled only at the school (principal or dean of discipline) level but, also instead, at the national level, through the Ministry of Education and the Ministry of Youth and Culture. Furthermore, adequate training is essential for educators and guidance counselors to properly understand sexuality and how it intersects with multiple variations of gender identity and expression (Blackburn & McCready, 2009).

**Sex Education.** When the proposed Health and Family Life Educational Curriculum was introduced for dissemination across Jamaica’s secondary institutions it met great criticism from the community and political representatives (Reid, 2012). The controversy surrounding the proposed curriculum was a result of the inclusion of content on homosexuality. While it is debatable whether sex education should be left to parents
and not the state, research has demonstrated that schools can play a unique role in delivering comprehensive sex education to all students (Starkman & Rajani, 2002). The parents of some JMSM in the present study attempted to discuss the issue of sex by telling them to read a book (i.e., “The Complete Tween”) or simply handing them a condom and asking them not to get their girlfriends pregnant. Typically, there were no reports of conversations about sex or sexuality.

Schools were suggested as a source for some form of sex education. Participants reported that the materials were administered predominantly by their guidance counselors. Conversely, the materials delivered to students were devoid of content related to sexual orientation, variations of gender identity, and anal health. Instead, participants reported content on abstinence, proper condom use, and vaginal sex. According to many JMSM there seems to be an apprehension by leaders within the Ministry of Education in developing and implementing a comprehensive sexual education curriculum that addresses the taboo issues of fellatio and anal intercourse. This void was filled by the Internet, cable television, and friends to provide same-sex sexual education and HIV prevention messages.

**The Role of the Church.** Regardless of the denomination, churches were identified as one of the major sources for socialization for most JMSM in this study. Due to their early introduction into a religious community, young men who recognized their same-sex desires struggled with accepting their homosexual identity or rejected it so they may continue to be members of their churches. This conflict led many young men to live a secretive homosexual lifestyle. Although they were unable to be open about their
sexuality in their religious communities, many JMSM took on active roles in their churches. Being a part of the youth ministry, choir, or Sunday school teacher gave them agency and support from others within the church. However, these positions were often temporary and were revoked if their sexual orientation became public. This sort of discrimination was identified as another source of psychological distress.

Further contributing to the psychological distress is the notion that a person is able to “pray the gay away.” “Asking God” to deliver JMSM from homosexuality was a task set forth by religious leaders and other members within the church. Their continued relationships with God and their church were contingent upon their ability to totally eradicate all same-sex desire from their lives.

The church and other religious communities in Jamaica have a distinctive role to play in combating the issue of homophobia and intolerance in Jamaica. As previously mentioned, over 62% of the population characterized themselves as religious and belonged to a sub-group of the Protestant faith (CIA World Factbook, 2012). On any given Sunday, men and women frequented their church homes to hear the word of God from their religious leaders. As in the US, the pulpit in Jamaica is powerful and may be used as a platform to discuss issues related to tolerance and acceptance. Additionally, as seen in some Black churches in the United States, ministers and other church leaders could be utilized to deliver messages around HIV, stigma, and discrimination.

**Mental Health.** Pervasive stigma and discrimination led to a multitude of undiagnosed mental health illnesses for JMSM. As a result, suicide and other self-mutilating behaviors may have been perceived as their only source of escape. Attempts
and contemplation of suicide were conflated with freedom from homosexual stigma and discrimination. Due to the high prevalence of suicidal ideation by JMSM within this sample, clinical providers offering care to these marginalized individuals must routinely assess for these maladaptive behaviors. Although, assessment of suicidal ideation should be done on a regular schedule, outside factors contributing to the problem must also be addressed. Evaluation, exploration, and treatment at the macro-level (repeal of the buggery law and passage of an anti-discrimination law; public policy changes; and advertisements promoting tolerance) and micro-level (parents, teachers, and religious communities) must be a part of any plan of care (Morrison & L’Heurux, 2001). Mental health practitioners, clinical providers, and educators working in collaboration with policy makers can create policies that promote tolerance and acceptance.

Young MSM who were victims of discrimination and sexuality-based harassment are more likely to engage in high-risk behaviors (Hightow-Weidman et al., 2011; Wong, Weiss, Ayala, & Kipke, 2010). Additionally, sexuality-based harassment and discrimination disenfranchise individuals, making them vulnerable to abandonment by their parents, homelessness, disrupted educational attainment, poverty, illicit drug use, and HIV acquisition (Wong et al., 2010). Similarly to what was reported by Wong and colleagues (2010), the young JMSM in this study who were disenfranchised by homophobia and discrimination dealt with their marginalization in different ways. As a result of having their economic lifeline disrupted (i.e., abandonment by parents) a number of the study participants resorted to a life of survival and commercial sex work. Many of the activities that they engaged in have a direct correlation with increased HIV risk.
Cathartic Effect of the Interviews. Many of the participants in the study commented on the therapeutic effect of the interview experience. Since this was a semi-structured one-on-one interview format, participants were able to share their life experiences in a private environment. After opening up about their sexuality, sexual behaviors, and other personal matters, participants commented on how comfortable they were with the interviewer. They felt invested in the project. Allowing participants to talk about themselves freely without interruption, except for clarification, created this therapeutic effect.

For many, this was the first time that they had ever discussed their sexuality with anyone except a close friend or intimate partner. Almost all of the participants who mentioned that they had once attempted or contemplated suicide told the investigator that they had never disclosed these behaviors to anyone, or sought mental health treatment. It was suggested, however, that due to the environment in which they have found themselves, suffering in silence was the only possible way for them to remain safe.

Adding to the therapeutic effect was the decision by the investigator to communicate in Patois with participants who chose to speak the dialect. This helped to ameliorate the “foreigner/outsider” effect. They suggested that the interview felt as if they were having a conversation with an older sibling or close friend. A small subset of individuals inquired about the sexual orientation of the investigator. It was believed that they were inquiring because they were unsure as to whether or not they could trust the investigator. Although the question was not answered explicitly, the calmness and welcoming personality of the investigator appeared to aid in developing a sense of trust,
which ultimately created a non-threatening and non-judgmental environment for the participant.

It is also important to note that during the interview one participant explained his apprehension with having the interview audio recorded. He gave a detailed account of having been audio recorded by an individual who pretended to be gay then later blackmailed him as a result. While his apprehension was rooted in the deceptive practice of another individual, the investigator had to assure him that his privacy and confidentiality would be maintained. Being blackmailed or extorted by unscrupulous individuals was a common experience for many of the JMSM in this study. Investigators conducting research with these populations of marginalized individuals must consider their safety and institute safeguards to protect them. This was true for this participant. His experience with being blackmailed left him with an enormous amount of unresolved psychological trauma.

**Era of Social Media.** Before the emergence of social media platforms, such as Facebook and Twitter, crimes and atrocities committed against MSM remained local and were not broadcast on the national or international level. In this new era of social media, anti-homophobic behaviors are almost immediately broadcast for the world to see. An example of this was observed early in the investigator’s time in Jamaica. In September, 2012, there was an incident involving two male students from a local university in Kingston, Jamaica. The two students were accused of being caught engaging in an alleged homosexual act. They were chased by students on the university property. While one escaped, the other was cornered and subsequently physically assaulted by security
personnel. The incident was captured on video and distributed through YouTube to an international audience. Within hours, the video went viral, and the world responded in outrage. This incident and many others like it renewed the conversations about the rights and protection of JMSM in public and private institutions across the island. The government has a critical role to play in changing the course of intolerance across all aspects of the society. Failure to do so will not only perpetuate the observed homophobia; it may also continue to publicly impact the negative image of the island.

**The Role of Women for JMSM.** Women played an important role in the lives of many of the JMSM in this study. For the majority, women’s presence provided them with a source of support. Overwhelmingly, mothers, aunts, female cousins and friends were identified as the most important persons in the lives of many JMSM. The young men who chose to reveal their sexual orientation were most likely to have shared that information just with a female friend. This finding underscores the importance of building on the positive support systems of JMSM. While there is a need to increase opportunities for strong male mentorship, we cannot overlook the roles women are playing in nurturing these individuals. Some of the topics JMSM reported struggling with when talking to their fathers lent themselves to easier conversations with non-judgmental and supportive female family members and friends.

**Study Limitations**

**Sample.** This sample of young JMSM was recruited primarily from the Kingston and St. Andrew area. While tremendous efforts were made to recruit a wide representation of JMSM, several challenges made this effort difficult; of these,
transportation was the main challenge. The investigator and study site were located at the University of the West Indies, in Kingston. Because of not having an easily accessible mode of transportation, travel to other areas outside of the Kingston and St. Andrew area was problematic. Additionally, the investigator’s local supervisor and the security and public relations section of the United States Embassy in Kingston advised against it.

The sampling strategy employed by the investigator did allow, however, for some variation of representation of JMSM in the sample. By utilizing the snowball sampling technique, participation by individuals living in St. Catherine, St. James, and St. Thomas was possible. Many of these individuals waited until they had personal business in Kingston and coordinated their schedules with the investigator to accommodate their interview. Although this was an option for potential participants, the burden and expense of travel to Kingston for an interview was deemed too great for men who were under- or unemployed. In the future, researchers planning on conducting research with this vulnerable population should take into account the personal challenges that are imposed on participants when seeking their participation in research.

**HIV and STD Status.** Young JMSM who participated in this project were asked to self-report their HIV and STD status to the investigator. It is important to note that the investigator’s reliance on participants’ self-reported sexual behaviors, HIV, and STD statuses may have a direct impact on the number of individuals who truthfully revealed that information. To combat the issues highlighted above, other studies in the United States required that participants be screened for HIV prior to their enrollment into the research project and provide the investigator with verification of their negative status
While this may be a practical approach within a society such as the United States, where resources and options for testing are reasonably available, this imposition would be impractical for many young JMSM who may not have access to free and confidential HIV testing or are afraid of being stigmatized, and discriminated against as a result of their sexual orientation.

**Location of Interview Sites.** Initially, the investigator began recruiting participants from the University of the West Indies and a local community-based organization (CBO). Recruitment from the local CBO may have had a direct relationship with the type of data collected because the patrons who sought services from that organization were more likely to be severely marginalized. Additionally, because of their marginalization, they may have had unique life experiences that are not shared by other sub-groups of JMSM. After the organization relocated, due to structural issues, other attempts were made to increase the participation of a wider array of participants. This effort made it possible for participation of older (men up to age 30), working, and educated individuals within the larger community.

**Implications**

**Implications for Future Research.** While the primary purpose of this study was to understand what it was like to be a man who has sex with other men and living in Jamaica and the strategies used by these men to mitigate their HIV-infection risk, it was clear throughout this investigation that there were many other issues that complicated the lives of these JMSM. Some of these issues were situational and were a result of their own actions. Other issues beyond the control of the JMSM were deeply rooted within a
societal and political context. Many sectors of the Jamaican society view homosexuality as a “lifestyle choice” and believe that it can be changed at any time by the individual. By characterizing homosexuality as a choice, limited opportunity is available to provide meaningful discussions around the rights and protections for this vulnerable population. Future research must take into consideration of the complex and unique nature of the lived experiences of many JMSM, both young and old. To more fully evaluate the experiences of these marginalized men, future research should be designed to include retrospective cohort studies, prospective longitudinal studies, and to research investigative reports of Jamaican MSM who have migrated to other countries.

A descriptive, retrospective cohort study could be designed for exploration of the intergenerational challenges of MSM living in Jamaica. Allowing JMSM to retrospectively recall major sequences of events that had occurred throughout their lives could influence how they are treated and regarded by the larger society. A retrospective study would offer insight into the resiliency of many older JMSM since they were part of a generation of MSM who had to live their lives in private. While considering the emergence of the HIV epidemic and the proliferation of anti-homosexual attitudes and behaviors, a retrospective cohort study could provide a contextual blueprint for examining these issues during adolescence. The retrospective study could be divided into several age cohorts going back as early as the 1970s. These four cohorts would represent a 10-year span going as far back as the initial onset of the HIV epidemic. This 10-year span would include persons born in: (a) 1970, (b) 1980, (c) 1990, and (d) 2000. Since many JMSM reported initiating sexual activity at an early age, participants in the study
could be divided based on the year that they reached 14 years of age. By going back to early adolescence the investigator could assess for challenges that might have influenced adolescent development and their impact after the transition into adulthood (i.e., early sexual debut, homelessness, mental health, and acquisition of HIV infection risk). The data collected from a retrospective study design could represent an important source of information that could be used in further research efforts and could further the creation of culturally relevant interventions more specifically designed for JMSM (Portney & Watkins, 2009).

Building on the retrospective cohort study, a prospective longitudinal study would allow the researcher to follow individuals over the same period of 10 years, from adolescence to adulthood. This would provide valuable insight into the developmental progress (i.e., sexual debut, romantic and sexual relationships, attitudes and beliefs around homosexual identity, and HIV risk perception and knowledge) of the adolescent and the external and long term impact of homophobia, neglect, and abuse. By taking this approach, the investigator would have “the advantage of accumulating longitudinal data through intensive documentation of growth and change on the same individuals” (Portney & Watkins, 2009, p. 279). Further, employment of a mixed methods approach to research throughout this time span would allow the researcher to routinely collect demographic and behavioral data, using the instruments from this investigation (see Appendix G and J). Demographic and behavioral surveys may be used over a six-month period. Since life situations may change dramatically for some JMSM, rendering them transient, assessing current circumstances through the demographic survey would be
important. Annually, participants could be encouraged to have an HIV test. This would provide the HIV statuses of the participants and aid the researcher in facilitating integration into HIV treatment services, if positive. An additional component to this longitudinal study would be a bi-annual face-to-face semi-structured interview to follow-up with participants on their life experiences. The questions presented could be similar to those used in this study’s interview guide (see Appendix I).

During this investigation, there was unanimous agreement among JMSM about wanting to leave the island so that they could openly live a homosexual life. There was also agreement about wanting to have the right to wed a same-sex partner. Future research could investigate the lives of JMSM after their migration from Jamaica. Studies might follow JMSMs who have relocated to the United States, Great Britain, and Canada to assess whether or not relocation made any difference in regard to perceived stigma, discrimination, and HIV risk.

**Implications for Instrument Development.** The instruments used in this research project were developed primarily for United States based groups of young MSM of color (see Appendix G and J; Fields, 2005; Wharton, 2013). While the content applied to the young JMSM, further refinement of the instruments is needed. For example, there were several items on the HIV-KQ for YMCSM that were not applicable to the JMSM population. On question #25, a significant portion of the population indicated that they have never seen or heard of a lambskin condom. The same sentiments were expressed for question #31, where participants indicated that they have never heard of a natural skin condom. Answers to these questions may be skewed as a result of a knowledge deficit
and generational differences. Future refinement of this instrument could include content that is more culturally relevant to young JMSM, such as questions that debunk myths related to HIV infection (i.e., having sex with a virgin can cure someone who is infected with HIV). Additionally, as suggested by Wharton (2013), further refinement of the sexual behavior inventory is also needed to address content related to types of lubrication (including brand and flavored) used during sexual intercourse and if lubrication is always used. These additions are vital as many MSM indicated other methods of lubrication (i.e., lotion, saliva, Vaseline, and sometimes nothing) that increase their risk for HIV acquisition.

**Implications for Intervention Development.** To combat the prevalence of HIV infection among young JMSM, public health officials must develop interventions that are culturally appropriate and economically feasible. These interventions must be multifaceted, meaning that they must address the social and cultural, behavioral, physical environment, economic, political and biomedical factors that contributes to increase HIV risk vulnerabilities (Wilton et al., 2009). Interventions such as Many Men, Many Voices (Wilton et al., 2009), increased participants’ awareness of how their risk behaviors were directly related to systemic homophobia, institutional racism, marginalization, and how they perceived themselves (Wilton et al., 2009). Through seven modules, each building on the other, participants were able to recognize how external factors that were beyond their control impacted or affected their sexual decisions. Interventions such as this could be readily adapted to address the complex external issues impacting the sexual decisions and practices of many young JMSM.
It was previously mentioned that many of the JMSM in this study sought potential partners through various forms of social media. Social networking sites, such as Facebook, Twitter, and Adam4Adam, allowed for discretion and privacy. Because these avenues are being utilized for intimate partner selection, the Ministry of Health and other agencies looking to offer services to this population may reach participants through this medium. Interventions could be created that provide HIV prevention messages and other menus of safer sex options for at risk individuals. Fields and colleagues (2006) suggested that within this era of social media boom, Internet chat rooms may be a cost-effective and viable way of meeting the challenging needs of sexual minorities in general, and MSM more specifically. Development of culturally appropriate interventions for MSM at risk for HIV transmission must have the full support and input of consumers of such interventions (Fields et al., 2006; Gullette & Tuner, 2004). With the emergence of smart phones with options to download content specific applications (“apps”), the Ministry of Health would be able to deliver confidential HIV prevention messages, locations for free and confidential HIV testing, healthy tips around anal health, and continuation of their condom education campaign (“pinch, leave an inch, and roll”).

**Implications for Clinical Practice.** Several implications for clinical practice based on the findings from this study can be suggested. The results from this study give critical insights into the challenges that impede JMSM from accessing HIV testing, treatment, and other prevention services. On the surface, the challenges may appear to be at the individual level; however, on the basis of in-depth analysis, it could be argued that the challenges are actually more structural in nature and require interventions on many
levels to curtail the oppressive systemic and institutional environments affecting the lives of many JMSM. Studies in the United States documented the many structural barriers that affect the lives of young Black MSM and increase their risk for HIV (Irvin et al., 2014; Levy et al., 2014; Malebranche, 2003; Phillips et al., 2011). Some of these challenges include culturally incompetent providers, lack of access to effective testing and treatment services, poverty, incarceration, and stigma and discrimination (Levy et al., 2014). Many of these challenges are similar for young JMSM.

On an educational level, student physicians, nurses, and other health care delivery personnel could be more appropriately educated on issues related to historically marginalized individuals, more specifically, JMSM. Training must also include content related to gender, gender identity, sexuality, gender expression, and sexual orientation. Furthermore, since some of the discrimination faced by JMSM from medical personal is rooted in religious pedagogy, extensive training is needed to curtail judgmental attitudes and behaviors. Local universities and the Ministry of Health could conduct research that explores homophobia and intolerance among health care workers. A majority of the JMSM interviewed for this study spoke passionately about the critical need to have clinical providers who are “MSM friendly.”

In addition to having access to culturally competent providers who are friendly and supportive, JMSM suggested improving public healthcare facilities so that they are accessible and welcoming. While some had encountered providers who were culturally competent, many reported being assaulted and discriminated against by hyper-masculine men in clinic waiting rooms while seeking care. Although some clinic staff implemented
unofficial procedures to deal with the issue (i.e., prioritizing the visit of the JMSM), a permanent policy or procedure needs to be created and implemented across all public health centers on the island.

Other areas of consideration include assessment of childhood sexual abuse (CSA). Consistent with previous research on CSA and high risk behaviors among MSM of color (Fields et al., 2008), clinical providers have a pivotal role to play in assessing and treating victims of CSA. This may aid in reducing the high-risk behaviors that place JMSM at tremendous risk for acquiring HIV infection. Additionally, treatment could also reduce maladaptive behaviors that may also affect mental health.

