ORIGINAL ARTICLE

Understanding the Antiretroviral Treatment Experiences of Men Attending a HIV Clinic in Jamaica

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ABSTRACT

Objective: Jamaican men experience socio-cultural norms that increase vulnerability to contracting Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome, and affect how they engage with their antiretroviral treatment. This paper reports on a study, conducted in 2016, that examined the treatment experiences of Jamaican men attending a HIV clinic.

Methods: This qualitative study utilized semi-structured interviews with 24 participants to explore the complexities surrounding sexuality, gender, and HIV status as interrelated dimensions that influenced HIV positive Jamaican men's engagement and adherence with antiretroviral treatment. Data were coded using NVivo and analyzed using the stepwise multi-level intersectionality framework of Winker and Degele.

Results: Men's treatment trajectory comprised five phases: HIV diagnosis, acceptance, adjustment, treatment initiation, and treatment continuation. The treatment phases were largely centered on the clinic, which was deemed to minimize some men's autonomy and liberty. As a result, the clinic was positioned as both an enabler and barrier to men's access to optimal health care.

Conclusion: The study makes an original contribution to understanding a population and issue that remains integral in effectively addressing the HIV epidemic in Jamaica. It is argued that there is a need for gender-sensitivity, tailored access to health services, and the provision of safe and enabling health environments to address HIV positive men's health in Jamaica.

Keywords

Gender; HIV/AIDS; Policy; Practice; Treatment Adherence

INTRODUCTION

A range of socio-cultural norms and processes position Jamaican men as increasingly susceptible to contracting Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), and affect how they engage with their treatment trajectory. Yet, there is a dearth of research pertaining to the health of HIV positive men in Jamaica.

Jamaica accounts for the third highest proportion of HIV cases (12%) in the Caribbean, following Cuba and the Dominican Republic, and has the largest number of persons living with HIV (PLHIV) in the English-speaking Caribbean, at 40,000 [1]. The HIV epidemic in Jamaica is characterized as both a low-level generalized epidemic as well as a concentrated epidemic, indicated by the low general adult prevalence rates (1.8%) and higher prevalence rates for at risk populations, namely men who have sex with men (MSM), commercial sex workers, inmates and the homeless [2].

In general, men account for approximately 63% of the number of PLHIV in Jamaica [1]. This has been attributed to the increased likelihood of men engaging in unprotected sex with a number of partners [3,4,5]. Throughout the Caribbean, 26% of new infections are among gay men and MSM [6]; and in Jamaica the prevalence rate is 29.8%, approximately one in three MSM [1]. Globally, the prevalence rate amongst the MSM population is around 32% [7,8].

The stigma attached to both HIV/AIDS and same-sex relationships in Jamaica compounds the health experiences of HIV infected men. These can be seen as intersecting markers of men's social identity that can further result in discrimination at varying levels in society [9], including health facilities. Indeed, research has found that social constructions of masculinity act as a barrier in men accessing HIV-related care, including their antiretroviral (ARV) treatment [10,11,12, 13]. According to Charles [14, p.13] "The government's policy to provide anti-retroviral treatment is failing because the human rights abuse against gay men causes gay men infected with the AIDS virus not to reveal their HIV status and their sexual orientation to health workers". Thus, the stigma attached to homosexuality or same-sex relationship prevents MSM from being tested, diagnosed, treated, and retained in care [5,8,15,16]. Gendered norms were noted to influence if, when, and how men present for care and treatment [8,17]. Walcott et al [17] assessed the relationship between the attitudes towards gender norms and risky sexual behaviors of 549 men in western Jamaica and found that the support for masculinity and inequitable gender norms promoted health risk behaviors, including the unwillingness to seek health information and access health services. Overall, Jamaican men delay seeking healthcare, often presenting late with an illness, as noted for the higher proportion of men diagnosed with advanced HIV and AIDS [18]. Further, they tend to either deny being unwell, over-rate their state of good health and fail to either initiate or sustain treatment in avoidance of sick roles that question their traditional masculine identities [19]. Thus, the health behaviors of Jamaican men diagnosed with chronic illnesses appear to be largely defined by the perceptions and impositions of sociocultural notions of appropriate masculinity [20,21,22]. The current study asked: How do the social identities of HIV positive Jamaican men intersect to influence their ARV treatment experiences and adherence outcomes?

