

Mapping of MARP-Friendly Health Facilities

In Jamaica

April 2012



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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
BCC	Behavior change communication
CHART	Caribbean HIV/AIDS Regional Training Network
CVCC	Caribbean Vulnerable Communities Coalition
HIV	Human Immunodeficiency Virus
IEC	Information, education, and communication
J-FLAG	Jamaica Forum of Lesbians, All-Sexuals, and Gays
LGBT	Lesbian gay bisexual transgender
MARPs	Most-at-risk populations
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Nongovernmental organization
PAHO	Pan-American Health Organization
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PLACE	Priority for Local AIDS Control Efforts
PLHIV	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
PSI	Population Services International
SBCC	Social and behavior change communication
STI	Sexually transmitted infections
SW	Sex workers
UHWI	University Hospital of the West Indies
UNAIDS	The Joint United Nations Program on HIV and AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

Executive Summary

FHI 360's Communication for Change (C-Change) project in Jamaica, through funding from USAID/PEPFAR, provides technical assistance in social and behavior change communication (SBCC) to improve the quality and scale of Jamaica's response to the HIV and AIDS epidemic. In 2012 the project conducted an assessment to map the types of most-at-risk population (MARP)-supportive services offered by public and private health facilities as well as the availability of SBCC material, using a checklist developed by C-Change. From the mapping activity C-Change hopes to present a picture of the level and availability of supportive services in MARP-friendly facilities in Jamaica to inform future program planning.

Nineteen public and private health facilities in four cities across Jamaica participated in the mapping exercise. Findings showed that public facilities offered greater services specific to MARPs and they were free of cost. Public facilities also had attached outreach and support programs facilitated by trained staff. Sexually transmitted infection (STI) testing at these facilities was limited to HIV and syphilis rapid tests, and pre- and post-test counseling was routine. Staff at these facilities was also more likely to have received training related to men who have sex with men and sex workers than those from the other facilities mapped.

At private facilities MARP-specific services were rare and outreach and support groups were not available. Services from some of these facilities were available at a cost. While private facilities offered a broader range of STI testing, pre- and post-test counseling was infrequent due to lack of trained staff. In general MARP-specific SBCC materials were nonexistent at all health facilities for reasons cited that included cultural and religious attitudes toward groups that were heavily discriminated against.

This study has implications for SBCC HIV-prevention programming in Jamaica to create a more accessible and user-friendly health sector environment for MARPs. In doing so, improved health-seeking behavior and the better provision of health services are envisioned.

Background

FHI 360's Communication for Change (C-Change) project in Jamaica provides technical assistance in social and behavior change communication (SBCC) to improve the quality and scale of Jamaica's current response to the HIV and AIDS epidemic. The project works toward the overall goal of a national-led, sustainable, integrated, and coordinated HIV-prevention effort that enables national programs to plan, implement, and evaluate evidence-based, comprehensive programs for most-at-risk populations (MARPs), including men who have sex with men (MSM) and sex workers (SW). C-Change works closely with: civil society and Ministry of Health (MOH) implementers at community, regional, and national levels; policymakers, as influencers of the programming environment; and MARPs, as end-users of the programs that address them.

Through this strategic approach, C-Change aims to achieve: increased coordination between the MOH and civil society actors; increased scale and reach of programs through technical assistance; increased quality of implementation and documentation; increased sustainability of programs; and accelerated momentum of social mobilization and advocacy. In keeping with its mandate to inform program planning and implementation for MARPs, guided by evidence-based data, C-Change conducted a study in 2011 aimed at mapping the types of MARP-supportive services and communication materials offered by public and private health facilities.

