

**HIV/AIDS RISK MAPPING STUDY OF  
MEN WHO HAVE SEX WITH MEN IN JAMAICA**

**FOR  
JAMAICA HIV/AIDS PREVENTION AND CONTROL PROJECT (GOJ/IBRD)  
MINISTRY OF HEALTH, JAMAICA  
OCTOBER 2003**

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This research was made possible by more than two hundred Jamaican Men who have sex with Men. They included facilitators, organizers, respondents, informants and reference sources. Laurence Chang, Brian Williamson and Steve Harvey must be thanked for their hard work.

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## **ACRONYMS**

|         |                                                     |
|---------|-----------------------------------------------------|
| AIDS    | Acquired Immunity Deficiency Syndrome               |
| AIDSCOM | Academy of Educational Development AIDS Project     |
| CDC     | Centre for Disease Control                          |
| CHARES  | Centre for HIV/AIDS Research Education and Services |
| CSW     | Commercial Sex Workers                              |
| GLABCOM | Gay/Lesbian/Bisexual Committee                      |
| HIV     | Human Immune Deficiency Virus                       |
| JAS     | Jamaica AIDS Support                                |
| J-FLAG  | Jamaicans for Lesbians and Gays                     |
| KABP    | Knowledge Attitudes Behaviour Practices             |
| MSM     | Men Who Have Sex With Men                           |
| NGO     | Non-Governmental Organizations                      |

## **EXECUTIVE SUMMARY**

### **1. Introduction**

The community of Men Who Have Sex with Men (MSM) in Jamaica has been identified in the National Strategy Plan of the Ministry of Health (MOH) as a priority target group in the campaign against the spread of HIV/AIDS. This observation is based on MOH surveillance data that has tracked the transmission of HIV/AIDS and the number of deaths from AIDS by sexual orientation. Few studies have been done on the MSM population. An Internet search done in 2003 for “Jamaica and Homosexuality” yielded 6,470 websites, most dealing with homophobia and discrimination in Jamaica. The need to investigate this priority group was correctly identified by the MOH as an important input in their campaigns. (See Appendix A: Terms of Reference.)

The general objective of this risk assessment study was to ensure:

- That MSMs are profiled, their number estimated, their geographical distribution, their meeting places determined, and informal networks identified.
- That their needs for HIV/AIDS prevention interventions are determined including preliminary estimate of condom use
- That an intervention is conducted among those MSMs involved in the study to assess the effectiveness of at least one intervention.
- That strategies to increase consistent condom use and MSMs demand for health services in particular STI treatment, voluntary testing and counselling and STI/HIV prevention education are developed to ensure that such service are effectively delivered to them.

The consultant or team of consultants were required to:

- Review other studies concerning MSM to assess recommended strategies and how these can be incorporated into the existing study.
- Identify MSM specifying the categories (if necessary) using informal channels of contact:
  - talk to MSM
  - work with existing groups/individuals that have targeted or are involved in targeting such groups for similar interventions
  - use MSM to find out how to contact other MSM
  - find out about informal networks
  - find out about MSM who are commercial sex workers (CSWs)
- Conduct a Needs Assessment Analysis among those identified to determine their level of need for HIV/AIDS prevention intervention and the type of intervention required:

- Use qualitative approach (in-depth interviews or focus groups to analyse and prepare a report of the findings)

Although the Terms of Reference did not mention a survey questionnaire, based on a request from the MOH, the Consultant and Team included one. This replaced the development and testing of an intervention, although the respondents discussed and recommended interventions.

## **2. Methodology**

The methodology included a three pronged approach as follows:

- Ten confidential interviews were conducted in order to collect as much cultural and social information as possible.
- Six focus groups were organized in four locations throughout the island, based on the information from the interviews, the Ministry of Health's surveillance data and the previous experiences of the members.
- Questionnaires were administered, both within small group settings and individually, with assistance from the Facilitators.

## **3. Findings**

### Profile of Target Population

- The results of this study indicate that the population of Men who have Sex with Men (MSM) in Jamaica is large and heterogeneous. In their wish to survive and to succeed in turbulent economic and social times, many of these men have carved out niches and subgroups within mainstream groups. At the same time, there are many who are too "out", too effeminate, and too articulate to be ignored. These men cause discomfort and dissonance to the rest of society.
- The literature, focus groups, questionnaires and confidential interviews revealed that a majority of the MSM population are or have been sexually involved with women, even though many of these same respondents self identify as exclusively homosexual. Thus, sexual orientation and gender identity evolved as two separate issues in this sample, indicating emotional inclinations and actual behaviours as separate components.
- Bisexuality is denied and denigrated in Jamaica, both by the MSM population and by heterosexuals. But it was directly and indirectly present in the results of the study. It inspires derision from men who identify as exclusively homosexuals as well as fear, due to the power, authority and social status that it emanates. Power due to the

need for at least one partner to present a charade and control several partners, and social status, because in many cases, they were referred to as “dem men” from uptown who hide, deny and operate in the shadows.

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- Many of those sampled did not use the word homophobia (which is part of the heterosexual vocabulary). They spoke more of detailed manifestations of discrimination or abuse. They did not seem preoccupied with the political or cultural propaganda. But they did relate a litany of transgressions from organisations, caretakers and social institutions that were supposed to protect them. Verbal and physical abuse from the police, the outside community and by their own men is a concern. This makes life and relationships vulnerable and fragile so that it actually negates any intentions for long-term or safe relationships.

### Geographic Locations and Social Settings

- As in many countries throughout the world, most MSMs in Jamaica are drawn to the cities and big towns. This urban drift allows them to be freer and more able to gather, socialize and conduct their lives, seeking “separate identities” in perilous times. Thus, location of residence and places of socialising were concentrated in big towns and cities, especially Kingston and Montego Bay.
- The actual number of MSM groups and sub-groups was difficult to assess since this was referred to in vague, secretive terms. But since respondents each claimed to know several hundreds of their own or sub-group through social situations, it could be extrapolated that each of the three urban areas investigated (Montego Bay, Kingston and Ocho Rios) as well as other urban centres have populations of several thousands. Add to this the larger number of hidden or bisexual men spread throughout the island and the total could be between 100,000 and 120,000 – which is in keeping with the international estimate of 5-10% of the male adult population.
- In the urban areas, many MSMs frequent numerous mainstream clubs and events. There is only one “occasional” gay club. In more rural settings, private parties and secret dates are the norm, as well as bisexual arrangements that conceal MSM activities.

### Need for HIV/AIDS Prevention Interventions

- Knowledge of HIV/AIDS and especially regarding protection against HIV/AIDS was high among this sample, but KABP studies in Jamaica result in high knowledge among the general public. On the other hand, respondents admitted to risky behaviour and this was confirmed in the survey data.
- Conversely, there was a high perception of personal risk indicating that either some form of intervention had sensitised them to risk-taking and safe sexual behaviours, or as was reflected in other results, the fact that they were gay heightened their perception of personal risk to HIV/AIDS.

- Discussions concerning interventions resulted in specific examples of activities and campaigns that targeted the MSM community and spoke in terms that identified their needs such as lubricants, condoms, oral, anal and vaginal sex, as well as non-penetrative forms of sexual activities.

### Strategies to Increase Condom Use and Demand for Health Services

- Strategies presented were based on suggestions of the participants. It should be noted that some of the literature promote other forms of sexual activities such as non penetrative sex as the primary intervention; while use of condoms and education are considered the secondary line of defence.
- Use of condoms among this sample was erratic, with more condoms used with casual partners, and less with steady partners and women. The study identified some reasons for this and indicated some solutions.
- Most of those sampled used private doctors and NGOs, and got condoms and lubricants from pharmacies and NGOs. Some used specific clinics and named doctors known to be accepting of, or comfortable with the MSM Community. These individuals are trusted by the MSM community and are important as gatekeepers.

### Strategies Recommended

Creating and increasing trust between the MOH's/GOJ's programmes and the MSM community is important at this stage. Recognising and acclaiming their pioneering work in HIV/AIDs prevention from 1986 through the Gay Freedom Movement and later the embryonic Jamaica AIDS Support, would extend and improve the relationship between the MOH and the various MSM groups in Jamaica.

- The main strategy recommended was that representatives of the MSM communities be involved in the design of specific interventions aimed at MSM target groups, and that these interventions not be generalised but relate in detail to their needs, lifestyle, culture and sexual practices.
- The secondary strategy depends on the named gatekeepers who are a network of care and services. These include fifteen private doctors and several individuals from the Comprehensive Clinic in Kingston and the Type 5 Clinic in Montego Bay.
- NGOs who have traditionally cared for the MSM community provide channels of communication and referral, as well as innovative means to involve those groups who will not meet in public nor with their own. These include promotion of non anal sex and non penetrative sexual activities.
- The training of health care providers and tertiary students in Sexuality and Sexual Identities, both within in-service programmes and at the University of the West Indies, would provide a more empathic cadre of professionals for the future.
- Working with sectors such as the Tourist Industry, Arts and Music/Entertainment Industry, the churches and tertiary institutions, to sensitise personnel and affirm the human rights of the MSMs could provide a more positive environment for this large section of the Jamaican population.

## A. BACKGROUND

The community of Men Who Have Sex with Men (MSM) in Jamaica has been identified in the National Strategy Plan of the Ministry of Health (MOH) as a priority target group in the campaign against the spread of HIV/AIDS. This observation is based on MOH surveillance data that has tracked the transmission of HIV/AIDS and the number of deaths from AIDS by sexual orientation. Few studies have been done on the population. A 2003 search for “Jamaica and Homosexuality” yielded 6,470 websites, most dealing with homophobia and discrimination in Jamaica. The need to investigate in an objective way this priority group was correctly identified by the MOH as an important plank in their programme, and this was confirmed by the HIV/AIDS Baseline Assessment funded by the InterAmerican Development Bank, July, 2002.

Studies done in Cuba, Costa Rica, the Dominican Republic, and Mexico have identified a wide variety of MSM groups ranging from exclusively homosexual, to transvestites, drag queens, bisexuals, and men in transactional relations. Each group develops survival strategies including their own language and modes of survival which can often be complex depending on the level of homophobia and discrimination in the wider society. In order to identify MSMs in Jamaica therefore, and the impact of HIV/AIDS on this community, it is important to determine the construct of social and economic factors that affect the MSM population. This includes their individual behaviour related to sexual activities, types of relationships, profile of various groups within the MSM population, their access to STIs/HIV/AIDS services, their gender identification, their sexual orientation and their geographical location.

HIV/AIDS is of special concern in Latin America and the Caribbean since its estimated 2% prevalence among adults is second only to that of sub-Saharan Africa's 8% (*Lancet* 2000, Voelker 2001). HIV/AIDS seems to be spreading more quickly in the Caribbean than in Latin America. A Christian Aid report states that while new infections represent 0.02% of the Latin American population, they were 0.18% of the Caribbean population. Indeed, in the English-speaking Caribbean, AIDS is the leading cause of death among 15-45 year olds (Christian Aid 2001). Jamaica was the location of the first diagnosed case of AIDS in the Caribbean, in 1982. In 1985-1986, Murphy *et al* (1988) calculated a seroprevalence rate of 15% among 123 homosexual and bisexual men in Kingston. By 1987 there were 32 reported cases of HIV/AIDS. Although HIV/AIDS initially struck homosexuals and bisexuals, heterosexual transmission played a more important role from the mid-1980s on (Hassad 1993). By 1991, new reported cases had quadrupled to 134, and cases in women were closing in on men's (Mann *et al* 1992, Hassad 1993). The cumulative national average rate of AIDS cases between 1982 and 2000 was 196.1 per 100,000, and the estimated rate of infection between 1% and 1.6% (Campbell & Campbell 2001). AIDS is now an urgent public health concern in Jamaica as it is the second leading cause of death for men and women between ages 30-34 (Campbell & Campbell 2001).