METHODS

The study adopted an intersectionality-informed methodology to explore the complexities surrounding sexuality, gender, and HIV status as interrelated dimensions of Jamaican men's identities that can impact their health outcomes. Intersectionality emerged from the work of Black feminists in the United States (Bilge, 2010). Since then it has evolved to being described as "the gold standard multidisciplinary approach for analysing subjects' experiences of both identity and oppression" (Nash, 2008, p. 2). The intersectionality lens was instrumental in understanding the experiences of HIV positive Jamaican men. Though Jamaican men are not traditionally identified as an oppressed group, literature points to their vulnerabilities as it pertains their sexual health risks and adverse health outcomes, which are largely embedded in the socio-cultural terrains of the Jamaican society [8,20,22,25,26].

Participants

Permission and support was obtained from the Center for HIV/AIDS Research and Education Services located in Kingston, Jamaica to access their patient population for recruitment of study participants. As a non-governmental organization, the semi-private clinic provides both clinical and psychosocial services to PLHIV who reside in varying parishes across the island spanning the lower and middle income levels; thus, represented a useful access point. It currently has 1356 patients enrolled, of which the majority are males (n≈ 900).

A social worker at the clinic was assigned the responsibility of making initial contact and inviting patients to participate. A poster was displayed in the clinic through which some persons contacted the researcher directly. The researcher frequently visited the clinic during specified times for clinic rotations which afforded interested persons an opportunity to meet and discuss information pertaining to the study. Potential participants were eligible to be recruited if they were aged 20 years or older, were diagnosed as HIV positive and prescribed ARV treatment at least 6 months in advance of the data collection process. The study was discussed prior to each interview and participants given the opportunity to have any questions addressed. They were advised of their right to withdraw from the study at any time and were assured that their participation would not impact the services accessed at the clinic. Consent was obtained prior to the interviews.

Over 30 men were invited to participate in the study over a 2 month period, from which 24 HIV positive Jamaican men aged 20-56 years were subsequently recruited. Most were diagnosed in the four years leading into the data collection (2010-2013); but spanned from as early as 1995. The majority initiated treatment the same year or a few months post their diagnosis; while seven participants started their ARV treatment post the year of diagnosis. The time period for the commencement of treatment ranged from 4 months to 14 years. See Table 1 for further participant demographics.

Data collection

Semi-structured, in-depth individual interviews are a principle data collection method in qualitative research [27]. Participants were asked questions surrounding their experiences of being diagnosed as HIV positive and prescribed lifelong ARV treatment; for example, *Tell me about your HIV diagnosis? What has been your process of following your treatment since your HIV diagnosis?* Of the 24 interviews, 21 were conducted in a private space provided by the clinic; and 4 participants opted for a telephone interview. Follow-up interviews were conducted with six men to develop emerging themes from interviews. Interviews ranged between 20 and 90 minutes, were digitally audio-recorded and subsequently transcribed verbatim.

Data analysis

Winker and Degel's [28] intersectionality multi-level framework provided a six-step process that facilitated an analysis of data across micro and macro levels beginning with coding of individual transcripts, moving to a comparative analysis interviews and a final synopsis that examined the interrelations across all levels. In Step 1, using NVivo software [27], transcripts were coded with references to treatment adherence practices and experiences. Thematic analysis uncovered key turning points such as HIV diagnosis, acceptance and treatment initiation which represented important junctures in the men's treatment journeys. Step 2 focused on how the men identified themselves in reference to categories of difference. Particular attention was given to gender, sexuality and HIV status. Each category was evaluated against the backdrop of the Jamaican culture. Step 3 aimed to make "all norms, values and ideologies to which persons refer explicit" [28, p.59]. Examples of prevailing norms and beliefs identified by participants included: men are expected to fulfill certain social roles such as father, leader and partner; HIV is no longer a death sentence because of the efficacy of ARV medications; HIV remains a stigmatized illness that can affect men's sense of belonging and wellbeing. Central to coding in Step 4 was the acknowledgement of power dynamics surrounding how the men's identities were shaped and/or negotiated; and the influence of social structures in terms of their identity and treatment behaviors. Step 5 involved identifying interrelations of categories across Steps 1-4; that is, to identify for each individual, instances of interplay between the men's identities, the social structures or processes they encountered and their perceptions and choices regarding ARV treatment. Finally, Step 6 synthesized the analytical process working both within and across the men's transcripts.