It is well documented that MSM of color reveal and discuss their sexual orientation with their providers at a much lower rate than other MSM (Millett, Malebranche, Mason, & Spikes, 2005). Medical providers in Jamaica should facilitate screening of sexual practices for all sexually active men and women within the society. Since sexuality occurs across a continuum, not all MSM engage in exclusive homosexual intercourse. Some still have primary female partners (Harawa et al., 2014). Therefore, asking broad questions to assess sexual behaviors (i.e., “are you currently having sex with men, women, or both?”) will normalize the process.

**Implications for Policy.** While the Jamaican government is unlikely to be able to legislate tolerance and acceptance, it can take the first step of addressing the issue of homophobia by voting to repeal the country’s antiquated sodomy laws. A full repeal of the *buggery* law would allow JMSM to disclose their sexual orientation with their medical provider without fear of retribution. It also would allow for meaningful
discussions about stigma and discrimination. Moreover, countries that have
decriminalized sexual acts between consenting adult males saw a large reduction in HIV
incidence among those populations (Lane et al., 2006). Nations that have laws that
criminalize same-sex practices continue to struggle with high HIV incidence and
prevalence (Poteat et al., 2011).

The government of Jamaica should pass legislation that protects the reproductive
deadline. Many JMSM reported seeking healthcare
services while their parents were present. This created an environment where they had to
withhold pertinent information from the provider because of the fear of divulging their
sexual orientation to their parent(s).

The role of Jamaican governmental agencies that offer services and protection of
all children should be far-reaching. The Ministry of Youth and Culture, the Child
Development Agency, and the Office of the Children’s Advocate must enforce Jamaica’s
Child Care and Protection Act. These agencies must work in collaboration with each
other to protect the health and wellbeing of marginalized youth. Parents who abuse or
neglect their children because of their sexual orientation should be held accountable as
prescribed by law. Enforcement of this law may aid in decreasing the rates of
homelessness among young JMSM, because many of these youth are displaced from their
homes as early as when they are ten years of age.

As mentioned above, to curtail the issues of homophobia and bullying in primary
and secondary institutions, the Ministry of Education must employ policies that directly
confront the issue. Policies addressing the issue of bullying must be systemic across all
institutions. As it stands, disciplinary measures are at the institutional level and at the discretion of the dean of discipline. By instituting a national policy the process could be streamlined across the island.

At the time of this writing, the Jamaican Parliament is debating passage of an anti-gang bill. This law is geared towards limiting the type of lyrics that can be aired across television and radio stations in an effort to curtail violent crime. As the country makes the transition by enforcing limitations on what songs can be played across local radio stations, consideration should be made regarding music that disseminates anti-homosexual content. JMSM indicated that anti-homosexual content disseminated through dancehall was one of the main reasons for the stigma and discrimination that they encountered on a daily basis. By implementing policies that address this issue, along with other messages of tolerance and acceptance, the Broadcasting Commission of Jamaica can aid in reducing intolerance and societal rejection of many young JMSM.

**Conclusion**

This research was the first of its kind that explored the experiences of young Jamaican MSM. While more research is needed, the results from this research have implications for future research, policy, education, and practice.

During the process of this investigation, it was evident that Jamaican men who have sex with other men are resilient, despite the many obstacles they faced on a daily basis. While the decisions they made had a direct impact on their risk for HIV infection, many JMSM developed effective strategies and skills that were necessary to mitigate the structural barriers that threatened their survival. At every level, JMSM who were
abandoned or disowned by their relatives created and fostered supportive networks of other MSM. This protective strategy allowed for MSM to love and provide for each other. While the larger society holds significant negative attitudes towards homosexuality, the findings of this research project suggest that the lives of these JMSMs were more important than their sexuality. Their lives had meaning. They visited each other when they were ill or in the hospital. They comforted each other when they arrived on the street after being displaced by their parents. They provided emotional support for each other when the effects of stigma and marginalization peaked. They supported each other when mental health issues arose. Their love and support for each other was notable. These findings present a paradigm shift from what was previously understood about JMSM. Moving forward, public health practitioners, educators, governmental officials, and researchers should reject a deficit model when working with this population. Clinical providers, when delivering HIV prevention services, must build on the strengths of JMSM and collaborate with them as partners.
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Appendix A

Study Eligibility and Screening Form

Introductory Script:
Thank you for expressing an interest to participate in this study. First I’m going to tell you a little bit about the project. Then if you are still interested, I will ask you some questions to ensure that you are eligible to participate in this study.

The study is being conducted by Mr. Orlando Harris, a nurse practitioner and doctoral candidate at the University of Rochester, Dr. Jane Tuttle a researcher at the University of Rochester, and Dr. Leith Dunn a researcher, Senior Lecturer/Head of the Institute for Gender Development Mona Unit at the University of the West Indies. The purpose of the study is to speak with Jamaican men who have sex with men (JMSM) in order to understand their experiences and views regarding their cultural and social environment. This study is limited to Jamaican MSM 18 years of age and older. Participation in the study consists of a 1½-2 hours interview and brief questionnaire packet.

Is it ok to ask you a few questions to see if you are eligible to participate in this study?
If YES, continue with questions listed below.
If NO, stop and thank respondents for their time and interest.

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<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
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<td>1.</td>
<td>How did you hear about this study?</td>
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<td>2.</td>
<td>How do you define your gender?</td>
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<td>3.</td>
<td>How old are you?</td>
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<td>4.</td>
<td>Were you born in Jamaica?</td>
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<td>5.</td>
<td>In what parish were you born?</td>
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<td>6.</td>
<td>In what parish are you currently living in?</td>
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<td>7.</td>
<td>Have you ever had sex with a man?</td>
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</table>
☐ Meets Criteria (read script below)

Name:
Phone #:
Email Address:

Appointment
Date:                          Time:     Am/PM
Location:

Disposition
☐ Request call-back reminder
☐ Does NOT meet eligibility. Why?

(read script below)

For individuals who **MEET ELIGIBILITY CRITERIA:**

*Based on your answers you qualify to participate in this study. If you would like we can conduct the interview today and have you complete a brief survey. However, before we can officially register you for this study there is one final step you must complete. We need to complete an informed consent form. This form explains the study in greater detail and also addresses your rights as a volunteer. Would you like to continue?*

*If yes:*  
*Let’s begin by reviewing and signing the consent form with me.*

*If No:*  
*Thank you for showing interest thus far in the study. Please feel free to pass my contact information on to anyone you think may be interested in participating in this project.*

For individuals who do **NOT MEET ELIGIBILITY CRITERIA** for **OTHER REASONS:**

*Unfortunately you do not qualify to be in this study because you do not meet all the study criteria at this time. If anything changes such as reaching your 18th birthday or becoming sexually active with another man, please feel free to call back and I will be happy to screen you again. Please tell your friends or others you think may be eligible about the study. Thank you for your interest.*
Appendix B

Study Poster

Understanding the Sexual Health of Jamaican Men

The purpose of the study is to speak with Jamaican men who have sex with men in order to understand their experiences and views regarding their cultural and social environment.

You will be asked to complete: 1. A brief demographic and behavioral survey, 2. An HIV knowledge questionnaire, and a 1-1 interview with the researcher.

You May Participate In This Study If You Are:
1. Biological male
2. 18 years and older
3. A man who have sex with other men
4. Jamaican born

1876-818-0589; orlando_harris@urmc.rochester.edu
Appendix C

Study Protocol

Social and Cultural Determinants of HIV Risk among Young Jamaican Men who have Sex with Men (JMSM)

Submitted By
Orlando Omar Harris, MS, RN, FNP
Doctoral Candidate
University of Rochester, School of Nursing
Fulbright Fellow
University of the West Indies, Mona

I. Objective and Background

A. Purpose:
The objective of the proposed study is to describe the lived experiences and HIV risk behaviors of a small sample of JMSM. This study will also describe JMSM’s cultural and social environment and their perspective about how that environment affects the options available to them to reduce HIV risk and to remain healthy if they are HIV positive. The final objective of the study is to explore strategies that JMSM have used to manage HIV risk. Three research questions have been conceptualized to guide this investigation.

Research Question #1: What it is like to be a MSM in Jamaica? The aim of this question is to describe, in this purposive sample, the experiences of JMSM as they pertain to being MSM, gay, or bisexual and living in a homophobic society such as Jamaica.

Research Question #2: What is the current state of HIV risk behavior knowledge and the current sexual practices of a small sample of JMSM. The aim of this question is to accurately assess and describe the level of knowledge of risk behaviors for HIV/AIDS and other sexually transmitted infections (STIs) among this purposive sample of JMSM. This question will also describe types of sexual behaviors, the frequency of interactions and safer sexual practices of JMSM.

Research Question # 3: What are the protective factors of JMSM and what are the strategies used by JMSM to manage HIV risk? The aim of this question is to describe the strategies that JMSM use to navigate risk behaviors that may place them at risk of contracting HIV. Another aim of this question is to describe and identify factors JMSM perceive as protective as they relate to homophobia and sexuality based violence in Jamaica.

Exploration of these research questions will allow the investigator to gather context rich qualitative data regarding the perceptions of the social and cultural environment of JMSM and how the environment contribute to their HIV risk behaviors. Additionally,
the data collected using quantitative instruments will provide useful information regarding the sexual practices of this small purposive sample of JMSM and how those behaviors may place them at risk for or contribute to the transmission of HIV. Furthermore, this investigation may provide healthcare providers, researchers, advocates, and policy makers in Jamaica with useful information pertaining to the lives, experiences, and sexual practices of this vulnerable population group. Ultimately, this may lead to the adaptation of MSM friendly policies, which may contribute to a reduction in the number of new HIV infections among JMSM.

B. Background

Rates of the Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), and other sexually transmitted infections (STIs) are disproportionately high among young people living in the Caribbean, and particularly on the Island of Jamaica (Geary et al., 2008; Genrich & Brathwaite, 2005; Hutchinson et al., 2007; Ministry of Health 2005; Robinson, Thompson, & Bain, 2001). The prevalence rate of HIV in the Caribbean region is second only to those rates reported within sub-Saharan Africa (Anderson, et al., 2008; UNAIDS, 2006; Voelker, 2001. The population of Jamaica consists of approximately 2.9 million people; with an annual growth rate of about 0.73%, and an adult HIV prevalence rate of 1.8% (UNAIDS, 2010). There are approximately 32,000-41,000 people in Jamaica who are living with HIV/AIDS (Hutchinson et al., 2007; Ministry of Health, 2008), of whom two thirds are unaware of their status (Foster, 2009). Thirty-two percent of the HIV infections in Jamaica occur among men (Figueroa, 2008; UNAIDS & WHO, 2008), and the HIV infections reported cluster predominantly within two major metropolitan areas, Kingston (St. Andrew) and Montego Bay (St. James)(Ministry of Health, 2005). In 2009, it was estimated by the Jamaican Ministry of Health that there were over 1,200 AIDS deaths on the island, of which 45% were young people below the age of 30 years (Olukoga, 2004). Same-sex sexual behavior is a criminal offense in Jamaica. Consequently, MSM in Jamaica experience high rates of verbal and physical violence, ranging from beatings to brutal armed attacks, to murder. For many, there is no sanctuary from such abuse. This form of violence and discrimination is often viewed as socially acceptable and is often supported by families, neighbors, community leaders, and police officers. MSM are often driven from their homes, forcing them to abandon their belongings and leaving many homeless (Human Rights Watch, 2004; Hutchinson et. al., 2007; Norman, Carr, & Jimenez, 2006).

II. Characteristics of the Research Population

The proposed study is limited to only Jamaican men who have sex with other men (JMSM). Jamaican men over the age of 18 years will be recruited to participate in the study. The study is expected to recruit approximately 20-30 JMSM who will be invited to complete a questionnaire packet. The questionnaire packet includes questions pertaining to HIV knowledge and a brief demographic and behavior survey. In addition to the questionnaire packet, participants will complete either a one-time in-depth one-on-one semi structured interview or participate in a focus group.
A. **Inclusion Criteria:** At the time of screening, participants must meet the following criteria to be eligible for the present study.

   a. Participants must be biologically male with the corresponding gender identity. Gender identity will be determined based on the gender that was assigned at birth. Transgender individuals or persons who are currently in the process of sex reassignment are not eligible for the present study.

   b. Individuals must be over the age of 18 years of age.

   c. Self-identification as a man who has sex with other men is a requirement for inclusion. The term MSM is a well-known and respected public health distinction for males who may not identify specifically as either gay or bisexual. Hence, for the purpose of this research, all men who have sex with other men regardless of their individual sexual identity (straight, gay, or bisexual) are eligible for participation.

   d. Must be Jamaican born

   e. Since the purpose of the study is to describe the protective and survival practices of, and the lived experiences of JMSM, participants may be HIV positive or negative.

   f. Participants must have the mental capacity to give consent. As the co-investigator is a licensed and practicing Nurse Practitioner, he will use the Mini-Mental Status Examination (MMSE) to determine cognitive functioning. A score between 25-30 is considered to be normal. Men with a score of 25 and higher will be eligible to participate in the study.

B. **Exclusion Criteria**

   a. Biological males who identify as female (or transgendered) are not eligible for the study.

   b. Persons under the age of 18 are also not eligible.

   c. Persons who have not had sex with another man or do not identify as MSM (or gay or bisexual) will be excluded.

   d. Natives of places other than Jamaica will be excluded.

C. **Vulnerable Populations**

   a. Due to the serious nature of the research topic and the potential risk it may place on the participants, children under the age of 18 will not be recruited. The questions asked in this project are sensitive in nature. Since homosexual behavior is illegal and not culturally acceptable in Jamaica, parents acquiring knowledge of their child’s sexual orientation or sexual behavior may place the child at risk of violence and abuse.

   b. Incarcerated men who have sex with other men face extreme discrimination and violence from other men who are also incarcerated. Currently in Jamaica, incarcerated men who have sex with men are
separated from the general population because of the potential for violence on their person. Due to their current living situation, incarcerated men will not be recruited for this study because the consequence for participation in this study may place them at risk for violence and discrimination.

III. Methods and Procedures

A. Study Design

This is a qualitative descriptive research design with supporting quantitative measures, which will be used to collect additional data for the present study. Approximately 15-20 individual interviews and one to two confirmatory focus groups consisting of approximately five to 10 individuals will be conducted with JMSM. In addition to the individual interviews, as participation in the study, all participants will complete a demographic and behavioral survey, and an HIV knowledge questionnaire.

B. Research Team

This study is being conducted in fulfillment of the requirement for the degree Doctor of Philosophy in Health Practice Research, from the University of Rochester School of Nursing. There are three members of the dissertation committee. They include Drs. Jane Tuttle and Craig Sellers, PhDs from the University of Rochester School of Nursing and Dr. Ann Dozier, PhD from the University of Rochester School of Public Health Sciences. Since the present study is focused on a population outside of the United States, Dr. Leith Dunn from the University of the West Indies Mona Institute for Gender Studies, a resident expert within Jamaica was brought on as a local principal investigator.

Jane Tuttle, PhD is a Professor of Clinical Nursing and Pediatrics at the University of Rochester School of Nursing. She is also currently the Director of the Family Nurse Practitioner program. Dr. Tuttle is the advisor and dissertation chair for the co-investigator (Orlando Harris) of the present study. She has worked with Mr. Harris previously as his Family Nurse Practitioner program advisor and nursing coordinator during his fellowship in the Leadership Education in Adolescent Health (LEAH). Dr. Tuttle’s research and clinical expertise is focused on adolescent health. She has almost 40 years of experience providing clinical care to the pediatric population. Dr. Tuttle has published numerous research articles around substance use, mental health, and positive health skills among high-risk adolescents. She is currently a fellow in the American Academy of Nurse Practitioners. Dr. Tuttle has agreed to be listed as the United States based principal investigator for the proposed study. She will provide direct oversight for this dissertation study.

Craig Sellers, PhD is an Associate Professor of Clinical Nursing, Masters Programs Director, and the Director of the Adult and Gerontological Nurse Practitioner program at the University of Rochester School of Nursing. Dr. Sellers’ research has been focused on end-of-life decision-making among people
living with HIV/AIDS and in intensive care units and recruitment and training of natural helpers as research partners, which focused on mental health promotion and violence prevention in urban neighborhoods. Dr. Sellers has also done several presentations on the topic of HIV and AIDS. Some of his presentations include decisions around advance directives and guardianships among people living with HIV/AIDS. He is also well versed in qualitative methodology. Dr. Sellers is the second member on this research team.

Ann Dozier, PhD is an Associate Professor in the School of Public Health Sciences at the University of Rochester. Dr. Dozier brings over 15 years of health service administration within the clinical setting. Dr. Dozier is currently the director for the Social and Behavior Medicine division at the University of Rochester. She is an expert in both qualitative and quantitative methodology. Dr. Dozier has participated in research endeavors within the United States and internationally, most specifically the Caribbean. Some of her work includes tobacco use in disadvantaged communities in Dominica Republic and cardiovascular health in Grenada. Dr. Dozier is the third member of this team.

Leith Lorraine Dunn, PhD is Senior Lecturer and Head of the Institute for Gender and Development Studies Mona Unit, at the University of the West Indies. Dr. Dunn has taught many courses on gender equality, reproductive health, and HIV disparities at the University of the West Indies. She has tremendous expertise in the field of HIV. Her work includes research on gender-based violence, gender, sexuality, and HIV/AIDS. Dr. Dunn’s local professional connections and expertise are important to the success of the present study. She has agreed to join the research team and she will be listed as the Principal Investigator for the submission to the UWI’s Ethics Committee as Mr Harris is attached to the IGDS Mona Unit at the University of the West Indies until July 2013.

The doctoral candidate, Mr. Orlando O. Harris who is the Co-Investigator, and the person conducting the research, is a Family Nurse Practitioner whose research interest focuses on adolescent sexuality, adolescent sexual development, reproductive health, HIV, and sexual transmitted infections. As part of his training in his doctoral studies program, he has completed a fellowship in Leadership Education in Adolescent Health (LEAH), which is funded through the United States Maternal Child Health Bureau (HRSA). Mr. Harris is currently a Fulbright fellow attached to the UWI’s IGDS Mona Unit in Jamaica. The program is funded by the United States Department of State Bureau of Education and Cultural Affairs. Mr. Harris has worked in the field of HIV/AIDS both as a clinician and as a researcher for a period of five years. He is currently on leave from his position as nurse practitioner with the Monroe County Department of Health’s Sexually Transmitted Disease Division. In this capacity, he provides clinical care to uninsured underserved adolescents and adults. Mr. Harris served as a research assistant on a number of projects focusing on HIV prevention among adolescent males and females. While focusing on his studies, Mr. Harris has worked as a research assistant for Dianne Morrison-Beedy, PhD, on the Health Improvement
Project for Teens (HIP Teens); he was responsible for transcription of participant interviews. Mr. Harris also worked as a research assistant for Sheldon Fields, PhD, on his research study involving sero-negative young MSM of color (Project YEAH). Mr. Harris’s responsibilities include weekly facilitation of group level intervention sessions, file management, and transcription of data. He will serve as co-investigator for the current study.

