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Homosexuality and HIV/AIDS stigma in Jamaica

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Abstract
This paper reports on a study of the relationship of homophobia to HIV/AIDS-related stigma in Jamaica. Ethnography, key informant interviews and focus groups were used to gather data from a sample of 33 male and female adults during the summer of 2003. The sample included health and social service providers, HIV positive men and women, and men and women with same sex partners in urban and rural Jamaica. A strong and consistent relationship between homophobia and HIV/AIDS-related stigma was reported, but the relationship varied according to geographic location, social class, gender, and skin colour (complexion)—to the extent that this coincided with class. Stigma against people living with HIV/AIDS and homosexuality was implicated in low levels of use of HIV testing, treatment and care services and the reluctance of HIV positive people to reveal their serostatus to their sexual partners. Data reveal a pressing need for anti-stigma measures for both homophobia and HIV/AIDS, and for training for health and human service professionals.

Résumé
Cet article rend compte d'une étude sur le rapport entre l'homophobie et les stigmatisations liées au VIH/Sida en Jamaïque.

L'ethnographie, des entretiens avec des informateurs clé et des groupes focus ont été employés durant l'été 2003 pour rassembler des données provenant d'un échantillon de 33 adultes des deux sexes. L'échantillon comprenait des professionnels de la santé et des services sociaux, des hommes et des femmes séropositif(ve)s, des hommes et des femmes ayant des partenaires du même sexe et vivant dans des zones urbaines et rurales de la Jamaïque. L'étude révèle que le lien entre l'homophobie et les stigmatisations liées au VIH/Sida est fort et constant, mais qu'il varie selon l'emplacement géographique, la classe sociale, le genre et la couleur de la peau (le teint) – lorsque celle-ci coïncide avec la classe sociale.

La stigmatisation des personnes vivant avec le VIH/Sida et de l'homosexualité est l'une des causes des faibles niveaux de recours au dépistage du VIH et aux centres de soins, ainsi que de la réticence des personnes séropositives à révéler leur statut sérologique à leurs partenaires sexuels.

Les données révèlent des besoins urgents en matière de mesures anti-discriminatoires, aussi bien par rapport à l'homophobie que par rapport à la séropositivité, et en formation pour les professionnels des services sanitaires et sociaux.

Resumen
Este documento presenta un estudio sobre la relación de homofobia con respecto al estigma relacionado con VIH/sida en Jamaica. Se usaron datos etnográficos, entrevistas a informantes clave y grupos de discusión para recopilar datos de una muestra de 33 hombres y mujeres adultos durante el verano de 2003. En la muestra se incluyeron profesionales de la salud y servicios sociales, personas seropositivas, y hombres y mujeres con relaciones bisexuales en zonas urbanas y rurales de Jamaica. Se observó una relación sólida y uniforme entre la homofobia y el estigma relacionado con VIH/sida

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pero las relaciones cambiaban en función de las zonas geográficas, la clase social, el sexo y el color de la piel a medida que estos factores coincidían con la clase social. El estigma contra personas que viven con VIH/sida y la homosexualidad implicaba un nivel bajo en pruebas del sida, tratamientos y servicios sanitarios y la negativa de personas seropositivas de revelar su estado a sus compañeros sexuales. Los datos demuestran que son necesarias medidas urgentes para luchar contra el estigma de homofobia y VIH/sida y educar en este campo a los profesionales de la salud y los servicios sociales.

Keywords: *Homophobia, HIV/AIDS, stigma, Jamaica*

Introduction

Stigma has been associated with AIDS since the beginning of the epidemic, primarily because of its association with behaviors that are considered to be deviant: (male) homosexuality, prostitution (both male and female), promiscuity, and injecting drug use (IDU) (Herek 2002, Herek *et al.* 2003). According to UNAIDS (2002a: 21), ''HIV/AIDS-related stigma and discrimination rank among the biggest—and most pervasive—barriers to effective responses to the AIDS epidemic''. Parker and Aggleton (2002) suggest that AIDS-related stigma and discrimination remains one of the most poorly understood aspects of the epidemic because of its variations across cultures and limited theoretical frameworks for understanding how it is created, manifested, and maintained and how it impacts upon health behaviors.