## **B. TERMS OF REFERENCE**

The general objective of this risk assessment study was to ensure:

- That MSMs are profiled, their number estimated, their geographical distribution, their meeting places determined, and informal networks identified.
- That their needs for HIV/AIDS prevention interventions are determined including preliminary estimate of condom use
- That an intervention is conducted among those MSMs involved in the study to assess the effectiveness of at least one intervention.
- That strategies to increase consistent condom use and MSMs demand for health services in particular STI treatment, voluntary testing and counselling and STI/HIV prevention education are developed to ensure that such service are effectively delivered to them.

### Outputs

In close collaboration with the component Director for HIV Prevention and liaising with other parties deemed relevant the consultant or team of consultant is expected to perform the following tasks and produce the following outputs:

- Risk Assessment Map of Men Who Have Sex With Men (MSM) indicating their estimated number, their level of condom use and the existence of informal network among them.
- Needs Assessment Analysis of the identified MSM.
- Detailed strategies to increase the demand of MSM HIV/AIDS/STI intervention services and to effectively deliver such services to them.
- Number of type of MSM participating in specified intervention and their level of participation.

## C. METHODOLOGY

The confidential, in-depth interviews with informants were conducted before the field work in order to validate focus groups guidelines and the survey questionnaire, to seek out new areas and to get a general perspective of the MSM community in Jamaica. These interviews were conducted in privacy but several cross cutting topics continued to emerge that concerned the informants. They were; modes of survival as MSMs, professional/religious/marital concerns, their relationships with their families and the social lives carved out of a dangerous environment. Ten confidential interviews were conducted in order to collect as much cultural and social information as possible.

Participants in the confidential interviews were opportunistically chosen although there was an attempt to vary age and social class. Most of them were employed, had tertiary education, and a general sense of the community island-wide. They included: three 22 year olds, two men in their thirties, two in their forties and two in their fifties. Two of the participants had been or were involved with women. One intended to marry and have a family. Religion was important to at least four, one being an active member of an evangelical church and another, a former member of the Ethiopian Orthodox Church.

Six focus groups were organized in four locations throughout the island, based on the information from the confidential interviews, the Ministry of Health's surveillance data and the previous experiences of the members. Venues were selected that were known as "safe places" for the men to enable them to relax and discuss sensitive issues. Protection of the identity of participants is mandatory to an effective sampling strategy. This also directly impacts the ability to generate transcripts for content analysis. The traditional methods of videotaping/audio taping and transcribing such tapes for content analysis were not possible. Therefore, note taking during the session by trusted members of the research team, (a generally accepted practice with such populations,) was the method used to record information. This qualitative data was analysed and compared to the data gathered through the interviews, literature and survey questionnaire.

A pre-tested, pre-coded questionnaire was administered individually to persons attending each focus group and separately to men who were reluctant to participate in group settings. This captured a select number of key variables and demographics. A total of 165 interviews were completed. 34 were separately administered by an interviewer and the rest were completed by respondents in a group setting, with the assistance of a facilitator. The criteria for the selection of respondents were based on the facilitators' knowledge of the MSM community and networking within the community in order to access a variety of respondents. The validity of these selection criteria was borne out by the fact that of 186 questionnaires only one was completed by a self-identified heterosexual.

- 186 MSMs turned out to participate in the groups
- Six groups were convened four in rural/urban towns, which included men from Montego Bay (2 groups), Ocho Rios, Mandeville and two groups in

Kingston and St. Andrew at different locations, and with differing sub-groups

Occupational levels varied and included management executives, students, cooks, persons in commercial sex work, service workers, gardeners, and some unemployed. Efforts were made to vary socio-economic class, age and educational level.

### **Facilitators and Participants**

- Four facilitators were selected from the 4 main geographical/social categories: rural, urban (2), rural/urban (tourist oriented). This included a variation of socio-economic groups, especially in the Kingston area in an attempt to cover the wider population and to identify groups not connected to organisations or formal groupings.
- Their basic qualifications included the ability to organise groups, to take detailed notes, to submit reports on time and, most of all, to have the trust and credibility of the MSM community, and to have immediate access to the target groups.
- Participants were invited from a wide net of persons, particularly in the areas where it was felt that there is a geographic cluster or likelihood of regular MSM congregations.
- Based on the preliminary confidential interviews, certain categories were included that may not disclose themselves or are invisible, except to their partners or like-minded men. These include transvestites, bisexuals, beach boys, drag queens, persons in transactional relations.

### **LIMITATIONS**

#### 1. Focus groups:

- a) Due to the length of the survey questionnaire and the need to explain certain concepts to the respondents, time taken for this activity ranged from 2 to 2½ hours, which left less time for focus group discussions and in some cases, appeared to detract from in-depth discussions.
- b) In the question regarding "partners", some participants said that this was irrelevant to them since they did not have a partner, meaning a partner during that particular time. The Interviewer/Facilitator had to breakdown the concept into time periods e.g. 6 weeks or 6 months previously. Also, the interpretation of "partner" was a "significant other" who was a permanent fixture and possibly sharing residence. The respondents also noted that there were no questions which asked whether they had 2 partners of different sexes – indicating that the permutations of relationships were even wider than originally perceived.

- c) Some respondents indicated that they were uncomfortable answering certain questions in the questionnaires that “were giving out too much information on me”. The result was that some returned questionnaires with specific sensitive questions unanswered.
- d) The lead Facilitator noted that several of the respondents who were known to have been involved in transactional relationships or who were commercial sex workers, did not self-identify themselves in these categories. Thus the data for transactional relations and commercial sex workers (CSWs) under-reports the number of men involved in such relationships.

## 2. Survey

- a) Given the clandestine nature of the target population, it was not possible to sample randomly, therefore, the representativeness of the sample is not known. Persons included in the sample represent those who are known by the Facilitator and the contact person to be from the community. Although efforts were made to illicit information from MSMs who are secretive about their sexual orientation (separate interviews), this cohort in the majority were reluctant to be included.
- b) There were significant levels of missing data especially for more sensitive questions. This had been explained previously in the section on method and reflects the ability of questionnaires to probe so far and no further.
- c) Pre-testing of the questionnaire was confined to reviews by several persons within the community and by resource persons because wider pre-testing would have reduced the sample size. However, in spite of the intensive review, some questions were perceived by the respondents to be ambiguous or incomprehensible.

## D. REVIEW OF EXISTING STUDIES

*“...the flood of Caribbean (gay) fiction while there’s a dearth of academic material.... Novelists can take certain risks under the guise of artistic freedom whereas academics have to be concerned with reputation and tenure, if not homophobic victimization. Besides which, it requires that the scholar be sufficiently secure in his/her sexuality, or at least open-minded enough to even broach the subject.”*

Laurence Chang. Founder of the Gay Freedom Movement (1977), Co-founder of Spectrum (1987), Co-founder of Jamaica Aids Support (1991), Founder of J-Flag, Human Rights Activist, Writer and Presenter of “Separate Identities”, Washington, D.C. Source: email to Heather Royes, dated June 12, 2003.

### 1. The Existing Research

This literature review covered concepts and variables that were relevant to the study. Since there were few studies that related directly to MSMs in Jamaica, It was necessary to look at work done in the region and elsewhere in order to indicate the definitions and results in the literature, and to avoid interpreting the results in a vacuum.

#### a) Size and Scope of the MSM Population

The few studies on the MSM population in Jamaica have provided crucial information on homosexual and bisexual male sexual behaviour and implications for public health strategies. Royes (1993)’s foray into MSM’s “social, cultural and sexual realities” to formulate appropriate prevention and targeting strategies was the first to show the wide scope of MSM in Jamaica, as well as the link with the heterosexual population. Her work revealed that MSM ranged across all social classes, age groups and socio-economic statuses in Jamaica, and that **most** MSM were bisexual. Jamaica’s Ministry of Health recognised in the late 1980s that there was virtually no data on the homosexual and bisexual population and that research was needed, given the shift of HIV/AIDS into the heterosexual population. Still, there has been relatively little research. As late as 2001 Campbell & Campbell noted the scarcity of literature specifically on MSM, and Norman stated that “adequate and reliable demographic data on MSM in Jamaica are unavailable.” Her own study calculated 110,960 gay and bisexual males in Jamaica between the ages of 15 and 49 (Norman 2001), a number that suggests the need for sustained attention.

Other statistics clearly show the need for greater understanding of male sexual behaviour in the Anglo Caribbean. According to the Ministry of Health, only 3.6% of AIDS deaths were of men who identified as bisexual,

but the “unknown” category was 25%, and 86% of these “unknowns” were men (Ministry of Health 2000). Many men were therefore unwilling to report their sexual behaviour. And a subsequent study reported that “one out of every fifteen men reported with AIDS had sex with both men and women” (National HIV/STI Control Programme 2001). These statistics suggest that men who have sex with men are more numerous than it would appear, that they are unwilling to identify as such, but that they are certainly being infected with HIV/AIDS and therefore are almost invisible victims. The statistics also indicate that bisexuals are a bridge to the population of women and children and are an important nexus for the spread of HIV/AIDS.

#### **b) Profile of MSM Community**

A complicating factor has been the emergence from Royes’ research of at least three categories of MSM (there were further subgroups, according to age and socio-economic status):

- men who identify as gay
- men who identify as bisexual
- men who identify as heterosexual but who also have sex with men.

This was confirmed years later by PAHO which estimated that 17% of MSM in some Caribbean countries did not consider themselves homosexual (Voelker 2001). Royes concluded that “Jamaican male sexual expression [is] a fluid range of possibilities which are not necessarily bound by restrictive terminology” (1993: 16), a reality that had to be matched by research, targeting and prevention strategies. This is already well known in Latin America where research has shown a variety of arrangements around sexual identities, sexual behaviours, and gender stereotypes. Informants have self-identified as bisexual, transsexual, transvestite, homosexual and more (for example, AIDSCAP 1997 in the Dominican Republic). The 2002 figure of 80% of Caribbean AIDS cases owing to heterosexual transmission (Mayorga 2003) is contradictory in view of other data from the region. Latin American figures, excluding Central America and the Hispanic Caribbean, range between 30 and 50% (Mayorga 2003). PAHO’s figure of 10% of cases owing to homosexual and bisexual transmission in the Caribbean is widely accepted as an underestimate (Voelker 2001). The definition or categorisation of homosexuality has generally been a problem in the study of priority groups for HIV/AIDS policy and interventions, and has probably led to some of the conflicting data (Gonsiorek 1991).

#### **c) The Impact of Cultural Beliefs, Gender Roles and Homophobia**

Research shows the impact of Jamaica’s cultural reality on HIV/AIDS transmission. Cultural ideas about gender roles, for example, have important implications. The receptive partner is usually considered the

“woman” (usually the younger partner, and/or with less social and economic status) and, as in wider society, has a more submissive role than the insertive, “masculine” partner. That is, “there is that perception in the gay community that the person who is fucked is the weaker person... the ‘woman’...it tends to be equated to a female role” (HOPE 1995a: 7). We see parallels in the rich data on Latin America, which tells us about the dichotomy between the *activo* (insertive) who is also the more dominant partner, and the *pasivo* (receptive) (e.g., Carrier 1995 in Mexico, Caceres & Rosasco 1999 in Peru). Since the insertive partner holds virtually all the power in the relationship, the receptives are not in a position to demand condom use (HOPE 1995a, Royes 1999). In general, receptives have been found to engage the most in high risk behaviour (HOPE 1995b). Paradoxically perhaps, focus groups suggest that all MSM do want to be receptive on occasion, but are too embarrassed to admit this to their main partner, and therefore seek other men with whom to assume this role (which again could contribute to HIV transmission) (HOPE 1995a).

The most important cultural influences on MSM and transmission of HIV/AIDS are the attitudes and beliefs about homosexuals common to Jamaican society. Homophobia is the most lethal. Intolerance by Jamaican society of homosexual behaviour takes a toll on homosexual relationships. Lack of institutional support means that men are left to themselves to work out problems and issues that heterosexual couples can take to a counsellor, pastor, family member etc. The intolerance makes instability in relationships, multiple partners and riskier sex that much more likely (Royes 1993, HOPE 1995a).