C. Setting
Private and public institutions in Jamaica will be utilized to recruit study participants. The University of the West Indies Mona Unit, one of the local universities on the island as agreed to serve as a location for recruitment. Additionally, one community-based organization that provides services to JMSM, Jamaica AIDS Support for Life (JASL) will also be used as a location for recruitment. The co-investigator currently serves as a volunteer at JASL. As a result of this partnership, JAS has agreed to allow the co-investigator to use their facilities for study purposes. JASL will provide the co-investigator with a letter of support.

D. Procedures
The following represent independent segments of data that cannot be combined to retrieve the identity of an individual subject.
   a) Screening and Consent
   Individuals who are interested in participating in this study will be given the contact information for the co-investigator. Individual participants will be asked several screening questions either by phone or in person to determine eligibility for participation in the study.
   Once eligible participants have successfully completed the screening process the co-investigator will explain the study to the participant and answer any questions they may have. The co-Investigator will also explain the content of the informed consent form verbally and allow additional time for questions. Two signed consent forms will be obtained from each study participant. The Co-investigator will retain one of the consent forms, while the other will be issued to the participant for their records. It is estimated that this process will take approximately five to ten minutes to complete.

   b) Study Questionnaires
   After individuals have consented to participate in the study, the Co-Investigator will provide a safe, private, and quiet space for participants to complete the demographic questionnaire which includes questions on religious affiliation, educational attainment, and employment status (Appendix B) and the HIV Knowledge
Questionnaire (Appendix C). It is estimated that it will take no more than 10-15 minutes to complete these two instruments. Both the demographic survey and the HIV Knowledge Questionnaire will be administered using a Computerized Assisted Survey Interview (CASI) with audio components. This computerized device will have a password-protected feature, which will be used to protect participants’ information. Paper and pencil copies of the demographic survey and the HIV Knowledge Questionnaire will be available in the event of technological difficulties. The co-investigator will be on hand to assist with reading of the surveys instruments if participants are unable to do so on their own.

c) In Depth One-on-One Interviews

After completion of the computerized assisted survey, the co-investigator will ask participants if they would like to take a break before continuing on with the interview portion of the encounter. If no break is requested, the researcher will continue on with the interview by asking the specified questions in the interview guide (Appendix D). Participants will be reminded that their responses will be kept confidential and that participation in the study is completely voluntary. The interview will be conducted and audio recorded using a digital recorder by the co-investigator. At no point will the identification of the participant be used and all audio recordings will be audio encrypted using a voice-altering device in order to conceal the identities of the participants. The co-investigator will ask the participant to select a pseudonym for the duration of the interview. After the completion of each interview, all audio recordings will be copied to a computer and portable hard drive. This will ensure two copies of each interview. Both the computer and the portable hard drive will be password protected.

After completion of the survey instruments and the interview, each participant will be given an honorarium. Participants will be compensated based on their degree of participation in the study. All subjects will be required to sign a receipt acknowledging that they have received an honorarium.

d) Focus Groups Discussion

After all in depth one-on-one interviews have been completed and following the completion of preliminary data analysis, the co-investigator will convene one or two focus groups, each consisting of approximately 5-10 individuals for a total of 10 participants. The purpose of the focus groups is to convene a small sample of not previously interviewed participants to review thematic findings from the one-on-one interviews. It is estimated that the focus group
will be no more than 90 minutes in length. The focus groups will be conducted at either the University of the West Indies Mona campus Institute of Gender Development Studies Institute or at the community-based organization previously identified. The conversation generated from the focus group will be audio recorded and transcribed. Participants will be reminded not to use their real names in order to maintain confidentiality. Participants will also be reminded that participation in the focus group is voluntary and that they may withdraw at any time. They will also be ensured that the audio recording will remain with the co-investigator and will be kept in a secured locked space at the university. At no point will the identification of the participant be used and all audio recordings will be audio encrypted using a voice-altering device in order to conceal the identities of the participants. Participants within the focus group will be provided an honorarium for their time. All participants will be required to sign a receipt acknowledging that they have received an honorarium for their time.

e) Field Notes

Field notes will be generated after the completion of both the in depth one-on-one interviews and the focus groups discussion. Additionally, reflective memos of the co-investigator’s experience in Jamaica will be documented. The purpose of the field notes is to record the co-investigator’s observations of expressions from participants and any other impressions that may have been observed. Each field note will be either audio recorded or written in a personal journal owned by the co-investigator. No identifiers of individuals will be recorded in the field notes. Information will be limited to description of the social and geographic context. All recordings and field notes will be kept in a secure location at the University and on a password protected computer.

D. Data Analysis and Data Monitoring

CASI surveys, digital audio recording of interviews and focus groups, and immediate reactions will be uploaded and stored on a password-protected electronic device owned by the co-investigator. Additionally, a backup of the above information will be uploaded and stored on a password-protected server hosted by the University of Rochester, School of Nursing. Data acquired through CASI will be imported into SPSS and analyzed with the following descriptive statistics: frequencies, means, medians, and modes.

All interview transcripts and recordings will be stored in a locked cabinet located at the University of the West Indies, Mona. Only de-identified Transcript files will be sent directly through secure electronic mail to the principal investigator back in the United States. Data analysis will be
conducted simultaneously with data collection. The co-investigator will review and confirm interview transcripts for accuracy. After transcription is complete, the researcher will import the transcribed text into the analysis program, ATLAS.ti to organize data files and facilitate data analysis. Field notes will also be imported into ATLAS.ti for analysis. Qualitative content analysis will be used to identify themes and patterns in the data. After patterns have been identified, they will be coded using line-by-line format. The co-investigator will use the information that was derived directly from the interviews to generate code families. Broad descriptors will be attached to these codes. Next, codes will be reviewed for commonalities and refined by either clustering them into existing codes, refining code names, or eliminating codes altogether. Finally, a descriptive matrix will be used to describe the study’s findings, looking for patterns among the categories, codes, and themes, and building a logical chain of evidence supporting the interpretations. The logical chain of evidence will be supported by the use of direct quotations from subject interviews.

E. Data Storage and Confidentiality

After eligibility has been determined and each subject has expressed their willingness to participate in the study, they will be given a unique numeric identifier, which will be used instead of their legal name on all written materials, with the exception of the consent form. This numeric identifier will be pre-applied in order to eliminate the need for the use of the subject’s name.

Digital recordings will be transcribed by either the co-investigator and/or sent to a transcriptionist familiar with both the University of Rochester and the University of the West Indies Ethics/Institutional Review guidelines. Data will be de-identified by replacing the legal names of the participants with a numeric identifier, which will only be known to the co-investigator. Digitally acquired data will be stored on the co-investigator’s computer and the University of Rochester, School of Nursing server, both of which are password-protected and are only accessible to the co-investigator.

Printed materials (e.g., print versions of study questionnaires, or written artifacts from interviews or focus groups) will be kept in a locked office located in the Institute for Gender and Development Unit at the University of the West Indies, Mona. Consent forms, receipts, printed transcripts and field notes will be stored in a separate locked, file cabinet to further reduce the risk of identifying subjects.

Electronic data management files (e.g., SPSS, MS WORD, and ATLAS.ti files) and digital audio recordings will be archived on a password-protected server hosted by the University of Rochester, School of Nursing. All audio files will be destroyed at the completion of the project. However, all de-identified transcripts and analysis records will be kept indefinitely.

IV. Risk/Benefits Assessment
A. Risk Category

The proposed study presents a moderate risk to adults with possibility of benefits.

B. Potential Risk

The potential risks for participating in the study include: a) breach of confidentiality for participants, b) a lengthy interview that may result in becoming fatigued, c) the potential for the participant’s sexuality to be exposed as a result of associating or participating in the project, d) emotional distress, brought on by the evocation of feelings, thoughts, and experiences around JMSM culture, sexuality, HIV stigma, and discrimination.

This study poses a minimal risk of disclosing the sexual orientation of the subject. If an individual has chosen to divulge his sexual orientation, their choice of interview location or association with the co-investigator may place them at risk for speculation of an alternate (i.e., non-heterosexual) orientation. To reduce the risk of sexual identity disclosure, subjects will have the option to choose to be interviewed at one of three locations; 1) a private office in the Institute for Gender Development Unit at the University of the West Indies, 2) a private area located at Jamaica AIDS Support for Life, or 3) a public/common area location (i.e., classroom, library, or unoccupied common area) that is safe and is conducive to allow for a private interview. Allowing the participants to choose the location of the interview provides a necessary layer of privacy and comfort if sexual identity other than heterosexual has been disclosed.

The co-investigator is charged with the responsibility of protecting the participants in the study. Therefore several measures will be used to minimize any potential risk of participation in the study. The risk of breach of confidentiality will be safeguarded through every step of the research process. The co-investigator will have sole responsibility for the collection and storage of the research data. Participants will be given a numeric identifier and only de-identified data will be entered into the computerized data analysis program.

Because of the nature of the topics to be discussed during each interview is of a personal nature, the Co-investigator is aware that some participants may feel uncomfortable with some of the questions being asked. In the case the participant expresses any distress or feelings of an uncomfortable nature with the questions being asked, the co-investigator will provide an opportunity for a qualified independent professional with experience working with MSM populations to be available. This independent professional will be within the facility and be notified when an interview is in progress, so he/she can be prepared to come in if the co-investigator or the participant requests, to consult as to the need to stop and/or seek additional help. For situations were additional support is required, participants will be encouraged to contact their medical/mental health provider or any of the following agencies below; JASL at (876) 978-2345 or the University of the West Indies Mona Student Health Center at (876) 970-1992 (or 2270/2370). It should be noted that the co-
investigator is a Family Nurse Practitioner who specializes in Adolescent Health and, as such, is capable of making both an initial medical assessment and diagnosis of medical and psychological disorders.

Consistent with the University of Rochester Research Subjects Review Board (RSRB) policy, a hard copy of a consent form will be given to each subject. This document contains the names of the investigators, purpose, and description of the study, risks and benefits of participation, compensation, confidentiality statement, voluntary participation clause, and contact information of the principal investigator and human subjects representative. The information on this form will be explained to every potential subject and he will then have the opportunity to ask questions regarding its content. If after reviewing the consent form a subject wishes to enter the study he must sign the consent form.

C. Potential Benefits to the Subjects

There are no direct benefits to be gained from participation in this study. However, participants may be able to discern or may be made aware through their discussion with the co-investigator how the social and cultural factors affect or influence how they feel about themselves and the decisions they make regarding their sexual behaviors. Other benefits of participation include a resource sheet which includes information on agencies on the island that offer free or low cost STD/HIV testing and treatment, identified “MSM friendly” medical providers, members of the clergy, and law enforcement (i.e., victims’ rights advocates). The resource guide will also include information on how to perform a self-administered testicular examination, and genital and anal health.

D. Alternatives to Participation

Eligible participants may choose not to participate in this study without any loss of services that might be available to them.

V. Subject Identification, Recruitment, and Consent

A. Method of Subject Identification and Recruitment

Potential participants will be recruited via: 1) direct/in-person recruitment from the University of the West Indies community and a local community-based organization (CBO), JASL; and 2) peer referrals;

The recruitment process will commence immediately after review board approval from the University of Rochester and the Ethics Committee at the University of the West Indies. Direct recruitment will occur in one of three fashions. First, through the Institute for Gender Studies, the researcher will attend weekly meetings of a gender support group on campus in order to advertise his project. Participants who are eligible and are interested in participating will be given the co-investigator’s contact information (telephone number and e-mail address). Second, at JASL, staff will inform
patrons of the study and the intended target population. General information about the purpose and the structure of the study will be provided. Interested parties will be directed to speak with the Co-investigator. Third, individuals in previous acquaintance with the co-investigator who meet eligibility requirements will be recruited. The co-investigator will also engage potential participants at private social gatherings organized by other MSM.

All participants will be requested to engage in peer recruitment at the end of their interview. The co-investigator will provide the subject with his contact information and request that they pass it on to their friends or anyone who is interested so that they may contact him to gain more information about the study and be screened for inclusion.

Participants for the focus groups will be recruited in a similar fashion after all interviews have concluded. They will be informed of the study’s purpose, screened, and then consented according to the policies of the University of Rochester RSRB protocol and the Ethics Committee guidelines at the University of the West Indies. Participants will be reminded that participation is voluntary and that they may decline at any time to participate in the interviews or focus groups without fear of reprisal.

B. Process of Consent

Potential subjects will be considered for participation after they have been screened to ensure that they meet the inclusion criteria. The screening process will be administered by the co-investigator, either via the phone line or in person, depending on the manner in which they were recruited. The screening script (Appendix A) will be read and potential participants will be requested to provide consent before answering 8 screening questions. Identifying data (i.e., name and telephone number) will only be collected for individuals who meet eligibility criteria and verbally agree to participate. All screening data will be kept in a locked cabinet in the office of the co-investigator.

After successfully completing the screening process, eligible participants will be asked to provide contact information: name (actual or pseudonym), telephone number, and email address (optional). They will then be asked to provide two dates (one primary and one alternate) and will be provided the options for interview locations. Interview venues from which the participant may select are either: 1) a private office in the Institute for Gender Development Unit at the University of the West Indies, 2) a private area located at Jamaica AIDS Support for Life, or 3) a public/common area location (i.e., classroom, library, or unoccupied common area) that is safe and is conducive to allow for a private interview. Participants who were recruited directly or in person will be consented on the same day of the recruitment and will be solicited to complete the survey instrument and the interview. Pursuant to the University of Rochester RSRB policy and the University of the West Indies protocol, all participants will be given a copy of the appropriate consent form. They will also be given a highlighter and will be instructed to highlight any terms or phrases that they do not understand as the
co-investigator reads the form aloud. The co-investigator will first review what is highlighted then briefly provide meanings or explanations as necessary.

Individuals who do not qualify for the study because they fail to meet eligibility criteria will be given a resource sheet with information regarding places across the island that offer free or low-cost testing and treatment services.

C. Consent Forms
All subjects will need to complete the consent form prior to their participation in the study.

D. Costs to subjects
There are no costs to participate in this study.

E. Payment for Participation
Subjects will be remunerated with honorarium totaling up to a maximum of $1,800 JA or the equivalent of $20.00 US for their participation in either the individual interviews or the focus group. This small remuneration will be used to compensate individuals for their time and for transportation to the interview location. Participants will be given $900.00 JA or $10.00 US for completion of the surveys and $900.00 JA or $10.00 US for the completion of the semi-structured interview. The same will be applied for participation in the focus group. Subjects will need to sign a receipt indicating that they have received payment for their participation. This receipt will include the date, amount of payment received, subject’s name and signature, and interviewer’s name and signature. All participants will receive a copy of their receipt. The co-investigator will keep an additional copy for his records. All receipts collected by the co-investigator will be kept in a locked cabinet at the University of the West Indies Institute for Gender Development Studies Unit. All receipts will be destroyed at the end of the study.
Appendix D

Informed Consent Form: Individual Interview

Study Title: Social and Cultural Determinants of HIV Risk among Young Jamaican Men who have Sex with Men

**Introduction:**
My name is Mr. Orlando Harris, MS, RN, FNP and I am a doctoral candidate and Fulbright Fellow to Jamaica. The above titled research study is being conducted in fulfillment of the requirement for the degree of Doctor of Philosophy in Health Practice Research, from the University of Rochester, School of Nursing. We invite you to take part in this research study to understand the experiences of men who have sex with men (MSM) in Jamaica. The results are expected to improve our understanding of critical issues affecting their health and social well-being. This consent form describes the research study and what you may expect if you decide to participate. You are encouraged to read this informed consent form carefully and ask the person who presents it any questions that you may have before you decide whether or not to participate.

**Purpose of Study**
The purpose of the study is to understand the lived experiences of Jamaican MSM, (i.e. being MSM and living in Jamaica) and to identify strategies that MSM have used to manage HIV risk living in Jamaican society.

**Description of Study Procedures**
If you decide to take part in this study, you will be asked to:

1. Complete a brief demographic / behavioral questionnaire about yourself. The questions on this form ask for general information about who you are (i.e. age, religious/spiritual background, and hobbies), your social experiences, sexual identity, and your sexual history. This will take approximately 10 minutes to complete.

2. Complete a HIV knowledge questionnaire. The questions on this form are related to general knowledge about HIV/AIDS. Estimated time to completion = 10 minutes.

3. Participate in an in-depth one-on-one interview with the co-investigator, Mr. Orlando Harris.

   This interview will focus on: your experiences and sexual encounters with other men in the Jamaican cultural context and experiences of support or discouragement from people within your immediate social network (community, family, and friends). This will take 60-90 minutes to complete.
Interviews will be audio recorded, later transcribed, and then destroyed. Your name and any other identifying characteristics will not be used. If you desire, you may ask that the audio recorder be turned off at any time during the interview and I will take written notes instead. During transcription from recording to paper, the transcripts of the audio recordings will be de-identified so that the identities of the participants cannot be recognized. Audio recordings will be kept under lock and key in the Institute for Gender and Development Studies Mona Unit at The University of the West Indies and used solely for the purpose of this study. Transcripts without identifying data will be analyzed.

**Risks of Participation**

*There are moderate risks associated with participating in this study. Some participants may feel uncomfortable with some questions being asked. In addition, there is a small risk that your participation may increase the likelihood that your sexual activities will become known to others. These risks will be managed as described below.*

If you express or I observe any distress or feelings of an uncomfortable nature with the questions being asked, I will insure that a professional unconnected to the study is available within the building during the interview who can be called in to discuss whether to discontinue the interview and assess as to whether or not you would like to continue and if additional support or services are needed. For situations were additional support is required, you are encouraged to contact your medical provider or you may contact any of these agencies below; Jamaica AIDS Support for Life (JASL) or Jamaica Forum for Lesbians, All-Sexuals and Gays (JFLAG) at (876) 978-2345 (the services provided at JASL and JFLAG are free and should not be of any burden to you) or the University of The West Indies Health Center at (876) 970-1992 (or 876-970-2270; 876-970-2370). The co-investigator is required by law to report disclosures of current child abuse or concerns about the welfare of a minor. This means that if you tell the researcher that a child is being neglected or abused or that you have plans to hurt yourself or someone else, the researcher is required by law to report such situations to the appropriate authorities.

**Benefits of Participation**

There are no direct benefits to participation in this study; however, our discussions may make you aware of your own potential HIV risk.

**Alternatives to Participation**

Participation in this study is voluntary. You may choose not to participate at any time in this study.

**Sponsor Support**

This study is partly sponsored by the United States Department of State, Fulbright Scholars Program, which provided a scholarship to the Co-Investigator, Mr. Orlando O. Harris, MS, RN, FNP. Funding was also made available from the National Institutes of
Health (NIH) through the University of Rochester Development Center for AIDS Research (DCFAR). Neither of these two organizations will have access to the information collected during this study.