Around the world, HIV/AIDS-related stigma is manifested in a variety of contexts within any given society. These contexts include law and politics; institutions such as employment, educational, health and human service agencies, and religious organizations; and socially, within the family and community (Snyder *et al.* 1999, Surlis and Hyde 2001, PANOS Institute 2002). Because health and human service professionals are on the front lines of HIV/AIDS prevention, care and treatment, Sowell *et al.* (1997) argues that discrimination in these sectors has a direct impact on access, utilization and quality of care for people affected by HIV/AIDS.

HIV/AIDS-related stigma is directly linked to delays in testing and the initiation of treatment, and this is particularly true in Jamaica. Jamaica's National AIDS Committee (2003) report that 67% of all newly diagnosed Jamaican AIDS cases test late in the progression of their illness and between January and June 2002, 34% of reported new cases were reported as deaths. UNAIDS (2003) reports that in the Caribbean, national expenditures to high-risk populations such as men who have sex with men and sex workers do not reflect their role in the epidemic and surmise that discrimination is the main reason for this. According to UNAIDS (2004) Jamaica, with a population of approximately 2.7 million, has a 1.4% rate of adult infection at the end of 2002. Jamaica had the second highest number of cases and deaths in the region with 980 children and adults dying of AIDS in 2001, and 5,100 children having lost at least one parent to the disease since the epidemic begun in the mid-1980s (UNAIDS 2002a).

Despite the increasing feminization of the epidemic in Jamaica, as elsewhere, HIV/AIDS is still perceived by some to be a gay disease, although the data from this study reveals that this is slowly changing as the spread of infection has brought many people face to face with AIDS in their own families and communities. Robillard (2001) found that even though their general knowledge of HIV transmission was quite accurate, Jamaican youth believed that HIV was primarily transmitted by homosexuals. The 2002 *Global AIDS Report* (UNAIDS 2002b) also cites recent studies that show that most Caribbean men who have sex with men also have sex with women, and that bisexual behaviour is widespread but hidden. UNAIDS also acknowledges that HIV/AIDS prevention, care and support

programmes in Jamaica are hampered by legislation which criminalizes male homosexual behaviour (UNAIDS 2002b).

Dowsett (2003) argues that North American-derived conceptualizations of the relationship between HIV/AIDS stigma and discrimination and homophobia may not provide the culturally specific relationships needed to develop culturally appropriate intervention strategies. His work in Bangladesh explored this relationship in a cultural context ''where sex between men does not conform to categories of human sexuality privileged in Western theory'' (p. 121). This study sought to extend such an analysis to Jamaica in the hope of informing and inspiring studies of HIV/AIDS stigma and discrimination and homophobia, as separate and connected issues, in the Caribbean region.

HIV/AIDS-related stigma and discrimination (HASD) in Jamaica

According to health and human service professionals working in the field, HIV/AIDS-related stigma can be so severe in Jamaica that some people become suicidal when they first receive their diagnosis. These suicidal ideations are often rooted in the fear of isolation and discrimination that will come as a result of having others find out about the disease, and not as much from the potential of death associated with it. For example, although cancer carries the same association with death, the lack of social stigma attached to the disease and the accompanying sympathy and support that it evokes from family and friends results in a different emotional reaction to the diagnosis than that brought about by someone hearing for the first time that they have HIV or AIDS.

There have been few reports of HIV/AIDS-related stigma and discrimination in the Caribbean within the academic literature (Trotman 2000, Carr 2002). Two studies have explored the phenomenon among health or human service workers, one using qualitative methods (Bain 1998) and the other quantitative approaches (Wickramasuriya 1994). Both reported a consistent unwillingness of healthcare workers to work with people living with HIV/AIDS, particularly if they are homosexual.