Homophobia also leads to dangerous denial. Some MSM claim heterosexuality, as the figures above have suggested, but still engage in sex with men, often unprotected, since HIV/AIDS is believed by many to be a “gay disease,” and because they are often in real emotional turmoil that precludes sensible decision-making (HOPE 1995a). Others claim bisexuality. One of Royes’ informants explained that “society demands that a man should have a woman. To be labelled as gay or homosexual is a name no man likes. So, as a result, men resort to play the game with same-sex and opposite-sex activities” (1993: 11). Bisexuality confers a degree of acceptability among family and friends, but the “game” contributes to HIV transmission in two related ways, by potentially infecting their wife/girlfriend through unsafe sex practices, and through the men’s perceived lack of need to engage in safe sex with any of their partners since the “gay disease” cannot affect them. This last point is seen in Royes’ (1993) study, which reported that since older bisexual men did not believe themselves to be gay, they may not feel at risk of HIV. A later study discovered that some bisexual men do use condoms with their male partners, but not with their female ones (HOPE 1995a).

Homophobia, fuelled by religious hostility, can also lead to feelings of guilt and a fatalistic attitude towards HIV/AIDS. These are dangerous emotions

because they can coalesce into disregard for safe sex practices since the men feel they “deserve” God’s punishment (HOPE 1995a). Shame perhaps explains informants’ emphasis on homosexuality as an occasional indulgence rather than a “major life style pattern” in an early study of homosexual and bisexual men (Whitehead 1976: 124). Other cultural notions impact on transmission. The Jamaican understanding of what homosexuals “are like” leads many MSM to “honestly” believe that they are not homosexual, according to Royes (1993). Notions that homosexuals are effeminate and are the “receptives” in anal sex (Voelker 2001) for example, allow many MSM who do not fit these criteria to deny they are homosexuals.

**d) Risk and Behaviour Change**

Most gays and bisexuals did not think they are at greater risk than other populations since HIV/AIDS affected their population early and they have made efforts to educate themselves about the disease (HOPE 1995a). Some do think however that those bisexuals who continue to believe in HIV/AIDS as a gay disease are at particular risk. One study found that while bisexuals believed they were at greater risk than homosexuals, they did not think they were more at risk than heterosexuals (HOPE 1995b).

Studies have also revealed the mythology surrounding HIV transmission, although there is evidence that their salience is waning. HIV was believed to be transmitted by semen in pools, by sweating, shaking hands and sharing toilets (Hassad 1993, HOPE 1995b). Royes was told by informants that “men who have sex with women can’t get AIDS,” and “if you look healthy you don’t have HIV or AIDS” (1993: 9). Hassad’s informants also believed that prayer, antibiotics, food and rest could cure HIV/AIDS. One 1995 study suggested that myths had declined in significance, although some did remain (HOPE 1995a).

More worrying findings are that although there has been some behaviour change and increased awareness since the epidemic, the *commitment* to changed behaviour was dubious. Royes (1993) found that although knowledge of condoms was high, their use was erratic. While over 90% of informants in a later study endorsed condom use as an effective way to reduce HIV infection, only about half were actually using them (Hassad 1993, HOPE 1995b).

**e) Commercial Sex Workers**

A recent study considered MSM under the rubric of sex work. Although there were only 4 MSM (and two men who sold their services to women), compared to 21 female sex workers, results pointed to the need to approach MSM as a heterogeneous group. Their results were sometimes at odds with previous studies. For example, they did not suffer from feelings of guilt or low self-esteem noted in other research. They did not

believe that homosexuality was worse than any other “sin,” and had high self-esteem, judging from their opinions on their own attractiveness. The researchers considered MSMs “a particularly vulnerable group” (Campbell & Campbell 2001: 100), due primarily to low use of condoms and other safer sex practices as well as the violence sometimes involved in their transactions.

Poor job prospects and a need to survive were cited as the main reason more young men are turning to prostitution (Taylor, Gayle & Grant 2002). This study which focused on young men below 18 years working in the sex industry, revealed that more teenage boys between 15-17 years are engaging in prostitution and that there is a growing demand for male prostitutes by both men and women. With limited education, these young men view prostitution as a way to gain quick cash (up to \$20,000 per week) to support a lifestyle of fashionable clothes and expensive jewellery. “We...like wearing the finest clothes and eating well so we’ll sell our bodies to maintain our lifestyle.” Clients are mainly wealthy upper class to middle class, male and female, some of whom are married. They usually make contact at night clubs, beaches, massage parlours, gyms, and on the street and many have regular clients.

## **2. The Construct of Homosexuality in Jamaica**

There is some explanation of the complexities of male sexual behaviour and identities suggested in the studies noted above in the research on masculinity that has emerged in the past decade in both Latin America and the Caribbean. Paternostro explains that in Latin America, “The man who is most macho fights harder, drinks harder, fathers more children, fucks anything...In a culture that sees men as superior beings, fucking a man is the ultimate proof. Having sex with a woman is not at all impressive. Having sex with many women is somewhat better, but having sex with a man is the uttermost expression of manhood” (1998: 136-7). Given the focus on male-male relationships as the fundamental expression of masculinity (see Ramírez & Casper 1999, Lancaster 1995), it may not be surprising that in Latin America male-male sex is often considered an indicator of true manhood, as long as the man is the *bugarrón* (Paternostro 2000) (de la Torres 1999, Lancaster 1992.) Probably the closest and most insightful study in the Caribbean was the 1996 research done by Tabet, deMoya, Holmes et al which looks at 354 men. Several main sexual identity groups emerged, and receptive anal and oral intercourse were commonly reported by men self-identified as cross-dressers or exclusively homosexuals. Another provocative result was that sexual contacts with women were also commonly reported although consistent condom use was infrequent.

While masculinity here is similarly “homosocial” (Kimmel 1996: 15-6), it is also virulently homophobic, what Chevannes calls an “anti-homosexual heterosexuality” (1999: 30), unlike Latin America, where Lumsden says “homophobia, insofar as it implies fear of same-sex sex, is a problematic term to apply to Cuban (and Latin American) machismo” (Lumsden 1996: 32). But in the

Jamaican and Anglo-Caribbean case, stemming in part perhaps from colonial society's feminisation and infantilisation of the black man (Beckles 1996: 10), and from biblical injunctions against homosexuality, an essential part of being male is the "propulsion to early heterosexual relations driven by the fear of being branded a 'batty man'" (Chevannes 1993: 29), and one's vocal, and if need be, violent denunciation of homosexuals and homosexuality. All males – from 6 year olds (Bailey 1998) to street children (Robinson, Bain & Thompson 2001), to leading DJs – understand that "all battyman must get beating" (HOPE 1995a: 5).

Although it has been convenient to consider homosexuality a foreign import (see Royes 1993: 3-4), Kerr (1952) makes an early passing reference to it in her discussion of "Sex and Marriage" in Jamaica, pointing to Pocomania groups that were exclusively homosexual, male and female (1952: 89-90). Further, if Martinique's example is any indication, it is not inconceivable that male-male sexual relationships were a feature of plantation life, as strongly hinted by the diary references of a nineteenth century French planter to one of his male slaves (Forster & Forster 1996). The historian Ronald Hyam (1990) claims that sexual practices, including homosexual ones, were integral to the development of the British Empire at least. Lesbian relationships in early twentieth century rural Jamaica were common according to the numerous stories of Makeda Silvera's (1992) mother and grandmother about local "man royals and sodomites" (lesbians) in their village. Whitehead (1976) found a network of homosexuals in Kingston in the 1970s, a time Royes (1993: 4-5) tells us, when they enjoyed a period of freedom and visibility. And MSMs report that despite the loud public condemnations of homosexuality, in private many people are sympathetic and supportive (HOPE 1995a).

Kerr says that in the minds of her informants, homosexuality was firmly associated with Kingston, a rural equivalent of its association with "foreign" noted by Royes (1993). Silvera states that there was a "shameful silence" surrounding lesbianism in her village, and that lesbians were sometimes "punished" through ostracism, and on rare occasions, by gang rape (1992: 524). Already noted is Whitehead's bisexual subjects' ambivalence about their behaviour. Chevannes observes that homosexuals are allowed a space within homophobic societies as long as they avoid "sexual indiscretions and maintain a curtain of privacy around their sexuality" (2001: 221), and that their sexuality is controlled through ridicule and labels that symbolically reduce them to the status of women. This historically ambiguous relationship to homosexuality explains the reports by subjects in the above studies, where men will tick "unknown" or "heterosexual," or choose bisexuality to distance themselves from homosexuality. It also explains the lack of research on the subject in the region (Chevannes 1993) as homophobia may prevent researchers from considering it a subject worth serious academic attention, and/or discourage potential informants from discussing it.

Homosexuality or homosexual behaviour is approached indirectly in Caribbean Studies, either as a small subsection of a larger issue, for example, in Kerr's (1952) research on sex and marriage, in which homosexuality is afforded scant paragraphs, or, as in Kempadoo's (1999) Caribbean-wide survey of tourism-

related prostitution, in which there are very few references to homosexual prostitution, the exceptions being Mullings on Jamaica, Cabezas on the Dominican Republic, and Martis on St Maarten and Curaçao, although it is quite clear that male sex work is on the increase (Campbell & Campbell 2001, Royes 1993). Or it is considered in oblique, relational terms by considering, for example, what homophobia reveals about Caribbean society, rather than as an issue in itself (see, for example, Chevannes 2001). There may be a shift in the making, however. Recent exceptions to the above are Chin's (1999) discussion of representations of homosexuality in Caribbean literature and Jamaican popular culture, and a volume of the journal *Small Axe* devoted to gender and sexuality that included Lokhasingh-Meighoo (2000)'s research uncovering the homoerotic subtext of Indo-Caribbean identity, and two commentaries about gay activism and homophobia in Jamaica (Glave, Williams). The Anglo Caribbean lags behind the Hispanic Caribbean, where many books and articles have been published on homosexuality in Puerto Rico, the Dominican Republic and Cuba (e.g. Ramírez & Casper 1999, de Moya et al 1992:5. Bejel 2001, Leiner 1998, Lumsden 1996). The entire Caribbean is itself leagues behind the scholarship on homosexuality in Latin America. Mexico (Carrillo 1999, Carrier 1995), Brazil (Parker 2000, Kulick 1998), Peru (Caceres & Rosasco 1999) and Costa Rica (Schifter-Sikora 1998, 1999a&b) are only a few of the countries that have been studied.

Where homosexuality in the Caribbean is being broached most bravely is in the literary field. Recent years have seen a surge in fiction involving gay characters. While homosexuality, if mentioned, has typically been cast as foreign and unnatural (Chin 1999: 17, speaking of Claude McKay and Paule Marshall), more recent writers have "cleared a discursive space for the articulation of an 'indigenous' gay/lesbian subjectivity" (Chin 1999: 27). Michelle Cliff's (1991) *Abeng* pioneered the use of a non-heterosexual orientation in a Caribbean novel. Describing a girl coming to terms with her sexuality, she exposes Jamaica's homophobia and rejects the notion of homosexuality as foreign contamination. The Vincentian H. Nigel Thomas (1994) tells the story of a man who eventually comes to accept his homosexuality despite his country's heterosexism. Patricia Powell (1994) writes a sensitive novel about a gay Jamaican man facing the deaths of his friends and lovers from a fatal illness. There are many other Caribbean writers directly addressing homosexuality in their works. In fact, an anthology of these works from across the Caribbean will soon be published (Glave, forthcoming). Other works include Jamaica Kincaid's "My Brother" (1997), which details her personal experience of caring for her brother who was dying of AIDS in Antigua; and "Aenid's Sin" by Lawrence Scott (1998), winner of the Commonwealth Book Award, which portrays vividly the experiences of a young Trinidadian who aspires to be a Monk in the Roman Catholic Church while dealing with his homosexuality.