**Costs**
There will be no cost to you to participate in this study.

**Payments**
A small honorarium of J$900 will be given to you for completing the questionnaires. An additional J$900 will be given for completing the interview.

You will be asked to sign a receipt to confirm that you received these funds.

**Confidentiality of Records**
Your name will appear only on this Informed Consent Form and on the receipt and these documents will be stored separately and apart from the other research documents. This will ensure that your name will not be associated with the data. A code number will be assigned to the information you give to protect your privacy. All research records will be kept in a locked cabinet and only the principal and co-investigators will have access to them. All audio files will be destroyed at the completion of the project. However, all de-identified transcripts and analysis records will be kept to write peer-reviewed articles for publication.

While we will make every effort to keep information you give confidential, this cannot be guaranteed. Other people such as the principal investigator and the co-investigator’s supervisor, Dr. Jane Tuttle may need to see the information in order to ensure that your confidentiality is protected. Results of the research may be presented at meetings or in publications, but your name will not be used. We will only use your demographic form, information on the HIV knowledge questionnaire, and de-identified excerpts of transcribed text from the interview.

The principal investigator and the co-investigator are required to keep copies of this informed consent form for review by the Ethics Committees at The University of The West Indies, Mona and the University of Rochester.

**Contact Persons**
For more information concerning this research or if you feel that your participation has resulted in any emotional or physical discomfort please contact: Dr. Leith Dunn at (876) 977-7365 or mailto:leith.dunn@uwimona.edu.jm.

For independent advice on your rights as a research participant please contact Professor Horace Fletcher, Dean, Faculty of Medical Sciences, University of the West Indies, Mona, Kingston 7 (Tel: (876) 927-1297, e-mail: medsci@uwimona.edu.jm). Additionally, you may also contact the University of Rochester Research Subjects Review Board at 265
Voluntary Participation
Participation in this study is voluntary. You are free not to take part or to withdraw at any time, for whatever reason. No matter what decision you make there is no penalty for not participating in the study. In the event that you do withdraw from this study, the information you have already provided will be destroyed.

Signature/Dates
After reading and discussing the information in this consent form you should understand:
- Why this study is being done;
- What will happen during the study;
- Any possible risks and benefits to you;
- Other options you may have instead of being in the study;
- How your personal information will be protected;
- What to do if you have problems or questions about this study.

Subject Consent
I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I agree to participate in this study. I have received (or will receive) a signed copy of this form for my records and future reference. I confirm that I am over the age of 18.

____________________________  ____________________________
Subject Name (Printed by Subject)  Date

____________________________  ____________________________
Signature of Subject  Date

Person Obtaining Consent
I have read this form to the subject and/or the subject has read this form. I will provide the subject with a signed copy of this consent form. An explanation of the research was given and questions from the subject were solicited and answered to the subject’s satisfaction. In my judgment, the subject has demonstrated comprehension of the information. I have given the subject adequate opportunity to read the consent before signing.

____________________________
Name and Title (Print)
Appendix E

Informed Consent Form: Focus Group

Study Title: Social and Cultural Determinants of HIV Risk among Young Jamaican Men who have Sex with Men

Introduction:
My name is Mr. Orlando Harris, MS, RN, FNP and I am a doctoral candidate and Fulbright Fellow to Jamaica. The above titled research study is being conducted in fulfillment of the requirement for the degree of Doctor of Philosophy in Health Practice Research, from the University of Rochester, School of Nursing. We invite you to take part in this research study to understand the experiences of men who have sex with men (MSM) in Jamaica. The results are expected to improve our understanding of critical issues affecting their health and social well-being. This consent form describes the research study and what you may expect if you decide to participate. You are encouraged to read this informed consent form carefully and ask the person who presents it any questions that you may have before you decide whether or not to participate.

Purpose of Study

The purpose of the study is to understand the lived experiences of Jamaican MSM, (i.e. being MSM and living in Jamaica) and to identify strategies that MSM have used to manage HIV risk living in Jamaican society.

Description of Study Procedures

If you decide to take part in this study, you will be asked to:

4. Complete a brief demographic / behavioral questionnaire about yourself. The questions on this form ask for general information about who you are (i.e. age, religious/spiritual background, and hobbies), your social experiences, sexual identity, and your sexual history. This will take approximately 10 minutes to complete.

5. Complete a HIV knowledge questionnaire. The questions on this form are related to general knowledge about HIV/AIDS. Estimated time to completion = 10 minutes.

6. Participate in a focus group with four other subjects to discuss your experiences of being a man who have sex with other men.

This focus group discussion will focus on: your experiences and sexual encounters with other men in the Jamaican cultural context and experiences of support or discouragement from people within your immediate social network (community, family, and friends). This will take 60-90 minutes to complete. Focus group discussions will be audio recorded, later transcribed, and then
destroyed. Your name and any other identifying characteristics will not be used. If you desire, you may ask that the audio recorder be turned off at any time during the focus group discussion and I will take written notes instead. During transcription from recording to paper, the transcripts of the audio recordings will be de-identified so that the identities of the participants cannot be recognized. Audio recordings will be kept under lock and key in the Institute for Gender and Development Studies Mona Unit at The University of the West Indies and used solely for the purpose of this study. Transcripts without identifying data will be analyzed.

**Risks of Participation**

There are moderate risks associated with participating in this study. Some participants may feel uncomfortable with some questions being asked. In addition, there is a small risk that your participation may increase the likelihood that your sexual activities will become known to others. These risks will be managed as described below.

If you express or I observe any distress or feelings of an uncomfortable nature with the questions being asked, I will insure that a professional unconnected to the study is available within the building during the focus group discussion who can be called to discuss whether to discontinue your participation in the focus group discussion and assess as to whether or not you would like to continue and if additional support or services are needed. For situations were additional support is required, you are encouraged to contact your medical provider or you may contact any of these agencies below; Jamaica AIDS Support for Life (JASL) or Jamaica Forum for Lesbians, All-Sexuals and Gays (JFLAG) at (876) 978-2345 (the services provided at JASL and JFLAG are free and should not be of any burden to you) or the University of The West Indies Health Center at (876) 970-1992 (or 876-970-2270; 876-970-2370). The researcher is required by law to report disclosures of current child abuse or concerns about the welfare of a minor. This means that if you tell the researcher that a child is being neglected or abused or that you have plans to hurt yourself or someone else, the researcher is required by law to report such situations to the appropriate authorities.

**Benefits of Participation**

There are no direct benefits to participation in this study; however, our discussions may make you aware of your own potential HIV risk.

**Alternatives to Participation**

Participation in this study is voluntary. You may choose not to participate at any time in this study.

**Sponsor Support**

This study is partly sponsored by the United States Department of State, Fulbright Scholars Program, which provided a scholarship to the Co-Investigator, Mr. Orlando O. Harris, MS, RN, FNP. Funding was also made available from the National Institutes of
Health (NIH) through the University of Rochester Development Center for AIDS Research (DCFAR). Neither of these two organizations will have access to the information collected during this study.

**Costs**
The will be no cost to you to participate in this study.

**Payments**
A small honorarium of J$900 will be given to you for completing the questionnaires. An additional J$900 will be given for completing the focus group discussion.

You will be asked to sign a receipt to confirm that you received these funds.

**Confidentiality of Records**
Your name will appear only on this informed consent form and on the receipt and these documents will be stored separately and apart from the other research documents. This will ensure that your name will not be associated with the data. A code number will be assigned to the information you give to protect your privacy. All research records will be kept in a locked cabinet and only the principal and co-investigators will have access to them. All audio files will be destroyed at the completion of the project. However, all de-identified transcripts and analysis records will be kept to write peer-reviewed articles for publication.

While we will make every effort to keep information you give confidential, this cannot be guaranteed. Other people such as the principal investigator and the co-investigator’s supervisor, Dr. Jane Tuttle may need to see the information in order to ensure that your confidentiality is protected. Results of the research may be presented at meetings or in publications, but your name will not be used. We will use your demographic form, information on the HIV knowledge questionnaire, and de-identified excerpts transcribed text from the focus group discussion sessions.

The principal investigator and the co-investigator are required to keep copies of this informed consent form for review by the Ethics Committees at The University of The West Indies, Mona and the University of Rochester.

**Contact Persons**
For more information concerning this research or if you feel that your participation has resulted in any emotional or physical discomfort please contact: Dr. Leith Dunn at (876) 977-7365 or mailto:leith.dunn@uwimona.edu.jm.

For independent advice on your rights as a research participant please contact Professor Horace Fletcher, Dean, Faculty of Medical Sciences, University of the West Indies, Mona, Kingston 7 (Tel: (876) 927-1297, e-mail: medsci@uwimona.edu.jm). Additionally, you
may also contact the University of Rochester Research Subjects Review Board at 265 Crittenden Blvd., CPU 420315, Rochester, NY 14642-8315, Telephone (585) 276-0005 or toll-free (877) 449-4441. You may also call this number if you cannot reach the research staff or wish to talk to someone else.

**Voluntary Participation**

Participation in this study is voluntary. You are free not to take part or to withdraw at any time, for whatever reason. No matter what decision you make there is no penalty for not participating in the study. In the event that you do withdraw from this study, the information you have already provided will be destroyed.

**Signature/Dates**

After reading and discussing the information in this consent form you should understand:

- Why this study is being done;
- What will happen during the study;
- Any possible risks and benefits to you;
- Other options you may have instead of being in the study;
- How your personal information will be protected;
- What to do if you have problems or questions about this study.

**Subject Consent**

I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I agree to participate in this study. I have received (or will receive) a signed copy of this form for my records and future reference. I confirm that I am over the age of 18.

__________________________
Subject Name (Printed by Subject)

__________________________   __________
Signature of Subject                Date

**Person Obtaining Consent**

I have read this form to the subject and/or the subject has read this form. I will provide the subject with a signed copy of this consent form. An explanation of the research was given and questions from the subject were solicited and answered to the subject’s satisfaction. In my judgment, the subject has demonstrated comprehension of the information. I have given the subject adequate opportunity to read the consent before signing.
Appendix F

Study Resource Guide

Social and Cultural Determinants of HIV Risk among Young Jamaican Men who have Sex with Men (JMSM)

Thank you for expressing an interest to participate in this study. Please tell your friends or others you think may be eligible about the study. Thank you for your interest.

<table>
<thead>
<tr>
<th>Health Centers in Kingston and St. Andrew</th>
<th>Lawrence Tavern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duhaney Park</strong></td>
<td>Opening Hours: 8am-4pm</td>
</tr>
<tr>
<td>Opening hours: 830am-8pm</td>
<td>Address: Lawrence Tavern Road</td>
</tr>
<tr>
<td>Address: 112A Baldwin Ave, Kingston 20</td>
<td>Phone: 942-8523</td>
</tr>
<tr>
<td>Phone: 933-3484</td>
<td>Web address: <a href="http://www.serha.gov.jm/HC/LawrenceTavern.pdf">http://www.serha.gov.jm/HC/LawrenceTavern.pdf</a></td>
</tr>
<tr>
<td><strong>Gordon Town</strong></td>
<td>Olympic Gardens</td>
</tr>
<tr>
<td>Opening Hours: 8am-4pm</td>
<td>Opening Hours: 8am-4pm</td>
</tr>
<tr>
<td>Address: Gordon Town Road</td>
<td>Address: Olympic Way</td>
</tr>
<tr>
<td>Phone: 702-1908</td>
<td>Phone Number: 923-7474</td>
</tr>
<tr>
<td><strong>Hagley Park</strong></td>
<td>Stony Hill</td>
</tr>
<tr>
<td>Opening Hours: 8am-4pm</td>
<td>Opening Hours: 8am-8pm</td>
</tr>
<tr>
<td>Address: 118 Hagley Park Road, Kingston 11</td>
<td>Address: Christopher Road, Stony Hill</td>
</tr>
<tr>
<td>Phone: 757-6267</td>
<td>Phone Number: 942-9677</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Diseases Clinic Sites</strong></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Health Center</td>
<td>Ministry of Health HIV Prevention Helpline</td>
</tr>
<tr>
<td>Address: 55 Slipe Pen Road, Kingston 5</td>
<td>HIV/STD Helpline at 967-3830/3764 or toll free 1-888-991-4444.</td>
</tr>
<tr>
<td>Jamaica</td>
<td></td>
</tr>
<tr>
<td>Phone Number: 922-2095; 924-9473;</td>
<td></td>
</tr>
<tr>
<td><strong>Ministry of Health HIV Prevention Helpline</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Gordon Town
Opening Hours: 8am-4pm
Address: Gordon Town Road
Phone: 702-1908

Hagley Park
Opening Hours: 8am-4pm
Address: 118 Hagley Park Road, Kingston 11
Phone: 757-6267

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Opening Hours: 8am-4pm
Address: Lawrence Tavern Road
Phone: 942-8523
Web address: http://www.serha.gov.jm/HC/LawrenceTavern.pdf

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Opening Hours: 8am-4pm
Address: Olympic Way
Phone Number: 923-7474

Stony Hill
Opening Hours: 8am-8pm
Address: Christopher Road, Stony Hill
Phone Number: 942-9677

Sexually Transmitted Diseases Clinic Sites
Comprehensive Health Center
Address: 55 Slipe Pen Road, Kingston 5
Jamaica
Phone Number: 922-2095; 924-9473;

Ministry of Health HIV Prevention Helpline
HIV/STD Helpline at 967-3830/3764 or toll free 1-888-991-4444.
Community-Based Organizations (CBOs)

**Jamaica AIDS Support for Life (JASL)**
Kingston
4 Upper Musgrave Ave, Kingston, 10
Phone: 978-2345
E-Mail: infojasl2010@gmail.com
Hours of Operation: Mon-Fri 9am-5pm

Ocho Rios Chapter
2 Douglas Close, Ocho Rios, St. Ann
Phone: 974-6461

Montego Bay Chapter
1st Floor Van Haze Building, 16 East Street,
Montego Bay, St. James
952-9817

**Jamaica Forum For Lesbians, All-Sexuals and Gays (J-FLAG)**
Phone: 978-8988
Digicel: 379-9834
Web Address:
http://www.jflag.org/contact/

**Jamaicans For Justice (JFJ)**
Address: 2 Fegan Avenue, Kingston 8
Telephone: 755-4524 (6)
Email: ja.for.justice@cwjamaica.com
Web Address:
http://jamaicansforjustice.org/contact-us/

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**Testicular Self Examination (TSE)**
The **testicular self-examination (TSE)** is an easy way for guys to check their own testicles to make sure there aren't any unusual lumps or bumps — which can be the first sign of testicular cancer.

Although testicular cancer is rare in teenage guys, overall it is the most common cancer in males between the ages of 15 and 35. It's important to try to do a TSE every month so you can become familiar with the normal size and shape of your testicles, making it easier to tell if something feels different or abnormal in the future.

Here's what to do:
• It's best to do a TSE during or right after a hot shower or bath. The scrotum (skin that covers the testicles) is most relaxed then, which makes it easier to examine the testicles.

• Examine one testicle at a time. Use both hands to gently roll each testicle (with slight pressure) between your fingers. Place your thumbs over the top of your testicle, with the index and middle fingers of each hand behind the testicle, and then roll it between your fingers.

• You should be able to feel the epididymis (the sperm-carrying tube), which feels soft, rope-like, and slightly tender to pressure, and is located at the top of the back part of each testicle. This is a normal lump.

• Remember that one testicle (usually the right one) is slightly larger than the other for most guys — this is also normal.

• When examining each testicle, feel for any lumps or bumps along the front or sides. Lumps may be as small as a piece of rice or a pea.

• If you notice any swelling, lumps, or changes in the size or color of a testicle, or if you have any pain or achy areas in your groin, let your doctor know right away.

Lumps or swelling may not be cancer, but they should be checked by your doctor as soon as possible. Testicular cancer is almost always curable if it is caught and treated early.

Reviewed by: T. Ernesto Figueroa, MD Date reviewed: June 2012
http://kidshealth.org/teen/sexual_health/guys/tse.html

Anal Health
(http://www.health.ny.gov/diseases/aids/facts/helpful_resources/lgbt/gay_men_health_concerns.htm)

Of all the sexually transmitted infections gay men are at risk for, human papilloma virus - which causes anal and genital warts - is often thought to be little more than an unsightly inconvenience. However, these infections may play a role in the increased rates of anal cancers in gay men. Some health professionals now recommend routine screening with anal Pap Smears, similar to the test done for women to detect early cancers. Safe sex should be emphasized. Treatments for HPV do exist, but recurrences of the warts are very common, and the rate at which the infection can be spread between partners is very high.


Genital human papillomavirus (HPV) is a common virus. Most sexually active people will have HPV at some time in their lives. There are more than 40 types of HPV that are passed on through sexual contact. These types can infect the genital areas of men, including the skin on and around the penis or anus. They can also infect the mouth and throat.

HPV is passed on through genital contact—most often during vaginal and anal sex.
HPV may also be passed on during oral sex. Since HPV usually causes no symptoms, most men and women can get HPV—and pass it on—without realizing it. People can have HPV even if years have passed since they had sex. Even men with only one lifetime sex partner can get HPV.

**Some men are more likely to develop HPV-related diseases than others:**
Gay and bisexual men (who have sex with other men) are about 17 times more likely to develop anal cancer than men who only have sex with women.

Men with weakened immune systems, including those who have HIV, are more likely than other men to develop anal cancer. Men with HIV are also more likely to get severe cases of genital warts that are harder to treat.

**What are the signs and symptoms?**
Most men who get HPV never develop any symptoms or health problems. But for those who do develop health problems, these are some of the signs and symptoms:

**Genital warts:**
One or more growths on the penis, testicles, groin, thighs, or in/around the anus.

Warts may be single, grouped, raised, flat, or cauliflower-shaped. They usually do not hurt.

Warts may appear within weeks or months after sexual contact with an infected person.

**Health Topics for Men who have Sex with Men (MSM)**
Men who have sex with other men may have many concerns related to their health. The Gay Lesbian Medical Association (GLMA) has identified 10 key areas or topics as most commonly of concern for MSM. While not all of these items apply to everyone, it’s wise to be aware of these issues.

1. HIV/AIDS, Safe Sex
2. Substance Use
3. Depression/Anxiety
4. Hepatitis Immunization
5. STDs
6. Prostate, Testicular, and Colon Cancer
7. Alcohol
8. Tobacco
9. Fitness (Diet and Exercise)
10. Anal Papilloma (Anal HPV)

Appendix G

Demographic and Behavioral Survey

Directions: Please answer the following questions to the best of your ability. To move through the survey press “Back” or “Next” at the top of each screen. Remember that your answers will be kept confidential.