Although HIV and AIDS-related stigma and discrimination is still a significant and widespread problem (Carr 2002), it may decrease as the prevalence of HIV increases and more people come face-to-face with AIDS within their own families. National anti-stigma campaigns that include posters, speakers forums, anti-stigma training, and ongoing media campaigns may also be salient in this respect.

Homophobia in Jamaica

According to Williams (2000: 106), ''Jamaica is perceived to be the most homophobic Caribbean territory. It is also a badly kept secret that Jamaica has a perceptibly vibrant gay population''. Sexuality-based oppression in Jamaica is institutionalized throughout the legal system, health and social welfare institutions, popular media and culture, and, through extreme social stigma. Buggery and Gross Indecency laws are implicitly anti-gay and include maximum sentences of ten years imprisonment with hard labour for anal sex. Lesbians are not specifically targeted by these laws.

The Jamaica Forum for Lesbians, Allsexuals and Gays (J-FLAG 2003) has collected personal testimonies from gay, lesbian, and transgendered Jamaicans, to document the discriminatory and violent conditions faced by sexual minorities in Jamaica on a daily basis. Reports include verbal abuse by work colleagues; vicious beatings by police, relatives and community-members, some of which have resulted in death; and, homelessness after being driven from their communities by angry neighbours.

The Jamaican government has overtly sanctioned homophobia by including homophobic messages in their year-2002 political campaigns. Anti-gay sentiments can also been found in popular Jamaican songs that advocate anti-gay violence. These songs, and the artists who sing them, have been the subject of debate and boycott by American groups such as Gay and Lesbian Alliance Against Defamation (GLAAD) and Gay Men of African Descent (GMAD), as well as in forums such as *Vibe* magazine and the *Village Voice* (Chin 1999). Possible negative impacts on tourism, which is the main source of foreign exchange in Jamaica, preclude overt political acknowledgement of the problem.

HIV/AIDS workers have also experienced violence at the hands of community members who accuse them of ''promoting'' homosexuality and promiscuity, and a major prison riot resulted from public announcements in 1997 that the authorities were considering condom distribution in prisons. This was because of the assumptions that were being made about sexual activities between male prisoners.

In addition to the conservative religious beliefs that are key to understanding Jamaican sexual norms, the virulent forms of homophobia present in contemporary Jamaican society can be attributed to norms of hypermasculinity detailed in recent books by Chevannes (2002) and Reddock (2004). This hypermasculinity is equivalent in many ways to the sexual behaviours associated with *machismo* in Central and South America. Typical sexual behaviours include the early onset of sexual intercourse, concurrent multiple partners, and extramarital affairs; sex with women being the foundation of such behaviour.

Culture, class and gender

In a recent qualitative study of people living with HIV in Jamaica, Carr (2002) reported significant differences in the way in which female and male HIV positive people are treated by their community, with men being more accepted by friends, family, colleagues and employers. However, this acceptance is linked to the portrayal of a strong heterosexual identity that includes multiple partners and participation in male-oriented activities such as playing dominoes, drinking, hanging out at bars and fathering children—the latter being a ''key marker for heterosexual prowess in Afro-Caribbean communities'' (ibid.: 7). Women generally reported psychological and physical violence including ostracization and violence.

Because of the strong association between AIDS and sexual behaviour in the Caribbean, where transmission through injecting drug use is rare, those who have HIV are considered ''dirty''—a Caribbean concept used to describe people who have participated in sexual behaviours such as sex with sex workers and or homosexuals. Because of this, Carr (2002) noted that most HIV positive Jamaicans had not considered themselves vulnerable to HIV prior to becoming infected.

Methods

The methodology for this study including focus group discussions and individual interview based on protocols developed by UNAIDS, WHO and PANOS for their studies of HIV/AIDS-related stigma in other developing countries. This study was exploratory in nature and was not intended to be exhaustive. The goal was to provide some understanding of the nature of the relationship between HIV/AIDS stigma and homophobia in Jamaica. The data for this study was collected during June and July of 2003 in Jamaica in collaboration with the Jamaica Forum for Lesbians, Allsexuals and Gays (J-FLAG) and Jamaica AIDS Support (JAS).