## E. FINDINGS OF FOCUS GROUPS AND CONFIDENTIAL INTERVIEWS

### Profile of MSM Communities

Most of the participants in the focus groups described themselves as straight-gay or exclusively gay. But they said that there were many people who they knew that do not feel the same way. Those persons felt doomed and cursed, said they did not know many people who felt the same way about themselves. They listed the reasons they were different because their socialization is different, economical constraints and sexual preference. They described these people as *closeted, shy, living in denial, afraid, cautious and curious*. There were persons who thought that those people don't necessarily gather, while others gathered freely at clubs, restaurants, churches, JAS and many mainstream clubs and public places.

*“We have an extensive language. A very private language. The reason for this is like the slaves’ language during slavery.....”*

Several groups described other categories of men known to them in detail, using not only gay language but gay creole descriptions. (See Glossary of Jamaican Gay Terminology). They included:

*“Bisexual man, straight-gays, butch, heavy-act, fem, woman, man, convenient gay, tun back sport, closeted sport, drag queens, flip-flop, boatie, top, bottom, street-sport, terrible sport, country-sport.....”*

Another group was more specific about the categorization and described them as follows:

*“Right out batty man, closet batty man, bisexual man, men wid long dicks and man wid small dick, man wha only fuck and man wha only tek fuck, uptown sports and downtown sports, country sports and town sports, tun back sport, real woman, sports wha sell crotches, married sports, heavy hot, drag queen, ole time sport, sport what a tief and murders, prison bud sports, boatie”*

Yet a third group described the categorization of other men in derogatory terms:

*Some persons who are ‘out’ and did not care about exposing themselves or others to the detriment of others, predatory gays, who abuse young boys, those who want to be preyed on for money or pleasure, homophobic homosexuals who are violent towards gays, persons with an insatiable sex drive that leads them to promiscuity, obsessed and possessive men, straight men posing as homosexuals who*

*'out' you for financial gain, embarrassment etc. with no real plans to have a meaningful gay relationship.*

It was evident from the focus groups that there were numerous sub-groups, which could be identified by both gender identity and sexual orientation, as well as perceived social behaviour.

There was a tendency to refer to other groups negatively or with derision, especially "dem men" or those more privileged and closeted gays who live in comfort and were usually bisexual. Numbers of groups and communities were not reported and the respondents seemed vague and suspicious of such questions. They did refer to sub-groups of "a few hundred" but did not seem to know beyond their clique. Extrapolating from this, it would appear that there are several thousand MSMs in Kingston and Montego Bay "known" to their communities, with an even larger amount of closeted or bisexuals who are throughout the country. The illegality of homosexuality in Jamaica appears to shroud the identification of exact numbers and to encourage increasing forms of clandestine behaviour.

The confidential informants confirmed the wide differences between sub-groups of MSM and how this affected their abilities to traverse the phobia and discriminations of a socially complex society. This enabled the researchers to further validate their investigations into various forms of self-identification by the MSM sample groups. Those who had had a good education (secondary and tertiary education), who had a clear and successful professional path, who were able to travel overseas, and particularly those who felt good about themselves, reflected a surprising contentment that bordered in some cases on nonchalance.

*"Homophobia might play out in different ways according to social class. But violence is how we resolve conflict in Jamaica....my personal experience is that I zone out homophobia like I would zone out racism."*

*"I feel like I am standing on a sheet of glass over a river...I am looking down at it yet still protected".*

Most of the informants had developed ways of protecting themselves from discrimination, either by living double lives or by “don’t ask, don’t tell” attitudes.

*“If you go to church you are protected – you are not a pussy-bully because you are a god-fearing man, married and safe”.*

Although several of them had told their families or a family member of their sexual orientation, or had made an attempt to discuss homosexuality with someone close, the denial of the families enabled them to avoid going into details or to describe their feelings as MSMs in Jamaica.

For most of this group, relationships were important, including long-term relationships. But they described more passionately an environment which did not support or nurture long-term relationships due to the lack of societal acknowledgement, family approval and surprisingly, the dangers of the MSM community itself which was characterised by a large proportion of “seekers” (men on the lookout for a new partner) who prey on the break-ups of other men.

*“Gay relations are not stable because they are not sanctioned by society. No family support, no in-laws, no Christmas dinners with the family...there is very little supporting group”.*

Some men are unable to sustain long-term relationships due to family obligations, marriages and professional reputations. These tended to look out for what was immediately available or for opportunistic situations. One informant stated that the majority of relationships were short-term or based on traditional serial monogamy (one partner followed by another partner, not necessarily at the same time), which also marks the heterosexual population in Jamaica, “since we do not have the things that normally support relationships...”. Describing the situation for many men in the MSM community, one informant stated that, “If society requires you to create masks and to keep up appearances, then people will not have healthy concepts of themselves....and this will affect their self esteem and self concept.”

#### Self-image and Self-esteem

With regard to self-image and self-esteem, most participants in the focus groups felt that they receive respect and appreciation from their families and friends and even from people at work.

Most people thought that they were useful in their community as well as to family and friends. *"Although they know dat mi gay, dem love and respect me!* A few persons felt that their Supervisor appreciates their work. *"My boss know that if she leaves anything to me, it is going to get done very well"* Some persons felt that a lot of the respect they get are from their friends who are gay. *"That is why they choose me to be Peer Educator, They just love me!!"* Others said that in their families, their opinions are always asked on matters even though they know of their sexual orientation and don't "dis" him. Some persons have a steady partner and sometimes depending on the subject or the issue they discuss them. Some persons form friendships easily... Others do not bother with friends *"dem too mix up"* However, all felt that the few friends they have are good ones even though *"dem too mix up too sometimes"*.

They all agreed on the question of discussing personal issues with their partners, they all agreed that they would discuss personal issues with their long-term partners but not with their short-term partners. This they felt included issues about HIV/STIs. *"Mi have to get to know him first before revealing my personal business to him"* On the contrary, others said that they would want/appreciate a short term partner to tell them of his positivity of STI status before becoming physically involved. Most did not feel that they would still go ahead and have sex if they were told that his man is positive. Most persons felt that they are very confident in communicating with intimate partners and close friends without feeling afraid of losing the person. They all felt that they could as their intimate partner to use a condom and not feel afraid. Upon probing, some conceded that sometimes they allowed *"things to happen without a condom"* because they had *"long fi dis piece"* or they *"felt that the person looked good"* or *"mi did jus afraid"*

### Communities and Social Networks

Where differences were most obvious in the results from focus groups were in the aspect of communities and social networking. In the rural/urban areas, most socialised at people's homes and parties...other men prefer to have secret dates...*"I am one of those people who can't be bother wid de too-too up-front ting... Yes I know men who are like dat, but mi nuh badda wid dem."* Montego Bay reported a significant number of MSM who live and socialise in and around the town...both locals and foreigners. In Manchester, none of the respondents socialise in the area in which they live - many were bisexual and many had secret and hidden dates.

In Ocho Rios the participants were mainly seasonally employed in the tourist area. The majority did not originally hail from that area but came there either to work or in pursuit of love-relationships. The participants were quick to point out that these places change rapidly over the years. Presently they do so at JAS GLABCOM meetings, each other's homes, in Ocho Rios Square and the occasional Parties in the area or in other towns. There were times when gay people in the Ocho Rios area would meet upstream to the river mouth, or some secluded beaches along the coast or even at the clock. There are regular out-of-community interactions. Mostly these take place in Mandeville, Montego Bay or

Kingston areas. Group members revealed that they go out of town to party or simply to hang out with their friends. One person who is a drag queen said that he goes out of town to link up with *“my fellow sisters”*. *“We are able to shop for women’s clothes and make-up because I could not do this in Ocho Rios. I also get the chance to practice my dance moves for upcoming shows”*. Others conclude that sometimes their man lives outta town and so you have to go and *“catch up your stomach”* or *“do your wifely duties”* Two members who are sex workers said that they go out of town because *“we are business people”*. *“My customers maybe staying in Montego Bay and so we have to go there and stay with them”*. Or *“We have our regulars in Mandeville and you have to keep them satisfied too.”*

On the other hand in the urban areas there was a long list of places, where they socialised, including public places, mainstream night clubs and bars, friends, churches and JAS meetings. The corporate area allows MSM community numerous places to socialise and meet other like-minded men. There was the view that *“not everyone socialise and party together. They said that they (others) party elsewhere at private parties, private homes (especially uptown), Overseas... these people would rather have hidden, secret and private dates/meetings.”* These respondents said they met other gays on the bus, beach, churches, homes, parties. **An important aspect of this socialising is “gay-dar” or the ability to identify a gay man in a crowd (“to be one is to know one..”).**

In Kingston all persons admitted that they socialised in the same city in which they live. They said that most of the other gay men that they know socialise, party and hang out at places like:

- Kirk’s Place
- Hilton Hotel
- Emancipation Park
- JamRock
- Sandhurst Guest House
- Hope Gardens
- Devon House
- JAS
- Friends
- Churches
- Village Café
- Peppers

There was the view that not everyone socialised and partied together. They said that other party elsewhere at private parties, private homes (especially uptown) and overseas. Most of the persons thought that these people would rather have hidden, secret and private dates/meetings

Among the confidential interviews, none of the men were bisexuals in the traditional sense of the word, but they described those men who often successfully live two lives. What characterised the “double lifers” were education, financial status, power and authority of some kind, and social class.

They were not necessarily admired by the MSM community since they “played games” and were more concerned about their own survival than with the relationships they initiated and often ended abruptly. An interesting phenomenon mentioned by several of the informants was the new set of MSMs, the 25 to 35 year olds who were “more forward thinking and had a wider perspective”. They were characterised as being more self indulgent and interested in their own safety. They are not at risk of violence, and although they may be subject to verbal abuse, generally live secure lives. Here too, the class and financial status of the men were important, since many could rely on their parents support.

*“Rave parties (the ‘Mash Pit’) have become the masks for gay, young people. But they are still not ‘gay and proud’...”*

### Knowledge and Practices

The groups seemed quite confident that they had **information about HIV/AIDS** and prevention. One group said they *“had nuff-nuff information and is straight people want and need education now... Is tru cause when me meet straight man an him want fi grine me, I am the one that have too teach him about condom.”* Straight people do not know anything and they are spreading it!” Sources of information ranged from the Internet (gay websites in particular), the mass media, the doctors, nurses, friends, NGOs, pharmacies and books. There was a slight difference in the class of the participants since the more educated turned to the Internet and books and media, while the less educated depended on friends, doctors and nurses.

Upon further probing, the participants revealed that they would not be comfortable to ask and answer the most intimate questions in all of those locations listed. For example, when asked who you would talk to about a sore on your anus, most concluded that they would do so with their *“private doctor, the JAS nurse and some people in the Comprehensive and Windward Road Health Centres.”* It was at this juncture that the whole issue of the *“gate-keepers”* came up. Participants said that they knew very well the persons that they would turn to for that kind of intimate service. They pointed out that within each institution, there were persons that they would go to and there were some that they would not approach at all. Some also said that if they did not know the gay-friendly gatekeepers, they each knew at least one person who would tell them who to go to.