* Enter your 4-digit survey ID number (pre-assigned)

A. GENERAL INFORMATION: This section asks general questions about you.
   1. How old are you? _______
   2. In what parish were you born? __________________
   3. What parish do you currently live? ____________________
   4. What is your religious/spiritual background? ______________
   5. What are some of your hobbies/extra-curricular activities? __________________________________________

B. EDUCATION AND INCOME: This section asks about your education, job, and income.

   6. What is the highest grade/level of school that you have completed?
      □ grade (basic and primary) school
      □ some high school
      □ high school diploma
      □ some college/university
      □ associate’s degree
      □ bachelor’s degree
      □ master’s degree
      □ doctorate

   7. Are you currently enrolled in school?
      □ Yes
      □ No
      a. If yes, i.e. what grade, level, and/or program are you currently enrolled?
         __________________________________________

   8. What is your PRIMARY source of income – Specifically, what do you do to make money? ___________________________
a. How much do you make per year doing this? (all figures are in JA dollars)
   - less than $15,000
   - $15,001 - $20,000
   - $20,001 - $30,000
   - $30,001 - $40,000
   - $40,001 - $50,000
   - $50,001 - $60,000
   - $60,001 - $70,000
   - greater than $70,000

9. Do you have ALTERNATE or other sources of income?
   - Yes
   - No
   a. If yes, What ELSE do you do to make money?

   ____________________________________________________

b. How much do you make per year doing this?
   - less than $15,000
   - $15,001 - $20,000
   - $20,001 - $30,000
   - $30,001 - $40,000
   - $40,001 - $50,000
   - $50,001 - $60,000
   - $60,001 - $70,000
   - greater than $70,000

C. SEXUAL IDENTITY: The next section asks questions regarding your current sexual identity

10. In your own words how do you describe your sexual identity?

_____________________

11. On the scale below mark with an X where you would rate your Biological Sex
   (your anatomy and hormones).

   Male
   |___________________________|__________________________|

   Female
   |___________________________|__________________________|

12. On the scale below mark with an X where you would rate your Gender Identity
   (your sense of self).

   Man
   |___________________________|__________________________|

   Woman
   |___________________________|__________________________|
13. On the scale below mark with an X where you would rate your **Gender Expression** (how you present yourself).

Masculine | Feminine
|------------------|------------------|

14. On the scale below mark with an X where you would rate your **Sexual Orientation** (your erotic attractions).

Attracted to Women | Attracted to Men
|------------------|------------------|

15. On the scale below mark with an X where you would rate your **Sexual Behavior** (who you have sex with).

Sex with Women | Sex with Men
|------------------|------------------|

**D. RELATIONSHIPS/SEXUAL HISTORY:** This section asks questions regarding your relationship status and sexual behavior.

16. Are you circumcised or “cut” (has the foreskin been removed from your penis)?
   - [ ] Yes
   - [ ] No

17. How old were you when you had your FIRST SEXUAL EXPERIENCE (You were able to ejaculate/cum or have an orgasm with or because of someone else)? ________

18. Was it with a man or a woman? ________

19. What best describes your relationship status (Check all that apply)
   - [ ] Single
   - [ ] Dating a few people
   - [ ] Boyfriend or steady male partner
   - [ ] Girlfriend or steady female partner
   - [ ] Male Domestic Partner/ Civil Union
   - [ ] Female Domestic Partner/ Civil Union
   - [ ] Married to a male
   - [ ] Married to a female
20. On average, how long do your sexual relationships typically last?

- less than 1 week
- 1 – 2 weeks
- 3 – 4 weeks
- 1 – 2 MONTHS
- 3 – 4 MONTHS
- 5 – 6 MONTHS
- 6 – 8 MONTHS
- 8 – 10 MONTHS
- 10 – 12 MONTHS
- greater than 1 year

21. How many sexual partners have you had in the past 3 months? ________
   a. Of your sexual partners from the past 3 months, how many were men? ________
   b. Of your sexual partners from the past 3 months, how many of your partners were visitors or tourists? ________

22. How many sexual partners have you had in the past 12 months? ________
   a. Of your sexual partners from the past 12 months, how many were men? ________
   b. Of your sexual partners from the past 12 months, how many of your partners were visitors or tourists? ________

E. Sexual Behavior

23. The next section lists some common sex practices that men who have sex with men (and women) engage in. Review this list and indicate how often you have engaged in each activity. Remember your answers will be kept confidential and no judgments will be made about you. To each his own.

<table>
<thead>
<tr>
<th>Common Behaviors &amp; Sex Acts</th>
<th>Have you EVER done this?</th>
<th>How many MEN have you done this with in the past YEAR?</th>
<th>How many times in the past 3 months?</th>
<th>How many times in the past 30 days?</th>
<th>Did you use a condom the last time you did this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masturbated</td>
<td>yes /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Yes/No</td>
<td>How Many Times a Day Do You Masturbate?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td>----------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(by yourself)</td>
<td>no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kissed a man</td>
<td>yes/no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbated someone (Gave someone a hand-job)</td>
<td>yes/no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Given oral sex (your mouth on someone’s penis or vagina)</td>
<td>yes/no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received oral sex (someone’s mouth on your penis)</td>
<td>yes/no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rimmed (licked someone’s ass)</td>
<td>yes/no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Been rimmed (someone lick your ass)</td>
<td>yes/no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penetrated someone (your penis in their ass or vagina)</td>
<td>yes/no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Been penetrated</strong> (someone put their penis in my ass)</td>
<td>yes / no</td>
<td></td>
<td>yes / no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------</td>
<td>----</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Douched</strong> (cleaned your ass with a feminine douche or enema) before anal sex</td>
<td>yes / no</td>
<td></td>
<td>yes / no</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Used alcoholic or recreational drugs (i.e. poppers, cocaine, marijuana, ecstasy, crystal meth.) before or during sex.</strong></td>
<td>yes / no</td>
<td></td>
<td>yes / no</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24. **When YOU cum (or ejaculate), where do you cum?** (check all that apply)
   - □ on his face
   - □ in his mouth
   - □ on his chest
   - □ on his back
   - □ in his ass (with a condom)
   - □ in his ass (without a condom)
   - □ not on him at all

25. **When YOUR PARTNER cums (or ejaculates), where do you allow him to cum?** (check all that apply)
on my face
☐ in my mouth
☐ on my chest
☐ on my back
☐ in my ass (with a condom)
☐ in my ass (without a condom)
☐ not on me at all

26. What brand(s) of condoms do you use? ________________________________

27. Where do you get your condoms? ________________________________

28. When you have sex, who initiates condom use?
☐ I do
☐ He does

29. Has anyone ever forced you to have sex?
☐ Yes
☐ No

30. Have you ever been diagnosed with a sexually transmitted infection (STI)?
☐ Yes
☐ No

a. If yes, which STI(s) have you had (check all that apply)
☐ Chlamydia
☐ Gonorrhea
☐ Hepatitis
☐ Herpes Simplex Virus
☐ Human Papillomavirus / Genital Warts
☐ Pubic Lice
☐ Human Immunodeficiency Virus (HIV)
### HIV Knowledge Questionnaire

**Appendix H**

**HIV Knowledge Questionnaire**

**ID #__________**

Directions: For each statement, please check **True, False, or I don’t know.** If you do not know, please do not guess, instead check **I don’t know.**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>HIV and AIDS are the same thing.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>There is a cure for AIDS</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>A person can get HIV from a toilet seat.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Coughing and sneezing DO NOT spread HIV.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>HIV can be spread by mosquitoes.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>AIDS is the cause of HIV.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>A person can get HIV by sharing a glass of water with someone who has HIV.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>HIV is killed by bleach.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>It is possible to get HIV when a person gets a tattoo.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>A pregnant women with HIV can give the virus to her unborn baby.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Pulling out the penis before a man climaxes or cums keeps a women from getting HIV during sex.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>A woman can get HIV if she has anal sex with a man.</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Showering, or washing one’s genitals or private parts, after sex keeps a person from getting HIV.</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Eating healthy foods can keep a person from getting HIV.</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>All pregnant women infected with HIV will have babies born with AIDS.</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Using a latex condom or rubber can lower a person’s chance of getting HIV.</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>A person with HIV can look and feel healthy.</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>People who have been infected with HIV quickly show serious signs of being infected.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>A person can be infected with HIV for 5 years or more without getting AIDS.</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>There is a vaccine that can stop adults from getting HIV.</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Some drugs have been made for the treatment of AIDS.</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Men who only practice “Topping” (inserting their penis into another man’s anus) cannot get HIV.</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>A person <strong>cannot</strong> get HIV by having oral sex (mouth-to-penis) with a man who has HIV.</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>A person can get HIV even if she or he has sex with another person only one time.</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Using a lambskin condom is the best protection against HIV.</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>People are likely to get HIV by deep kissing, putting their tongue in their partners mouth, if their partner has HIV.</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>A person can get HIV by giving blood.</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>A woman cannot get HIV if she has sex during her period.</td>
<td></td>
</tr>
</tbody>
</table>
29. You can usually tell if someone has HIV by looking at them.
30. There is a female condom that can help decrease a woman’s chance of getting HIV.
31. A natural skin condom works better against HIV than does a latex condom.
32. A person can get HIV from “Rimming/Tossing Salad” (inserting your tongue into
or licking another’s anus).
33. Having sex with more than one partner can increase a person’s chance of being infected with HIV.
34. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.
35. A person can get HIV by sitting in a hot tub or swimming in a pool with a person who has HIV.
36. A person can get HIV through contact with saliva, tears, sweat, or urine.
37. A person can get HIV from the wetness from a woman’s vagina.
38. A person can get HIV if having oral sex (mouth on vagina) with a woman.
39. If a person tests positive for HIV, the test site will have to tell all of his or her partners.
40. Using vaseline or baby oil with condoms lowers the chance of getting HIV.
41. Washing drug use equipment with cold water kills HIV.
42. A woman can get HIV if she has vaginal sex with a man who has HIV.
43. Athletes who share needles when using steroids can get HIV from the needles.
44. Men who only practice “Bottoming” (having a penis inserted into their anus) cannot get HIV.
45. Taking vitamins keeps a person from getting HIV.
Appendix I

Study Interview Guide

The intent of this study is to get to know more about the lives of Jamaican men who have sex with men (JMSM) and how they experience their sexuality in Jamaica. Just because you may be a man who has sex with other men it doesn’t necessarily mean all guys who have sex with men act the same or have had the same experiences in life. I want to get to know more about you and your story. First, let’s talk about who (insert name) is here today, and then we’ll get to the sex stuff.

A. Warm-up Questions: Getting to know you! (5 minutes)
This section of the interview is designed to help the subject and interviewer develop rapport and establish a basic level of comfort. The questions within this section focus on the subject’s upbringing (particularly their home environment, experience of family and childhood).

1. What would you like for me to call you during the interview?
   ________________________________
   (Please choose a name other than your real name)

2. Where did you grow up? ______________________________

3. What was life like in your neighborhood? Where you close to anyone in your neighborhood? Why? What drew you to them?

4. When you were growing up, who lived in your household? Did you feel safe there?

5. Describe how you were the same or different from those in your household?

6. Right now, who is important in your life? Why is that person important?

Before we go much further, I want to make sure that during our conversation I am using words or terms that apply to you and are not offensive. When men who have sex with other men are asked to identify their attraction to other men some say they are “gay”, others say “same gender loving”, some say “queer”, and still others say they are “straight”.

7. How do you define yourself sexually?
   ________________________________

B. Sexual Identity Development (Aim I Questions: What is it like to be MSM in Jamaica?)
This section of the interview will access information about the sexual development of the subject. This area will also access information regarding their own identification of their sexual and gender expressions. Subjects will be asked to describe their experiences within the context of masculinity or femininity.

1. At what age did you realize that you were ________________? (i.e. gay, straight, or bisexual)
2. How did you come to that realization?
3. Did you tell anyone? Why or why didn’t you tell someone?
4. Are there things in your life that you think made or allow you to be this way?
5. How comfortable are you with your sexuality?
   a. What do you like the most about your sexuality?
   b. What do you like the least about your sexuality?
6. You were asked earlier about what life was like in your neighborhood, can you tell me about being teased or bullied based on your appearance, how you spoke, or ways you were different from other children or adolescents your age (masculinity or femininity)?

C. Experiences in Educational Institutions

This section of the interview is designed to assess information about the subject’s experiences within the different educational institutions that they have encountered in Jamaica. Subjects will be asked to describe these experiences within the context of stigma, discrimination, bullying, and homophobia.

Earlier, you said that you completed (_____________) level of education.

1. What were primary and high school like for you growing up?
2. How were you treated by peers or school officials in school?
3. Do you feel that you were treated any differently than other male students in your school?
   a. What led you to believe that you were treated differently?
4. Were there other male students in the school that others had identified as gay or bisexual?
   a. How were they treated?
5. If you were singled out or picked on because of your sexual orientation who were you able to talk to?

D. Maleness and Masculinity

This section of the interview will access information about the subject’s experiences and observations of maleness and masculinity while they were growing up. Subjects will be asked to describe how cultural issues around maleness and masculinity have influenced their life as a man both physically and psychologically.
Throughout your life you’ve probably met and/or observed many different types of men. Think back to when you were growing up:

1. While growing up, did you have a father or a male figure in your life?
   a. What was his role?
   b. What kind of power did he have?
2. How are men supposed to act?
3. What messages did you receive about maleness and masculinity?
   a. What does it mean to be a man?
4. What messages did you receive about men and sex?
   a. What role did they play in sex?
5. What messages did you receive about heterosexual men and homosexual men?
   a. How do their thoughts affect you?
6. Now that you are _____ years old, how do you see yourself as a man who has sex with other men?

E. Cultural Influences around Sex and Sexuality-Based Violence
This section of the interview will access information regarding sexual education received by JMSM and also assess sexuality-based violence. This section will also assist the interviewer in gaining information about the subject’s cultural and social interactions and how those interactions influence sexual practices.

1. What messages did you receive about sex?
   a. Who talked to you about sex? How did it go?
2. What type of sex was acceptable?
   a. What type of sex between men and women was acceptable? (Oral, anal, vaginal, other?)
3. From your experience, what do people generally think of men who have sex with men? How do their thoughts affect you?
4. Were there any identified or suspected gay men in your neighborhood in which you grew up? If so, how were they treated?
   a. Have any of those identified or suspected gay men faced any form of violence from people within your neighborhood?

F. Religion, Faith, Spirituality and Attitudes towards MSM
This section of the interview will assist the interviewer in gaining information about the subject’s interaction within their faith, spiritual, or religious environment and how those interactions influence sexual practices.

Thank you for sharing those very personal and intimate details about yourself. Let’s move forward by talking about your interactions in your faith, religious, or spiritual community.

1. What role has religion, faith, or spirituality played in making you the person you are today?
a. What does your religious, faith, or spirituality require of you as a man who has sex with men?
b. Ideally, what role would you like religion, faith, or spirituality to play in your life?

2. What messages have you heard from your religious, faith, or spiritual community regarding men who have sex with men?

3. Are there any identified or suspected gay or bisexual men in your religious, faith, or spiritual community?
   a. How were they treated?

4. As a (__________) man, do you feel like you are welcomed in your religious community?
   a. What have led you to believe this?

5. Who from your religious, faith, or spiritual community knows that you have sex with other men?
   a. What differences do you see in their interactions with you, compared to other men your age?

G. Music and attitudes towards MSM
This section of the interview will allow the interviewer to assess information regarding the affects of musical popular culture (i.e. dancehall music) on the subject’s life and sexual practices. This section will also explore issues related to maleness and masculinity, homophobia, and sexual behavior as it relates to MSM.

1. What types of music do you listen to?
2. What is your favorite genre of music?
   a. What is it your least favorite genre of music? Why is it you least favorite?
3. How has dancehall music influence your life?
4. What types of messages have you received from dancehall about maleness and masculinity?
5. What types of messages have you received from dancehall regarding men and sex?
   a. Were those messages different for gay men?
6. What messages have you received from dancehall regarding men who have sex with men?
   a. Does it make you feel welcomed?
7. What role has dancehall music played in terms of your sexual decisions and practices?

H. Sexual History and Sexual Practices of MSM
This section of the interview will assess information about the sexual history and practices of the subject. Subjects will be asked in depth questions about their sexual practices, specifically with other males.

Let’s talk about the first time you ever had sex with a man,
1. When was the first time you had sex with a man?
   a. How old were you?
   b. How did you meet him?

2. Who brought up the conversation about sex?

3. Have you ever been in a situation where you were forced to have sex?
   a. Was it with someone your age or older than you?
   b. Did you tell anyone?

4. Why or why not?

5. What are you currently looking for in sex?
   a. What does sex mean to you?

6. What type of things will you not do or allow to be done to you sexually?

7. Were there times when you kept yourself from having sex even though you wanted to have it?
   a. Tell me more about this.

I. Protective Factors of MSM and Strategies against HIV Risk

This section of the interview will access information on the protective and survival practices of JMSM. This section will also explore strategies JMSM have used to navigate HIV risk and preventative services in Jamaica.

1. What messages have you received about HIV?
   a. Were they any specifically targeted to MSM?

2. In your past sexual experience, can you identify any behaviors that you have engaged in that may have placed you at risk for HIV?

3. In your experience, have you done anything to prevent you from getting HIV infected?
   a. If yes, what are some of those things?
   b. If no, what could you have done to prevent getting HIV?

4. What are some other things that you believe have kept you from getting HIV infected?
   a. Do you think you have been lucky?

J. Interactions with and Perceptions of HIV positivity (stigma and discrimination)

This section of the interview will assess information related to JMSM interactions with people who are known to be HIV positive and their perceptions of their own HIV risk. This section will also explore issues related to HIV stigma and discrimination within the Jamaican cultural context.

1. Do you know anyone with HIV?
   a. If yes,
i. How close are you to this person?

ii. How did you discover they have HIV?

iii. How did you react when you found out that they have HIV?

iv. How has HIV affected their life?

b. If no,

i. How do you think you would react if one of your friends or family members told you they were HIV positive?

ii. How do you think having HIV would affect this person’s life?

K. Self-maintenance and HIV testing Practices of JMSM

This section of the interview will explore the HIV testing and health maintenance practices of JMSM. This section will also explore the protective factors used by JMSM to secure their safety within their individual communities.

1. Have you ever been tested for HIV? (_________)
   a. If yes,
      i. When was the first time you got tested?
      ii. What led you to get tested?
      iii. What was the experience like for you getting tested?
      iv. Did anyone go with you?
      v. Did you receive any form of counseling? What was the counseling like?
      vi. Were you afraid of receiving the results?
      vii. How did you react after receiving the result?
      viii. Did you tell anyone about your results? Who did you tell and why?
   b. If no,
      i. What are the reasons that are preventing you from getting tested?

2. What are some of the things you have done to protect yourself both sexually and physically in your current community or neighborhood?

L. Health Care Systems Utilization

This section of the interview will assess the health care utilization practices of JMSM. It will also explore possible instances of discrimination experienced by JMSM within the health care systems.

1. Have you ever experienced symptoms that you thought were sexually transmitted disease (STD) related?
   a. If yes,
      i. Did you seek medical treatment? What was that like?
      ii. How did the medical staff treat you?
      iii. Did you disclose that you were a man who had sex with another man? Why or why not? If you did disclose, how did the person react?
iv. How was this experience different from other medical centers visited in the past?

b. If no,
   i. What were some of the things that prevented you from seeking medical treatment?
   ii. Have you run into any barriers when obtaining condoms or lubricants? If yes, tell me about it.