The primary methods of data collection involved individual and focus group interviews with men who have sex with men; men and women living with HIV/AIDS; women who have sex with women; and, health and human service professionals such as doctors, nurses, community-based health workers, and social workers. Interviews took place between June and July of 2003 in four different locales—Montego Bay, Ocho Rios, Kingston and Black River. Supplementary data were obtained from archival research in the Jamaica-based collections of J-FLAG, the Jamaica Ministry of Health, the Pan American Health Organization; the Sir Arthur Lewis Institute of Social and Economic Studies at the University of the West Indies; and the Center for Gender and Development at the University of the West Indies. In addition, a brief period of ethnographic fieldwork took place on the western coast of the island and in the metropolitan Kingston area. Activities observed included training and meetings at Jamaica AIDS Support's offices, rural and urban marketplaces, and bars, nightclubs and other such areas where groups of men and women gather and socialize.

Instruments

Individual and focus group interviews used a semi-structured interview schedule to ask about perceptions of the experience of living with HIV/AIDS and having same sex relationships. Questions covered topics such as reactions to diagnosis; disclosure of serostatus; experience in various sectors such as education, employment, family, friends, church and health and human services; and the impact of gender, colour and class. Participants were asked their opinion of the government or official response to HIV/AIDS and were also asked to suggest ways in which to change the sociocultural environment facing people living with HIV/AIDS and people with same sex partners in Jamaica.

The sample

Convenience and purposive sampling of HIV/AIDS programme staff and clients and the participants of support groups for people with same-sex partners, were the main sampling strategies adopted. Key informants were identified and recruited in consultation with Jamaica AIDS Support and J-FLAG.

Professional informants composed two doctors, two nurses, three social workers, a journalist and four other HIV/AIDS workers. Other participants included ten men who have sex with men (MSM), four HIV positive women, three HIV positive men, and five women with same sex partners. The youngest participant was 19 years-old and the oldest was 54, with most being in their mid-20s to mid-30s. Three social workers were interviewed as a group but other professionals were interviewed individually. Men who have sex with men were interviewed in Kingston, Montego Bay and Ocho Rios. HIV positive women were interviewed in Kingston only. People living with HIV/AIDS were interviewed in Kingston only, although some of the men who have sex with men in all locations were also HIV positive.

Analysis

Thematic analysis using constant comparative method was used to analyse the data. Notes were taken during interviews, which were also taped. Interviews were not transcribed but tapes and notes were compared for accuracy. Notes were coded and analysed for recurrent themes.

Protection of human participants

Before participating in interviews or focus groups, the researcher read respondents the consent form, which explained the purpose and procedures of the study, its attendant risks and benefits to the participants, and provided contact information for the principal investigator and the local HIV/AIDS organization that helped recruit the sample. Participants were also given a business card of the principal investigator, which included a local number on the reverse so that if they did not want to have the document which might ''out'' them to others, they could still be able to contact the principal investigator in the future. Questions were elicited and answered before proceeding with any interviews. All participants were given the opportunity to read and sign the consent form that detailed the procedures of the study. Some chose not to sign anything, others signed with fake names. Because the study was of highly stigmatized behaviours and illness and the consent form was the only document linking the participants to the study, people were allowed to participate if they wanted to even though they did not wish to sign the consent form. Regardless of whether or not they signed the form, they were given a copy for their own records.

Notes were taken at all interviews and some interviews were taped, depending on the degree of comfort that was expressed by the participants. The obvious hesitation of many participants to have any evidence of their participation in the study, whether because of their sexual behaviour or sero-positive status, provided further evidence of the stigma associated with HIV/AIDS and homosexuality, even though participants were assured of confidentiality and anonymity, and the promise that the data would be stored several thousand miles away in Seattle, WA.