In one focus group that was attended by professional, bisexual men one member stated *“Thank God that I can afford anything I want. So I will pay for the relevant information to be couriered to me when I see it on the Internet. I cannot afford to have people speculate about me if I seek information locally.”* Another said that the youngster he was dating at the time *“went to that awful gay meeting up at JAS and came home with a great deal of printed information. I was scandalised that he could take public transportation with that stuff. Later when I exhaled and looked at them, I found them useful. It was the first time that I was ever seeing anything like that with explicit language and pictures of men with men”.*

A group in Ocho Rios were mostly in agreement with information regarding the transmission of the HIV Virus via unprotected sex (anal, oral, vaginal) and some agreed that through Tattoos. Some felt that *"sucking a man buddy"* could also lead to the disease spread. Three members of the group said that they did know of someone who is HIV positive or someone who has AIDS. Others revealed that they had heard rumours about someone but had no proof. One person said that he does not want to know anyone at all. *"I am just too afraid of that thing. I am not sure if I could deal with it at all."* Most group members said "yes" they think it's likely you could catch AIDS because of having unprotected sex and oral sex. *"I have taken risks in the past and so any card can play."* The bisexual man said "no" because *"I do not cum in a man, only in a woman and the disease cannot pass on unless you cum"*

On the subject of **condoms and negotiating condoms**, most people said they used condoms frequently, but mostly with casual partners, and not so regularly with long time partners and especially with women. A Montego Bay group respondent said he had one steady partner and so did not use condoms although he admitted that if he was to *"do something outta door"* he would use a condom. Another participant who was bisexual said that he felt that he could get HIV from his man but not from his woman *"she woulda wonder if mi a clap something outta road...and that (people) done think sey mi a batty man. Mi cannot do nuttin like use condom pon mi woman fi mek dem tink say mi have something fi hide."*

At one focus group meeting all the participants said that they were doing something to protect themselves from HIV/AIDS. This they stated is done through the use of condoms all the time of abstinence. When probed the group revealed that for them and most of their friends, abstinence was not the preferred choice. For them abstinence was only observed in between relationships or when they were *"just cooling out"*. The group identified latex condoms and water based lubricants as the two main protection tools. One member admitted to trying the female condom in sex. Others felt that it was too problematic and unattractive. Most said that they did not bother to use any form of protection when doing *"batty-wash or blow jobs"* because it was not very risky. Members admitted to avoiding having sex with someone if they felt that they had been with someone who was HIV positive. Further discussions revealed that all except two members of the group insisted that they used condoms every time since they came into the *"gay world"*. For them, it was the scare of having others find out their sexuality if they should test positive and proper education that help them to maintain that position. One person was involved with the same partner for four years. The use of water based lubricants was inconsistent because members conclude that it was a bit threatening to go into a shop or pharmacy and request them. Sometimes, they had received from JAS or had relied on their partner to take it to the sex act. Other admitted to using other form of lubricants. They recommended that JAS and the health centres actively distribute lubricants.

In one Kingston group, most participants said that they were doing something to protect themselves from HIV/AIDS. This is done by using condoms most of the

times, by abstaining and masturbating. The persons who said they were not doing enough sighted reasons such as:- (1) don't like condoms and (2) sometimes there are no condoms available.

All were in agreement that the use of water based lubricants was not always feasible since they were *"afraid to buy them from pharmacies cause dem wi bitta mi"* Their major source of water based lubricants was at JAS or from visiting friends. They all agreed that they would purchase lubricants if they were available in a safe space. One member of the group reported sending his lesbian friends to purchase KY for him. When probed he said that he could only purchase the one-use sachet because they could not keep the larger tubes at his home. Others were grateful for the Eve brand that JAS was presently distributing since it made them look as though they were having sex with women. Even with that, they contended that they still had to be very careful.

Group members reported that not all of their sexual encounters involved penetration. Many hailed outer-course and masturbation as something that they did often times instead of *"screwing"*.

Upon further probing, it was clear that members did not engage in condom usage every time. Some reported just not using it because of the *"heat of the moment"*, *"it was with my long time man"* or *"...it just never happened"*. All members reported that they always felt uncomfortable afterwards wondering if they had *"picked up something"*. There was also a general feeling that *"sucking cock and eating ass"* were low risk factors in spreading HIV/AIDS. Similarly, in the Ocho Rios group, participants said that they were aspiring to using condoms most of the times. Others said that they are not giving any blow jobs or *"undercarriage wash"*. *No one conceded to abstaining. "Mi love wood too much. Mi just have to tek it and protect mi self" This group also express certain reservations about using condoms. These were:*

- Condoms itches
- A few friends do not ever use condoms
- Dem slow down things
- No condom, no sex
- Because dem know dat me sell sex, dem nuh gi mi no problem fi use boots
- Mi partner wants to use it all the time. He is a big AIDS Counsellor so he practice what he preaches.

### Risk Assessment

Regarding **the perception of risk of contracting the HIV Virus**, one group believed that there was a high level of HIV infection in the gay community and that its members were more at risk than they thought they were. They felt that there needs to be greater education aimed at those people *"who are on top or who play the man's role"* since those were the ones with power and who called the shots when it came to sex, and that some of those people deluded themselves into thinking that they could not catch the virus because they were the penetrative

partner, or the one “on top”. Although this group believed that the receptive partner can also claim power, they still felt “that it was the top or those who play the man role” that could make a real difference. One person who had not been tested said “I walk with that possibility all the days of my life. I could be positive as we speak. Oh God, I do not want to think of it!! Ha ha!! Seriously though, guys this meeting here is making me feel so nervous. It is just bringing up the matter again. Imagine me....., afraid of anything?”

In a Montego Bay focus group three out of five have been tested for HIV. They claim to be all negative even though the facilitator knows that one of them is positive. It is understandable that he could not reveal his positivity in that forum,. One member is too scared of doing the test. He admitted that he had been at risk since “entering gay life and anything can happen” If he were to test, he said that he would go to JAS Kingston or Montego Bay or to a private doctor outside of Montego Bay. For him, “Montego Bay too small ya!” Other participants stated that they had gone to JAS or a private doctor to get tested. Not to Type Five Health or the Hospital because of the stories they have heard about how persons are treated there. One person stated that he knew one of the nurses there and would be afraid to “buk her up”.

In a Kingston group all persons present thought it was a possibility that they could get AIDS. There was also the view that no sex is 100% safe and that you could get AIDS through blood transfusion from the hospital. Many admitted to taking risks and worrying afterwards if they could be positive. They concluded that there was *something* that made it challenging to use condoms all the time. One member said that each time he heard of someone who was positive, his reflection was “but for the grace of God there go I” **A big discussion ensued in which members reported that there was a general feeling among gay men that they were doomed to get HIV because it was against God’s will that two men should have sex.** They said that as a result, some men are just sitting down waiting for HIV to come their way.

### Needs Assessment

Based on the discussions of the focus groups and the confidential interviews specific needs were identified, they included:

- Since Cable TV gave them advertisements that showed men and men and women and women and they felt that they got more from those advertisements than the general ones, the group recommended that the Ministry of Health should place some gay specific advertisements on local television.
- Some of the confidential informants stressed the need for education and information targeted to the various age graded groups of MSMs, ranging from the mass media to media products, since they had seen such materials in other countries.
- All reported high levels of confidentiality in the places that they had gone to get tested - but felt that the time spent waiting on the results was “killing”. One member said that something should be put in place for the results to come back quicker.

- Suitable lubricants and condoms to be made available in private areas such as JAS, from “good Clinic staff members”, CHARES.
- HIV positive gay men should be allowed to talk to the “bigger groups”, indicating their feelings of exclusion from consultations and forums on HIV/AIDS prevention and care.
- Improved condom distribution in public places, including condom vending machines and package lubricants (which are easier to carry around).
- More sensitised and accessible Health Care Workers for the Clinics and hospitals. The recommendations stated that there should be no discrimination, and recommended that Health Care Workers be sensitised with a course in HIV/AIDS, sensitisation to gay issues, and make it mandatory that Health Care Workers be exposed to training dealing with gay issues and HIV/AIDS/STIs.
- Expansion of testing to include other STIs and places where they usually go for testing.
- Utilisation of Gay Forums and MSM Peer Counsellors to penetrate those gay groups who do not normally attend meetings.

All groups discussed the need for the repeal of the “Buggery Law” which would make the MSM community feel more comfortable in assessing programmes that are already available to the public. Although this may be impossible, politically and socially, at this time in Jamaica, other means of reducing the distress of MSMs would assist them in feeling more in charge of their lives and more able to take the responsibility for their behaviour.

*“It is likely that those gay men with the highest self-esteem and the most positive sense of gay identity are the most likely to make effective behavioural changes. To the extent that a positive gay-affirming sense of identity for homosexual individuals is unacceptable to society, the most efficacious behaviour change programs run the risk of being compromised” (Gonsierek 1990).*

## F. SURVEY RESULTS

The main findings of the survey are presented in this section with the frequencies of all the questions being including in Appendix 4. The results confirm some of the findings of the confidential interviews and focus group discussions. In each of the tables presented, only respondents for whom there were valid responses for the particular variable are included. In other words, 'not stated', 'no response' and 'not applicable' were excluded from the tables.

### a) Socio-demographic Characteristics

The socio-demographic characteristics of the sample are shown in Table 1. It was evenly distributed between the youth i.e. those less than 25 years and older men, with the oldest being 58 years. Nearly 30 percent had a post-secondary education, which is higher than in the general population, particularly among men. So either MSM tend to be better educated or, and this is more plausible, MSM of lower educational levels are less likely to reveal their sexuality and therefore are not known/not available for interviews. Although the distribution by area of residence does not reflect the national picture, it should be noted that MSMs tend to move away from rural areas into larger towns and cities where they can live their sexual orientations outwardly and with more freedom of expression.

**Table 1**

**Socio-demographic characteristics of respondents**

|                               |                                         | Nos. | %    |
|-------------------------------|-----------------------------------------|------|------|
| Age group<br>(years)          | 16-24                                   | 71   | 46.7 |
|                               | 25 +                                    | 81   | 53.3 |
| Highest level of<br>schooling | Primary, all-age,<br>comprehensive high | 54   | 29.7 |
|                               | Technical, traditional high             | 68   | 37.4 |
|                               | Post-secondary, university              | 60   | 33.0 |
| Occupation                    | Student                                 | 13   | 9.9  |
|                               | Unskilled                               | 8    | 6.1  |
|                               | Semi-skilled                            | 61   | 46.6 |
|                               | Skilled/technical                       | 22   | 16.8 |
|                               | Professional                            | 27   | 20.6 |
| Area of residence             | City                                    | 87   | 53.4 |
|                               | Large town                              | 18   | 11.0 |
|                               | Small town                              | 16   | 9.8  |
|                               | Rural area                              | 42   | 25.8 |

**b) Sexual Identity and Orientation**

To determine the sexual identity and orientation of MSM, we asked respondents to choose the most apt description of themselves. The categories offered were as follows:

- I am exclusively homosexual/gay
- I have relations with men but have regular female partner/bisexual
- I have occasional relations with men, unpredictable and often not planned
- I do not have sexual relations with men but have emotional feelings and attractions that are strong for the same sex.
- I have transactional relations with men, i.e. in order to receive something back
- I deliberately have long term relations with men, for financial support, on a regular basis
- I have relations with men because that is my economic activity
- I am a drag queen
- I self identify as a woman.

Respondents also had the option of describing themselves if they did not consider that they fitted into the available categories. Tables 2 and 3 present sexual identity and orientation by age, level of schooling and area of residence. Due to the limitations of the study and to the suspected under-reporting in certain categories, 'I have transactional relations with men, i.e. in order to receive something back', and 'I deliberately have long term relations with men for financial support, on a regular basis', were grouped together. For the most part, the respondents chose one answer, but 14 chose more than one. Interestingly, 8 of the 14 had comprehensive schooling or lower, while 10 were in the younger age group, i.e. 16-24 years, suggesting that younger persons and/or those with lower levels of education had more ambivalence regarding their sexual identity and orientation.

As we see in Table 2, more MSM in the younger age group and in the lower level of schooling entered into transactional relationships, whether short or long-term, or as an economic activity. There was no significant difference by sub-groups of age and schooling in the percentage who said that they were exclusively gay (Table 2). However, fewer persons in the

rural areas identified themselves as exclusively gay compared with men living in the urban areas (Table 3).