M. MSM Experience with Law Enforcement
This section of the interview will assess JMSM interaction with law enforcement. This section will also explore issues related to stigma and discrimination as it relates to interacting with law enforcement.

1. In general, tell me about a time were you had to interact with the police?
   a. What was that like for you?
2. Have you ever had to file a report with police regarding an incident involving you (i.e. abuse or physical violence by community members, family, etc.)?
   a. Tell me how that went for you.

N. Community Environment and Personal Safety
This section of the interview will assess the living environment. This section will also explore issues related to personal safety, internalized homophobia, social networks, and community support systems.

1. Has there been a time were you felt unsafe in your community? What happened? How was the issue resolved? Who did you talk to about it?
2. Have you disclosed your sexuality to anyone in your community?
   a. Who have you told?
   b. How did they react? How have your interactions with them been since you told them?
3. Do you have any friends who identify as MSM?
   a. How is your relationship with them?
   b. There are different types of MSM; some are more masculine than others). As a result, some MSM may choose not to hang with other MSM if they are feminine or if others can identify them as MSM, how do you choose your friends in general? How do you choose your friends who are MSM?
   c. How does others treat you when you are out in public with your friends?

O. Final Thoughts (5 minutes)
This section of the interview is allotted for the subjects to vocalize additional topics of importance and interest that were not covered in the proceeding sections of this guide.
We’re nearing the end of the interview, but before we conclude I would like to hear about anything you feel we missed.

1. Are there any other things you’d like to tell me, that maybe I didn’t ask you about, but you think are important for me to know?

2. Do you have anything that you would like to ask me?

P. Conclusion
Thank you for your time and candid answers.
Appendix J

Study Focus Group Guide

The intent of this study is to get to know more about the lives of Jamaican men who have sex with men (JMSM) and how they experience their sexuality in Jamaica. Just because you may be a man who has sex with other men it doesn’t necessarily mean all guys who have sex with men act the same or have had the same experiences in life. The purpose of this focus group discussion is to confirm preliminary findings from previously conducted one-one individual interviews.

A. Aim I Questions: What is it like to be MSM in Jamaica?)

Relationships with Family and Community:

1. Some of the men in the study talked about not having a relationship with their fathers or other male figures in their lives as the reason why they are gay or bisexual.
   a. What do you guys think about that? What have you heard others say regarding this?

2. Some MSM have had negative interactions with their family members, like being called derogatory names (such as fish, battyman, etc.). What has your experience been like? Can you tell me more about this?

3. Many MSM mentioned being removed from their homes. What have you guys heard about people being kicked out of their home or community?

4. It was also mentioned that if family members found out that they were gay, they would disown them or not talk to them. What have you guys heard about this? Do you know of anyone that this had happened to?

5. MSM that I have spoken to suggested that they hated being gay because if they were straight it would have brought success and greater opportunities to their lives.
   a. Have you guys heard this before? What do you think about this statement?

6. MSM who I spoke to believe that being gay in the ghetto is more difficult than in uptown communities.
   a. Have you guys heard this before? What else have you heard about uptown gays and downtown gays? Do you guys have any gay friends who are from any of these two communities? What has their experience been like? Have you guys had any experiences that you would like to share?

B. Experiences in Educational Institutions

1. A few MSM have talked about not receiving sex education in school or if they did received sex education it was limited to only heterosexual sex. What do you guys think about this?
   a. Some even said that most of what they know about sex they learnt it from watching t.v., reading, and by talking to friends. How do you guys feel about that? Where else do MSM get sex education?
2. Some MSM talked about having to leave high school or transfer to another school because of their sexual orientation. A few even mentioned feeling unsafe at school at times because they were being bullied.
   a. Have you heard of instances where this had happened?
   b. What else have you heard about MSM feeling unsafe in school?
3. I have also heard that MSM felt as if they had no one that they could talk to in school (i.e. guidance counselor, principal, or teachers) if they were being bullied. Do you guys feel the same way? What have you heard from other MSM regarding this?

C. Religion, Faith, Spirituality and Attitudes towards MSM
1. Many MSM have expressed to me that religion is not important to them due to the level of hypocrisy they have observed within their church homes.
   a. What do you guys think about that?
2. Some MSM have expressed that they are welcomed in their church and that they have not experienced discrimination from church leaders.
   a. Have you guys noticed or experienced this?
   b. Is there a difference in how certain denominations view or accept homosexuality? What are those denominations?
3. The issue of punishment came up for a few men. Some thought that because of their religious beliefs, being gay was a punishment for God. Have you guys heard this before? Do you have the same view?

D. Music and attitudes towards MSM
1. I have heard from a few men that one major way they’ve learned how to be a man was through dancehall music.
   a. Do you believe that dancehall determines maleness and masculinity in Jamaica?
   b. What else have you heard about dancehall music and being/acting like a man in Jamaica?
2. Do you guys believe that dancehall music also dictates how a man must perform sexually between him and his female partners? Some of the men that I spoke to suggested that dancehall enforces the notion of ruff sex between partners (e.g. ‘tek buddy gal’ from Vibez Kartel). What do you guys think about this?
3. A significant number of men I spoke to were able to identify several songs that bash gay people. A few of them had identified the same song.
   a. Do you guys know of any songs that bash or speak out against homosexuals? What are those songs?
   b. Some men have said that when they listened to dancehall songs they tend to ignore the homophobic parts of it so they can enjoy the music. Have you guys done this before? Have you heard of others doing this too as well?
4. MSM have said that Soca music provide them with a space for them to be themselves. At soca events they are able to dance or wine the same way females do.
a. What do you guys think about this statement? Have you guys have similar experiences? Do you guys feel the same way about Soca?

E. Keeping safe in Jamaica

1. Some persons have given insights to instances where they were “mobbed” or attacked by members in their community just because they are gay.
   a. What have you guys heard about mob attacks on gay men in Jamaica?
   b. Do you know of anyone who had experienced this before? What was their experience like? Have any of you guys experienced this before?

2. “Show me your company and I will tell you who you are” is a statement that I have consistently heard being used by MSM here.
   a. Have you guys heard this statement before? Have you ever heard it used in the gay context? What do you think it means?

3. MSM have expressed or suggested several ways in which they have tried to keep themselves safe here in Jamaica. Some have suggested that there are places that they will not go with men who are feminine, REAL, or loud as ways of protecting themselves.
   a. Have you guys engaged in this type of protective behavior? Do you know or heard of other MSM who have engaged in this sort of practice?
   b. Who is considered to be a REAL guy? What does being loud mean? What else have you heard about how other MSM have kept themselves safe?

4. Another statement that I have heard from MSM is the use of code words when they are in public places so that others won’t know that they are gay.
   a. Have you guys heard this before? What are some of the words you’ve heard them use?

5. I have heard from a few MSM that one way they try to keep safe in Jamaica is to be mindful of how they may present themselves in public. Some have said that they try to “man up”, dress more masculine, and having less male company.
   a. What do you guys think about this? Have you heard of MSM who have done this before?
   b. Have any of you engaged in these practices? What was your experience like?

6. Many persons have suggested that there is no place in Jamaica for feminine men.
   a. Do you guys agree with this statement? What do you guys think about feminine men in Jamaica? What have you guys heard from feminine men in terms of how they are treated?

F. Use of Social Media

1. Many MSM individuals have expressed the use of social media sites to meet or connect with prospective sexual interest.
   a. What have you guys heard about this practice?
b. What are some of the sites you’ve heard being used by MSM (Facebook, Adam4Adam, Digicel Chat Room, Black Gay Chat, Tag, etc.)?

G. Terms used to identify MSM
1. MSM have said that people in Jamaica often refer to them using derogatory terms such as “fish”, “battyman”, “2”, etc.
   a. Have you guys heard the same thing? What other terms have you heard being used to refer to gay men?

H. Role Models
1. I have spoken to a few MSM who had expressed that not having positive gay role models to whom they could identify with has been a problem for them. Some believe that having such persons in their lives would help them develop as successful citizens.
   a. What do you guys think that statement? Do you guys feel the same way?

I. Health Care Systems Utilization and Mental Health
1. MSM had mentioned thoughts of wanting to hurt themselves because of their sexuality. Some had expressed frequent bouts of depression and not having anyone to talk to about what they were going through.
   a. Do you guys know of anyone who had experienced this? What do you guys think about this statement? What else have you heard from other MSM about this?
2. Many MSM have mentioned not having an issue seeking healthcare services.
   a. Have you guys experienced any barriers when seeking health care? What have you heard from other MSM regarding this issue?

J. MSM Experience with Law Enforcement
1. MSM had expressed that they felt reluctant to file reports with the police because they often refused to take their reports and that they have been mistreated or called derogatory names by the police.
   a. What have you heard from MSM about how the police treat them?
   b. Have any of you experienced this before too as well?
2. Persons have also expressed experiencing a difference in their interactions with female compared to male police officers.
   a. Have you guys heard this before?
   b. What have you heard from MSM about their interactions with male and female police officers?

K. Wanting to leave Jamaica
1. MSM have talked about leaving Jamaica if they could. Some say they would go to countries such as the United States, Canada, United Kingdom, Europe, or Trinidad.
   a. What have you guys heard about wanting to leave Jamaica?
b. What other countries have you heard of MSM wanting to migrate to?
c. Would any of you leave here? Where would you go?

L. Final Thoughts (5 minutes)
We’re at the end of the discussion, but before we conclude I would like to hear about anything you feel we missed.

3. Are there any other things you’d like to tell me, that maybe I didn't ask you all about, but you guys think are important for me to know?

4. Do you have anything that you would like to ask me?

M. Conclusion
Thank you for your time and candid answers.
Appendix K

Study Approval Letters
February 22, 2013

Professor Horace Fletcher, BSc, MBBS, DM (O & G), FRCOG, FACOG
Chairman
UWI Ethics Committee
Faculty of Medical Sciences
The University Hospital of the West Indies
Kingston 7

Dear Professor Fletcher:

Re: Jamaica AIDS Support for Life (JASL) Letter of Support for the research study entitled, 'Social and Cultural Determinants of HIV risk among Jamaican Men who have Sex with Men (JMSM)' to be conducted by Mr. Orlando O. Harris, MS, RN, FNP, Fulbright Fellow.

Please accept this letter of support for Mr. Orlando Harris to partner with JASL to complete his above captioned study. Mr. Harris has been oriented and has commenced working with the Programmes Department specifically the Treatment, Care & Support team. He has thus far been able to adequately represent his technical skills in carrying out functions related to the organisation's services. In addition, the above captioned research study being conducted in collaboration with JASL promises to be consistent with the organisation's mandate and strategic objectives.

JASL is the oldest and largest HIV/AIDS, human rights, non-governmental agency in existence since 1991 dedicated to and has been preserving the dignity and rights of persons living with HIV and AIDS and to help in the fight against the spread of HIV and AIDS. Our services are aimed at promoting changes in the attitudes and behaviour and empower persons to respond positively to the challenges associated with being vulnerable to HIV-infection in Jamaica. Operating out of its three (3) Chapters: Kingston (Head Office). Ocho Rios and Montego Bay, JASL’s services are designed to improve the social, economic and psychological well-being of persons living with HIV (PLHIV), men who have sex with men (MSM), sex workers (SWs), the hearing impaired (HI) and orphans and vulnerable children to HIV/AIDS (OVC).

"LOVE, ACTION & SUPPORT"
With our continued work with vulnerable populations, it is believed that Mr. Harris' research project will provide more insight into the socio-cultural determinants of gender and HIV risk among sexually marginalised individuals such as MSM. Emerging innovative and groundbreaking research is necessary to arm the organisation with strategic information in an effort to maintain its leadership in the national HIV response.

Although we are unable to provide Mr. Harris with any financial support, the organisation will provide him with access to a shared space in which he will be able to interview and hold focus group discussions with subjects. It is understood that the participation of subjects is completely voluntary. Should a participant choose to withdraw at any time during the study, they may do so without consequence or any impact to the services that they would have received from our agency.

If you desire further information or have any additional questions, please contact Mr. Dane Richardson, Programme Development Manager by email at drichardsonjansk@gmail.com or by telephone at (876) 978.2345 / (876) 978.4668

Yours Respectfully,

[Signature]

Kandasi Levermore (Mrs.)
Executive Director

"LOVE, ACTION & SUPPORT"
March 7, 2013

Dr. Leith Dunn
Senior Lecturer/Head
Institute of For Gender & Development Studies
The University of the West Indies
Mona, Kingston 7

Dear Dr. Dunn,

Re: Orlando Harris’s research proposal entitled- Social and cultural determinants of HIV risks among Jamaican men who have sex with men (JMSM). ECP 183, 12/13

Thank you for submitting the above mentioned proposal for review by the UHWI/UWI/FMS Ethics Committee.

The proposal was reviewed and approved, having met the required ethical standards.

Yours sincerely,

[Signature]

Professor Horace Fletcher
Chairman UHWI/UWI/FMS Ethics Committee
Letter of Approval

RSRB: RSRB00046006  Principal Investigator: Jane Tuttle

Study Title: Social and Cultural Determinants of HIV Risk among Young Jamaican Men who have Sex with Men (JMSM)

Initial Approval: 3/5/2013

Study Approval Expires: 3/4/2014

Length of Review: 1 year

Risk Level:
- Minimal Risk - Adults

Review Level: Expedited

Expedited Category(ies):
- 6 - collection of data from voice, video, digital, image recordings
- 7 - individual or group characteristics or behavior


- HIPAA: Does not apply

This approval is contingent upon the investigation being conducted in compliance with the approved study protocol including all requirements and/or determinations of the RSRB. Unless a Waiver of Consent is specified above, consent must be obtained and documented in the manner approved by the RSRB. Please note all remarks and/or attachments. Only consent forms and recruitment materials bearing a current RSRB Approved watermark may be used. Only the most recently approved version of any consent or recruitment document may be used when obtaining consent. Consent forms/recruitment letters must be printed on department letterhead.

As the Principal Investigator, you are responsible for the following activities:

- Timely submission of continuing review progress reports apply to RSRB at least 8 weeks before expiration. Federal Regulations require that the RSRB conduct continuing review of research. You will receive an email notification when the expiration date is approaching.
- Requesting any proposed changes in the above research activity. All subject recruitment materials must be approved prior to use. Changes may not be initiated without RSRB approval except when necessary to eliminate apparent immediate hazards to the subject(s) and then a report must be submitted along with the amendment request.
- Maintaining all approved study documents in your study file.
- Maintaining all approved pages of the signed consent form for at least three years after the research is completed (six years if protected health information was collected as part of the research) or for a longer term if required by FDA regulations or other contractual agreements.
- Reporting any unexpected serious problems involving risks to subjects or others (including unexpected deaths, hospitalizations or serious injuries) in accordance with the Guidance for Reporting Reportable Events to the RSRB.
- Submitting a final progress report to the RSRB upon completion of this study.

Steven Lambert, RSRB Chair 3/5/2013

The Department of Health and Human Services has approved a Federalwide Assurance (FWA) with the University of Rochester (FWA9386), which is in effect through August 23, 2017.
265 Crittenten Blvd. - Box CU420628; Suite: 1-250
Rochester, New York 14642
(585) 275-2388

DO NOT REPLY TO THIS EMAIL
For questions or to provide a response, please go into the RSRB Online Submission System (ROSS) or contact your RSRB Specialist: RSRB staff page.
Appendix L

Other Materials
MUTUAL NON-DISCLOSURE AGREEMENT

This Agreement is made and entered into as of the last date signed below (the "Effective Date") by and between the [Lloyd Walker], having his principal place of business at [University of West Indies Mona Kingston 7 ("The Company") and Orland Harris, a PhD Candidate whose principal mailing address is University of Rochester NY 14624-4408 (the "Second Party").

WHEREAS The Company and the Second Party (the "Parties") have an interest in participating in discussions wherein either Party might share information with the other that the disclosing Party considers to be proprietary and confidential to itself ("Confidential Information"); and

WHEREAS the Party agrees that Confidential Information of a Party might include, but not be limited to that Party's: (1) business plans, methods, and practices; (2) personnel, customers, and suppliers; (3) inventions, processes, methods, products, patent applications, and other proprietary rights; or (4) specifications, drawings, sketches, models, samples, tools, computer programs, technical information, or other related information;

NOW, THEREFORE, the Parties agree as follows:

1. Either Party may disclose Confidential Information to the other Party in confidence provided that the disclosing Party identifies such information as proprietary and confidential either by marking it, in the case of written materials, or, in the case of information that is disclosed orally or written materials that are not marked, by notifying the other Party of the proprietary and confidential nature of the information, such notification to be done orally, by e-mail or written correspondence, or via other means of communication as might be appropriate.

2. When informed of the proprietary and confidential nature of Confidential Information that has been disclosed by the other Party, the receiving Party ("Recipient") shall, NEVER disclose the information from the date of disclosure, refrain from disclosing such Confidential Information to any contractor or other third party without prior, written approval from the disclosing Party and shall protect such Confidential Information from inadvertent disclosure to a third party using the same care and diligence that the Recipient uses to protect its own proprietary and confidential information, but in no case less than reasonable care. The Recipient shall ensure that each of its employees, officers, directors, or agents who has access to Confidential Information disclosed under this Agreement is informed of its proprietary and confidential nature and is required to abide by the terms of this Agreement. The Recipient of Confidential Information disclosed under this Agreement shall promptly notify the disclosing Party of any disclosure of such Confidential Information in violation of this Agreement or of any subpoena or other legal process requiring production or disclosure of said Confidential Information.

3. All Confidential Information disclosed under this Agreement shall be and remain the property of the disclosing Party and nothing contained in this Agreement shall be construed as granting or conferring any rights to such Confidential Information on the other Party. The Recipient shall honor any request from the disclosing Party to promptly return or destroy all copies of Confidential Information disclosed under this Agreement and all notes related to such Confidential Information. The Parties agree that the disclosing Party will suffer irreparable injury if its Confidential Information is made public, released to a third party, or otherwise disclosed in breach of this Agreement and that the disclosing Party shall be entitled to obtain injunctive relief against a threatened breach or continuation of any such breach and, in the event of such breach, an award of actual and exemplary damages from any court of competent jurisdiction.

4. The terms of this Agreement shall not be construed to limit either Party's right to develop independently or acquire products without use of the other Party's Confidential Information. The disclosing party acknowledges that the Recipient may currently or in the future be developing information internally, or receiving information from other parties, that is similar to the Confidential Information. Nothing in this Agreement will prohibit the Recipient from developing or having developed for it products, concepts, systems or techniques that are similar to or compete with

CONFIDENTIAL
Non-Disclosure Agreement

the products, concepts, systems or techniques contemplated by or embodied in the Confidential Information provided that the Recipient does not violate any of its obligations under this Agreement in connection with such development.