Findings

The law

The Offences Against the Person Act of the Jamaican Criminal Code contains several sections that deal with male homosexual acts and non-gender specific anal intercourse. Article 76 stipulates that anyone committing buggery with man or animal is ''liable to be imprisoned and kept to hard labour for a term not exceeding 10 years''. Under Article 79, any male convicted of ''any act of gross indecency with another male person'' is liable to receive a maximum sentence not exceeding 2 years, ''with or without hard labour.''

Politics

The political situation in Jamaica is one in which homosexuality has been used in smear campaigns against opposing political parties. Graffiti in Kingston and discussions in the street focus on the sexual orientation of various politicians or political parties. Political response to J-FLAG's attempts at human rights legislation modeled after that in South Africa, has been to firmly reiterate that Jamaica will not legalize homosexuality. The response of columnists of all persuasions in the serious and respected and most popular press outlets has been to suggest that what is good for other countries is not necessarily good for Jamaica. According to sources at J-FLAG, *Jamaicans for Justice*, one of the leading human rights organizations in Jamaica, has shied away from taking on the issue of sexuality-based oppression because of the contentious nature of the issue.

The response to HIV/AIDS outside of the Ministry of Health has been limited. Until recently, initiatives to provide low-cost medications have come from the private sector, and HIV/AIDS has not been included in the list of conditions that qualify for coverage under the national low cost drug programme; a long list that includes depression, heart disease, hypertension, cancer and other costly illnesses. The response has been that there will be a separate programme to make antiretroviral treatment affordable, but this has been slow to materialize. While there has been a significant decrease in the price of ARV, the cost of treatment is still well above that which the average working person can afford.

The sociocultural environment

There is strong support in the literature, and from the data collected to date, for the homophobic nature of Jamaican society. Press reports of homosexuals caught in the act use terms such as the ''unholy position'' (*The Star* 2000: 3). Reference to religion recurred in discussions with participants in this study and in discussions of homosexuality in the Jamaican media. Recent reports of Anglican acceptance of homosexuality in the USA and UK have brought strong reactions from Jamaican clergy with suggestions that the West Indian Anglican church may consider breaking away from the British church because of its appointment of a gay bishop. One article on this issue linked homosexuality with the ''exploitation and seduction of children'', (Roper 2003) and Rev. Peter Garthas was quoted in the *Sunday Herald* describing homosexuality as ''a sickness like AIDS'' (*Sunday Herald* 2003).

When asked directly about the relationship between HIV/AIDS stigma and discrimination and anti-gay sentiments in Jamaica, almost all respondents reported that while there is a clear linkage of the two in Jamaica, the situation is gradually changing as AIDS affects more across families and communities. There was also some acknowledgement that even though people may know that there are other ways to get HIV/AIDS, if people believed the person was a man who had sex with other men, they would be much more stigmatizing towards them.

> HIV+ people are seen as perverts. (Female social worker)

> If they know you get it straight, then they will tolerate it. But if they think they deal that way, then it is an additional thing. (Female nurse)

Jamaican culture seems to support a ''Don't ask, Don't tell'' policy regarding the coming out of homosexuals within families and communities. As one author of a letter to the editor of *The Star* newspaper wrote in December of 1998 (p. 9), ''When we first heard of gays and lesbians, we had nothing to fear, the very thought of the idea in Jamaica was absurd, unthinkable, inconceivable, unheard of''. One doctor even asked the principal investigator of this study if there actually were homosexuals in Jamaica, as he had not ''come across any''.

Several men who have sex with men interviewed reported that they knew that family members and friends had heard of their homosexual activities, but that they had not been asked directly about their sexual orientation. One man even recently married the only woman he has been with in about 10 years, even though he identifies himself as homosexual. When asked if he had discussed the issue with his wife, he reported that he had not, but that she had heard rumours in the community. He had known this woman before he came out and his mother, who knew that he was homosexual, was present at the

wedding. Although this was an extreme case, many men reported that while they told few people about their homosexuality, many of their close friends simply ''knew''. This is in direct contrast to North American notions about coming out, which tend to involve direct conversations with loved ones. Although it is appropriate to view this as a culturally specific way of coming out, it also supports the secrecy and double lives that facilitates the spread of HIV.