A significant result of sexual identity and orientation (Table 2) is the outcome which indicates that about 60% of the respondents self-identified as exclusively homosexuals. It should be noted that, due to respondents ability to self-identify in several categories it was observed that a portion of those who self-identified as exclusively homosexual also identified as having female partners. The results of this range of categories presented, for the first time in Jamaica, evidence that gender identity and sexual orientation are two separate factors. Almost 9% of the sample either had transactional relations or relations with men because “that is my economical activity”, and if we are to take into account the observations of the facilitator, these categories were in fact under-reported.

**Table 2**

**Sexual identity and orientation by age and level of schooling<sup>a</sup>**

|                                                              | Age group (years) |      |      |      | Highest level of schooling                |      |                                |      |                               |      | Total |      |
|--------------------------------------------------------------|-------------------|------|------|------|-------------------------------------------|------|--------------------------------|------|-------------------------------|------|-------|------|
|                                                              | 16-24             |      | 25 + |      | Primary,all-age,<br>comprehensive<br>high |      | Technical,<br>traditional high |      | Post-secondary,<br>university |      | Nos   | %    |
|                                                              | Nos.              | %    | Nos. | %    | Nos.                                      | %    | Nos.                           | %    | Nos.                          | %    |       |      |
| Am exclusively homosexual                                    | 37                | 55.2 | 50   | 63.3 | 31                                        | 60.8 | 40                             | 60.6 | 37                            | 63.8 | 108   | 61.7 |
| Have relations with men but have female partner,bisexual     | 25                | 37.3 | 18   | 22.8 | 15                                        | 29.4 | 21                             | 31.8 | 15                            | 25.9 | 51    | 29.1 |
| I have occasional relations with men, unpredictable          | 2                 | 3.0  | 5    | 6.3  | 1                                         | 2.0  | 1                              | 1.5  | 5                             | 8.6  | 7     | 4.0  |
| No sex with men but have strong attractions for men          | 1                 | 1.5  | 1    | 1.3  |                                           |      | 1                              | 1.5  | 1                             | 1.7  | 2     | 1.1  |
| Have transactional relations with men                        | 1                 | 1.5  | 2    | 2.5  | 2                                         | 3.9  | 1                              | 1.5  |                               |      | 3     | 1.7  |
| Have relations with men because that is my economic activity | 4                 | 6.0  | 1    | 1.3  | 1                                         | 2.0  | 4                              | 6.1  |                               |      | 5     | 2.9  |
| I am a drag queen                                            | 2                 | 3.0  | 2    | 2.5  | 2                                         | 3.9  | 2                              | 3.0  | 1                             | 1.7  | 5     | 2.9  |
| I self identify as a woman                                   | 5                 | 7.5  | 4    | 5.1  | 7                                         | 13.7 | 1                              | 1.5  | 1                             | 1.7  | 9     | 5.1  |

a. Multiple responses, percentages add up to more than 100

**Table 3****Sexual identity and orientation by area of residence**

|                                                              | Area of residence |      |      |      |            |      |
|--------------------------------------------------------------|-------------------|------|------|------|------------|------|
|                                                              | City              |      | Town |      | Rural area |      |
|                                                              | Nos.              | %    | Nos. | %    | Nos.       | %    |
| Am exclusively homosexual                                    | 55                | 64.0 | 20   | 64.5 | 24         | 55.8 |
| Have relations with men but have female partner,bisexual     | 23                | 26.7 | 10   | 32.3 | 14         | 32.6 |
| I have occasional relations with men, unpredictable          | 5                 | 5.8  | 1    | 3.2  | 2          | 4.7  |
| No sex with men but have strong attractions for men          | 1                 | 1.2  | 1    | 3.2  |            |      |
| Have transactional relations with men                        | 1                 | 1.2  | 1    | 3.2  | 1          | 2.3  |
| Have relations with men because that is my economic activity | 2                 | 2.3  | 1    | 3.2  | 1          | 2.3  |
| I am a drag queen                                            | 3                 | 3.5  |      |      | 1          | 2.3  |
| I self identify as a woman                                   | 5                 | 5.8  |      |      | 3          | 7.0  |

a. Multiple responses, percentages add up to more than 100

### c) Sexual Behaviour

Respondents were asked what best describes their sexual behaviour and their current status regarding a partner. A half of the sample stated that they tended to be monogamous (having one partner), 2 persons were not sexually active, while 28 percent stated that they would have more than two partners of the same or different sexes. The non-response rate was 6.4%. These persons were obviously sexually active but were either uncomfortable about answering the question (as stated by one individual) or forgot to answer the question. Persons choosing monogamous relationships were younger and had lower educational levels (Table 4).

Of the 13 men who reported having relations for transactional purposes, financial support, or as an economic activity, the majority (12) stated that they had monogamous relations.

Fewer men with higher educational levels currently had a partner, but there was no difference by age group. Among those who currently had a partner, the older age group and men with higher educational levels were more likely to be 'the top' (Table 5). The latter category had been chosen by MSM representatives to interpret what is technically called the active partner or "he who penetrates". The younger age group and less educated were more likely to be "the bottom" or the passive, recipient partner.

There were no notable differences in sexual identity and orientation in terms of a current partner. However, persons who reported having sexual relations for transactional activities, financial support or as an economic activity were more likely to have a current partner (Table 6). It is important to note that those who self-identify as a woman were also more likely to have a current partner.

**Table 4****Sexual behaviour by age and level of schooling**

|                            |                                     |      | Which best describes your sexual behaviour? |                     |                                               |                                                |             |                     |
|----------------------------|-------------------------------------|------|---------------------------------------------|---------------------|-----------------------------------------------|------------------------------------------------|-------------|---------------------|
|                            |                                     |      | I have one partner                          | I have two partners | I have more than two partners of the same sex | I have more than two partners, different sexes | No response | Not sexually active |
| Age group (years)          | 16-24                               | Nos. | 38                                          | 12                  | 12                                            | 4                                              | 3           | 2                   |
|                            |                                     | %    | 53.5                                        | 16.9                | 16.9                                          | 5.6                                            | 4.2         | 2.8                 |
|                            | 25 +                                | Nos. | 34                                          | 7                   | 25                                            | 6                                              | 7           | 1                   |
|                            |                                     | %    | 42.5                                        | 8.8                 | 31.3                                          | 7.5                                            | 8.8         | 1.3                 |
| Highest level of schooling | Primary,all-age, comprehensive high | Nos. | 33                                          | 3                   | 12                                            | 4                                              | 1           | 1                   |
|                            |                                     | %    | 61.1                                        | 5.6                 | 22.2                                          | 7.4                                            | 1.9         | 1.9                 |
|                            | Technical, traditional high         | Nos. | 31                                          | 9                   | 18                                            | 3                                              | 4           | 1                   |
|                            |                                     | %    | 47.0                                        | 13.6                | 27.3                                          | 4.5                                            | 6.0         | 1.5                 |
|                            | Post-secondary, university          | Nos. | 26                                          | 9                   | 13                                            | 3                                              | 8           | 1                   |
|                            |                                     | %    | 43.3                                        | 15.0                | 21.7                                          | 5.0                                            | 13.3        | 1.7                 |
| Total                      | Nos.                                |      | 90                                          | 21                  | 43                                            | 10                                             | 12          | 3                   |
|                            | %                                   |      | 50.0                                        | 11.7                | 23.9                                          | 5.6                                            | 7.2         | 1.7                 |

**Table 5****Current partner and position in the relationship by age and level of schooling**

|                            |                                     |      | Currently have a partner? |      | In the relationship are you? |            |        |
|----------------------------|-------------------------------------|------|---------------------------|------|------------------------------|------------|--------|
|                            |                                     |      | Yes                       | No   | The top                      | The bottom | Either |
| Age group (years)          | 16-24                               | Nos. | 43                        | 27   | 8                            | 21         | 13     |
|                            |                                     | %    | 61.4                      | 38.6 | 19.0                         | 50.0       | 31.0   |
|                            | 25 +                                | Nos. | 50                        | 30   | 19                           | 15         | 10     |
|                            |                                     | %    | 62.5                      | 37.5 | 43.2                         | 34.1       | 22.7   |
| Highest level of schooling | Primary,all-age, comprehensive high | Nos. | 35                        | 19   | 7                            | 16         | 8      |
|                            |                                     | %    | 64.8                      | 35.2 | 22.6                         | 51.6       | 25.8   |
|                            | Technical, traditional high         | Nos. | 39                        | 27   | 11                           | 18         | 10     |
|                            |                                     | %    | 59.1                      | 40.9 | 28.2                         | 46.2       | 25.6   |
|                            | Post-secondary, university          | Nos. | 36                        | 24   | 13                           | 6          | 11     |
|                            |                                     | %    | 60.0                      | 40.0 | 43.3                         | 20.0       | 36.7   |
| Total                      | Nos.                                |      | 110                       | 70   | 31                           | 40         | 29     |
|                            | %                                   |      | 61.1                      | 38.9 | 31.0                         | 40.0       | 29.0   |

**Table 6****Sexual identity, behaviour and whether have current partner**

|                                                              |      | Currently     |
|--------------------------------------------------------------|------|---------------|
|                                                              |      | has a partner |
| Am exclusively homosexual                                    | Nos. | 64            |
|                                                              | %    | 59.8          |
| Have relations with men but have female partner, bisexual    | Nos. | 32            |
|                                                              | %    | 61.5          |
| I have occasional relations with men, unpredictable          | Nos. | 3             |
|                                                              | %    | 37.5          |
| No sex with men but have strong attractions for men          | Nos. | 1             |
|                                                              | %    | 50.0          |
| Have transactional relations with men                        | Nos. | 2             |
|                                                              | %    | 66.7          |
| Have relations with men because that is my economic activity | Nos. | 4             |
|                                                              | %    | 80.0          |
| I am a drag queen                                            | Nos. | 3             |
|                                                              | %    | 60.0          |
| I self identify as a woman                                   | Nos. | 7             |
|                                                              | %    | 77.8          |

**d) Level of Risk**

The level of risk of contracting a sexually transmitted disease is, in the main, dependent on sexual behaviour, use of condoms and to some extent, use of lubricants. As seen above, just about half of the men interviewed indulged in risky behaviour by having more than one partner. Transactional sex<sup>1</sup> was reported by 9.6% of the respondents but this was felt to be an underestimate as indicated previously.

As shown in Table 7a and 7b, only 65 percent of the men said that they used a condom all the time. Condom use seemed to increase with increasing level of schooling. On the positive side however, 90 percent stated that they used a condom at last sexual intercourse. No significant difference by sexual identity by sexual identity was noted. Unfortunately, it appears that the more they indulge in risky sexual behaviour, the less likely they are to use a condom all the time (Table 8). But again, there was no difference in condom use the last time they had sex.

<sup>1</sup> Used here as sex in exchange for money, drugs or other benefits.

