Jamaica HIV National Strategic Plan for

Men who have Sex with Men (MSM)

2012 -2017

ACRONYMS

AIDS – Acquired Immune Deficiency Syndrome
ART/ARV – Antiretroviral treatment, Antiretroviral
BCC – Behaviour Change Communication
CBO – Community based organization
CSO –Civil Society Organization
CVC – Caribbean Vulnerable Communities
FBO – Faith based organization
HCW – Health Care Worker
HEART NTA - Human Employment and Resource Training Trust, National Training Agency
HIV – Human Immunodeficiency Virus
JASL – Jamaica AIDS Support for Life
JFLAG – Jamaica Forum for Lesbians, All sexual and Gays
JFLL – Jamaica Foundation for Lifelong Learning
LMIC – Lower and Middle Income Countries
M&E – Monitoring and Evaluation
MERG – Monitoring and Evaluation Reference Group
MSM – Men who have Sex with Men
MSMCBO – Men who have Sex with Men Community Based Organization
MSMTWG – Men who have Sex with Men Technical Working Group
NGO – Non Government Organization
NHP – National HIV Program
NSP- National Strategic Plan
PHDP – Positive Health Dignity and Prevention
PLACE – Priority for Local AIDS Control Effort
PLHIV – Person Living with HIV
PLWA – Person Living with AIDS
S&D – Stigma and Discrimination
T&C – Treatment and Care
UNAIDS – United Nations Program on HIV/AIDS
UNDP – United Nations Development Program
UNFPA – United Nations Population Fund

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Literature Review

HIV Epidemic and MSM

Global trends in HIV prevalence among MSM

In 2012 high HIV prevalence persists globally among men who have sex with men. This issue is alarming as despite the decades of research, community, medical and public health interventions which have resulted in declining prevalence in other populations there is evidence of increasing prevalence among MSM. In high income settings for example, Australia, France, the UK and USA, the overall HIV epidemic trends are in decline except in MSM where there have been expanding in the era of highly active antiretroviral therapy (HAART). This has been described as re-emergent epidemics in MSM. In the USA HIV infections have been estimated to be increasing at approximately 8% per year since 2001. (Breyer et al. 2012) The increase in HIV prevalence in the USA disproportionately affects black men as although representing less than 1% of the total population, nearly a quarter of the new HIV infection in 2009 were in black men. According to US Centres for Disease Control (CDC), new HIV cases increased by 48% in young US black MSM from 2006 to 2009

The recent evidence from the literature suggests that men who have sex with men (MSM) are at an even higher risk of HIV infection in lower and middle income countries (LMIC) such as Asia, Africa, Latin America and the Caribbean, Eastern Europe and Central Asia. (IBRD 2011). The report further suggests that research among the population in the LMIC has been limited by; the 'criminalization, discrimination and social stigmatization of their behaviours, safety considerations for study participants, the hidden nature of the population and lack of targeted funding. However the evidence from available research seems to suggest that contextual or structural risk factors which include; socioeconomic, political and legal environment are likely to be major contributors to the prevalence in the MSM population in the LMIC. Other factors such as network level, community level and biological drivers require further research and could be critical in providing the responses for the persistent high transmission rates in the population.

MSM HIV prevalence in the Caribbean

According to UNAIDS 2010, HIV prevalence among MSM in the Caribbean ranges from 0.09 % in Cuba to 31.8 % in Jamaica, which reflects the increasingly serious nature of the epidemic in the region. Three territories - Jamaica, Trinidad and Tobago and Guyana have prevalence above 20%. Other prevalence rates in the Caribbean include Dominica Republic - 11%, Bahamas - 8% and Suriname - 6.7%. These rates are significantly higher than the general population and also higher than rates in other populations which are considered most at risk.

HIV epidemic in Jamaica

Jamaica has an estimated adult HIV prevalence of 1.7% in 2010. There is an estimated 32,000 persons living with HIV *(PLHIV) (UNAIDS 2010).* Approximately 50% of these persons *are* unaware that they are living with the virus. There has been a 25% decline in new HIV infections in Jamaica, however an estimated 2,100 persons become newly infected each year and AIDS remain one of the leading causes of death among adults 15 – 49 years. The Jamaican epidemic can be described as both

generalized and concentrated among key populations which have higher prevalence. The prevalence in female sex workers is 5% and among men who have sex with men (MSM) the HIV prevalence is 32%. (UNAIDS 2010).

The MSM population in Jamaica

The MSM population in Jamaica is estimated at 33,000 MSM[1]. A survey of 201 MSM in 2008 and of 453 MSM in 2011 both found an HIV prevalence of 32% (Figueroa et al 2011) which is considerably higher than the 10% HIV prevalence in a sample of 125 MSM in 1985 (Murphy et al 1988). The modes of transmission study conducted in 2012, adjusted the prevalence to 20% based what the study regarded as biased sampling in the previously mentioned survey. The majority of respondents in the 2008 and 2011 surveys were from the lower socioeconomic group who either accessed the public health services or were part of the network that accessed services.

MSM Sexual Practices

Sex with females: In the 2007 survey 56.7% MSM had at least one female partner in the past 12 months and almost two thirds (64.3%) who self-identified as bi-sexual.
Multiple partnerships: 27.4% of MSM had multiple male partners within the last 4 weeks.
HIV testing: 57.7% had ever done an HIV test and 32.9% had done so in the past 12 months.
Condom use: 67% reported using a condom at last sex with their main male partner while 62% reported doing so at last sex with a female partner.
The study on the modes of transmission also indicates that 1.76% of the total female population are partners of MSM and the estimated HIV prevalence in this group is 1.4%. These findings suggest that men who have sex with men and women function as a bridge population and may account for the increasing rate of HIV seen in women. According to the model used for prediction in the modes of transmission study 30% of new HIV infection will occur among MSM and 7.2% among their female partners.

Qualitative research suggests that sexual identities and relation patterns among MSM are diverse (Royes, 2003; Anderson, 2010; UWI HARP, unpublished). However, data on some subgroups within the MSM population (e.g. MSM with high socioeconomic status, adolescent MSM and "down low" MSM) is sparse as these persons remain underground and are not accurately captured in the surveillance system.

The UNAIDS projection model does not indicate any meaningful decline in new HIV infections among MSM over the next few years. Given the large number of MSM who are HIV infected, the frequency of multiple partnerships and condom use patterns, the high HIV prevalence will be maintained or even increase if meaningful behaviour change is not achieved within this strategic planning period 2013 -2018. More effective ways need to be found to reduce the high prevalence of HIV

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[1] 4.4% of adult male population

among MSM in Jamaica including measures to reduce their social vulnerability, combat stigma and discrimination and empower them to practice safe sex. (NSP 2013-2018)

MSM and Sexual Health

Defining sexual health in the rights based framework: Sexual health among MSM is more than the presence or absence of disease. It is a holistic concept that includes how MSM approach their sexual behavior and relationships, how they feel about themselves and how their mental and physical health is affected by them. (Wolitski & Fenton 2011). Sexual health also acknowledges the need for positive and respectful approach to sexuality and sexual relationships which is pleasurable and safe, free of coercion, discrimination and violence. For sexual health to be attained the sexual rights of all persons have to be recognized and respected.

Individual Risk factors and sexual health

1. Sexually transmitted infections

Although sexual health goes beyond absence of STIs research indicate that existing behaviors among MSM place them at higher risk for STIs. According to the Jamaica MSM study conducted in 2011, among 453 participants, 61% of those who identified as MSM sex workers had ever been told by a doctor that they had an STI compared to 47% among the non- sex work, MSM.

In the same study respondents were asked what they had done the last time in the past 12 months when they had a symptom of a STI. Only 20.9% told their main partner. And only 32.3% had either gone to a health center or private doctor. About 59% of respondents reported that they had at least one one-night stand.

2. Unprotected anal intercourse (UAI)

UAI has been identified as another major factor in the transmission of HIV. A study conducted by Figueroa et al in 2008 indicated that 73% of the participants had used a condom at last anal sex. There are several sub factors which impact the practice of unprotected anal intercourse. These include;

I.   *Lubricant use:* The use of water based lubricant is promoted as means to reduce the trauma that can result from unprotected anal intercourse. The study revealed that only 60% of participants indicated lubricant use almost always in the last 3 months. (Figueroa et al 2008).

II.   *Multiple sexual contacts* another risk factor for HIV transmission is common practice as indicative in results from the same study, 54% of participants reported more than two male sex partners in the past 12 months, while 34% reported two or more female partners in the past 12 months.   (Figueroa 2008 et al).

III. *Transactional sex and commercial sex:* in the 2008 MSM survey 43% of the participants indicated that they had been helped with money following sex and 21% were paid cash for sex. (Figueroa et al 2008)

IV. *HIV risk perception:* Data from other research conducted in six US cities among young MSM in 2007 by Mckellar et al suggest that many young MSM underestimate their lifetime risk for acquiring HIV. The study showed that among young MSM who perceived themselves at low risk for acquiring HIV, approximately one in five were unaware that they had acquired HIV. Additionally the same study found that approximately 50% of all unrecognized HIV infections were found among young MSM who perceived themselves at low risk. In Jamaica the MSM study conducted in 2011 by Figueroa et al indicated that of the 453 participants 47% perceived that they had little or no chance of being infected with HIV.

V. *Disclosure of HIV status:* HIV positive MSM who are aware of their status are engaging in unprotected anal intercourse. This is confirmed in a recent study conducted in the United States on unprotected anal intercourse (UAI) among HIV diagnosed *MSM* who had a steady partner with either a negative or unknown HIV serostatus. The study reported that of the 674 HIV positive MSM who were aware of their infection for an entire year before being interviewed for the study, 144 (21%) reported engaging in unprotected UAI in the year before the interview. 36% never used condoms during anal intercourse and 64% sometimes used condoms. (Denning & Campsmith 2005).

VI. *Educational level:* MSM with lower education level might be challenged to access and understand HIV prevention information. Also they may lack communication skills to negotiate safer sex. This according to a study conducted in the USA by Denning & Campsmith in 2005.

VII. *Non- disclosure of sexual orientation:* Some MSM are not willing to self-identify as MSM, but rather as heterosexuals. MSM in this category may not be as aware of the specific risk associated with gay sexual activity. They may fail to associate themselves with prevention messages directed at the MSM community and are unlikely to be involved in prevention programmes which are designed for the community. According to the U.S. Department of Health and Human Services 2003; "young MSM who do not disclose their sexual orientation (non-disclosers) are thought to be at particularly high risk of HIV infection because of low self-esteem, depression, or lack of peer support and prevention services which are available to MSM."