Introduction

Universal access to health care is a primary goal in response to the HIV pandemic and is of special concern when it comes to MARPs, including MSM and SW. Certain MARP-specific behavior is often criminalized and discriminated against, resulting in barriers to accessing clinical and nonclinical services, including HIV prevention, care, and treatment. The World Health Organization (WHO 2007) identified five priority areas for the health sector to make significant progress toward achieving the goal of universal access. These priority areas are:

1. Enabling people to know their HIV status
2. Maximizing the health sector's contribution to HIV prevention
3. Accelerating the scale-up of HIV and AIDS treatment and care
4. Strengthening and expanding health systems
5. Investing in strategic information to guide a more effective health response

These priority areas are relevant to MARPs because of their specific health needs, which may not be formally addressed within health facilities. Considering the high rates of sexually transmitted infections (STIs) within these populations, primary health care and sexual health services are critically important in mitigating the effect of HIV and other infectious diseases (UNAIDS 2009).

Mental health and psycho-social support are also critical components of a basic health package. Emotional and behavioral health problems occur at high enough rates in both the general and most-at-risk population to warrant screening as part of general primary care, according to a Pan American Health Organization (PAHO) 2009 regional consultation report. MARPs, especially those who are HIV-positive, have a higher risk of developing psychiatric illness because of the double stigma associated with HIV and their lifestyles (UNAIDS 2009). According to the Centers for Disease Control and Prevention, MSM are at heightened risk for major depression and generalized anxiety disorder during adolescence and adulthood as well as bipolar disorder, the common basis of which is likely homophobia (Ayala et al. 2011).

Internationally, little information exists about the most suitable package of services to offer in each setting and to each sub-population that would bring about a significant long-term decline in new infections. However, based on population characteristics locally, key components should include HIV prevention, testing, counseling, risk assessment and reduction discussions, as well as access to primary care services that are non-discriminatory and staffed by those knowledgeable about the specific health needs of the population.

The PAHO report cited above states that health services, including primary health care, have typically not been adequately responsive to the needs of MSM in the Latin America and Caribbean Region. The same report states that the formal health sector often lacks personnel with expertise in the diverse health needs of MSM populations (PAHO 2009). Conversely, health centers designed to specifically serve the MSM population often lack resources to provide the full array of needed services (WHO 2009).

There is a strong need for adequate health services for MARPs in Jamaica. While the country has a generalized HIV epidemic, pockets of concentrated epidemics exist among MARPs. It is estimated that 1.7 percent of the adult population is infected with HIV with higher prevalence among MSM (31.8 percent) and SW (4.9 percent). Approximately 50 percent of those infected are unaware of their HIV status and 14,000 are in need of treatment (NHP 2010). The MSM population in Jamaica is characterized by high HIV incidence, frequent multiple partnerships, and poor condom use patterns. The sex worker population in turn is characterized by high levels of mobility, multiple sexual contacts, low condom use with regular partners, and high levels of substance abuse (NHP 2012).

For both the MSM and SW populations probable decline in the projected number of new HIV infections in Jamaica is unlikely in the foreseeable future without meaningful change (NHP 2012). The design and performance of the health care system is an important consideration when, according to the 2012–2017 National HIV Strategic Plan, *“there are far too many reports of discrimination within the health sector, which often hinders persons from accessing HIV testing and treatment.”*

To better understand the availability of health services and resources that are suitable for MARP populations in Jamaica mapping research was conducted. This report summarizes the methodology used and findings of the study, which can be used to improve the design of the health sector to address the needs of MARPs.

Methodology

The purpose of this assessment was to map current public and private health facilities serving MARPs, with a focus on SW, MSM, and at-risk youth in Jamaica. The mapping sought to catalog the range of services and the availability of MARP-specific communication materials offered by facilities considered MARP-friendly.

Mapping Locations

The assessment was conducted across four locations in Jamaica: Kingston and St. Andrew, St. Catherine, St. Ann, and St. James (see Figure 1). The study locations represented the urban capitals of the country where the largest proportion of the population lives as well as the areas with the highest HIV prevalence.