Last, but definitely not least, Jamaican culture supports violence against gay men, with shouts of ''death to all battyman'' being prevalent in popular culture, street corner discussions and hurled at any suspected gay man. In a recent article, Carr (2003) reported on judgments against gay men, which is a term for violence directed at gay men, particularly in poor urban communities. These judgments are socially sanctioned and have resulted in men being stoned, beaten, cut, shot and even killed by violent mobs or individuals.

Gender

Jamaican homophobia is not generalized to both women and men to the same degree but is more targeted towards males. All of the 33 participants in this study reported that men were on the receiving end of anti-gay sentiment in Jamaica and that this carried over into the HIV/AIDS arena. When describing the experiences of HIV positive men and women, one social worker stated that,

> Gender makes a difference. If you're a woman you are promiscuous or commercial sex worker or victim of circumstances. But if you're a man people assume you are gay.

However, one respondent reported that,

> People look at the female as bad person and have sympathy towards the male. (Male doctor).

This response refers to the perception that women who get HIV/AIDS have stepped outside of culturally accepted boundaries of sexuality by being promiscuous. As the cultural expectation is that men will have multiple partners, some people find it easier to sympathize with men because they will consider HIV to be the consequence of a man's masculine behaviour with women, and not necessarily a consequence of sex with men.

Most reported that when anti-gay opinions are expressed they are almost always targeted at men. There were reports from various groups and individuals that women can be seen together in public with impunity. Some reported that women can hold hands, be affectionate and even express public displays of affection without causing a stir in places where two men who even *appear* to be gay would be the target of verbal aggression at the very least. Several respondents suggested that it was easier for women to mask the level of intimacy in their relationships because women are expected to ''cling together'' (female social worker), whereas there are certain things that ''men are not supposed to do'' (female social worker).

Although cultural critics and academics cite a religious basis for this homophobia, the fact that it is unequally directed towards men suggests that there may be something else at the root of strong anti-gay sentiment. The culprit may be cultural definitions of masculinity that emphasize sexual prowess with women and eschews ''softness'' in a man. In one conversation overheard in a taxi, one man stated that he had a better understanding of bestiality than homosexuality. As astounding as this was, and despite being challenged on

his position by one of the authors of this paper, the speaker held forth in his opinion and gained the support of at least one other passenger. What was interesting was that one passenger who expressed an interest in ''seeing two men together'' received no negative reaction from the group of five men present in the car at the time.

Class

In Jamaica, class is a significant determinant of exposure to anti-gay stigma and discrimination. Poverty directly impacts on access to resources of all kinds and therefore influences individual and community responses to crisis. With regards to the relationship between anti-gay sentiments and HIV/AIDS stigma, wealth provides an ability to ''opt out'' of public services and health services in Jamaica and fosters an invisibility of HIV/AIDS among the more wealthy sectors of the populations. As one social worker stated, ''If you're poor, [and you have HIV] you did something bad like being promiscuous, but when you're rich no one knows''. Therefore, HIV/AIDS carries the public face of poverty and this link implies to some members of the middle class that it is the dirty behaviour of others that results in their misfortune and that they themselves are somehow shielded from the disease. Wealth also guarantees the privacy that a gated compound in the hills provides.

Time and again, respondents reported that rich men who lived in the suburbs were protected from violence by their access to resources but that poor men ''did their business in the street'' and so were more ''exposed'' to police intervention, community exclusion and personal violence. This was also a factor influencing stigma and discrimination against people living with HIV because poor people were much more likely to display the physical symptoms of AIDS due to their lack of access to anti-retroviral medication and general healthcare services. Thus, poor people were much more likely to experience either homophobia or stigma and discrimination because of their inability to hide as well as those with money could. Poverty thus serves as a juncture between homophobia and HIV/AIDS stigma and discrimination such that poor men with HIV were assumed to have participated in homosexual acts and poor men who participated in homosexual acts were assumed to be HIV positive.