3. Substance use

Substance use has been identified as one of the individual risk factors associated with increased prevalence in the MSM population and particularly among young MSM. The literature suggests that young gay and bisexual men in the 18 -29 age cohort have higher prevalence of substance use than the

general population and that sexual risk is exacerbated by substance use during sexual encounters. (Parsons 2012). In addition to drug use, particular stimulant use has been linked to unprotected anal sex, HIV sero- conversion and multiple sex partners.   In Jamaica this link between substance use and HIV prevalence has not been explored in any of the research conducted with the population.

4.   Mental health and the MSM (anxiety and depression)

The recent data has highlighted the need to consider the mental health of MSM as a factor impacting individual risk taking behavior. One study suggests that those MSM who are more anxious also reported more frequent high risk sex and also more high risk sex under the influence of drugs or alcohol. Some investigation among young gay MSM also indicate that anxiety predicts HIV risk as it has been shown to be associated with higher numbers of sexual partners and encounters, substance abuse symptoms and unprotected anal intercourse over and above the existence of social support and communication about condom use. One crucial factor contributing to anxiety in the MSM is gay related stigma. (Weinberger –Lelutiu C. 2011) A study conducted in four US cities among MSM between 1996 and 1998 indicated that rates of depression in men who have sex with men was 17.2%, higher than in adult U.S. men in general. Both distress and depression were associated with lack of a domestic partner; not identifying as gay, queer, or homosexual; experiencing multiple episodes of antigay violence in the previous 5 years; and very high levels of community alienation. (Mills T.C. 2004)
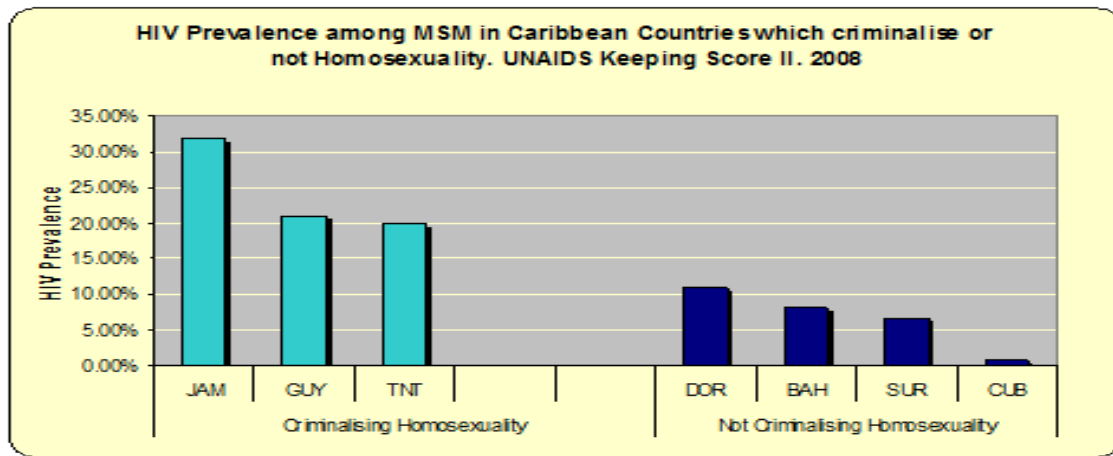
5.   Childhood sexual abuse

Childhood sexual abuse has been suggested as a factor that can influence risk taking behaviors among MSM, leading to the practices of substance use and engaging in unprotected anal intercourse. However one recent study suggest that a history of child sexual abuse is more likely to be associated with MSM trading sex for money or drugs especially among currently active substance users. Therefore the association is with the risk resulting from exchanging sex for money or drugs. The researchers conclude that interventions to resolve issues of child sexual abuse are urgently needed to improve the emotional wellbeing and mental health of MSM who are survivors of sexual abuse. (Felton-Gore Cheryl 2006) While these individual risk factors for acquiring HIV have been well documented, recent data suggest that individual level of risk might be insufficient to explain the high transmission dynamics in the population.

Structural factors and sexual health

1.   Legislative environment

In addition to individual level risk factors, there is increasing recognition that structural factors also impact the rates of transmission among MSM. There is limited available data on the impact of structural factors on the HIV prevalence among MSM nonetheless the more recent literature have highlighted these factors for considerations. In the Caribbean region for example the issue of the existing legal framework which criminalizes buggery (anal sex) in 11 jurisdictions in the English speaking Caribbean has been mooted as contributing to the differing prevalence in the territories which have not criminalized this act. The graph below reflects the higher prevalence among MSM in Jamaica, Guyana and Trinidad

and Tobago all countries which have criminalize buggery (anal sex), while the significantly lower prevalence is evident in Dominica Republic, Bahamas, Suriname and Cuba. (Avrett 2011).

The legislative framework is reinforced by strong religious beliefs that forbid male same sex relationships. Together they perpetuate stigmatization and discrimination against persons based on sexual orientation and results in marginalization of the MSM populations. This stigma and discrimination contributes to risk taking behaviour among those persons who feel demeaned and rejected by society. It also sustains a climate where persons are reluctant to disclose their sexual orientation or their HIV status which drives the epidemic underground and increases the risk of HIV transmission.

2. **Access to health care**

A 2009 study conducted by Caribbean Vulnerable Coalition (CVC) in five territories in the Anglophone Caribbean (Jamaica, Trinidad and Tobago, Belize, Antigua and Barbuda, St. Kitts and Nevis) on access to health care revealed that MSM encounter several barriers when accessing health care. These include: social discrimination, judgmental or moralistic attitudes, overtly hostile health care providers, concerns about privacy and confidentiality, shame, a lack of health care specific to their needs and the inability to pay for alternate private sector health care. It is likely that faced with these barriers MSM are not willingly accessing health care services. The 2007 study conducted by Figueroa et al indicated that of the MSM who had symptoms of STI, 39.2% did not go anywhere for treatment and 8.8% obtained drugs without a prescription and self- treated, 41.2% went to a private doctor while 22.5% went to a public health center. Owing to the diversity of the homosexual community, the health needs vary however in most countries there has been no special training for health care providers to address issues faced by MSM which results in MSM accessing care in uncomfortable and less than friendly settings. (Avrett 2011) There is also an absence of a MSM specific package of services which includes provider initiated introduction of rectal examinations.

3. Gender and sexual identity and disclosure

According to the literature, MSM are faced with conforming to societal norms of gender and masculinity, especially MSM in the black diaspora. For example in Port au Prince, Haiti when HIV prevention services were destroyed by the earthquake in 2010, MSM adopted a more masculine manner to avoid harassment and to gain access to emergency services. Also, in a Jamaican qualitative study, some MSM blamed the more effeminate MSM for fuelling societal homophobia. (Millett et al 2012) This societal discrimination partly contributes to MSM keeping their homosexual relationship secret and chose to engage in relationships with women as a cover. Some   qualitative research shows that black MSM in the UK, South Africa and Jamaica are less likely to identify as gay as this term is associated with emasculation of being the receptive partner. However some studies conducted in the USA, the Caribbean and Africa have revealed that MSM "men who do not identify as gay or exclusively homosexual are less likely to be HIV infected compared to men who identify as gay or exclusively homosexually active" (Millett et al 2012). In India, despite the research which shows that between 30% and 60% of Indian MSM are married, (Go et al 2004; Gupta et al 2006) there is no consistent evidence which links this bisexuality to higher HIV risk. In some studies risk has been higher among actively bisexual men, while in some cases risk has been lower. However preliminary results from a recent study conducted in Mumbai, India, suggest that MSM who are married are 2.7 times more likely to be HIV infected than unmarried MSM. (Kumta et al 2010)

4. Policy and Human rights

As the HIV epidemic continues to increase among MSM there is intense public debate relating to the human rights and social and political standing of MSM. The report from the Global commission on HIV and the Law indicated that a key mandate was to advance the creation of legal environments that defend and support international human rights and legal norms. The report also revealed that several countries including Jamaica had laws on the books (or in the streets) that dehumanize MSM and other persons who were most at risk of HIV. Therefore the law instead of providing protection for these key populations was increasing their vulnerability to HIV.   In some instances agents of the state, that is, the police force engage in violent acts against MSM and other most at risk persons. These acts are sometimes illegal yet they persist either because "the law or social attitudes tacitly authorizes (the police) to do so in an effort to maintain public safety, social order or morality. (UNDP 2012)

The commission made the call for donors and civil society and the UN to hold governments accountable to their human rights commitments and to act decisively to remove laws that hinder those most at risk. It is understood that the law cannot stop HIV but the law and its institutions can "protect the dignity of all those living with HIV and so doing fortify the most vulnerable to HIV'. (UNDP 2012) The reports further stated that although sexual orientation is not specifically listed as a category for protection under international human rights treaties, it has generally been classified under the category of "other status." In this context the Global commission on HIV recommended that countries embrace a human rights framework for MSM and should undertake the following:

i) Reform their approach to sexual diversity, rather than punishing consenting adults engaging in same sex activity, countries must offer such people access to effective HIV prevention and health services and commodities.

ii) Repeal all laws that criminalize consenting sex between adults of the same sex/and or laws that punish homosexual identity

iii) Respect existing civil and religious laws and guarantees relating to privacy

iv) Amend anti-discriminatory laws expressly to prohibit discrimination based on sexual orientation (as well as gender identity)

v) Promote effective measures to prevent violence against MSM.

vi) Countries must prohibit police violence against key populations. Countries must also support programmes that reduce stigma and discrimination against key populations and protect their rights. (UN Global Commission on HIV and the law 2012)

There has been recent major legal developments relating to sexual minorities in India, where the sodomy law was repealed and in Nepal that saw the end of criminalization of same sex relations and diverse gender identities. There are crucial issues which should be highlighted in relation to policy and human rights.