Figure 1: Location of Health Facilities Mapped in Jamaica



Facility Recruitment and Sample

C-Change recruited a purposeful sample of what was considered MARP-friendly facilities via a three-stage process. First, six organizations working with MSM and SW populations were consulted to obtain information on health facilities where they referred clients. Second, the project informally sought information on health facility preference from a number of SW and MSM. From these consultations, C-Change developed a list of facilities (public and private). The list was then further expanded using referrals from the facilities themselves once the mapping activity began. The final sample is shown below of 19 facilities that participated in the mapping exercise between January and February 2012 (see Table 1).

Table 1: Health Facility Sample by Location

Location	Number of Health Facilities
Kingston and St. Andrew	12
St. Catherine	3
St. James	2
St. Ann	2
Total	19

Data Collection

C-Change developed a checklist (Annex 1) to collect data, which an investigator administered to health professionals at the identified facilities. The checklist was close-ended and covered areas such as:

- HIV prevention, treatment, and care and STI screening and treatment services available
- Services available for MSM/SW/at-risk youth’s sexual and reproductive health needs
- SBCC material available, including MARP–audience specific

Ethical Considerations

The Ministry of Health Institutional Review Board in Jamaica granted ethical approval for this assessment. Before engaging public facilities, the respective regional health authorities were contacted and approval sought from the regional technical directors.

Study Limitations

The assessment covered only 19 facilities and is therefore not fully representative of the situation in Jamaica. Labeling facilities as MARP–friendly was subjective and based on user expectations, since there are no set local standards. Additionally, most public health facilities either declined to participate or did not respond to the invitation so findings are heavily based on private health care responses. The study was also designed to measure the availability of services for MARPs and did not seek to determine attitudes or quality of care, which may also represent barriers to accessing services. The use of the checklist also limited the amount of qualitative data that could be collected to further describe service availability.

Research Findings

Facility Profile

A total of 19 facilities were mapped, 63 percent (n=12) of which were located in the Kingston and St. Andrew region. Seventy-four percent (n=14) of facilities were private, three government-funded, and two received both private and public funding. Forty-two percent (n=8) of facilities mapped had a MARP-specific mandate, with their main target groups representing MSM, SW, and people living with HIV (PLHIV). Of the eight MARP-specific facilities, three were public, four private, and one received both public and private funds (see Table 2).

Forty seven percent (n=9) of facilities provided services free of cost. This included all public facilities, five private facilities, including two which offered a waiver to patients who were unable to pay, and one public-private facility. Seventy-seven percent (n=7) of those that offered free services had a MARP-specific mandate.

Table 2: Table Showing Profile of Facilities Mapped

	Public (n=3)		Private (n=14)		Public-Private (n=2)		Total (n=19)	
	%	(n)	%	(n)	%	(n)	%	(n)
Sample Size	100.0	(3)	100.0	(14)	100.0	(2)	100.0	19
MARP-specific mandate	100.0	(3)	28.6	(4)	50.0	(1)	42.1	8
Services free of cost	100.0	(3)	35.7	(5)	50.0	(1)	47.4	9

HIV-Prevention Services for MARPs

Testing

HIV testing services were available in all 19 facilities assessed. All offered rapid testing and results within a half an hour. Rapid HIV testing was free at all three public facilities and all public-private facilities. Only three private facilities offered free testing while all others required payment. Voluntary counseling and testing (VCT) was standard at only seven of the facilities that offered free HIV testing. Some private facilities indicated they did not offer users pre- and post-counseling because staff was not trained in VCT. Except for syphilis and HIV, few STI testing services were available in the public-sector facilities mapped. STI diagnosis was primarily performed using a syndromic approach as either observed by the doctor or described by the patient. Private facilities offered a broader range of STI testing for a fee. CD4 tests were performed free of cost on-site at one of the private MARP-friendly facilities, and all other facilities referred users either to the National Public Health Laboratory or to nearby hospitals.