5. Notwithstanding the above, the Parties agree that information shall not be deemed Confidential Information and the Recipient shall have no obligation to hold in confidence such information, where such information:

(a) Is already known to the Recipient, having been disclosed to the Recipient by a third party without such third party having an obligation of confidentiality to the disclosing Party; or
(b) Is or becomes publicly known through no wrongful act of the Recipient, its employees, officers, directors, or agents; or
(c) Is independently developed by the Recipient without reference to any Confidential Information disclosed hereunder; or
(d) Is approved for release (and only to the extent so approved) by the disclosing Party; or
(e) Is disclosed pursuant to the lawful requirement of a court or governmental agency or where required by operation of law.

6. Nothing in this Agreement shall be construed to constitute an agency, partnership, joint venture, or other similar relationship between the Parties.

7. Neither Party will, without prior approval of the other Party, make any public announcement of or otherwise disclose the existence or the terms of this Agreement.

8. This Agreement contains the entire agreement between the Parties and in no way creates an obligation for either Party to disclose information to the other Party or to enter into any other agreement.

9. This Agreement shall remain in effect for a period of two (2) years from the Effective Date unless otherwise terminated by either Party giving notice to the other of its desire to terminate this Agreement. The requirement to protect Confidential Information disclosed under this Agreement shall survive termination of this Agreement.

IN WITNESS WHEREOF:

LLOYD WALLER
Signature
Date
Printed Name
Title

ORLANDO HARRIS
Signature
Date
Printed Name
Title

-Page 2 of 2-
CONFIDENTIAL
MUTUAL NON-DISCLOSURE AGREEMENT

This Agreement is made and entered into as of the last date signed below (the "Effective Date") by and between the Orlando Thompson, having his principal place of business at University of West Indies Mona Kingston 7 ("the Company") and Orlando Harris, a Ph.D Candidate whose principal mailing address is University of Rochester, NY 14620-4408 (the "Second Party").

WHEREAS the Company and the Second Party (the "Parties") have an interest in participating in discussions wherein either Party might share information with the other that the disclosing Party considers to be proprietary and confidential to itself ("Confidential Information"); and

WHEREAS the Party agrees that Confidential Information of a Party might include, but not be limited to that Party’s: (1) business plans, methods, and practices; (2) personnel, customers, and suppliers; (3) inventions, processes, methods, products, patent applications, and other proprietary rights; or (4) specifications, drawings, sketches, models, samples, tools, computer programs, technical information, or other related information;

NOW, THEREFORE, the Parties agree as follows:

1. Either Party may disclose Confidential Information to the other Party in confidence provided that the disclosing Party identifies such information as proprietary and confidential either by marking it as the case of written materials, or, in the event of information that is disclosed orally or written materials that are not marked, by notifying the other Party of the proprietary and confidential nature of the information, such notification to be done orally, by e-mail or written correspondence, or via other means of communication as might be appropriate.

2. When informed of the proprietary and confidential nature of Confidential Information that has been disclosed by the other Party, the receiving Party ("Recipient") shall, NEVER disclose the information from the date of disclosure, refrain from disclosing such Confidential Information to any contractor or other third party without prior, written approval from the disclosing Party and shall protect such Confidential Information from inadvertent disclosure to a third party using the same care and diligence that the Recipient uses to protect its own proprietary and confidential information, but in no case less than reasonable care. The Recipient shall ensure that each of its employees, officers, directors, or agents who has access to Confidential Information disclosed under this Agreement is informed of its proprietary and confidential nature and is required to abide by the terms of this Agreement. The Recipient of Confidential Information disclosed under this Agreement shall promptly notify the disclosing Party if any disclosure of such Confidential Information in violation of this Agreement or of any subpoena or other legal process requiring production or disclosure of said Confidential Information.

3. All Confidential Information disclosed under this Agreement shall be the property of the disclosing Party and nothing contained in this Agreement shall be construed as granting or conferring any rights to such Confidential Information on the other Party. The Recipient shall honor any request from the disclosing Party to promptly return or destroy all copies of Confidential Information disclosed under this Agreement and all notes related to such Confidential Information. The Parties agree that the disclosing Party will suffer irreparable injury if its Confidential Information is made public, released to a third party, or otherwise disclosed in breach of this Agreement and that the disclosing Party shall be entitled to obtain injunctive relief against a threatened breach or continuation of any such breach and, in the event of such breach, an award of actual and exemplary damages from any court of competent jurisdiction.

4. The terms of this Agreement shall not be construed to limit either Party’s right to develop independently or acquire products without use of the other Party’s Confidential Information. The disclosing party acknowledges that the Recipient may currently or in the future be developing information internally, or receiving information from other parties, that is similar to the Confidential Information. Nothing in this Agreement will prohibit the Recipient from developing or having developed for it products, concepts, systems or techniques that are similar to or compete with
Non-Disclosure Agreement

The products, concepts, systems or techniques contemplated by or embodied in the Confidential Information provided that the Recipient does not violate any of its obligations under this Agreement in connection with such development.

5. Notwithstanding the above, the Parties agree that information shall not be deemed Confidential Information and the Recipient shall have no obligation to hold in confidence such information, where such information:

(a) Is already known to the Recipient, having been disclosed to the Recipient by a third party without such third party having an obligation of confidentiality to the disclosing Party; or

(b) Is or becomes publicly known through no wrongful act of the Recipient, its employees, officers, directors, or agents; or

(c) Is independently developed by the Recipient without reference to any Confidential Information disclosed hereunder; or

(d) Is approved for release (and only to the extent so approved) by the disclosing Party; or

(e) Is disclosed pursuant to the lawful requirement of a court or governmental agency or where required by operation of law.

6. Nothing in this Agreement shall be construed to constitute an agency, partnership, joint venture, or other similar relationship between the Parties.

7. Neither Party will, without prior approval of the other Party, make any public announcement of or otherwise disclose the existence or the terms of this Agreement.

8. This Agreement contains the entire agreement between the Parties and in no way creates an obligation for either Party to disclose information to the other Party or to enter into any other agreement.

9. This Agreement shall remain in effect for a period of two (2) years from the Effective Date unless otherwise terminated by either Party giving notice to the other of its desire to terminate this Agreement. The requirement to protect Confidential Information disclosed under this Agreement shall survive termination of this Agreement.

IN WITNESS WHEREOF:

OTHDASE THOMPSON

Signature

C. Thompson

Date

Othdase Thompson

Printed Name

Teacher Assistant

Title

ORLANDO HARRIS

Signature

Orlando Harris

Printed Name

Family Nurse Practitioner

Title

Page 2 of 2

CONFIDENTIAL
Data Transcription

Item Description

This certified letter of destruction is provided to Orlando Harris as it pertains to the destruction and disposal of material relative to the transcriptions and preliminary analysis done for the completion of his thesis. I hereby acknowledge the receipt of the above described material from Mr. Orlando Harris has been destroyed or will be destroyed within five days of the date of receipt.

I acknowledges that the materials above contains confidential and proprietary information of participants of the study and that, if disclosed, may harm the participants. Accordingly, I Lloyd Waller guarantees protection against third party access to the material before data is destroyed and further agrees not to disclose any information contained in the material to any third party for any reason.

Using our data destruction procedure does not eradicate all the data available, but to access any readable portion of the data after our process is performed is beyond the capability of any data recovery forensic process we are aware of.

Should you have any further questions please do not hesitate to contact me.

Sincerely,

Lloyd Waller

June 18, 2013
December 9, 2013

Orlando O. Harris, M.S., A.P.R.N., F.N.P.
School of Nursing
University of Rochester Medical Center
Box SON

Re: Recertification for Greater Than Minimal Risk Behavioral

Dear Orlando:

This letter is to confirm that you successfully completed the recertification program to conduct greater than minimal research with human subjects at the University of Rochester.

You completed the GREATER THAN MINIMAL RISK BEHAVIORAL program.

Your certification will expire in three years (DECEMBER 7, 2016).

For recordkeeping purposes, you have been assigned a new certification number (your CITI Learner ID number). Your new number is 2103426.

Your profile in the RSRB Online Submission System (ROSS) will be updated with the program you took, your certification number, and expiration date. This information is required for all RSRB and WIRB submissions.

Congratulations! Thank you for your continued commitment to human subject protections and compliance with research regulations and policies.

Sincerely,

Bill Kelvie
Director, Research Education

PLEASE RETAIN A COPY OF THIS LETTER FOR YOUR FILES
OHSP DOES NOT KEEP A COPY OF THIS LETTER
October 4, 2011
The National Screening Committee
Fulbright Scholar Program
United States Department of State
Bureau of Education and Cultural Affairs
Washington, DC 20522
USA

Dear Members of the National Screening Committee:

Re: Institutional Affiliation for Mr. Orlando Harris - Fulbright Applicant

It gives me great pleasure to write this letter of support for Mr. Orlando O. Harris’ application for a Fulbright Fellowship. I have read Mr. Harris’ research proposal entitled: "Social and Cultural Determinants of HIV Risk among Young Jamaican Men who have Sex with Men (MSM)" and have determined that this project is consistent with the mission and mandate of the Institute for Gender and Development Studies Mona Campus Unit at the University of the West Indies, Mona Campus in Jamaica. Mr. Harris and I have communicated on several occasions and I have agreed to serve as a member of his advisory panel for his dissertation project. Please accept this letter as an invitation for Mr. Harris to partner with our Institute here at the UWI for the 2012-2013 academic year.

Mr. Harris and I have planned to meet in January 2012 to discuss the University’s Research Subjects Review Board process prior to his arrival in August of 2012. While here at the University in the fall of 2012, I will work with Mr. Harris to get his research study approved. Although we are unable to provide Mr. Harris with any financial support, my department will provide him with access to shared space in which he would be able to interview research participants and hold focus groups. This space will have a locked file cabinet in order to secure confidential study materials. Additionally, because the University provides tuition fee waiver for Fulbright scholars, I will encourage Mr. Harris to register for one of our courses in our Institute for Gender and Developmental Studies Unit. Some of the course titles include: Introduction to Men and Masculinity in the Caribbean, Gender in Caribbean Culture: Linguistic, Popular Culture and Literature, and Gender, Sexual and Reproductive Health and HIV/AIDS. Mr. Harris and I will continue to work on a plan of study when he arrives here at the UWI.

As Senior Lecturer/Head of the Institute for Gender and Development Studies Mona Unit, I will utilize my professional resources to connect Mr. Harris with key stakeholders for his research and these include: academics and researchers, community leaders, and colleagues in the Ministry of Health with whom we work closely on issues related to gender and HIV/AIDS and vulnerable communities. Mr. Harris’ research project will provide some insight into the socio-cultural determinants of gender and HIV risk among sexually marginalized individuals such as men who have sex with men, which is an emerging area of much-needed research.

Based on our conversations, written communications, and his research proposal, Mr. Harris continues to impress me with his knowledge, skill and dedication to his work. If awarded the Fulbright fellowship, I am sure he will continue to excel and to make a significant contribution to available literature on Jamaican men who have sex with men. It is my hope that your Committee will award him this fellowship. Please contact me if you require additional information.

Sincerely,

Leith L Dunn PhD
Senior Lecturer/Head

The University of the West Indies,
Allison McLean Building, Block 6, Ground Floor,
Mona, Kingston 7, JAMAICA
Tel. (876) 977-7565, 936-4644 Fax. (876) 977-9953
e-mail: leith.dunn@uwimona.edu.jm
Supplementary Information
U.S. Student Fulbright Grantees to Jamaica 2012-13

If you are affiliated with or attending classes at the University or West Indies, Mona, please contact Bernadette Hutchinson at the email address below as soon as possible. Student status for visas is granted mainly on the basis of affiliation with a recognized educational institution. In addition, PAS, Kingston will send a letter to the relevant officer at the university seeking tuition waivers for these students.

The Post will also facilitate the process of getting a Taxpayer Registration Number (TRN) soon after arrival. They will need this number to apply for a bank account telephone service, etc. much like a social security number.

U.S. students traveling to Jamaica as part of the Fulbright Exchange Program must obtain a valid student visa prior to entry into Jamaica. Securing a visa is your responsibility. Visa applications can be submitted in person or by mail to the Jamaican Embassy in Washington DC or to one of the Jamaican Consulates in Chicago, Miami or New York. Please start the visa process at least 3 or 4 months before your scheduled departure.

When applying for a visa you will need the following materials:

- Be sure to apply for the full 10 month term of your grant.
- A completed visa application form (found online at: http://www.embassyofjamaica.org/EmbassyofJamaica_VisaApplication.pdf)
  - Include a contact email address or phone number at your host institution in the References in Jamaica section.
- Your passport
- One (1) passport sized photo (2” x 2”).
- A cashier’s check or money order (no personal checks) in the amount of $140 made out to the “Embassy of Jamaica.”
- An acceptance letter or letter of invitation from your host institution in Jamaica.
- A prepaid addressed express delivery envelope (e.g. Fedex, DHL, etc.) if you’re unable to retrieve the visa in person and you want the Embassy/Consulate to mail it back to you.

Grantees are advised to contact the Embassy/Consulate to confirm their applications are complete before submitting. Particularly if you intend to submit it by mail.

Please remember, all grantees must send their arrival information to the U.S. Embassy Public Affairs Section (PAS) and arrange to meet with Public Affairs staff for a country briefing upon arrival in the country. If you will be based outside of Kingston, then be sure to schedule this meeting before you leave and plan to spend a day or two in Kingston. Failure to attend a briefing at the embassy will result in a delay in your second stipend payment until such a meeting takes place.

US EMBASSY CONTACT INFORMATION

Public Affairs Section
American Embassy
142 Old Hope Road
Kingston 6, JAMAICA
Tel: 1-876-935-4053/4
Fax: 1-876-929-3637 or 929-6743

PAO: Yolonda Kerney
Email: KerneyYV@state.gov

Cultural Affairs Specialist: Bernadette Hutchinson
Email: HutchinsonBG@state.gov
June 26, 2012

Mr. Orlando Harris  
500 Wilson Blvd  
CPU Box 371504  
Rochester, NY 14627-0001

Dear Mr. Harris,

On behalf of the U.S. Department of State, which funds and administers the Fulbright Program and the J. William Fulbright Foreign Scholarship Board, I am pleased to offer you an award for study in Jamaica during the 2012-2013 academic year.

The Terms and Conditions of Award describing the benefits and requirements of the award are attached. The only financial benefits included in this award are those described on page one. Please examine the Terms and Conditions of Award carefully and return two signed award documents and one signed set of Terms and Conditions of Award to my attention as soon as possible, but within 21 days at the latest.

Please be aware that information on how to prepare for your stay overseas is posted on the webpage Resources for Pre-Grantees. Please bookmark this webpage as it is not posted on our website.

http://us.fulbrightonline.org/resources-for-pre-grantees

We urge you to review this page carefully and pay particular attention to your World Region section under the heading Grant Administration for Non-Commission Countries. Here you will find several other forms that you need to complete and return to IIE when you have finalized your travel plans. It is your responsibility to understand what documents are required and for the timely submission of documents and forms.

Please remember, we cannot issue your first stipend payment until all paperwork is completed and payments will not be issued more than four weeks prior to your scheduled departure. We also encourage you to go to general website section for Current Fulbrighters. Here you will find the Orientation Handbook and other information related to your grant.

The Resources webpage also includes sample letters to your U.S. Congressman, expressing support for the Fulbright program. I strongly urge you to send such a letter in order that the program will continue in the future to help other American students to study abroad.

Once you have accepted the award, the administration of grant funds is contingent upon completion of all grant formalities as indicated in the letter from the FSB. Again, your timely attention to these matters is critical.

Sincerely yours,

Theresa Granza  
Director  
U.S. Student Programs

Enclosure: Award Authorization  
Terms and Conditions
INSTITUTE OF INTERNATIONAL EDUCATION

Fulbright US Student Award Authorization

NAME AND PERMANENT ADDRESS OF GRANTEE:
Name: Mr. Orlando Harris
Address: 500 Wilson Blvd
CPU Box 271504
Rochester, NY 14627-0001

Date: June 25, 2012
Field: Medicine Sciences
Duration of Award: 10 months
Dependents: Single

COUNTRY: Jamaica
A fixed sum of $20,850.00 is authorized payable as follows: $8,250.00 prior to the beginning of the grant; $5,400.00 by the end of the third month; $5,400.00 by the end of the sixth month; $1,800.00 in the last month*

BENEFITS COVERED BY AWARD

RESEARCH ALLOWANCE: $300.00 (included in 1st check)
BASE AMOUNT: $2,350.00 (included in 1st check)
MONTHLY STIPEND: $1,800.00

TOTAL AWARD: $20,850.00 * (subject to Terms & Conditions of Award)

SPECIAL CONDITIONS OF AWARD (Also see attached sheets)

*See #1 of Terms & Conditions of Award

The awarding of this grant is contingent upon documented receipt by the Institute of International Education of the cooperating agency of any/all research materials, visa, and affiliations as required by the host country, receipt of a satisfactorily completed Medical Report Form, and receipt of the final transcript indicating the award of a bachelor's degree (if degree was received after September 1, 2011 and not indicated on the undergraduate transcript submitted with the application).

Grant Confirmed By: 
Theresa Grauza, Director
U.S. Student Programs Division

Date: June 25, 2012

ACCEPTANCE OF AWARD

I hereby accept the award offered and agree to abide by the conditions of the grant as specified above. By signing this acceptance of the Fulbright Award, you agree that you will comply with the laws of your host country; and you affirm that you have not and will not promote or engage in violence, terrorism or the destruction of any State through violent means.

Signature of Grantee: ___________________ Date: ____________

May I share your name, address, and email address with fellow grantees? ___ Yes ____ No

DECLINATION OF AWARD

I cannot accept the award offered to me for the reasons indicated on the reverse.

Signature of Grantee: ___________________ Date: ____________

NOTE: Sign all copies of this form. Retain original and a copy for your file and send two copies to the address indicated above within two weeks of receipt.
TERMS AND CONDITIONS OF AWARD

ALL APPLICATIONS AND GRANTS ARE SUBJECT TO THE POLICIES OF THE
J. WILLIAM FULBRIGHT FOREIGN SCHOLARSHIP BOARD.