The human rights framework recognizes the need for mainstreaming programs and services for MSM into public health systems. However issues relating to harm to the MSM as they seek to access these services have to be considered. Research also indicate that interventions in highly discriminatory political and human rights environment have to be context specific and requires the MSM community participation in all areas of programme development and implementation. Hence laws and policies that promote universal access and gender equality in principle for MSM may fail in practice where homophobic cultural, religious or political are dominant in the environment. "Good policies for HIV do not guarantee good outcomes for MSM (Breyer et al 2011)

5. **Other social vulnerabilities**

MSM have often been the target of violence in several societies. The 2011 study conducted in Jamaica indicated that of those MSM who were infected with HIV 41% reported engaging in sex work. However within the MSM sex work sub group approximately 54% suffered violence, 51% had ever been to jail and 50% had slept outdoors. It is interesting to note that 65% of MSM sex workers had ever been raped and 31% of MSM non sex worker also reported ever been raped. This suggests that coerced sex is common and is a likely factor which increases vulnerability to HIV infection.

Other social consideration includes educational level which limits access to employment as well as to housing and other social services. These have been identified in the literature as contextual issues which increase risk to HIV infection not only among MSM in lower and middle income countries but also

in high income countries where the burden of the higher prevalence has been recorded among some racial minority such as black MSM in the USA.

HIV Prevention Interventions: What are the lessons?

In response to the HIV prevalence among MSM a range of HIV prevention interventions have been developed and implemented in various settings. The interventions have included stand- alone behavioural interventions, biomedical and barrier combination prevention, community intervention, the use of anti-retrovirals, microbicides and vaccination, HIV testing and diagnosis and treatment of STIs. The research indicates HIV prevention interventions have had varying degrees of success but generally have not significantly impacted HIV prevalence among this population. This therefore suggests that gaps exists in the HIV prevention response for MSM and it is imperative that new approaches be developed and brought to scale to effectively address the prevalence.

1. Behavioural Interventions

Prevention programmes tend to focus on stand- alone behavioral interventions which addressed individual sexual risk behaviors of unprotected anal intercourse, multiple partners, adherence to antiretroviral (ARV), alcohol and substance use. According to the findings from the review of several behavioural interventions which were conducted globally, Sullivan et al 2012 concludes that these interventions seem to decrease the frequency of unprotected sex by 27% in the intervention group compared with the control population who are exposed to few or no HIV prevention interventions and by 17 % compared to control populations who are administered the standard HIV intervention usually counseling and testing. The literature points to limitation of MSM behavioral interventions, which include difficulties in obtaining a fairly accurate measure of effectiveness owing to a dependence on reported behaviours. Fidelity as a prevention practice presents a grave concern as well and limited resources to scale up interventions or to afford multi sessions with the population.

Best practice behavioral intervention

The 2004 HIV NET study (Explore) is one of few studies of behavioral interventions which have seen reduction of HIV prevalence as an outcome. The study was conducted among 4000 US men in six cities and compared biennial HIV testing and intensive risk reduction counseling. Investigators reported significant reduction in the practice of unprotected receptive anal intercourse in the intensive risk reduction counseling group. The results also show that the HIV incidence in the intervention group was not significantly lower than the control group. Further analysis of the data also showed that the reduction in the incidence was transient and pointed to the need for longer term assessment of behavioral interventions. (Koblin, 2004 in Sullivan et al 2012)

2. Biomedical and Barrier interventions

These approaches destroy HIV in the rectal or vaginal compartment thus creating a hostile environment for the non - replication of the virus or acting as a barrier between the virus and susceptible cells.

i. Condom use

Evidence shows that condoms and pre- exposure treatment with anti- retroviral reduces the risk of HIV infection in non MSM populations. Studies show that condom use has reduced transmission in HIV discordant heterosexual couples by 85%. Research also indicated that for receptive anal intercourse condom use can reduce risk of HIV infection by 78% compared with unprotected anal intercourse (Sullivan et al 2012). However condom use in the MSM community remains challenging and involves issues relating to negotiating condom use, condom breakage and slippage and in some developing countries condom availability. The use of the female condom has also been promoted among MSM but there have been complaints of slippage, pain and rectal bleeding.

ii. Lubricant use

Lubricant use has been encouraged to provide additional prevention benefits when used with condoms because they reduce condom breakage and rectal trauma. The issue of access to water based lubricants presents new challenges as MSM without access will use non water based substitutes which increase the risk of condom failure and transmission of viral infections. In addition the literature speaks to an increased risk of STI being associated with regular use of lubricants without condoms.

iii. HIV testing

HIV testing is integral to the effectiveness and implementation of HIV prevention interventions. Studies have shown that most people who know that they are HIV positive take action to reduce the risk of transmission. HIV testing also acts as an entry point for the provision of other services. In the MSM community several persons are unaware of their serostatus.

HIV testing best practice

Knowledge of serostatus has been associated with the decision relating to partner selection and other community specific prevention strategies. A study was conducted by Denning in 2005 in the US among 970 HIV positive men who were newly diagnosed and had steady sex partners. The term newly diagnosed for the purpose of analysis focused on those MSM who were aware of their infection for more than 12 months after diagnosis. (Denning 2005) The results suggest that knowledge of HIV serostatus was a major modifier of sexual risk behavior among MSM. The practice of unprotected anal sex was markedly lower among men who were aware of their infection which suggest that the MSM reduced their sexual risk behavior after they learned of their infection. This is consistent with other studies with similar findings. Knowledge of their steady partner HIV serostatus also influenced the men's sexual risk behaviours. Compared with men who were unaware of the serostatus of their male partners, men who knew the HIV negative status of their partners were less likely to engage in unprotected anal intercourse. This contrast with HIV positive MSM who are unaware of the serostatus of his partner or whose partner has not tested. The MSM may assume that his partner is already positive and thus engage in UAI. (Denning et al, 2005)

iv. Diagnosis and treatment of STI

The presence of bacterial and viral STIs can increase the efficiency of HIV transmission. The literature does not conclusively show that syndromic treatment of STI with antibiotics prevents HIV acquisition; however STI incidence clearly indicates a history of sexual risk and can likely lead to the

acquisition of HIV infection. Therefore diagnosing STIs provides a gateway to identifying high risk MSM for prevention services.

v. Anti- retroviral therapy ART

It is established that antiretroviral therapy can be given to HIV negative people after high risk exposure or before potential high risk exposure. Recent studies have been conducted to assess the safety and efficacy of ART. One example was a study which included MSM from the low and middle income countries of South Africa, Thailand, Peru and Ecuador which yielded positive results. However issues relating to long term toxic effects and acceptability have emerged from these studies. These and other issues such as drug resistance, diagnosis of infections in the window period and the effective monitoring of adverse effects will have to be addressed in further research before oral pre-exposure prophylaxis can be fully integrated into HIV prevention strategies.

More recent literature has indicated that ART lowers the viral load in all body compartments. In a systematic review of cohort studies done among serodiscordant couples in whom routine use of condoms was encouraged, transmission risk depended on whether HIV Infected index patients were on antiretroviral (0.46 cases of HIV per 100 person years) or not (5.64 per 100 person years). There were no transmissions when the index patient had a viral load below 400 copies per ml. (Dabis 2010) A subsequent study based on a statistical model predicted that universal testing of all sexually active adults and immediate ART regardless of CD4 count could have a severe effect on a generalized epidemic. Follow up studies have identified other factors which are likely to influence the effectiveness of immediate ART such as heterogeneity, and concurrency and mixing. These factors could also have negative effect dependent on the assumptions. (Dabis et al 2010) However despite the possible challenges this approach can be advocated for the MSM population.

vi. Male Circumcision

Evidence indicates that circumcised men may have a lower risk of HIV infection. Global observational studies typically show that male circumcision (MC) provides a two- to eight-fold protection against HIV infection (Morris 2007) .Three large Random Control Trials (RCT) of adult MC conducted in African countries with generalized HIV epidemics showed strong risk reduction, ranging from 48% to 61% (Auvert et al. 2005, Bailey et al. 2007, Gray et al 2007) This procedure can possibly be used in the MSM community to reduce rates.

3. Structural Interventions

Structural interventions generally refer to public health interventions which seek to promote health by altering the structural environment in which health is produced and reproduced. (Blakenship et al 2006) There has been a long history of utilizing structural intervention in public health, however the approach is gaining prominence as a strategy in HIV/AIDS prevention and includes interventions which target the physical, sociocultural, economic, political and organizational factors. Structural factor are mainly those contextual features which are outside the control of the individual that act as a barrier or facilitator of an individual's ability to prevent acquisition of HIV (Saunders R.A. & Ellen J.M. 2010). These factors are

embedded in policies, practices and norms of society and can influence the impact of large social forces such as; poverty, gender inequality, racism, mobility and stigma. These large social forces affect STI transmission and distribution, behavior, networks and the overall risk of exposure to infection. (Blakenship, et al 2006

The Jamaica National Strategic Plan 2012 -2017 reinforces some of the issues which highlight the need for structural interventions within this context. In Jamaica, approximately 20% of the population lives below the poverty line. These persons experience an increased vulnerability to HIV infection because making safer healthy choices sometimes conflicts with decisions for daily survival. Therefore despite a high level of knowledge and attempts at practicing the new behaviours, the behaviours are not sustained as they are usually in conflict with choices for daily existence, gender norms and the constantly evolving sub cultural norms and values.

Prevention interventions need to extend beyond the individual and the interpersonal to execute strategies that mobilise other players who critically impact the environment. These strategies must of necessity include the social agencies as well as those organizations that are responsible for the economic development that translate into employment opportunities for those below the poverty line.