Treatment

Sixty-eight percent of all facilities (n=13), mainly private, had a pharmacy on-site. One facility in Montego Bay with a large MARP clientele did not have a medical officer on staff but had clinic days when a doctor was present. However, the doctor was limited in his/her capacity to prescribe drugs as government pharmacies in the vicinity reportedly did not honor prescriptions written by medical practitioners not employed by them. The facility was therefore reduced to providing only over-the-counter products such as supplements, vitamins, and pain and fever

reducers. During data collection, it was noted few persons sought HIV care in private facilities. This might be due to the fact that antiretroviral therapy is institutionalized in the public sector and not covered by private health insurance.

Condoms and Lubricant Availability and Distribution

All government-funded public facilities mapped (n=3) provided condoms free of cost (see Table 3). Male condoms were generally distributed during support groups, VCT, upon patient request, and during outreach activities by behavior change communication (BCC) officers or peer educators. Thirty-six percent (n=5) of private facilities distributed male condoms to MARPs and three provided them free of cost. Both male and female condom demonstrations were conducted at public facilities in waiting areas, during support groups, and through interventions. Private facilities did not conduct condom demonstrations or did so infrequently upon request of the client. Lubricant was only available and distributed in facilities identified as having a MARP-specific mandate (42 percent, n=8), free of cost in all cases. One facility did so to MSM upon request or during MSM support groups. The other facilities distributed to anyone who asked.

Table 3: Condom and Lubricant Availability by Facility Type

Commodity	Public Facilities (n=3)		Private Facilities (n=14)		Public-Private (n=2)		Total (n=19)	
	%	(n)	%	(n)	%	(n)	%	(n)
Male condom	100.0	(3)	35.7	(5)	50.0	(1)	47.3	9
Female condom	100.0	(3)	35.7	(5)	50.0	(1)	47.3	9
Condoms available free of cost	100.0	(3)	21.4	(3)	50.0	(1)	36.8	7
Lubricant	100.0	(3)	28.6	(4)	50.0	(1)	42.1	8

Psycho-Social Support

All public facilities provided access to social workers on-site daily for mental health and adherence counseling. Psychologists also visited these facilities once a week. All public facilities offered support groups aimed at promoting healthy, positive lifestyles and strengthening linkages to clinical services, especially for PLHIV. Weekly and monthly support groups were also facilitated for PLHIV, MSM, and SW (male and female). These facilities reported that existing counselors were limited and stretched to serve several regions. They were also primarily provided by the National HIV/STI Program through project funds from the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Only three private facilities offered support groups and each of these facilities had a MARP-specific mandate. Other private facilities provided referrals to mental health counselors since services were not available on-site. Both public-private facilities offered psycho-social support through support groups and outreach services for MSM and SW.

MSM/SW/At-Risk Youth Friendliness

NGO Collaborations

All public and one public-private facility had established ties with NGOs to increase the range of services that they offered; most private facilities did not have such ties. For example, partnerships were formed with the National Council on Drug Abuse to provide HIV testing for

homeless drug users and with the Jamaica Cancer Society for subsidized rates for pap smears. Overall, however, collaborations were infrequent or nonexistent.

Anonymous Services

Eighty-eight percent (n=7 of 8) of facilities with MARP-specific mandates offered anonymous services or used pseudonyms and codes with clients. One private facility accepted aliases for patients providing they were not using health insurance to access services. All other facilities mapped did not provide anonymous services. All facilities (n=19) provided a private area for consultations and visits.

Peer Educators

Twenty-one percent (n=3) of private facilities used peer educators for outreach activities. All public facilities employed peer educators trained by the National HIV/STI Program or Jamaica AIDS Support for Life who also visited PLACE¹ sites and disseminated SBCC materials.

Staff Trained in SW/MSM Sensitivity

Forty-two percent (n=8) of all facilities mapped indicated staff had received formal training in MSM/SW/youth sensitivity. Of this, 75 percent (n=6) had previously indicated having a MARP-specific mandate. One public facility in Montego Bay included security personnel in training sessions as the first point of contact to the facility. Trainings were mainly carried out by the National HIV/STI Program and included topics related to sexuality, terms used by MSM and SWs, confidentiality, stigma and discrimination reduction, and the interplay of culture and risk.