Colour

Almost all respondents reported that skin colour was not a factor in community reactions to homosexuality except for the association between colour and class that is inherent to any post-colonial society. Participants seemed to agree that class was much more likely to impact upon a homosexual man's life than colour, because people do not care what colour you are if they know you are gay. At the same time, there is a feeling among many Jamaicans that homosexuality and HIV have been brought to Jamaica by tourists. The high rate of HIV in Montego Bay is associated with the sexual promiscuity and more liberal sexual mores of a tourist haven in which local men and women trade sex for cash, goods and other rewards.

Discussion

As reported previously, the link between homosexuality and AIDS is weakening in Jamaican society as more families and communities are touched by the disease. This has led to an understanding of HIV/AIDS as a disease that may also impact upon the lives of

Christian married women. Efforts to increase awareness of issues related to people living with HIV have been reported as being successful in reducing the ignorance that fuels the *dirty* image of people who have HIV/AIDS.

This perception appears to be a key factor in a widespread reluctance to get tested or receive treatment, especially at publicly-funded facilities. Despite confidentiality rules common to any modern health service provider, there is the well-grounded fear that hospital staff—particularly, paraprofessionals and auxiliary staff are likely to report to the community the HIV status of any individual who presents at a hospital. In one rural community, a nurse reported that when one young, attractive man came from a nearby community to receive treatment for AIDS, many members of the same community travelled several miles to the hospital to ''see'' the patient. Hospital security staff had to be summoned to have them removed.

Fear of one's HIV status becoming known about in this way is directly related to the fear of being ostracized from the community or from family. Those who can afford to do so, seek testing and treatment from private providers locally or abroad. This does not protect the individual from being outed, however, because HIV in Jamaica is a reportable communicable disease. Reporting results in a visit by the contact investigator who then asks for names of partners. A source at the Ministry of Health said there have been demands for anonymous and confidential testing, but others argue that in order to control the spread of the epidemic, there has to be intervention by healthcare providers.

Recently, there seems to be growing acknowledgement in Jamaican society that societal support for promiscuity and early sexual initiation are stronger contributing factors in HIV transmission than is male homosexual behavior. Despite widespread knowledge of methods of transmission of HIV and other STIs, condom use is still inconsistent because it is common to provide evidence of one's fidelity by eschewing the need for a condom. The recent appearance of a gay man on a popular TV talk show (Our Voices, June 2003, CVM television, no date available) did not produce the strong response that was expected by certain sectors of the Jamaican public. As one columnist reported, ''Whatever the reason, one thing is clear, times certainly are changing in this society'' (*The Star* 2003). He opined that it may be a result of more exposure to gay images on cable television. It may also be related to the frequent reporting of the sexual behavior of homosexual men in the popular media. A recent onslaught of articles with headlines such as ''Politician loves to call gay lover his wife'', various ''caught in the act'' reports and the regular appearance of gay-related questions to various advice columnists may have resulted in desensitization to the issue of homosexuality.

Limitations

The primary limitation of a study such as this must be its small sample size and selection bias that resulted from one organization being the link to most of the primary respondents. Because that same agency serves populations that already experience stigma due to their poverty or sexual behaviors such as sex work and homosexuality, their may have been a strong bias towards experiences of stigma. Including clients from one or more other organizations might have resulted in different perceptions. However, in an environment in which stigma and discrimination is attached to both homosexuality and HIV/AIDS, it would be difficult for a relative outsider (despite having some insider status) with limited time and fiscal resources to gain access to such populations without the support of a local agency.

Providing an incentive to participants might have increased the response rate. Many attempts were made to convene various focus groups. Some of these did not happen and others were rescheduled several times. This was due to the ever-changing life circumstances of these vulnerable populations, as well as their limited access to transportation and other resources. Furthermore, there are few, if any, *natural* gathering places for homosexual men or for people living with HIV/AIDS other than the organizations with whom the researcher collaborated.