In addition infrastructural and service weaknesses across sectors contribute to these behavioural and societal challenges. Within the health sector, for example, there is a perceived lack of tolerance and respect for the MSM and other categories of clients and hence quality assurance is undermined. In the education sector, school guidance counsellors do not provide adequate sex and sexuality counselling either for the heterosexual or homosexual adolescent. (Jamaica, NSP on HIV/AIDS 2012 -2017)

Four important types of structural interventions have been recommended for future HIV prevention efforts:

(a) Community mobilization

(*b*) Service integration,

 (*c*) Economic interventions such as microfinance

(*d*) Contingent funding reform to remove gag rules that prevent organizations from supporting effective prevention strategies in local contexts (i.e., syringe exchange, drug-substitution treatment, and harm reduction for sex workers) in order to receive funding. (Blakenship, et al 2006)

There are two examples of structural interventions approaches which the literature highlights. The approaches target the cultural, political and organizational factors that help to reduce vulnerability among sex workers through the implementation of condom policies in Thailand and the Dominican Republic. In each approach the brothel or bar managers and police had a key role in promoting condom use (Gupta et al., 2008, Kerrigan et.al 2006). There are also examples of programmes which have worked at the community level. The Sonagachi project in Calcutta, India worked at the community level

to mobilize sex workers to design and implement activities and enable participants to make their own decisions including those that would protect from HIV infection. Among the MSM community an example of structural intervention has been to have condoms and lubricants, HIV testing and screening onsite at gay bathe houses. (Sanders and Ellen 2010)

The need for integration of services and the provision of funding without preordained conditions have also been suggested as workable strategies to increase coverage to the MSM population. For example owing to the high prevalence of mental health concerns in MSM who use substances, integrated services and interventions could provide improved benefits. Substance using MSM should be routinely screened for HIV and STIs. (Mayer et al 2012)

Structural interventions are not being advocated as replacements for behavioral and biomedical interventions but rather should be incorporated into comprehensive, multilevel, and multi sectoral responses (Sumartojo et al 2000)

4. **New Technologies**

The use of new technologies in particular computer based interventions has resulted in increasing condom use, reducing numbers of sex partners as well as reduced incidence of STI. The technology interventions delivered interventions seem as efficacious as those which are human delivered. (Noara, Blackburn, Pierce 2009) It is worthy to note that computer technology-based interventions have many advantages when compared to human-delivered interventions. These include lower cost to deliver, greater intervention fidelity, and greater flexibility in dissemination channels, which might include in person (for example, clinic setting), mail, internet, cell phones, or other delivery channels. (Noara, Blackburn, Pierce 2009)

Technologies interventions can also potentially assist in scaling up the efficiency of administering intervention content and by reaching hard to reach populations with limited access to prevention services such as rural and non-gay identified MSM.

Another suggestion from the literature is that new technologies have the flexibility for use in high, middle and low income countries. In high income countries technologies interventions can be delivered by high- speed or mobile internet. In middle and low income countries, text messaging can be used as most of the population has access to this technology. (Sulllivan et al 2012) In Jamaica's context a recent study conducted by C-Change reinforced the frequent use of new technologies among the MSM and other most at risk populations. The study looked at the use of mobile phones and internet, including social media for communication and for preference for receiving health information. The results indicated that cell phone use and text messaging were high among MSM in Jamaica; 77.8% of MSM and 57.6% of the male sex worker sent and received pictures, videos, and sound clips from their phones (C-Change 2012). However most of the MSM did not seek health information from the internet as most reported using social media sites for entertainment. They however did indicate a preference for

receiving group specific health information via private channels e.g. email, in person and text and print. (C-Change 2012)

5. Modeling HIV transmission and intervention for the MSM populations
The basic concept central to modeling highlights the need to develop an evidence based response to the HIV epidemic. It incorporates the need understand:

I.   the features of the country's epidemic,
II.   the cost of various response options and
III. knowledge of appropriate and effective interventions for prevention, treatment and care.

Four scenarios relevant to MSM and the epidemic have been developed by the IBRD.

I.   Risks among MSM are the predominant exposure mode for the HIV e.g. South America.
II.   Risks among MSM occur within mature established HIV epidemic driven by injecting drug use e.g. Central Asia and Eastern Europe.
III. Risks among MSM occur within the context of mature and widespread epidemic among heterosexuals .e.g. Sub-Saharan Africa particularly East and Southern Africa.
IV.   Transmission among MSM, Intravenous Drug Users and heterosexual all contribute significantly to the epidemic e.g. south, south eastern and northeast Asia. (Breyer et al 2012*)*

Gathering the evidence on the fraction of the epidemic that is attributable to same sex men allows for calculations using mathematical models and cost estimates to assess and estimate appropriate interventions to meet public health priorities. Also to inform national and local programming by providing estimates of resources necessary to reach targets. (Breyer et al 2012)

i.   Recent evidence from modeling suggests some key notions for HIV prevention for MSM:
ii.   Packages of interventions with sufficient coverage can have pronounced effect on the incidence of HIV infection in MSM worldwide.
iii.   Significant coverage of effective interventions is essential in order to increase their effectiveness. Coverage is not only influenced by funding availability but also by other factors such as ease of access to services for MSM, comfort level to discuss sexual practices in varying health care settings and skills and knowledge to use prevention methods and services.
iv.   Packaging of complementary interventions can increase the effect of primary biomedical interventions. e.g. support for adherence to medication can improve effectiveness of ART.

6. Community leadership and MSM
Leadership from within the MSM community has been identified as critical to addressing the persistently increasing HIV epidemic in the community. Historically the gay and MSM community have led and participated in the HIV response primarily through advocacy, education, research and design and delivery of prevention, treatment and care programmes for the population. However leaders in the community have continued to face challenges including pervasive stigma and threats of violence, limited funding and the need to represent a highly diverse community.

Evidence suggests that specific approaches led by the community have proven effective in particular programmes relating to community empowerment for health, community led services and community leadership and governance in government programmes. Some challenges exist within the community and these will have to be addressed. Among them are nascent MSM community groups who are frequently expected to represent the needs of all MSM irrespective of cultural identity, sexual orientation, and socio-demographic characteristics such as age and marital status. These groups are also expected to provide services with the same level of monitoring and evaluation as transnational implementing HIV entities but with negligible funding. These community groups as a result tend to remain periphery to the response and usually compete rather than collaborate with one another. (Trapance et al 2012)

Summary of the issues

1. HIV prevalence continues to be highest in MSM communities both in high and middle and low income countries.
2. The MSM prevalence is fueled by individual risky sexual practices. However issues relating to the context in which the individual operates and functions will have to be researched and addressed.
3. Structural issues especially those related to socioeconomic conditions are impacting prevention interventions for MSM
4. Particular attention must be given to the mental health of MSM as increasing numbers of MSM are reporting mental illness especially depression and anxiety. There also appears to be an association between mental health and increasing drug use in the population.
5. Several MSM are hampered by social factors including limited education, access to housing and employment all these contribute to risky individual behaviours and an increased vulnerability to HIV infection.
6. The stigmatized environments in particular those with restrictive legal framework criminalizing same sex relationships has impacted the health seeking behavior of the population and also the quality of care received by MSM.
7. The response to the epidemic has had a heavy focus on behavioural interventions which have not yielded the significant behavior change or contributed to a decline in prevalence.
8. Some biomedical interventions have had more success, these have mostly been implemented in high income countries as low and middle income countries have been constrained by funding. Nonetheless issue of adherence to ART and the access to prophylaxis remain as challenges.
9. Interventions which promote condom use have been effective as well as interventions which provide HIV testing and counseling.

Suggestions for new directions for the response:

- The need for a rights based approach as guided by recommendations from the human rights commission on HIV and the law.
- The need to combine behavioural and biomedical interventions with structural interventions. The evidence is not conclusive relating to the effectiveness of structural intervention hence there is need for more research especially within the context of low and middle income countries.
- New technologies appear to be promising in terms of effectiveness to reach hard to reach rural and non- gay identified MSM. There is the need to ensure that the technology is appropriate and can contribute to scale up in coverage.
- Modeling of the MSM prevalence in the country's epidemic can provide evidence for more efficient and effective use of interventions and the allocation of resources.
- Circumcision has also been identified as an effective approach and further research should be conducted to determine efficacy in the MSM population.
- Leadership from within the community has proven to be effective in addressing early challenges affecting the population however specific challenges now exist as it relates to community leadership and work with nascent MSM community organizations.

References

Avrett, S. (2011) *Men who have sex with men and HIV in the Anglophone Caribbean.* Arlington VA. USAID's AIDS support and Technical Assistance Resources, AIDSTAR-One, Task Order 1

Blankenship, K. M., Friedman, S. R., Dworkin S., Mantell J.E. (2006) *Structural Interventions, Concepts, Challenges and Opportunities for Research,* Journal of Urban Health: Bulletin of the New York Academy of Medicine vol. 83 no.1

Beyrer, C. Baral, D. S., Van Griensven F., Goodreau, S.M., Chariyalerstak, S., Wirtz, A. L., Brookmeyer R., *Global Epidemiology of HIV infection among MSM,* The Lancet July, 2012

Beyrer, C., Writz, A.L., Walker. D., Johns, B., Sifakis, F., Baral, S. D., (2012) T*he Global Epidemics among Men who have Sex with Men;* The World Bank Washington D. C.

Beyrer, C., Sullivan, P.S., Sanchez, J., Dowdy, D., Altman, D., Trapance, G., Collins, C., Katabira, E., Kazatchkine, M., Sidibe, M., Mayer, K.H., *A Call to Action for Comprehensive Services for MSM,* The Lancet July, 2012

Coleman E. (2011) *What is sexual health? Articulating a sexual health approach to HIV Prevention for Men who have Sex with Men.* AIDS Behaviour ,March 2011, Springer Science+ Business Media, LLC http://www.springerlink.com/content/22j0867576lu54/fultext.htm

Dabis F., Newell, M. L., Hirschel, B., *HIV Drugs for treatment, for prevention,* Lancet vol. 375 Issue 973 pp.2056-2057, June 2010, DOI.10.1016/s0140-6736(10)60838-0

Denning, P. H. & Campsmith, M. L. (2005). Unprotected anal intercourse among HIV-Positive men who have a steady male sex partner with negative or unknown serostatus. *American Journal of Public Health vol. 95(1), 152-158*

Figueroa, J.P., Weir, S. S., Jones-Cooper, C., Byfield, L., Eastman, S., Hobbs, M. McKnight & I., Cummings, S. *High HIV Prevalence among Hard to Reach Gay Men in Jamaica is Associated with High Social Vulnerability.* Abstract #MOPE0400. Presented at the XVII International AIDS Conference, August 3–8, Mexico City, Mexico. Available at http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200718384

Gore-Felton, C., Kalichman S.C., Brondino M.J., Benotsch E.G., Cage M., DiFonzo K., (2006) *Childhood Sexual Abuse and HIV risk among MSM: Initial test of conceptual Model,* Published online Springer Science+ Business Media, LLC

Kalichman S. C., Weinhardt L., DiFonzo, K., James, A., Webster, L., (2002) *Sensation seeking and alcohol use as markers of sexual transmission risk behaviours in HIV positive Men who have sex with Men,* Society of Behavioral Medicine 24, (3) 229 -235

Mayer K.H., Bekker L.G., Stall R., Grulich A.E., Grant C., Lama J, R., *Comprehensive clinical care for MSM: an integrated approach,* The Lancet, July, 2012