Health Services Specific to MARPs

Twenty-six percent (n=5) of all facilities mapped provided health services that were specific to MARPs. This included two public facilities, three private, and one public-private institution. Two public facilities indicated anal/rectal exams were only provided if a case required it or upon patient request, however, this exam was rare even if the client identified as MSM. It should be noted that three facilities that previously identified having a MARP-specific mandate did not report providing any services that were considered specific to MARPs.

Community Education/Outreach

None of the private facilities mapped hosted or implemented its own community outreach initiatives. Two private facilities reported participating in health fairs and general health events when invited. Public facilities reported heavily participating in community education activities, conducting outreach (including HIV/AIDS counseling, HIV testing, and condom demonstrations) as well as sending peer educators to PLACE sites to conduct risk assessments and disseminate HIV/STI-related information. Specific outreach activities included weekly “Lunch & Learn” days where PLHIV and MSM were given a meal and hygiene package while engaging in an HIV 101 and risk-reduction discussion. An in-school program “Hold on-Hold

¹ PLACE or Priorities for Local AIDS Control Efforts is a rapid assessment tool to monitor and improve AIDS prevention program coverage in areas where HIV transmission is most likely to occur (MEASURE Evaluation).

off' was used to enhance student life skills and encourage abstinence. Communities were also identified and workshops and sessions coordinated according to community health needs.

Referral to Legal/Social Services

No referral services were reported by the mapped private facilities. Thirty-six percent (n=5) of private facilities reported assisting patients in obtaining social support through organizations such as the National Health Fund and the Program of Advancement through Health and Education. Within the public sector, referrals were provided for persons who needed counseling, legal aid, or social support. Some referral sources named included the Ministry of Health Stigma and Discrimination Redress Body, Jamaica Forum for Lesbians, All-Sexuals and Gays, Center for HIV/AIDS Research, Education and Services, and the Child Development Agency.

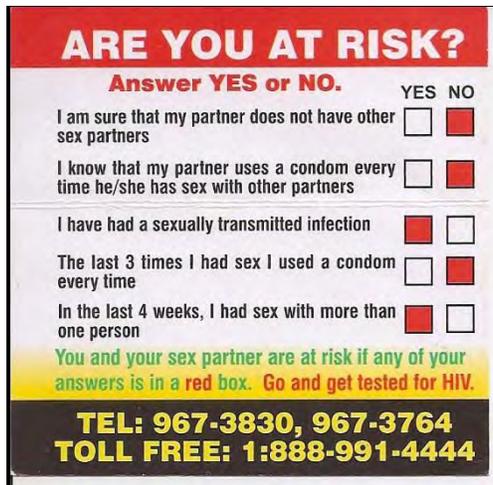
Available SBCC Material

HIV-related information, education, and communication (IEC) materials were observed at all public and one public-private health facility but none specifically targeted MARPs. Reasons given for the lack of MARP-specific materials were: cultural attitudes toward specific populations, safety, security, comfort of clients, and also to prevent the facility from being branded or known as one that provides services to MARPs. As a result, most materials viewed by the investigator were related to HIV risk, prevention, and condom use. Most material had also been obtained from the National HIV/STI Program. IEC materials were not readily available at private facilities. One private hospital highlighted their connection to the Catholic Diocese that prohibited the display of any sexual or reproductive health poster and chart, although the government had recently purchased the facility. Sample materials from public facilities are displayed below.

Figure 2: IEC Material Sample 1



Figure 3: IEC Material Sample 2



Views on MARP-Friendly Services and Materials

Twenty-one percent (n=4) of all facilities mapped did not think the services available to MARPs needed improvement. Thirty-six percent (n=7) reported that more training was needed for staff in MSM/SW sensitivity and also identified lack of appropriate SBCC material as an area to be strengthened. Staff recognized the need for training in VCT. One public facility suggested an increase in resources and staff to improve general program implementation.