**Table 7a****Condom use by age group and level of education**

|                                    |                                               | Age group (years) |      | Highest level of schooling                |                                   |                               | Total |      |
|------------------------------------|-----------------------------------------------|-------------------|------|-------------------------------------------|-----------------------------------|-------------------------------|-------|------|
|                                    |                                               | 16-24             | 25 + | Primary,all-age,<br>comprehensive<br>high | Technical,<br>traditional<br>high | Post-secondary,<br>university |       |      |
| Best description<br>of condom use  | All the time                                  | Nos.              | 38   | 44                                        | 30                                | 39                            | 33    | 102  |
|                                    |                                               | %                 | 58.5 | 63.8                                      | 56.6                              | 65.0                          | 75.0  | 65.0 |
|                                    | Most of the time                              | Nos.              | 24   | 18                                        | 18                                | 19                            | 9     | 46   |
|                                    |                                               | %                 | 36.9 | 26.1                                      | 34.0                              | 31.7                          | 20.5  | 29.3 |
|                                    | Only when having casual<br>sex, rarely, never | Nos.              | 3    | 7                                         | 5                                 | 2                             | 2     | 9    |
|                                    |                                               | %                 | 4.6  | 10.1                                      | 9.4                               | 3.3                           | 4.5   | 5.7  |
| Last sex, did you<br>use a condom? | Yes                                           | Nos.              | 61   | 62                                        | 47                                | 54                            | 43    | 144  |
|                                    |                                               | %                 | 93.8 | 88.6                                      | 90.4                              | 93.1                          | 91.5  | 91.7 |
|                                    | No                                            | Nos.              | 4    | 8                                         | 5                                 | 4                             | 4     | 13   |
|                                    |                                               | %                 | 6.2  | 11.4                                      | 9.6                               | 6.9                           | 8.5   | 8.3  |

**Table 7b****Condom use and sexual identity<sup>a</sup>**

|                                                              | Best description of condom use |             |                  |             |                                            |            | Last sex, did you use a condom? |             |           |            |
|--------------------------------------------------------------|--------------------------------|-------------|------------------|-------------|--------------------------------------------|------------|---------------------------------|-------------|-----------|------------|
|                                                              | All the time                   |             | Most of the time |             | Only when having casual sex, rarely, never |            | Yes                             |             | No        |            |
|                                                              | Nos.                           | %           | Nos.             | %           | Nos.                                       | %          | Nos.                            | %           | Nos.      | %          |
| Am exclusively homosexual                                    | 70                             | 66.7        | 31               | 29.5        | 4                                          | 3.8        | 98                              | 95.1        | 5         | 4.9        |
| Have relations with men but have female partner, bisexual    | 34                             | 64.2        | 17               | 32.1        | 2                                          | 3.8        | 46                              | 88.5        | 6         | 11.5       |
| I have occasional relations with men, unpredictable          | 7                              | 87.5        |                  |             | 1                                          | 12.5       | 7                               | 87.5        | 1         | 12.5       |
| No sex with men but have strong attractions for men          | 1                              | 100.0       |                  |             |                                            |            | 2                               | 100.0       |           |            |
| Have transactional relations with men                        | 2                              | 66.7        | 1                | 33.3        |                                            |            | 2                               | 100.0       |           |            |
| Have relations with men because that is my economic activity | 4                              | 80.0        | 1                | 20.0        |                                            |            | 5                               | 100.0       |           |            |
| I am a drag queen                                            | 1                              | 25.0        | 3                | 75.0        |                                            |            | 3                               | 60.0        | 2         | 40.0       |
| I self identify as a woman                                   | 5                              | 55.6        | 2                | 22.2        | 2                                          | 22.2       | 7                               | 77.8        | 2         | 22.2       |
| <b>Total</b>                                                 | <b>114</b>                     | <b>65.9</b> | <b>50</b>        | <b>28.9</b> | <b>9</b>                                   | <b>5.2</b> | <b>156</b>                      | <b>91.2</b> | <b>15</b> | <b>8.8</b> |

a. Multiple responses

**Table 8**

**Sexual behaviour and condom use**

|                                 |                                            |      | Which best describes your sexual behaviour? |                     |                                               |                                                |             |                     |
|---------------------------------|--------------------------------------------|------|---------------------------------------------|---------------------|-----------------------------------------------|------------------------------------------------|-------------|---------------------|
|                                 |                                            |      | I have one partner                          | I have two partners | I have more than two partners of the same sex | I have more than two partners, different sexes | No response | Not sexually active |
| Best description of condom use  | All the time                               | Nos. | 64                                          | 14                  | 25                                            | 5                                              | 7           | 2                   |
|                                 |                                            | %    | 70.3                                        | 63.6                | 58.1                                          | 50.0                                           | 77.8        | 100.0               |
|                                 | Most of the time                           | Nos. | 20                                          | 7                   | 16                                            | 5                                              | 2           |                     |
|                                 |                                            | %    | 22.0                                        | 31.8                | 37.2                                          | 50.0                                           | 22.2        |                     |
|                                 | Only when having casual sex, rarely, never | Nos. | 7                                           | 1                   | 2                                             |                                                |             |                     |
|                                 |                                            | %    | 7.7                                         | 4.5                 | 4.7                                           |                                                |             |                     |
| Last sex, did you use a condom? | Yes                                        | Nos. | 79                                          | 21                  | 40                                            | 9                                              | 10          | 3                   |
|                                 |                                            | %    | 90.8                                        | 95.5                | 95.2                                          | 90.0                                           | 83.3        | 100.0               |
|                                 | No                                         | Nos. | 8                                           | 1                   | 2                                             | 1                                              | 2           |                     |
|                                 |                                            | %    | 9.2                                         | 4.5                 | 4.8                                           | 10.0                                           | 16.7        |                     |

With regard to lubricants, 179 respondents answered the questions and of these, 79.3% stated that they used lubricants, while 5.6% said that they did not use lubricant and 15.1% said that they did not indulge in anal sex. The types of lubricants used are shown in Table 9a. The majority using lubricants used KY jelly, an appropriate lubricant. However they also used inappropriate lubricants such as Vaseline, butter and baby oil.

Table 9a

**Lubricants used**

|             | Nos. | %    |
|-------------|------|------|
| Aqualube    | 12   | 8.5  |
| Vaseline    | 19   | 13.5 |
| KY jelly    | 125  | 88.7 |
| Hand lotion | 35   | 24.8 |
| Baby oil    | 13   | 9.2  |
| Butter      | 1    | .7   |
| Other       | 14   | 10.0 |

**e) Perceived Risk**

Two-thirds of the men felt that they were at risk of HIV/AIDS. There was no difference in perceived risk by age but as level of schooling increased, perceived risk decreased. More men with multiple partners and those using condoms only some of the time perceived themselves at risk (Table 9). Results indicated that those who had two or more partners considered themselves more at risk as well as those who used condoms most of the time, reflecting perhaps some successful interventions or fear of already contracting AIDS.

**Table 9****Whether respondent considers himself at risk by age, schooling, sexual behaviour and condom use**

|                                |                                            | Do you consider yourself at risk of HIV? |      |      |       |
|--------------------------------|--------------------------------------------|------------------------------------------|------|------|-------|
|                                |                                            | Yes                                      |      | No   |       |
|                                |                                            | nos.                                     | %    | nos. | %     |
| Age group (years)              | 16-24                                      | 42                                       | 60.9 | 27   | 39.1  |
|                                | 25 +                                       | 54                                       | 70.1 | 23   | 29.9  |
| Highest level of schooling     | Primary,all-age, comprehensive high        | 36                                       | 70.6 | 15   | 29.4  |
|                                | Technical, traditional high                | 39                                       | 60.0 | 26   | 40.0  |
|                                | Post-secondary, university                 | 35                                       | 59.3 | 24   | 40.7  |
| Sexual behaviour               | One partner                                | 44                                       | 51.8 | 41   | 48.2  |
|                                | 2 partners                                 | 15                                       | 68.2 | 7    | 31.8  |
|                                | 2+ partners                                | 45                                       | 83.3 | 9    | 16.7  |
|                                | No response                                | 6                                        | 54.5 | 5    | 45.5  |
|                                | Not sexually active                        |                                          |      | 3    | 100.0 |
| Best description of condom use | All the time                               | 60                                       | 52.6 | 54   | 47.4  |
|                                | Most of the time                           | 44                                       | 88.0 | 6    | 12.0  |
|                                | Only when having casual sex, rarely, never | 7                                        | 77.8 | 2    | 22.2  |
| Total                          |                                            | 111                                      | 64.2 | 62   | 35.8  |

Apart from the usual reasons of multiple partners, non-use of condoms or bursting condoms, some MSM perceived that they were at risk by virtue of them being homosexual the risk was higher. Other reasons included:

the possibility of transmission by oral sex;  
paranoia;

Reasons for perceiving that they were not at risk included:

Always used a condom;

Has only one partner;

Only has non-penetrative sex.

Worth mentioning was the comment "I only had sex for 2 minutes and the person did not discharge in me". This suggests that the respondent considered that the virus is transmitted by the seminal fluid but did not recognize that it could be passed via blood if there was any tearing.

**f) Knowledge Regarding Sexually Transmitted Diseases**

This survey examined respondents' knowledge regarding how persons can protect themselves against HIV/AIDS (Table 9) and regarding symptoms of sexually transmitted diseases (Table 10). Generally, knowledge regarding HIV/AIDS protection was high but this appears in other KABPs in Jamaica among the general public (Hope Enterprises, 2000).

**Table 10**

**Knowledge regarding protection against HIV/AIDS by age and level of schooling**

|                                                 |       |           | Age group (years) |      | Highest level of schooling                |                                   |                               |
|-------------------------------------------------|-------|-----------|-------------------|------|-------------------------------------------|-----------------------------------|-------------------------------|
|                                                 |       |           | 16-24             | 25 + | Primary,all-age,<br>comprehensive<br>high | Technical,<br>traditional<br>high | Post-secondary,<br>university |
| Having a good diet                              | False | Nos.      | 51                | 67   | 37                                        | 49                                | 46                            |
|                                                 |       | %         | 72.9              | 83.8 | 69.8                                      | 72.1                              | 78.0                          |
| Staying with one faithful partner               | True  | Nos.      | 51                | 64   | 40                                        | 47                                | 49                            |
|                                                 |       | %         | 72.9              | 80.0 | 75.5                                      | 69.1                              | 83.1                          |
|                                                 |       | Dont know | 2                 | 3    | 2                                         | 3                                 | 2                             |
|                                                 |       | %         | 2.9               | 3.8  | 3.8                                       | 4.4                               | 3.4                           |
| Avoiding public toilets                         | False | Nos.      | 53                | 71   | 40                                        | 52                                | 56                            |
|                                                 |       | %         | 75.7              | 88.8 | 75.5                                      | 76.5                              | 94.9                          |
| Using a condom every time                       | True  | Nos.      | 64                | 75   | 48                                        | 61                                | 56                            |
|                                                 |       | %         | 91.4              | 93.8 | 90.6                                      | 89.7                              | 94.9                          |
| Avoid touching someone with AIDS                | False | Nos.      | 63                | 76   | 48                                        | 63                                | 57                            |
|                                                 |       | %         | 90.0              | 95.0 | 90.6                                      | 92.6                              | 96.6                          |
| Avoid sharing food with person with AIDS        | False | Nos.      | 62                | 74   | 47                                        | 59                                | 57                            |
|                                                 |       | %         | 88.6              | 92.5 | 88.7                                      | 88.1                              | 96.6                          |
| Avoid being bitten by mosquitoes                | False | Nos.      | 55                | 72   | 44                                        | 52                                | 54                            |
|                                                 |       | %         | 78.6              | 90.0 | 83.0                                      | 76.5                              | 91.5                          |
| Abstain from having sex                         | True  | Nos.      | 54                | 65   | 42                                        | 47                                | 48                            |
|                                                 |       | %         | 77.1              | 81.3 | 79.2                                      | 69.1                              | 81.4                          |
| Injections with clean needle                    | True  | Nos.      | 59                | 70   | 45                                        | 56                                | 54                            |
|                                                 |       | %         | 84.3              | 88.6 | 84.9                                      | 83.6                              | 93.1                          |
| Dont touch corpse of someone who died from AIDs | False | Nos.      | 49                | 68   | 36                                        | 50                                | 48                            |
|                                                 |       | %         | 70.0              | 86.1 | 67.9                                      | 74.6                              | 81.4                          |