McKellar, D., Valleroy, L.A., Secura, G.M., Behel, S., Bingham, T., Celentano, D.D., Koblin, B.A., Shehan, D., Hanne, T. & Torian, L.V. (2007). Perceptions of lifetime risk and actual risk for acquiring HIV among young men who have sex with men. AIDS Behavior *(2) 263 -70 DOI: 10.1007/s10461-006-9136-0*

Millette, G. A., Peterson, J.L., Stephenson, A., Hart, T.A., Williams J.L. 4th, Bourke, S. B., Hellig, C.M., Elford, J., Fenton, K.A., Remis, R.S., *Comparison of disproportionate risk of HIV Infection in black and other MSM in Canada, UK, and USA ; a meta- analysis;* The Lancet July, 2012

Millette, G. A., Williams, J.L. 4th, Peterson, J.L., Malenbranche, D. J., Lane, T., Flores, S. A., Fento, K.A., Wilson, P.A., *Common roots; a contextual review of HIV epidemics in black MSM across the African Diaspora*, The Lancet July, 2012

Mills, T.C, Paul, J., Stall, R., Pollack, L., Jesse, C., Canchola, M.S., Chang, J.Y., Moskowitz, J., Catania, J.A. *Distress and Depression in Men who have sex with men: the urban men's Health Study,* Am J,. Psychiatry 2004:161:278-285. 10.1176/1ppi/ajp. 161.2.278

Royes, H., McKnight, I., Fox, K., (2003) *Seeking separate identities; risk assessment mapping study of Men who have sex with men in Jamaica;* National HIV Program, Ministry of Health Jamaica

Sanders, R.A. (2010) *Structural Interventions with an emphasis on Poverty and Racism, Chap 14 in McCree D.H. et al African Americans and HIV/AIDS.* DOI 10.1007/978-0-387-78321-5-14, Springer Science+ Business Media, LLC 2010

Sullivan, P.S., Dieguez, A., Coates, T., Goodreau, S.M., McGowan, I., Sanders, E. J., Smith, A., Probudhagopal, G., Sanchez, J., *Successes and Challenges of HIV prevention in Men who have sex with Men,* The Lancet July, 2012

Trapance, G., Collins, C., Avrett, S., Carr, R., Sanchez, H., Ayala, G., Daouda, D., Beyrer, C., Baral, C.D., *From Personal Survival to Public Health: Community leadership By MSM in response to HIV,* The Lancet July 2012

UNDP (2012) Global Commission on HIV and the Law; risks, rights and health, Secretariat Global commission on HIV and the law. Retrieved www.hivlawcommission.org

USAID (2012) *Report on Survey of PLACE patrons, PLACE workers and Men who have sex with men in Jamaica* (unpublished)

U.S. Department of Health and Human Services. Center for Disease Control and Prevention (2002, February 7). *HIV/STD risks in young men who have sex with men who do not disclose their sexual orientation--- six U.S. cities, 1994-2000.*Retrieved from www.cdc.gov/htm mm5205a2

U.S. Department of Health and Human Services. *National Health Institute (2005)., Theory at a glance, a guide for health promotion practice* (2nd edition).

U.S. Department of Health and Human Services. National Institute of Health (2009) *The Past, Present and Future of HIV Prevention Integrating: Behavioral, Biomedical, and Structural Interventions for the Next Generation of HIV Prevention.*

Wolitski, R.J., Fenton, K. A. (2011). *Sexual Health, HIV, and other sexually transmitted infections among gay, bisexual and other men who have sex with men in the United States.* *AIDS Behavior (15) : 9-17 DOI: 10.1007/s10461-011-9901-6*

STRATEGIC FRAMEWORK ON HIV AND AIDS PREVENTION **FOR MEN WHO HAVE SEX WITH MEN IN JAMAICA**

2012 -2017

Introduction

The recent evidence from the literature suggests that men who have sex with men (MSM) are at an even higher risk of HIV infection in lower and middle income countries (LMIC) in Asia, Africa, Latin America and the Caribbean, Eastern Europe and Central Asia. (IBRD 2011)

This is reinforced from the UNAIDS 2010 report which indicates that HIV prevalence among MSM in the Caribbean ranges from 0.09 % in Cuba to 31.8 % in Jamaica which reflects the increasingly serious nature of the epidemic in the region. Three territories; Jamaica, Trinidad and Tobago and Guyana have prevalence above 20% The prevalence in Dominica Republic was 11%, in Bahamas 8% and in Suriname 6.7%. These rates are significantly higher than the general population and also higher than rates in other populations which are considered most at risk.

MSM population in Jamaica

The MSM population in Jamaica is estimated at 33,000 MSM[2]. A survey of 201 MSM in 2008 and of 400 MSM in 2011 both found an HIV prevalence of 32% (Figueroa et al 2011) which is considerably higher than the 10% HIV prevalence in a sample of 125 MSM in 1985 (Murphy et al 1988). The modes of transmission study conducted in 2012, adjusted the prevalence to 20% based on biased sampling in the previously mentioned survey. The majority of respondents in the 2007 and 2011 surveys were from the lower socioeconomic group who either accessed the public health services or were part of the network that access services.

Sex with females: In the 2008 survey, 56.7% MSM had at least one female partner in the past 12 months and almost two thirds (64.3%) self-identified as bi-sexual.

Multiple partnerships: 27.4% MSM had multiple male partners within the last 4 weeks.

HIV testing: 57.7% had ever done an HIV test and 32.9% had done so in the past 12 months.

Condom use: 67% reported using a condom at last sex with their main male partner while 62% reported doing so at last sex with a female partner.

The study on the modes of transmission also suggests that 1.76% of the total female population are partners of MSM and the estimated HIV prevalence in this group is 1.4%. These findings suggest that men who have sex with men and women function as a bridge population and may account for the increasing rate of HIV seen in women. According to the model used for prediction in the modes of transmission study, 30% of new HIV infection will occur among MSM and 7.2% among their female partners.

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[2] 4.4% of adult male population

Perspectives on the current response to MSM

Qualitative research was conducted with key stakeholders, partners and beneficiaries of current interventions to reach MSM.   Ten key informant in-depth interviews were conducted with managers and senior technical representatives of the Ministry of Health, the international and the civil society partners. These included, Jamaica AIDS Support for Life (JASL) Jamaica Forum for Lesbians, All Sexual and Gays (JFLAG), Caribbean Vulnerable Community(CVC) representatives from UNAIDS and UNFPA as well as independent members of MSM community and the coordinators of the BCC interventions for MSM in the NHP. Two focus groups were conducted, one with the beneficiaries, that is, the MSM and the other with the behavioral intervention team of the NHP. The discussions reinforced the issues identified from the literature review. Highlighted are some of the perspectives from the qualitative research:

> ➤ *Prevention interventions have been limited to the individual risk behaviors, however intensive and sustained structural interventions are required to create a more supportive environment for the population*

> ➤ *Treatment and care interventions need to be expanded to address other MSM specific issues which include mental health and other psychosocial issues. By the same token, health care providers have to be adequately prepared to provide services to this population*

> ➤ *Need for research in biomedical interventions to determine effectiveness in this context .e.g. circumcision, ART as prevention.*

> ➤ *More sectors need to be drafted into the response to address the crucial issues of stigma and discrimination and also structural issues confronting the population.*

> ➤ *An assessment of the interventions being conducted is urgently needed in an effort to determine effectiveness of strategies and to provide the information for scaling up of interventions and defining areas of focus.*

> ➤ *Interventions with the population have not strategically addressed the diversity in the MSM population. Interventions have to be varied to improve reach and coverage of the population. There is also the need for qualitative research to explore the concept of 'community' as it relates to MSM in Jamaica.*

> ➤ *The legislative environment has to be addressed as it is felt that the existence of the buggery law acts as 'crutch' for some critical players who are the providers of treatment, care, support and prevention services.*

> ➤ *There is the need to reframe the platform for advocacy to engage more players in order to support respect for diversity and human dignity*

> *A more coordinated approach is needed to intervening with the population and also for an increased emphasis on standard intervention package for the population as well as established monitoring and evaluation framework*

These and other crucial issues have been fused into the strategic framework for the MSM population in Jamaica.

Strategic framework rationale:

Strategic approaches relating to HIV and AIDS prevention for MSM have to acknowledge the need for sexual health within a rights based framework. The UN Global commission on HIV and the Law indicated that a key mandate was to advance the creation of legal environments that defend and support international human rights and legal norms. The reports stated that although sexual orientation is not specifically listed as a category for protection under international human rights treaties, it has generally been classified under the category of "other status." In this context the Global commission on HIV recommended that countries embrace a human rights framework for MSM and should undertake the following:

vii) Reform their approach to sexual diversity, rather than punishing consenting adults engaging in same sex activity, countries must offer such people access to effective HIV prevention and health services and commodities.

viii) Repeal all laws that criminalize consenting sex between adults of the same sex/and or laws that punish homosexual identity

ix) Respect existing civil and religious laws and guarantees relating to privacy

x) Amend anti-discriminatory laws expressly to prohibit discrimination based on sexual orientation (as well as gender identity)

xi) Promote effective measures to prevent violence against MSM. (UNAIDS Global Commission on HIV and the law 2012)

The strategic framework should also seek to address the several factors which influence sexual health among MSM. These can be categorized as individual risk factors and structural or contextual factors.

Individual risk factors include: the presence of sexually transmitted infections (STI), unprotected anal intercourse which is influenced by lubricant use, multiple partners, risk perception, transactional sex, and sex work, disclosure of HIV status as well as disclosure of sexual orientation among other factors. In addition individual risk among MSM is impacted by substance use, childhood sexual abuse and mental health in particular anxiety and depression.

Structural factors impacting risk have been identified as the legislative environment, access to health care, policy and human rights related issues as well as gender and sexual identity. Other factors

include access to employment, education and housing as well as general opportunities for facilitating social mobility.

The strategies to be implemented will have to reflect a combination of behavioral, biomedical and structural interventions.

Strategic Objectives

1. Strengthened leadership and management of the national MSM strategic framework.

2. Improved advocacy for legislative, policy and other structural changes to facilitate an enabling environment for MSM to access prevention services, treatment, care and support.

3. Strengthened stakeholders' capacity in data use, collection and dissemination to ensure scaled-up coverage and quality of interventions targeting MSM.