Nevertheless, the common themes that crossed professional boundaries and type of participant, including non-agency affiliated professionals, provide some assurance as to the generalizability of the opinions that were expressed. These responses were also supported by reports in the media and by other research reports. Despite the small sample, theoretical saturation and redundancy was reached very early on, as there seemed to be a general consensus across geographic boundaries and professional strata about the ways in which homosexuality and HIV/AIDS stigma are linked in Jamaican culture.

Conclusions

All participants were asked to make suggestions with regard to improving the situation for both people living with HIV/AIDS and people in same sex relationships in Jamaica. They all reported that there need to be continued efforts to put AIDS in the public eye and respondents believed that past attempts to reduce stigma and discrimination through ''meet the people'' panels and forums both in the community and in the media have resulted in changed behavior. One HIV positive man suggested that, organizations should, ''use people from one area to speak in other areas to reduce risk of discrimination'', because as one HIV positive woman reported,

> A guy [at a speakers forum] said that people with AIDS should be locked up and isolated and he changed his mind [after the forum] and he hugged me and stayed in touch. (28 year-old HIV positive male)

Stories like this one were repeated on several occasions and provide evidence of the success of such programmes. Many people reported that their own behaviour has changed after meeting someone with HIV because it dispelled the myths they previously had about people who were infected had HIV/AIDS. One healthcare provider admitted that despite knowing how HIV was transmitted, the anti-stigma training she has received has made a big difference in her own approach to patients. It is therefore strongly recommended that these efforts continue, especially at the community level.

Access to treatment may increase the likelihood of testing. The still largely prohibitive cost of HIV medications makes testing seem futile to some respondents. It is therefore imperative that a national anti-stigma campaign be developed and implemented. This campaign should be founded on findings from rigorous study of the contributing factors to HIV/AIDS stigma and discrimination within the particular cultural context that is Jamaica.

So long as HIV/AIDS continues to be closely linked to male homosexual behavior, it is crucial that efforts be made to reduce the social isolation and discrimination that homosexual men face in Jamaican culture. This is a difficult challenge that is directly linked to the seemingly more straightforward challenge of changing attitudes towards people living with HIV/AIDS who can be seen as worthy of sympathy and attention.

Nevertheless, the brutal treatment of homosexual men is linked to the recriminations against other perceived transgressors and will continue to provide an avenue for stigma and

discrimination at levels unacceptable in the twenty first century. Homosexuality may be a long way from being ''normalized'' in Jamaican society as one man suggested, but changes to discriminatory laws would reduce some of the work that needs to be done in securing basic human rights in this religious and conservative society.

Link and Phelan (2001) have argued that stigma is a ''persistent predicament'' (p. 9), which is hard to eliminate because the ''range of mechanisms for achieving discriminatory outcomes is both flexible and extensive'' (p. 9). They propose that stigma can shape the course and outcome of a disease by creating conditions which lead to disease and by limiting access to resources that may serve as protective factors while heightening exposure to risks.

With respect to AIDS in Jamaica, stigma and discrimination occur at structural, personal and intrapersonal (or psychological) levels. Therefore, any and all attempts to eradicate it must focus on all three aspects of this phenomenon: laws must be changed or created that protect the human rights of all persons; people must be discouraged from attaching stigma to individuals and to conditions; and people who are stigmatized must be encouraged to shed the shame of stigma and fight for their rights, both collectively and individually. Structural changes need to lead the social and cultural changes that must occur. Laws and professional practices need to be changed so that people's behavior changes; even if their attitudes do not.

As so aptly stated by Cogswell (2001), so long as AIDS is related to homosexual behaviour, men who identify as straight—whether they have sex with men or not—will not use condoms, people will go untested because they think they are immune or they are afraid of anti-gay or anti-AIDS violence, people will delay treatment, and the epidemic will continue to grow unchecked.

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