**Table 11****Knowledge of symptoms of sexual infections in men by age and level of schooling**

|                         |     |      | Age group (years) |      | Highest level of schooling                |                                   |                               |
|-------------------------|-----|------|-------------------|------|-------------------------------------------|-----------------------------------|-------------------------------|
|                         |     |      | 16-24             | 25 + | Primary,all-age,<br>comprehensive<br>high | Technical,<br>traditional<br>high | Post-secondary,<br>university |
| Abdominal pain          | Yes | Nos. | 23                | 42   | 23                                        | 29                                | 24                            |
|                         |     | %    | 34.8              | 53.8 | 44.2                                      | 43.3                              | 45.3                          |
| Genital discharge       | Yes | Nos. | 41                | 63   | 36                                        | 43                                | 41                            |
|                         |     | %    | 62.1              | 80.8 | 69.2                                      | 64.2                              | 77.4                          |
| Foul smelling discharge | Yes | Nos. | 38                | 59   | 30                                        | 41                                | 38                            |
|                         |     | %    | 57.6              | 75.6 | 57.7                                      | 61.2                              | 71.7                          |
| Fever                   | Yes | Nos. | 27                | 37   | 25                                        | 25                                | 28                            |
|                         |     | %    | 40.9              | 47.4 | 48.1                                      | 37.3                              | 52.8                          |
| Constipation            | Yes | Nos. | 16                | 17   | 12                                        | 15                                | 10                            |
|                         |     | %    | 24.2              | 21.8 | 23.1                                      | 22.4                              | 18.9                          |
| Blood in urine          | Yes | Nos. | 33                | 50   | 29                                        | 41                                | 29                            |
|                         |     | %    | 50.0              | 64.1 | 55.8                                      | 61.2                              | 54.7                          |
| Weight loss             | Yes | Nos. | 34                | 51   | 34                                        | 38                                | 29                            |
|                         |     | %    | 51.5              | 65.4 | 65.4                                      | 56.7                              | 54.7                          |
| Unable to have a child  | Yes | Nos. | 15                | 18   | 14                                        | 11                                | 10                            |
|                         |     | %    | 22.7              | 23.1 | 26.9                                      | 16.4                              | 18.9                          |
| Rashes                  | Yes | Nos. | 34                | 56   | 30                                        | 39                                | 39                            |
|                         |     | %    | 51.5              | 71.8 | 57.7                                      | 58.2                              | 73.6                          |

**Sources of health care**

As Table 12 shows, the majority of MSM seek health care at the private doctor (76%) and/or government health facilities (37%), with 25% using both and 11% using neither. Health care was also sought at JAS/JFLAG (26%). Most persons i.e. about 90% of persons using the facilities stated that they did not experience any discrimination at these providers, but the highest level of discrimination was reported among those using government facilities (9%). In Jamaica, use of private is the norm for ambulatory health care so these results are not surprising. Also it is expected that MSM would only seek care at those facilities where they do not experience discrimination. Thus, a significant percentage of MSM prefer seeking services at JAS/JFLAG although that organization cannot really be classified as a health care facility.

**Table 12****Preferred source of health care**

|                                  | Nos. | %    |
|----------------------------------|------|------|
| Seek care at govt. health centre | 59   | 36.9 |
| Seek care at private doctor      | 135  | 75.8 |
| Seek care at pharmacy            | 30   | 16.9 |
| Seek health care at JAS/JFLAG    | 46   | 25.8 |
| Seek care at NGO health facilit  | 5    | 2.8  |
| Seek care - other place          | 2    | 1.1  |

**Sources of condoms and lubricants**

Sources of condoms and lubricants are shown in Table 13. Again, JAS/JFLAG emerged as a significant provider of both condoms and lubricants. The only other source of significance was the pharmacy that was used by over 50% of MSM for condoms.

**Table 13****Sources of condoms and lubricants**

|                                       | Nos. | %    |
|---------------------------------------|------|------|
| Source of condoms - govt. health      | 30   | 16.5 |
| Source of condoms - pharmacy          | 106  | 58.2 |
| Source of condoms - private doctor    | 24   | 13.2 |
| Source of condoms - JAS,JFLAG         | 106  | 58.2 |
| Source of condoms - Shop              | 52   | 28.6 |
| Source of condoms - supermarket       | 64   | 35.2 |
| Source of condoms - bar,hotel         | 13   | 7.1  |
| Source of condoms - friend            | 49   | 26.9 |
| Source of condoms - other             | 7    | 4.3  |
| Source of lubricants - govt. health   | 9    | 5.3  |
| Source of lubricants - JAS,JFLAG      | 81   | 47.9 |
| Source of lubricants - private doctor | 7    | 4.1  |
| Source of lubricants - friend         | 33   | 19.5 |
| Source of lubricants - supermarket    | 32   | 18.9 |
| Source of lubricants - other          | 9    | 5.5  |

**g) List of Places Frequented by MSM**

Table 14 shows the list of places where MSM socialized. Since these include places frequented largely by heterosexuals, socializing or ‘cruising’ appears to take place more openly than originally perceived. Special nights, secret codes, dress and other means of non-verbal communication help to locate like-minded men in public places. Only one gay club is now open, a decrease from the 1991 AIDSCOM/MOH study when several clubs were operating. Homes, private parties, and JAS (although categorized as “other”) emerged as crucial “safe places” in the interviews and focus groups.

**Table 14**

| <b>Bars</b>        | <b>Clubs</b>        | <b>Plaza</b>                  | <b>Other</b>    |
|--------------------|---------------------|-------------------------------|-----------------|
| Jamrock            | Kirks/Belvedere     | Pavillon                      | Homes           |
| Asylum             | Entourage           | Sovereign                     | Private parties |
| Clock Tower        | Mystic              | KFC –Montego Bay              | JAS             |
| Community gay bars | Asylum              | Ocean Village                 |                 |
| Compass bar        | Belvedere           | Bay West - Montego Bay        |                 |
| Coral cliff        | Brians (now closed) | Island Plaza - Margaritaville |                 |
| Half Way Tree      | Coral Cliff         |                               |                 |
| Hilton             | La Roose            |                               |                 |
|                    | Margaritaville      |                               |                 |
|                    | Patrick’s           |                               |                 |
|                    | Paulas              |                               |                 |
|                    | Twilight United     |                               |                 |

## G. STRATEGIES BASED ON FINDINGS

These strategies were based on the original objectives of the MSM Risk Mapping Study and on the findings. They included:

- (1) Creating trust and co-operation between the MSM community and the MOH/GOJ's programmes for prevention of HIV/AIDs
- (2) Encouraging increased and sustained condom use, taking into consideration the concerns of the target population, including their own responses to the epidemic
- (3) Ensuring expanded use of health services by the MSM community and of the referral network, and participation in interventions
- (4) Motivating MSM regular use of voluntary testing facilities, taking into consideration their concerns related to the time for waiting for results.

**According to international studies, “the most effective HIV prevention behaviour change programs for gay men rest upon a foundation of valuing, supporting and affirming gay men and their sexuality” (Gonsiereck, 1990).**

Although same sex activities and especially homosexuality among men are still illegal in Jamaica, the human rights of MSM present an issue for both the National HIV/AIDs Programme, the Justice System and the Police. Discussions with the Human Rights NGOs such as Jamaicans for Justice and with the Police Federation would be helpful. Although frequently gay men are not charged nor have they been seen committing an illegal act, the harassment and abuse meted out to them by the police, according to their reports, is not helpful in reassuring them about the trustworthiness of authorities especially in the public sector. As one informant said: “We are socialised to distrust authorities and therefore, we are forced to mask or hide our true intentions...”. Building trust and offering services that are genuinely helpful to the MSM community will be important in establishing a strategy that can extend into interventions that are effective and successful in these groups.

Another mechanism for securing the trust and cooperation of groups from the MSM community, and especially hidden and secretive sub-groups, would be to recognise and acclaim the pioneering work done by exclusively homosexual men. This would include Laurence Chang and the Gay Freedom Movement from 1977 to 1986, their education programme and clinic for STDs, and the mobilisation of the MSM community to prevent the HIV virus from spreading.

This work was expanded in 1990 with the embryonic group of men who formed what is now the Jamaica AIDS Support/JAS. Some of these men who are now in their 50s and 60s, are professional men and no longer active in the sector. Some of them have died (including several dancers from the National Dance Theatre Company) and many have migrated overseas. Documenting their early work or at least, allowing others to speak openly about their contribution to HIV/AIDS prevention and care in Jamaica would ensure future involvement and increased cooperation from the MSM Community.

**Securing the participation of members of the MSM community is essential for developing and implementing comprehensive interventions.**

These interventions should address not only personal factors directly related to health...but also personal factors and structural factors..." (Family Health International, 2003). Jamaica is no different. With the involvement of more than 200 men from the MSM community in this study, this offers the MOH an opportunity to build trust and ensure participation of MSMs in strategies for the protection of their groups from HIV/AIDS. The main strategy therefore, would be to involve the MSM community in the design and implementation of interventions that relate to them. appropriate community level interventions to reduce risky **These interventions should include interpersonal approaches to behaviour change, promoting non anal sex and non penetrative sexual activities, peer counseling programs and lifestyles and behaviour. The mechanism of institutionalising** the involvement of the MSM community is important in order to reflect the good intentions of the MOH and to encourage them to be involved. The creation of "safe places" where MSM can feel relaxed and discuss personal problems is important. This could be linked to access to STI care, counseling and promotional activities. This according to respondents, is not possible in the public clinics and recommendations are for separate locations. Distribution of condoms and lubricants is important to them. It would require an MSM specific approach. In many settings, the lack of access to water-based lubricants forces men to use other forms of lubricants (such as hand lotion, butter, cooking oil) that destroy condoms and can even cause breakage in condoms.

One successful approach to working with MSM has been to create or provide safe spaces where men can talk openly and receive STI care and counselling. Such centres offer a space for men to gather, and may also operate male sexual health projects with medical and psychological services for MSM. Another successful approach is integrating safer sex education into existing social activities. It is well accepted that peer-led interventions are most effective in reaching this target group. Peers should be brought into the decision-making process and invited to help develop interventions. These services can be provided through clinics, clubs, drop-in centres or outreach/street-based providers. Peer counsellors can provide education and services to MSM and their families and can host regular support group meetings. Here, MSM can explore topics of sexuality and sexual identity, such as safer sex, gay relationships, commercial sex work, living in a homophobic society, strengthening the gay community, relating to peers, values, attitudes and conduct. In addition, long term counselling and support services to men living with HIV or AIDS is an important service that should be provided.

**Another prong to the strategy deals with “gatekeepers” to information and care.**

An important aspect would be the involvement of the private doctors who are listed and named by the MSM groups (there are about fifteen of them). They are crucial to the education and care of the community, and seem to be one of the first lines of prevention. Health care workers who are known by the MSM community and named as being sympathetic to them (such as the Type 5 Clinic in Montego Bay and Nurse Gaynor in Ocho Rios), should be encouraged to target these men and to educate and assist them in turn to educate their own groups. This would include pre and post- test counseling, and promotion of regular voluntary testing. Training health professionals in Sexuality and Sexual Diversity could prove helpful. This could be done through in-service training as well as at the University of the West Indies. Whereas previously it was treated as an esoteric subject, Sexuality is now recognised internationally as having both scientific and sociological aspects that are relevant to many professions.

**The network of NGOs named by the participants as resources include CHARES, GLABCOM and JAS.**

It is possible that JN+ is another important NGO for them but they did not mention it probably due to fear of being categorised as HIV+. These NGOs could be used as channels of information and services for the community, as well as advocates within the community for safer sexual practices. Another important nucleus of influence is the professional and upper-middle class MSMs of Jamaica. A cadre of these men could be convened by one of the NGOs to address urgent needs for prevention and responses to the HIV/AIDS epidemic in Jamaica. Sectors of the economy which are most frequented by MSMs could be approached to assist in reaching groups that relate directly and indirectly to them. These sectors include: Tourism, Arts and Music, the Entertainment Industry including Modeling, the churches, Teaching/tertiary level. Programmes dealing with Commercial Sex Workers are also cross-overs to reach MSMs who are in the sex trade. Both literature and focus group respondents indicate that non-insertive gay male sexual behaviour and abstinence are appropriate methods of HIV prevention among the target population. This type of gay specific information can only be transmitted by MSM organisations and networks. The use of social settings and gay gathering places for distribution of information and condoms and lubricants is appropriate also, for gay specific groups and "gatekeepers". Outsiders would be considered intrusive and untrustworthy.

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