4. Improved delivery of comprehensive high quality treatment care and support for adult and adolescent MSM.

5. Increased structural interventions to reduce social vulnerability for adult and adolescent MSM

6. Improved delivery of a comprehensive package of behaviour change communication based prevention interventions targeting adult and adolescent MSM

Strategic objective 1: Build leadership, management and coordination of the MSM strategic framework

Key objective: strengthened leadership and management
The strategic framework for MSM has been developed within a context where although the response has been long established it has not been well coordinated. The numbers of partners/implementers have increased but there has been duplication of efforts and the reach to the population is limited. The partners have recognized that there are several crucial factors impacting the population which require a concentrated and comprehensive response. The issues of leadership and coordination are therefore essential to the effective implementation of the strategic framework.

Expected results: strengthened leadership management and coordinated MSM strategy

i.   **Increased coordination and collaboration among partners**
The NHP in collaboration with the MSM technical working group (MSMTWG) will coordinate the implementation of the MSM strategic plan

➢ NHP to build internal capacity to provide core functions of national leadership in the areas of; coordination, advocacy, mobilizing other partners, resource mobilizations and monitoring and evaluation.
➢ NHP and lead MSM agency to facilitate involvement of other sectors through the principles of 'shared responsibility' in the MSMTWG e.g. education, youth, labour, justice ,social services

➢ Lead MSM agency to utilize the mechanism of regular meetings of the MSMTWG to facilitate reporting on the implementation process of the MSM strategic framework

➢ NHP and MSM agency to lead dissemination of the MSM strategic framework to key government sectors, civil society partners, international partners, faith based leaders and community leaders

➢ NHP to provide technical guidance to internal team and partners on implementation of the strategic and operational plan.

ii.   **Strengthened involvement of MSM civil society partners in leadership management and coordination of MSM strategic framework.**

➢ Lead MSM agency to facilitate the capacity assessment of organizations working with MSM and MSMCBOs with the aim of formulating a strategy for capacity development relevant to the MSM strategic framework

➢ Lead MSM agency to build internal capacity to identify and train influential MSM and MSM CBOs to sensitize new and existing civil society partners regarding universal access to services for MSM

- Lead MSM agency to develop leadership skills of CBOs working with MSM and MSMCBO's to facilitate more effective representation of MSM issues in national policy and program decision making process

- Lead MSM agency to increase the coordination of programmes conducted by MSMCBOs at the national level through regular updates at the MSMTWG meetings

Strategic objective 2: Improved advocacy for legislative, policy and other structural changes to facilitate an enabling environment for MSM to access prevention, treatment, care and support services.

Key objective: Reduce stigma and discrimination (S&D)

       Structural factors such as the legislative frameworks reinforced by strong cultural beliefs that forbid male same sex relationships perpetuate stigmatization and discrimination against persons based on sexual orientation and results in marginalization of the MSM populations. Stigma and discrimination sustain a climate where persons are reluctant to disclose their sexual orientation or their HIV status which drives the epidemic underground and increases the risk of HIV transmission.

Expected results: Reduce stigma and discrimination

1. *Increased advocacy for legal and policy reform environment*

   ➤ Lead MSM agency to contract legal consultant to build the capacity of the MSMCBOs regarding the process of law reform and human rights law and how they impacts the rights of MSM

   ➤ Lead MSM agency and other agencies working with MSM to engage political leaders and policy makers to initiate and support public declaration relating to respect for the individual's rights and dignity.

   ➤ Lead MSM agency and other agencies working with MSM to advocate with political leaders for amendment of the Buggery Law to allow for consensual sex between consenting adults in private

   ➤ Lead MSM agency and other agencies working with MSM to conduct sensitization of civil society organizations to support public discourse on Sexual Offences Act for expansion of the definition of sex to include same sex

2. *Increased public awareness of stigma and discrimination affecting MSM*

   ➤ Lead MSM agency and MSM TWG to develop public education campaign on universal access to services, commodities, information and education.

   ➤ Lead MSM agency to develop media alliance to increase awareness on how the existing legislative and cultural environment negatively impacts the MSM.

   ➤ Lead MSM agency to build the capacity of MSM leaders and other individuals in the MSM community to facilitate a speakers' bureau in select settings which addresses stigma and issues relating to respect and diversity.

3.   *Increased multi sectoral advocacy for reducing stigma and discrimination*

➢ NHP policy unit to advocate and facilitate key influential within social institutions e.g. the church, civil society, and community leaders to engage in public discourse relating to respect for diversity.

➢ NHP policy unit to mobilize and involve the private sector to review the workplace policy and protocol to facilitate the integration of issues relating to stigma and discrimination faced by the MSM at the workplace.

➢ NHP policy unit to engage the Justice Sector to facilitate re-orientation training for lawyers and the judiciary through continued legal education regarding human rights, sexual orientation and marginalized populations.

➢ NHP policy unit to involve the Ministry of Education and stakeholders e.g. parents association, principals and the teachers association in creating a nondiscriminatory environment for adolescent MSM to access education.

➢ NHP and lead MSM agency to support the Ministry of National Security to review codes of conduct for Police force regarding sexual orientation to address discrimination.

➢ NHP to engage the Department of Correctional Services to ensure that the rights of MSM inmates are upheld

➢ NHP policy unit to expand training of church leaders and individuals in the faith based community as advocates to conduct sensitization session with their constituents regarding respect for diversity, human rights and dignity

Strategic Objective 3: Strengthen stakeholders' capacity in data use, collection and dissemination to ensure scaled coverage and quality of interventions targeting MSM

Key objective: MSM programs informed by improved collection and application of strategic information.

Strategic information on the epidemic and the national HIV response is essential to guide programme planning and implementation, ensure accountability and assess progress towards the achievement of universal access to HIV/AIDS prevention, treatment, and care.

Expected results: MSM program design and quality informed by improved collection and application of strategic information

> **Improved collection and application of strategic information for MSM program design and quality**

> The monitoring and Evaluation unit of the NHP will monitor the international research being conducted on the biomedical HIV prevention interventions including circumcision, microbicides and the provision of treatment upon diagnosis for MSM,

> The monitoring and Evaluation unit of the NHP will provide technical support in the use of the core MSM indicators included in the national monitoring and evaluation framework to monitor the implementation of the MSM strategic framework and operational plan by partners

> MSMTWG in collaboration with the MERG to coordinate research priorities for improved evidence based programming. This includes qualitative research relating to;
>   o diversity in the MSM community
>   o sexual networks
>   o drug use and the MSM
>   o MSM and sex work
>   o factors affecting adherence among MSM living with HIV/AIDS
>   o the impact of stigma and discrimination (including self-stigma) on MSM health seeking behaviour and access to prevention services
>   o factors affecting adherence among MSM
>   o Factors influencing disclosure of HIV status to partners

> The monitoring and Evaluation unit of the NHP and the MERG will also facilitate the development of a mechanism to reduce double-counting of programme beneficiaries including unique identifiers

> The M& E unit to apply national indicators to the MSM Programs

> ➤ The NHP Prevention coordinator to develop detailed actionable user-friendly intervention guidebook outlining treatment, care and support and prevention strategies targeting MARPs to support the National Strategic Plan

Strategic Objective 4: Improved delivery of comprehensive high quality treatment care and support for adult and adolescent MSM

Key objectives; (a) Strengthen the delivery of comprehensive care and treatment for MSM, (b) Reduce stigma and discrimination in the health care setting, (c) Expand Positive Health Dignity and Prevention (PHDP) programmes for HIV positive adult and adolescent MSM

Owing to the diversity of the homosexual community, the health needs vary however there has been no special training for health care providers to address the issues faced by MSM. The MSM tend to access care in an uncomfortable environment which suggests that there have been several missed opportunities to advance prevention messaging in the health care setting. There is the need to ensure universal access to care treatment and support services for MSM and all other marginalized groups. To achieve this objective several activities are being proposed for the strengthening of the services.

Expected results: increased access of quality treatment and care services for MSM
1. *Strengthen the delivery of comprehensive care and treatment for MSM,*
    NHP treatment and care coordinator will:
    - Collaborate with partners to develop comprehensive integrated treatment and care for MSM to include mental health and substance use and also referral network for adolescent and adult MSM with psychosocial issues.

    - Review protocol and train health care providers to routinely include HIV testing, STI diagnosis rectal examinations and information on anal sex in providing a care package to MSM

    - Review treatment protocol to pilot antiretroviral therapy on diagnosis of HIV positive MSM to support treatment as prevention intervention

    - Improve contact tracing for MSM

    - Improve the linkages between the treatment and prevention services through the development of effective referral mechanisms for NHP prevention team, MSM CBOs and other civil society partners working in HIV prevention and treatment facilities.

    - Integrate MSM treatment and care into existing NGO clinics which provides specialized care e.g. Cancer Society. Diabetes Association

2. *Reduce stigma and discrimination in the health care setting*

➢ NHP treatment and care coordinator to expand collaboration with partners for the systematic re-training of Health care workers (HCW) regarding stigma and discrimination, confidentiality and other MSM specific issues in an effort to improve accepting attitudes to MSM

3. *Expand Positive Health Dignity and Prevention (PHDP) programmes for HIV positive adult and adolescent MSM*

Universal access to HIV treatment has dramatically improved the life expectancy and quality of life for people living with HIV. These achievements magnify the urgent need to empower and enable the HIV positive MSM to improve their health outcomes, increase their awareness around gender, stigma and discrimination, know their rights, and to become active stakeholders in an effort to decrease HIV transmission. The empowerment of the MSM will be encouraged through the promotion of safer sex practices and reinforcing individual responsibility in preventing the spread of HIV.

NHP treatment and care coordinator in collaboration with the Prevention team will:
➢ Develop module reflecting MSM specific experiences in treatment literacy for inclusion in the PHDP curriculum developed to train Health care providers.

➢ Improve linkages with social support agencies to institutionalize access to social support programmes such as nutritional and other kinds of support

➢ Develop protocol for the establishment of sustainable 'Self Support '(peer) Group mandated to recruit self-identified HIV positive MSM for membership in the National PLHIVs networks.