Discussion

The availability of trained staff at health facilities affects critical aspects of service delivery. While staff from within public and public-private facilities reported training and systems in place such as weekly and monthly support groups and peer education sessions to address MARP-specific needs, limited resources prevented far-reaching and sustainable MARP-specific programs within these facilities. This was mainly because peer educators and BCC officers were contracted under short term project funds. In addition staff in private facilities lacked the relevant training to address the specific needs of MARPs. VCT services were also rare in the private sector, again due to the lack of staff training, even with the widespread availability of HIV rapid testing. Training on interpersonal communication with an on MSM and SW needs was seldom made available, particularly in the private sector. This is critical in offering MARPs nondiscriminatory access to services, improving their health-seeking behavior, and providing life-saving prevention, care, and treatment services.

Fiscal issues also affected the range of services available to MARPs. Key informants reported the availability and longevity of psycho-social support staff was affected by short-term project funds. The growing rate of HIV and AIDS in Jamaica has increased the demand for clinical and counseling services. Treatment and care is no longer only centered on clinical support but also includes psycho-social needs. Many of the facilities surveyed saw the need for counseling and mental health support for MARPs but admitted that human and financial resources restricted the development and expansion of this area. Funding also affected the availability of treatment. Antiretrovirals were only available in the public sector pharmacies and were not covered by private health insurance.

In the absence of funding, it seems beneficial to coordinate service provision and optimize the various strengths of service providers. NGOs and faith-based organizations have assisted the public health system in expanding the availability of supportive services in this way. This has increased the health facilities' ability to attract and retain clients through the provision of referral services. Recognizing and forming partnerships with organizations that have been successful in reaching MARPs may benefit populations in need. Study findings show that public and private facilities have not yet fully capitalized on such partnership opportunities, from which both would benefit. Private facilities offered a broader range of STI testing than public, which were limited to mainly HIV and syphilis rapid testing and using a syndromic approach to diagnose infections—an approach that precludes strain-appropriate treatment options. Coordinating with the private sector to increase testing options could offer clients a broader range of services and better health outcomes.

Public facilities tended to have numerous outreach programs, which is useful when targeting populations that are heavily stigmatized and discriminated against and have, as a result, developed poor health-seeking behavior. Some facilities used the PLACE method to reach their target audiences, expanding the geographical catchment of programs. Private facilities rarely fostered outreach or support groups. Neither did they refer clients to public facilities or NGOs known to offer these services, which can provide clients with much-needed mental health and psycho-social support.

Potential privacy and confidentiality concerns were also found with the private sector. Private facilities rarely offered clients the option of using code names to allow for anonymity and confidentiality, while all public facilities did. The need to pay for services and health insurance requirements were the determining factors for private health providers.

The use of MSM– or SW–targeted SBCC materials was nonexistent in most health facilities, mainly because of the negative cultural attitudes toward these target populations. A practical mix of communication channels should be considered when determining how best to convey messages to populations that are stigmatized and discriminated against. Most facilities had obtained SBCC material from the National HIV/STI Program and had not developed it themselves. Only one private facility had developed its own material, but it was not specific to MARPs.

Conclusions and Recommendations for SBCC Programming

While staff training, client services, and educational materials addressing the needs of MARPs appear to be more available in public than in private health facilities, a number of gaps exist across so called “MARP–friendly” facilities in Jamaica. With targeted health services for MARPs becoming a public health necessity and priority for addressing the HIV epidemic, a program plan for MARP–friendly health facilities is recommended. Overall, planners and implementers should consider using evidence-based approaches to develop and implement basic packages of essential services for MARPs, which address their direct health needs and are driven by client demand and illness presentation. More specific recommendations are summarized below:

1. Conduct staff training to provide support and psycho-social services for MARPs, free access to condoms with condom demonstration, VCT, HIV and other STI testing, or referrals for these services. Training should discuss MARP sexual practices and their basic and specific needs. In addition, training and retraining should be conducted on a continuous basis for health care workers on interpersonal communication and counseling, especially in public facilities where most MARP–specific services are provided. The medical association could take the lead in working with health providers on the main barriers to health care access and the implications of these barriers for MARPs.
2. Provide anonymous and confidential services in light of the stigma and discrimination MARPs face locally. Positively branding health facilities and clinics that have successfully packaged essential services for MARPs as offering high quality sexual and reproductive health services for all may prevent labeling, which health facilities are eager to avoid.
3. Establish links among government facilities, private facilities, and civil society organizations to strengthen the quality, scale, and sustainability of services available to MARPs by playing on the strengths of these service providers.
4. Strengthen policies to ensure that health care providers are stringent in their provision of VCT at all health facilities.
5. Develop and use MSM/SW–targeted materials to close gaps and enable direct engagement with these groups. Use nontraditional SBCC messaging channels such as social media and the Internet to provide the anonymity that MARPs need and request.

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Annex 1: MARP–Friendly Clinical Mapping Checklist

Organization Background	
Name:	
Location and catchment area:	
Referred by:	
Population/s served:	
MARP–specific mandate/target:	
Public/private/partnership:	
Mobile/stationary/both:	
Average number of patients seen per month	
Contact person (position) and information:	
Date of assessment:	
Conducted by:	

HIV–Prevention Services	YES	NO
Pharmacy onsite?		
Services free of cost? If not all free, which ones are:		
Community education/outreach? If yes, specify what type and whom:		
Support groups? (types of groups and how often meet)		
Male condoms available?		
Male condoms distributed? (how distributed, who distributes)		
Female condoms available?		
Female condoms distributed? (how distributed, who distributes)		
Condom demonstrations?		

HIV–Prevention Services	YES	NO
(who conducts them? Female/male demonstrations)		
Lubricant distributed? (how distributed, who distributes)		
Information (if not demonstrations) provided on proper use of condoms and lubricants?		
Commodities provided free of cost? (how distributed, who distributes)		
STI diagnosis? (If no, referrals?)		
STI treatment? (If no, referrals?)		
VCT services? (If no, referrals?)		
ART? (If no, referrals?)		
OI (opportunistic infection) treatment/prophylaxis? (If no, referrals?)		
Referral to related health services? (TB clinic, PMTCT, ART, etc.) If yes, specify:		
Basic lab services? Specify? (viral load testing, etc.) Where sent, if not?		
Psycho-social support Specify? (social worker on staff, adherence counseling conducted, mental health/depression counseling, etc.) – how often? (number of days SW at site)		

MSM/SW/Youth Friendliness	YES	NO
Ties with NGOs? Name/s and type of relationship:		
Are there anonymous services available? Which ones?		
Is there a private area for visits/counseling? If yes, please ask to see.		
Are there peer educators? Who were they trained by? What is their role?		
Do the peer educators or someone else conduct outreach? Who and types of activities?		
Staff training in MSM/SW sensitivity? Specify type, who trained, when, and what training covered:		
Referral to legal, social services? (type and who): Specify:		
MARP-specific session conducted—IEC, HIV 101, risk reduction, communication/counseling, violence, etc. Specify which ones:		
Screenings/referrals—drugs/alcohol, violence, etc.		
Specific health services for MARPs Specify which ones (anal/rectal health):		
Any additional support/areas needed to improve services available to MARPs?		

SBCC Material	YES	NO
Available?		
Specific materials available. Please take copies if possible.	MARP specific?	
Fill out the information below for each individual material.	YES	NO
<ul style="list-style-type: none"> • Type (poster, brochure, pamphlet, cards, flipcharts, pocket size, video, manual, others) • Source—developed and distributed (MOH, CVCC, J-FLAG, etc.) • Audience • Name of material • Content specific (HIV care, prevention, human rights, empowerment, ART, VCT, etc.) 		
Type : Source: Audience: Name of material: Content specific:		
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