GRANT BENEFITS AND HEALTH COVERAGE CANNOT BEGIN UNTIL ALL REQUIRED DOCUMENTS
HAVE BEEN SUBMITTED AND HAVE BEEN APPROVED BY IIE.


   a. Financial benefits under this grant are limited to those described on the page attached to
      these terms and conditions of award plus a supplemental health benefit policy (see #18
      below) for the grantee only. No additional funds will be provided for the purchase and
      shipment of teaching, research or study materials which a grantee may wish to have to carry
      out the purposes of this award. The fixed sum payment indicated will not be changed after
      the beginning date of the grant unless 1) the length of the grant is altered; or 2) the schedule
      of benefits for all similar grants is increased. Grant benefits cannot be paid for any period in
      which the grantee is in the United States.

   b. The initial payment under the grant will include a one-time or initial start-up expenses
      payment and three months of grant benefits. This payment will be made no more than one
      month prior to the beginning date of the grant or as soon thereafter as possible, provided the
      grantee completes all required forms and notifies IIE of departure itinerary at least six weeks
      prior to departure. Any remaining installments will be paid on a quarterly basis during the
      month preceding the period for which the payment is being made or as described on the
      financial benefits page attached. Information on travel payments is contained below in
      number 4.

   c. Any authorized adjustments in payments will be added to, or subtracted from, the next
      payment. If the final regular payment has been made, a separate payment will be made for
      any funds owed to the grantee. If adjustment following issuance of the last payment results
      in the grantee owing repayment, the grantee is required to make such repayment, by certified
      check to the Institute of International Education, within 20 days of receiving notification of the
      amount due.

   d. For the purpose of determining the amount of the grant, the following three classes are
      considered for accompanying dependents only: zero dependents, one dependent, and, two
      or more dependents. Determination of the applicable dependent group is made at the time
      the grant is awarded but may be altered up to the time of travel under the grant to adjust for
      changes certified by the grantee, provided sufficient program funds remain available.
      Changes occurring after the beginning date of the grant will not affect the grant benefits.
      Dependents allowances are not available for all countries. Dependents for this purpose are
      defined as a spouse or a relative (child, parent, sibling) who is financially dependent on the
      grantee. An accompanying dependent is one who will spend at least 50% of the grant period
      abroad with the grantee. No allowance is provided for any dependent who holds a grant from
      any source.

   e. Deductions from the grant amount will be made for duplicating benefits received from sources
      other than the host government, which may provide additional benefits if the grant is joint.
      Funds provided by any other source will be deducted, if in foreign currency, at the estimated
      exchange rate at the time the grant is issued. Non-monetary benefits (such as housing) will
      be translated into dollar values at the time the grant is awarded, and these amounts will be
      deducted. No applicant may receive concurrently a grant from the Fulbright Student Program
      and a grant from the Doctoral Dissertation Research Program.

   f. Grant duration is established and grant benefits are determined on the basis of half-month
intervals. Duration is the time spent in the country of assignment on the authorized program. Five to fifteen days is considered one-half month. Sixteen to thirty-one days is considered a full month. Monthly stipend funds will not be provided for less than five days in the host country.

2. Grant Obligations

a. Full-time performance of professional duties as described in the Statement of Grant Purpose in the grant application is required; for extended recess or vacation periods in the host country, the grantee will be expected to perform ancillary professional duties as agreed upon by the United States Department of State Public Affairs Section, U.S. Embassy abroad (hereafter the Post), the host institution and the grantee. During host country holidays or vacation time, it is the responsibility of the grantee to continue to pursue their primary or secondary grant objectives to the best of their ability. Acceptance of remunerative employment abroad, unless approved in writing by the Post and IIE, violates the conditions of the grant.

b. Grantees may be required to attend any orientation program conducted for them in the United States or in the host country or region (See #4 below). Expenses related to such attendance are not compensated for in addition to the fixed sum of the grant. Only if grantees and/or dependents are required to attend an orientation program before beginning their trip abroad will they receive a separate orientation allowance.

c. Reports:

The grantee is required to submit periodic and final reports as specified by the Post and the Institute of International Education. Payment of the final month’s grant maintenance will be withheld until the satisfactorily completed final report is received at IIE, even if this follows the grantees return to the United States. All final reports are expected to be filed within three months of grant completion in order to receive final payment.

3. Leave Periods

A. Fulbright Study/Research and ETA grants require a full-time commitment; therefore grant leave which is unrelated to the grant purpose is to be kept to a minimum. The following terms and conditions apply to leave periods; violation of these terms and conditions will result in reduction of grant stipend amounts and may result in revocation of the grant:

1. Leave outside of host country: Leaves during the grant period are limited to recesses or normal vacation periods. The grantee may leave the host country for no more than a grand total of 14 days, including weekends and travel days. Such absence must be approved prior to traveling by the Cultural Affairs Officer or other appropriate officer of the Post, the host institution, and the appropriate IIE world area program manager. Grantees may not leave the host country for other periods, without prior approval by the Cultural Affairs Officer or appropriate officer of the Post and IIE.

2. Leave within the host country: Any travel conducted outside of the primary grant location, but within the host country, must be approved by the Cultural Affairs Officer or appropriate officer at the Post and must be restricted to the guidelines for leave—duration, restricted locations, etc. provided by them.

3. Emergency leave: Should it be necessary for the grantee to leave the host country in the case of extraordinary medical or personal emergency, the grantee can either use part or all of the 14 days leave enumerated in Section 3.A.1., or take unpaid leave time not to exceed 14 days. Grantees must immediately notify the Cultural
Affairs Officer or other appropriate office of the Post, and IIE world area program manager. In the case of a medical emergency, grantees must also immediately notify the health benefits provider (Seven Corners) for approval of coverage outside of the host country. In extenuating circumstances, a maximum of 6 months emergency leave time will be considered for grant suspension.

B. The grant may not be postponed to a subsequent academic year.

4. Travel

A. Pre-Departure Orientation

a. Attendance at any pre-departure orientation that is planned and conducted by the United States Department of State Bureau of Educational and Cultural Affairs (ECA) in the summer prior to a grant (regardless of formal grant start date) may be required. Grantees who fail to attend the orientation, without explicit exemption from the authorized ECA representative, or who fail to participate fully in all of the required sessions will have their grants withdrawn.

b. If a grantee declines his/her grant 2 weeks before the PDO (when costs are nonrefundable) or any time after the PDO without justification/approval, he/she will be held responsible for the costs incurred and billed accordingly. All grantees are required to complete their travel arrangements by the deadline provided by each region (this date will be highlighted throughout the PDO website, as well as on the registration form). If a grantee fails to complete their travel arrangements by the deadline, and has not received prior approval to do so, they will be responsible for the difference between the cost of the travel at the time of the deadline date and the actual cost of the travel post the deadline. This policy will not apply to certain grantees, including upgraded alternates who may not receive notification of their grants until after the deadline date. U.S.-based pre-departure orientations are not planned for all grantees to all countries.

B. Travel Arrangements

a. All air travel and all air shipments paid for with United States Government funds must conform to the Fly America Act, which requires that all such travel and shipments be on “U.S. flag” airlines where such service is available. Exceptions may be available under the US-EU “Open Skies” amendment. Please see the attached Policy for International Flights for Fulbright Student Grantees for further information.

b. Some grantees will be required to book their international travel using the services of IIE’s travel agent. If this is the case, you will be provided with instructions and further information regarding your rights and responsibilities. Any grantee who withdraws following issuance of a ticket will be required to reimburse IIE for all costs associated with the purchase of the ticket.

c. Grantees who are permitted to make their own travel arrangements will be provided a fixed sum in addition to the base allowance described in #1 above, subject to the same stipulations contained therein.

d. The grantee is personally responsible for obtaining a passport and any visas that may be required by the countries in which the project will be undertaken or through which the grantee will pass en route to the final destination. The grant does not provide for expenses related to any passport or visa fees. Such expenses must be borne by the grantee without recourse to claim for reimbursement. The grantee is responsible for making all travel arrangements in conjunction with the grant. The effectuation of a grant is contingent upon availability of transportation, stable conditions in the host country, and the grantee’s ability to obtain a passport, the necessary visas and research clearances.
e. Grantees are required to enter their country of assignment using their US passports, regardless of any others which they may hold, and must represent themselves as Americans for the full tenure of their awards. Failure to do so will result in the immediate suspension and possible revocation of the Fulbright Grant.

5. Contingencies

a. A candidate who, at the time of application, or at any subsequent time prior to becoming a grantee as defined in Section 12a, has been convicted of commission of a felony or a misdemeanor (excluding minor traffic violations), must inform IIE in writing of such fact. Similarly, a candidate who at the time of application, or at any subsequent time prior to becoming a grantee has been arrested for, indicted for, or charged with a felony or a misdemeanor (excluding minor traffic violations), and the criminal matter has not been resolved, must inform IIE.

b. If the candidate has been convicted of a felony, the Board will not select such a candidate for a grant (or, if the candidate has already been selected, the Board will annul the selection) unless the Board is satisfied that the conviction does not represent an absence of the requisite moral and social attitude desired of grantees. Such a determination will be based upon the nature of the crime, the time and place of conviction, and the subsequent conduct of the candidate. A candidate who has been convicted of a misdemeanor shall be eligible for selection unless the Board finds that the conviction represents an absence of the requisite moral and social attitude desired of grantees. Similarly, a selected candidate who has been convicted of a misdemeanor shall have his or her selection annulled only if the Board finds that the conviction represents an absence of the requisite moral and social attitude desired of grantees. Such a determination will be based upon the nature of the crime, the time and place of conviction, and the subsequent conduct of the candidate.

c. If the candidate is arrested for, indicted for, or charged with a felony or a misdemeanor, the application (and, if already made, the selection) may be suspended by the Board until the criminal matter is resolved, or until such time that the Board is satisfied that the arrest or the charges do not represent an absence of the requisite moral and social attitude desired of grantees.

d. Similarly, a candidate who, at any time after becoming a grantee as defined in Section 12a, is arrested for, indicted for, or charged with, a felony or a misdemeanor, must inform IIE in writing of such fact. The grant may be suspended by the Board until the criminal matter is resolved, or until such time that the Board is satisfied that the arrest or the charges do not represent an absence of the requisite moral and social attitude desired of grantees. If a grantee is convicted, the Board may revoke the grant.

e. If an application, selection, or a grant is suspended on the basis of the criteria stated above, and the matter causing the suspension has not been resolved prior to the date set for the commencement of the grant activities, the Board may reject the application, rescind the selection, or revoke the grant, as applicable. Any funds disbursed to the grantee must be immediately returned to the source.

f. Neither the U. S. Department of State, the Post, the J. William Fulbright Foreign Scholarship Board, nor the Institute of International Education assumes responsibility for any injury, accident, illness, loss of personal property or other contingencies which may befall the grantee or his or her dependents during or in connection with the grantee's stay abroad under this grant.
6. Temporary Country Program Suspension

Political instability, natural disasters or lack of personal safety may make it necessary to temporarily suspend a country program or part of that program. Such circumstances may necessitate short- or long-term withdrawal of grantees. A country program suspension may also require that grantees who have not yet begun their grants defer travel until authorized to do so by the U.S. Department of State or seek reassignment.


It is understood and agreed that, if conditions beyond the control of the United States Department of State prevent or unduly hamper the timely and adequate implementation of the grant, the grantee may be reassigned to another country agreed to by the grantee and the grant issuing organization. Financial terms will be adjusted in accordance with the schedule in the country to which the grantee is reassigned. Factors affecting reassignment include timely request, qualifications, time remaining in grant, and timeliness of proposed host country clearance process. In the event such a reassignment is not satisfactorily arranged, the grantee, if abroad, will be provided not to exceed the equivalent of one month’s grant benefits beyond the date of departure from the host country. If the grantee has not departed from the United States and if no mutually acceptable assignment can be arranged all rights and obligations shall cease.

8. Early Termination

A grantee is expected to remain in the host country for the full tenure of his/her award. Any grantee leaving the host country or resigning from the grant at a date earlier than that specified in the Terms of Award, without formally requesting and substantiating the request to the appropriate officer in the Public Affairs Section at the U.S. Embassy, and IIE and receiving the consent of the United States Department of State, will be required to repay grant benefits affected by early departure.

9. Remaining Abroad after Grant Expiration

Because a factor in selection is the expected benefit to the United States of the grantee’s overseas experience, a grantee who remains abroad after expiration of the grant without advance approval will forfeit the return travel entitlement. Approval of any additional period abroad is at the discretion of the Post and the Bureau, and will be contingent upon compliance with visa requirements and any other limitations imposed by the host country. A person remaining abroad after the expiration of the grant will no longer be considered a grantee, and must not continue to represent himself or herself as such.

If a grantee requests and receives permission from a Post and the Bureau to remain abroad after the grant has expired, return transportation may be extended, but any increases in cost of travel after the initial period of the grant must be borne by the grantee.

10. Rights and Responsibilities

a. A person accepting a grant under the Mutual Educational and Cultural Exchange Act of 1961, as amended, is not by virtue thereof an official or employee of the United States Department of State or other agency of the Government of the United States of America, or of an agency of the government of the host country.
b. Grantees are private citizens, retaining their rights of personal, intellectual and artistic freedom as guaranteed by the Constitution of the United States and generally accepted by the academic community. As enacted by the Congress and applied by the laws of the United States, all recipients of Fulbright academic exchange awards shall have full academic and artistic freedom, including freedom to write, publish, and create.

c. Pursuant to the Act, as amended, no award granted by the Fulbright Board may be revoked or diminished on account of the political views expressed by the recipient or on account of any scholarly or artistic activity that would be subject to the protection of academic and artistic freedom normally observed in universities in the United States. The Fulbright Board shall ensure that the academic and artistic freedoms of all persons receiving grants are protected.

d. Grantees are responsible for observing satisfactory academic and professional standards and for maintaining a standard of conduct and integrity which is in keeping with the spirit and intent of the Fulbright Program and which will contribute positively to the promotion of mutual understanding between the peoples of the United States and those of other countries. Grant recipients are expected to obey the laws of the host country.

e. Grantees are expected to satisfy all legitimate debts incurred in the host country.

11. Web-Based Media

Grantees who share their Fulbright experiences publicly via web-based media are responsible to acknowledge that theirs is not an official Department of State website or blog, and that the views and information presented are their own and do not represent the Fulbright Program or the U.S. Department of State. Any grantee who posts inappropriate or offensive material on the Internet in relation to the Fulbright Program may be subject to revocation or termination of their grant (see section 14a below, grounds for revocation 2 and 8).

12. Revocation, Termination, and Suspension of Grants

Grants are subject to revocation, termination and suspension.

Definitions

a. A “grantee” is defined as a selected candidate who has signed the grant document (including all terms and conditions thereof) without qualification and has returned a signed copy to IIE.

b. A candidate who has been selected, but who has not so signed and returned the grant document, is defined as a “selected candidate”. In the event a selected candidate fails to sign and return a copy of the grant document within one month after it has been received by the selected candidate, the selection may be withdrawn by the Board, the Post, or IIE by notice of such withdrawal delivered to the selected candidate.

c. A grant may be revoked, terminated, or suspended. After a revocation, the grantee is considered as not having received the grant and will not be an alumnus or alumna of the Fulbright Program; after a termination, unless otherwise stated, the grant will be considered to have ended when the Board announces its decision to terminate; and after a suspension, the grant will be considered inoperative until a decision is made to reinstate, revoke or terminate the grant.

13. Authority to Recommend Revocation or Termination

A Post has authority to recommend that the Board revoke or terminate the grant held by a grantee who has departed the United States for the host country.
IIE has authority to recommend that the Board revoke or terminate a grant to a grantee who has not yet departed the United States for the host country.

14. Grounds for Revocation or Termination

a. In addition to the grounds specified in Section 5a, grounds for revocation or termination include, but are not limited to: (1) violation of any law of the United States or the host country; (2) any act likely to give offense to the host country because it is contrary to the spirit of mutual understanding; (3) failure to observe satisfactory academic or professional standards; (4) physical or mental incapacitation; (5) engaging in any unauthorized income-producing activity; (6) failure to comply with the grant's terms and conditions; (7) material misrepresentation made by any grantee in a grant application form or grant document; (8) conduct which may have the effect of bringing the Department of State or the Fulbright Program into disrepute; (9) violation of the Policies of the J. William Fulbright Foreign Scholarship Board.

b. In addition, the Board may terminate a grant, unless prohibited by law, if (1) the grantee has exhausted all benefits of the U.S. State Department’s health and accident benefits policy in connection with the grant and continued medical treatment would lead to the grantee’s becoming a public charge, or (2) the grantee requires such protracted medical treatment that successful completion of the grant is jeopardized, or (3) medical information submitted in the application is found to be substantially inaccurate or incomplete. The procedure for any such termination shall be the same as that provided for the termination of grants generally, except that the recommendation for such termination, supported by the corresponding factual information, shall be made by the Bureau (not a host institution, Post, or IIE). In the event any such grounds occur during the period of a grant, it is the Board’s policy that such a grant should not be renewed or extended.

15. Procedure for Revocation or Termination

The procedure for revoking or terminating a grant is:

a. The Post or IIE consults initially with the Bureau of Educational and Cultural Affairs and the Staff Director of the Fulbright Scholarship Board;

b. The Post or IIE prepares a Statement of Fact and Recommendations for Specific Action by the Board and forwards them to the Staff Director;

c. The FSB Staff Director provides a copy of these documents to the grantee and obtains proof of delivery;

d. The grantee sends a written reply to the Staff Director within two weeks of receipt of the documents. The Board may grant additional time for reply if circumstances warrant. The Staff Director will inform the Board if the grantee does not reply within the specified time;

e. The Staff Director provides a copy of all documents to the Post, or IIE for review and to the Bureau for review, evaluation, and recommendation; following receipt of the Bureau's evaluation and recommended action, the Staff Director provides a copy of all relevant documents to the Board.

f. The Board informs the grantee, the Post, the relevant IIE, and the Bureau, expeditiously and in writing, of the Board's decision and the reasons therefore.

16. Suspension
A. The Board, at the recommendation of a Post may suspend a grant pending the procedure for revocation or termination of the grant, or if the grantee is arrested for, indicted for, charged with, or convicted of commission of a crime, either before or after the grantee’s departure from the United States.

B. The Post may suspend a grant if:

a. the grantee ceases to carry out the project during the grant period; b. the grantee leaves the host country for more than two weeks without the prior authorization of the Post; c. conditions in the host country require the departure of grantees for reasons of personal safety; d. the grantee requests suspension of the grant for personal reasons and the IIE concurs.

17. Financial Issues Related to Revocation, Termination and Suspension

Unless otherwise specified by the Board, when a grant is suspended, revoked or terminated, disbursement of any allowances and benefits will cease, except for medical benefits that may be authorized under the Bureau’s accident and sickness program for exchanges; the grantee will also be required to immediately repay any advances in allowances or benefits disbursed for use in the period of time after the suspension, revocation or termination. Unless otherwise authorized by the Board, Bureau, or Post, no further claim for disbursements of allowances or benefits will be honored. This provision shall not apply to grants which are suspended because conditions in the host country require the departure of grantees for reasons of personal safety. The Bureau or the Post will inform the grantee whose grant has been suspended, terminated or revoked of the impact of the Board’s decision on past and future allowances and benefits; the Bureau the Post or the IIE will take the necessary measures to implement the Board’s decision, and to collect any advances in allowances and benefits that must be repaid.

18. Accident and Sickness Health Benefits Policy

As part of the Fulbright award, the United States Department of State provides supplemental accident and sickness health benefits coverage. This health benefit policy is not all-purpose health insurance; it is subject to specific limitations. This coverage is not intended to replace any insurance a participant may already have. Instead, its intent is to supplement existing health insurance coverage and to ensure that a participant’s basic health is protected in a foreign country. Fulbright recipients are responsible for providing their dependents with a health insurance policy that includes medical evacuation and repatriation coverage. It is in the best interest of the grantee to continue their current health insurance policy, as accident and sickness health benefits are not subject to COBRA coverage nor will they satisfy an insurance requirement for credible coverage.

Signature

By my signature, I accept the Terms and Conditions of Award.

_______________________________  __________________________
Signature                                      Date

3/2012