Strategic Objective 5: Increased structural interventions to reduce social vulnerability for adult and adolescent MSM

Key objective: (a) increased involvement of the providers of social services, (b) increased access to integrated services for homeless adolescent MSM

Structural factors are mainly those contextual features which are outside the control of the individual that act as a barrier or facilitator of an individual's ability to prevent acquisition of HIV (Saunders R.A. & Ellen J.M. 2010). These factors are embedded in policies, practices and norms of society and can influence the impact of large social forces such as; poverty, gender inequality, racism, mobility and stigma. These large social forces affect STI transmission and distribution, behavior, networks and the overall risk of exposure to infection. (Blakenship, et al 2006)

Expected results: Increased capacity of social service providers to serve MSM clients (b) reduced social vulnerability for adolescent and young MSM.

i. *Increased capacity of social and community service providers to provide services for MSM*

➢ NHP prevention coordinator and lead MSM agency to sensitize the government social services, skills training agencies and other providers to the MSM specific issues thereby enhancing service provision in a stigma free environment to adolescent and youth MSM

➢ NHP prevention coordinator and lead MSM agency to sensitize the Community Development Committees (CDC) of the Social Development Commission (SDC) to integrate information on respect for diversity in existing community development programs.

i. *Reduce vulnerability for homeless adolescent and youth MSM*

Young MSM are mostly affected by homelessness which often results from: homophobia, rejection by family and friends, verbal and physical abuse and harassment at home or in their community. A short term drop in centre for homeless adolescent and youth MSM will be established to improve access to social services, and HIV prevention, treatment care and support services.

➢ NHP prevention coordinator in collaboration with MSM CBOs to establish a drop in centre for homeless adolescents and youth MSM with strict operational guidelines. The centre will provide:
   o Personal development programmes (including conflict resolution and intimate partner violence)
   o Psychosocial support including family counselling for reintegration
   o Referrals to drug use rehabilitation program
   o VCT and partner notification, referrals for ART and STI testing
   o Increased support and linkages to organizations offering educational training and skills building

Strategic objective 6: Improved delivery of a comprehensive package of behaviour change communication (BCC) interventions targeting adult and adolescent MSM

Key objective: MSM Knowledgeable about HIV risk and empowered with skills to reduce risky sexual practices.

Expected results: MSM able to protect themselves from HIV and other STI

i. *Scale up HIV testing for MSM in outreach settings and at treatment sites*
   Expanding testing and counseling including rapid testing outside of health facilities diminishes the stigma associated with knowing one's status and is an important opportunity to provide risk reduction counseling. Higher rates of undiagnosed/untreated STIs may also increase the risk of both acquiring and transmitting HIV.

   ➢ NHP prevention team to establish non-traditional VCT centres and conduct VCT training for civil society, private practitioners, pharmacies, FBOs and Youth Information centres to provide VCT services for adults and adolescent MSM
   ➢ NHP prevention team and civil society partners to increase site based testing for MSM

II. *Small group interventions and community-level behavioral interventions to prevent HIV*
   ➢ Interventions for MSM have been shown to be effective in reducing high-risk sexual behavior if they have an interpersonal skills training component and are conducted over multiple sessions. A series of empowerment workshops which facilitate repeat interactions as well as some of the other aforementioned components have been initiated for MSM. These will be scaled up by the MSM CBOs, other NGO working with MSM and the NHP prevention team

   ➢ NHP prevention team TO coordinate evaluation of the empowerment strategy

   ➢ NHP prevention team and lead MSM agency to standardize the empowerment workshop based on findings from evaluation and build capacity of civil society partners and other stakeholders to implement. This specifically includes;

      o The Implementation of the 45hr Empowerment Model which provides repeat interactions with each cohort. Approximately forty-five (45) contact hours in which MSM will be exposed to standardize modules addressing; sexuality, self - efficacy, HIV testing, risk reduction skills, access to condoms and lubricants and referrals to agencies that address social and psychosocial needs.

III. Improved prevention service delivery for MSM sex workers.

Owing to the criminalization of buggery and prostitution, MSM Sex workers face double stigma. They are also socially marginalized and as a result are at increased risk. In some instances there is another layer of stigma as some of them are also living with HIV.

➢ Outreach workers in the NHP and civil society partners to conduct regular outreach activities using Priority for Local Control Efforts (PLACE) methodology at street, club and other socializing sites and safe spaces
➢ Provide referral services to address psychosocial issues, mental health and drug use in this population.
➢ Establish mechanism to link MSM sex workers to the short term drop-in centre.

IV. Development of MSM friendly IEC messages and graphics using traditional media and new technology

Critical to reaching the MSM hidden population effectively will be the design of coordinated population-specific messages to be delivered by Internet banner ads on MSM-related sites and social media, tailored text messaging, community mobilization and interpersonal communication activities.

➢ Lead MSM agency and the NHP to
   o develop IEC materials focusing on ano-rectal care; correct and consistent condom and lubricant use; knowing your HIV status; Adherence; Intimate Partner Violence and STI Treatment
   o Develop campaign using traditional media targeting MSM youth (15-24 years) to provide information on the efficiency of HIV transmission through anal sex.
   o Develop campaign utilizing new technologies i.e. text messages and the internet to provide information to MSM and adolescent MSM on anal sex and self –efficacy skills to reduce risk taking practices

V. Increased access to condoms and lubricants

Correct and consistent condom and lubricant use is effective in preventing sexual transmission of HIV. Ensuring condom and lubricants are available and easily accessible has been shown successful in reducing risk behaviour.

➢ NHP prevention coordinator to procure lubricated male and female condoms and sexual lubricant (safe for rectal use/without nonoxynol 9) for free distribution.

➢ MSM agencies and other agencies working with MSM as well as the NHP prevention team to establish non-traditional condom and lubricant outlets to facilitate ease of access

Year 1: 2013 -2014

National Operational Plan
MSM Strategic Plan

Strategic objective 1: Build leadership, management and coordination of the MSM strategic framework

Key objective: Strengthened leadership and management

Expected results: Strengthened leadership management and coordinated MSM strategy

Activities	Output	Target	Responsible agency	Indicator
i. Increased leadership, management and coordination among partners NHP to build internal capacity and capacity of civil society partners in the specific areas of; leadership, management, advocacy, mobilizing other partners,	NHP and civil society staff trained in requisite skills and able to undertake core functions	4 series of training workshops	NHP international partners	**PEP3.1 N**umber of individuals trained by gender to support leadership activities. **PEP 4.11** Number of individuals trained in HIV institutional capacity development
The NHP to facilitate involvement of other sectors through the principles of 'shared responsibility' in the MSM technical working group e.g. education, youth, labour, justice ,social services	Sectors sensitized and mobilized around specific roles in MSM strategic framework	# sensitization sector meetings	NHP MSMTWG coordinator	**Number** of MOU signed **Number** of sectors implementing one MSM related programme on respect for diversity.
MSM TWG coordinator to utilize the mechanism of regular meetings of the MSM TWG to facilitate reporting and provide technical guidance on the implementation process of the MSM strategic framework.	Develop reporting standards and guidelines for MSM TWG meetings Organized regular meetings of MSM TWG	Scheduled quarterly meetings Reporting tools developed	MSMTWG coordinator	**Number** of partners work plans developed reflecting the MSM strategic framework
NHP to disseminate the MSM strategic framework to key government sectors, civil society partners, international partners, faith based leaders and community leaders	Partners aware of MSM strategic framework and their roles in implementation	4 dissemination meetings conducted	NHP Lead MSM agency	**Number** of partners work plans developed reflecting the MSM strategic framework

Lead MSM agency to coordinate management and leadership skills building of MSM CBO's and other agencies working with MSM to facilitate more effective representation of MSM issues in national policy and program decision making process	Improve skills among MSMCBOs to represent MSM issues at national level	2 workshops conducted per year	Lead MSM agency	**PEP 3.1** Number of persons trained by gender to support leadership activities **PEP 4.11** Number of individuals trained in HIV institutional capacity development
MSM TWG coordinator to Increase the coordination of programmes conducted by MSMCBOs at the national level through regular updates at the MSM TWG meetings	Coordinating mechanism improved for MSM CBOs programmes via MSM TWG Reporting guidelines developed and implemented	MSM TWG members reports at Scheduled meetings.	TWG coordinator NHP, CVC, JASL, JFLAG	**Number** of MSMCBOs work plans developed reflecting the MSM strategic framework

Strategic objective 2: Improved advocacy for legislative, policy and other structural changes that facilitate an enabling environment for MSM to access treatment, care and support and prevention services**.**

Key objectives: Reduce stigma and discrimination against MSM, advocacy for change in the legal and policy environment, raising public awareness of stigma and discrimination, improved coordination and strengthen leadership

Expected result 1: Reduced stigma and discrimination

Activities	Output	Target	Responsible agency	Indicator
i. Increased advocacy for change in legal and policy environment Lead MSM agency to contract a legal consultant to build the capacity of MSM organizations regarding the process of law reform Lead MSM agency to build capacity of MSM and other organizations working with MSM to engage political leaders to initiate/support public declaration on the need to reform discriminatory legislation affecting MSM and promote respect for diversity	Training workshop on the law reform process for MSM organizations Sensitization meetings with key politicians	3 workshops conducted 1 meeting for the year 5 politicians sensitized per year	**MSM CBOs, (JFLAG, JASL, CVC)**	**PEP 4.11** Number of individuals trained in HIV institutional capacity development **PEP 3.1** Number of persons trained by gender to support leadership activities
ii. increase public awareness of stigma and discrimination affecting MSM Lead MSM agency to develop public education campaign on universal access	Develop and place one public education campaign	Reported recall of message of public education campaign from media recall survey	CVC, other MSM organization, NHP	**Percentage** of MSM and SW who report experiencing stigma within the last 12 months
MSM agency to establish MSM speakers' bureau	MSM and other interested partners involved in speaker's bureau	Speakers manual developed Speakers trained	NHP	**PEP3.1** Number of persons trained by gender to support leadership activities.

Activities	Output	Target	Responsible agency	Indicator
iii. Increased multi sectorial advocacy for reducing stigma and discrimination NHP policy unit to engage the Justice sector and or Bar Association of Jamaica to facilitate re-orientation for lawyers and judiciary through continued education training regarding human rights, sexual orientation and marginalized populations.	Sensitization meetings with Min of Justice, Bar Association of Jamaica Conduct training workshop for lawyers	One sensitization meeting One training workshop	NHP policy unit, JFLAG, CVC, JASL, JFJ	**PEP 3.1** Number of organizations provided with technical assistance for HIV related policy development
NHP policy unit to collaborate with the Ministry of National Security to review codes of conduct for Police force regarding human rights and sexual orientation.	2 sensitization meeting with the police high command and partners regarding the need to review code of conduct for officers interacting with MSM 2 Collaborative meetings to develop process for revision of code of conduct within agreed time frame	Police high command sensitized regarding revising code of conduct First draft of revised code of conduct developed	NHP MSM organizations	**PEP 3.1** Number of organizations provided with technical assistance for HIV related policy development
The NHP policy unit to expand the training of church leaders to engage in the public discourse on respect for diversity.	Sensitization meetings with church leaders one per quarter	Church leaders sensitized	NHP JASL, Children First	**PEP3.1** Number of persons trained by gender to support leadership activities.

Strategic Objective 3: Strengthened stakeholders' capacity in data use, collection and dissemination to ensure scaled coverage and quality of interventions targeting MSM

Key Objective: MSM programs informed by improved collection and application of strategic information

Expected results 1: MSM program design and quality informed by improved collection and application of strategic information

Activities	Output	Target	Responsible agency	Indicator
I .improved collection and application of strategic information for MSM program design and quality MSMTWG to collaborate with the MERG to identify specific qualitative research priorities to be conducted in an effort to improve evidence based MSM programs. MSMTWG to be represented on the MERG	Research agenda developed, research consultants contracted 2 qualitative research conducted and findings disseminated	2 research undertaken per year	MSMTWG & MERG	**Number** of MSM interventions developed guided by evidence
MSMTWG and the MERG to disseminate research findings on MSM and facilitate application of findings to programmes	Dissemination meetings to discuss findings and develop strategies for application to programmes	Stakeholders meeting to discuss implication of findings	MSMTWG & MERG	Number of MSM interventions developed guided by evidence
NHP to develop and disseminate user-friendly guide book for MSM interventions to civil society partners	Consultant contracted to developed User friendly guide book	Guide book developed and disseminated to stakeholders	NHP	Number of NGOs/CSOs providing HIV/AIDS prevention, treatment, care and support interventions for MSM according to the guidebook

Activities	Output	Target	Responsible agency	Indicator
NHP and MERG to apply National M&E indicators to MSM programs	Standardize the use of common indicators		MERG NHP	**G6** Number of NGOs/CSOs providing HIV/AIDS prevention, treatment, care and support interventions for MSM according to the national standards and guideline

Strategic Objective 4: Improved delivery of comprehensive high quality treatment care and support for adult and adolescent MSM

Key Objective: Strengthen delivery of quality treatment and care services to MSM, reduce stigma in health care facilities, expand positive health and dignity programmes for MSM living with HIV**.**

 Expected results 1: increased access of quality treatment and care services by MSM

Activities	Output	Target	Responsible agency	Indicator
NHP treatment and care (T&C) coordinator to develop comprehensive integrated treatment and care for MSM to include STI, mental health and substance use and also develop referral network for adolescent and adult psychosocial issues with civil society partners	Sensitization training with key treatment partners regarding development of integrated strategy to provide comprehensive care e. g. Mental health substance use and other psychosocial issues	4 meetings to sensitize key treatment partners Package of care services developed and disseminated	NHP	**Number** of persons trained to provide services by client and service area (**process indicatorP7 – P10, P12, P16**) **Number** of MSM reached with minimum package of treatment and care and prevention services **Percentage** of MSM SW with active syphilis
NHP Treatment & Care coordinator to review treatment protocol to pilot antiretroviral therapy on diagnosis of HIV positive status of MSM to support treatment as prevention intervention	NHP treatment and care coordinator to conduct stakeholders meeting to review HIV treatment protocol.	Revised protocol	NHP	**UN-GE 16** % of MARPS with HIV still alive 12 months after initiation of ART **GF23** Percentage of PLWHA on ART reporting 90% adherence by pill count
NHP Treatment &Care Coordinator to review protocol and train health care providers to routinely include HIV testing, STI diagnosis rectal examinations and information on anal sex in providing a care to MSM. Also to include stigma	2 Training workshops for HCW in delivery of care	2 training workshops	NHP	**Number** of persons trained to provide services by client and service area (**process indicatorP7 – P10, P12, P16**)

Activities	Output	Target	Responsible agency	Indicator
reduction and Positive health dignity and prevention	package for MSM			**Number** of MSM reached with minimum package of treatment and care and prevention services **Number** of persons trained to provide services by client and service area (**process indicatorP7 – P10, P12, P16)**
NHP Treatment and Care to strengthen adherence support for MSM PLHIV among NGOs and adherence counselors.	Conduct small group education sessions for adherence counselors in existing meetings.	4 training sessions	NHP	**GF23** Percentage of PLWHA on ART reporting 90% adherence by pill count

Strategic Objective 5: Increased structural interventions to reduce social vulnerability for adolescent and young MSM

Key objective: Increase involvement of the providers of social services, access to integrated services for homeless adolescent and young MSM

Expected results 1: Increased capacity of social service providers to serve MSM, increased opportunities for social mobility for adolescent and young MSM

Activities	Output	Targets	Responsible agency	Indicator
Lead MSM agency and NHP to sensitize the government social services, skills training agencies and other providers to MSM specific issues thereby enhancing service provision in a stigma free environment to adolescent and youth MSM	Sensitization workshops for social service providers using standardize training modules on MSM and stigma and MSM testimonials	2 workshops conducted Module developed	Lead MSM agency NHP	**PEP 3.1** Number of persons trained by gender to support leadership activities **PEP 4.11** Number of individuals trained in HIV institutional capacity development. **GOJ MOH** Percentage of MSM who report experiencing stigma within the last 12 months
NHP to sensitize the Community Development Committees (CDC) of the Social Development Commission (SDC) to integrate information on respect for diversity in existing community development programs	Sensitization workshop conducted with SDC utilizing standardized training modules and testimonials	2 workshops conducted at regional level	NHP	**GOJ MOH** Percentage of MSM who report experiencing stigma within the last 12 months **PEP 3.1** Number of persons trained by gender to support leadership activities **PEP 4.11** Number of individuals trained in HIV institutional capacity development

Activities	Output	Targets	Responsible agency	Indicator
Lead MSM agency to establish a short-term drop- in centre for homeless MSM to provide psychosocial support including family counselling for reintegration and support, referral for drug rehabilitation, personal development programmes and links to organizations offering vocational skills training	Homeless shelter established with strict operational guidelines and services provided to reduce vulnerability	Homeless shelter established and functional	Lead MSM agency MSM CBOs	**Percentage** of MSM sex workers receiving the country defined minimum package of services
NHP Technical support to MSM to facilitate access to financial institutions offering small business financing	Technical support provided to MSM to access via small group meetings with MSM and financial agencies. MSM empowered to access small loans	2 small group meetings for MSM and financing partners	NHP and MSM CBOs	**Number** of MSM and sex workers reached through prevention activities

Strategic objective 6: Improved delivery of a comprehensive package of behaviour change prevention interventions targeting adult and adolescent MSM

Key objective: MSM Knowledgeable about HIV risk and empowered with skills to reduce risky sexual practices.

Expected results: MSM able to protect themselves from HIV and other STI

Activities	Output	Target	Responsible agency	Indicator
NHP Prevention team to promote routine offering of VCT by private health care providers and pharmacies	Sensitization of private practitioners and private pharmacy re: testing protocol	4 meetings at the regional level	NHP	**Percentage** of most at risk populations (youths, sex workers, MSM)who received HIV testing in the last 12 months and who know the results
NHP Prevention team to standardize the empowerment workshop and build capacity of civil society partners and other stakeholders to implement.	Develop guidelines to standardize empowerment workshops, conduct meeting with existing implementing agencies Provide ongoing technical support to civil society partners to conduct workshops.	1 meeting conducted	NHP	**Percentage** of MSM sex workers receiving the country defined minimum package of services **Number** of MSM and sex workers reached through prevention activities **Percentage** of most at risk populations (youths, sex workers, MSM)who received HIV testing in the last 12 months and who know the results **UNGASS process indicator** percentage of MARPS (MSM, OSY, SW) reached by prevention programme

Activities	Output	Target	Responsible agency	Indicator
NHP scale –up implementation of the 45hr Empowerment Model of workshop. MSM will be exposed to standardize modules on; self -efficacy, HIV testing, risk reduction skills, access to condoms and lubricants and referrals to agencies that address social and psychosocial needs.	Empowerment workshops conducted for MSM	4 per region, per year for NHP2 per year for civil society partners	NHP

MSM CBOs | **Percentage** of MSM sex workers receiving the country defined minimum package of services Number of MSM and sex workers reached through prevention activities

Percentage of most at risk populations (youths, sex workers, MSM)who received HIV testing in the last 12 months and who know the results

UN-C/LPE9b percentage of men reporting using a condom the last time they had anal sex with a male partner

UNGASS process indicator percentage of MARPS (MSM, OSY, SW) reached by prevention programme |
| NHP and partners to conduct risk reduction activities and site based testing using PLACE methodology at street, club and other socializing sites and safe spaces for MSM | PLACE survey conducted to identify and map sites

HIV testing and risk reduction activities conducted at MSM sites | 1 survey conducted per parish

 Weekly / fortnightly activities | NHP

MSM CBOs | **Percentage** of MSM sex workers receiving the country defined minimum package of services

Number of MSM and sex workers reached through prevention activities

Percentage of most at risk |

Activities	Output	Target	Responsible agency	Indicator
		conducted		populations (youths, sex workers, MSM)who received HIV testing in the last 12 months and who know the results **UN-C/LPE9b** percentage of men reporting using a condom the last time they had anal sex with a male partner **UNGASS process indicator** percentage of MARPS (MSM, OSY, SW) reached by prevention programme
Lead MSM agency to develop IEC materials focusing on Ano-rectal care; condom and lubricant use; knowing your HIV status; Seeking STI Treatment	IEC materials developed to inform on ano –rectal hygiene, condom and lubricant use, seeking STI treatment	IEC materials developed		**Percentage** of MSM and SW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions
MSM agency to develop campaign utilizing new technologies i.e. text messages and social media to provide information on anal sex	Campaign using new technologies; social media developed text messages providing information reducing risk of anal sex	Campaign developed and placed using new technologies	Lead MSM agencies	**Percentage** of MSM and SW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions **UNGASS process indicator** percentage of MARPS (MSM, OSY,

Activities	Output	Target	Responsible agency	Indicator
				SW) reached by prevention programme
NHP to procure lubricated male and female condoms and sexual lubricant (safe for rectal use/without nonoxynol 9) for free distribution	Constant supply of suitable condoms and lubricants available for MSM condoms and lubricants distributed		NHP	**CIMT3 %** of people 15 -49 years old who can access a condom almost immediately (less than 5 minutes)