Throughout, researcher reflexivity was maintained by the first author engaging in a presuppositions interview to explore personal values, cultural awareness and

Table 1: Demographic profile of participants

Participant	Age	Sexuality	Area of Residence	Education	Employment Status
Bird	45	Heterosexual	St Catherine	Secondary	Part-time
Bones	44	Heterosexual	St Andrew	Skills training	Unemployed
Brenton	47	Heterosexual	St Andrew	Secondary	Self-employed
Dante	37	Heterosexual	Kingston	Secondary	Unemployed
Dan	36	MSM	St Thomas	Tertiary	Part-time
Eric	24	MSM	Kingston	Secondary	Part-time
Jay	43	Heterosexual	St Andrew	Skills training	Self-employed
John I	43	Heterosexual	Kingston	Secondary	Full-time
John II	43	Heterosexual	St Thomas	Secondary	Part-time
John III	45	Heterosexual	St Andrew	Secondary	Full-time
Kevin	33	Heterosexual	St Catherine	Primary	Unemployed
Marcus	24	Transgender	Kingston	Tertiary	Self-employed
Mark	41	Heterosexual	Kingston	Secondary	Self-employed
Mario	20	MSM	St Catherine	Secondary (incomplete)	Unemployed
Paul	35	Heterosexual	Kingston	Secondary	Full-time
Que	44	Heterosexual	St Catherine	Secondary	Unemployed
Richard	27	Heterosexual	St Catherine	Secondary	Full-time
Richie	40	MSM	Kingston	Secondary	Full-time
Steve	47	Heterosexual	Carendon	Secondary	Self-employed
Tallist	27	Heterosexual	Kingston	Secondary (incomplete)	Full-time
Trevor	56	Heterosexual	St Catherine	Tertiary	Self-employed
Troy	29	MSM	St Andrew	Secondary	Unemployed
Vincent	51	Heterosexual	Manchester	Primary	Unemployed
Whitey	37	MSM	St Catherine	Secondary	Unemployed

sensitivities going into the field; recording memos to capture insights and critical reflections of the study [29]; and debriefing with supervisors as an opportunity to reflect and interrogate aspects of the data collection and analytic process. Together these reflexivity methods enhance the study's rigor and credibility [30].

FINDINGS

The influence of HIV positive Jamaican men's social identities on their treatment experiences and adherence outcomes manifested across four phases: HIV diagnosis, acceptance, adjustment, treatment initiation and continuation. Each of these phases are described below supported by participant quotes (participants are identified using self-selected pseudonyms).

HIV diagnosis

In this phase, men were introduced to the reality of living with a chronic illness requiring lifelong treatment. The majority did not actively solicit an HIV test and were often diagnosed through routine testing: "*I just did a routine run of the mill. Summer I have nothing to do so I went to do a HIV test*" (Dan). For others, diagnosis was linked to another activity such as donating blood or having a test as part of health screening for insurance. Paul was made aware of his diagnosis when "*couple* *months after* [donating blood] *I think, I get a letter from a clinic say I'm to come out… But you done know, I wasn't pree-ing (paying attention to) it because that was the furthest thing from my mind*". Indeed, many participants visited the doctor for other health reasons; reporting symptoms such as skin rashes, itching, constant diarrhea, fainting, noticeable weight loss, sleeplessness, and thrush.

> *I find that I was just getting sick for a while (long time). I was getting sick while I was on the work and I don't know what's the reason why you know. So, I end up going to the doctor and took the test [HIV]. (Jay)*

Being 'visibly' sick propelled men to seek medical attention; 15 participants consulted with a physician due to the onset of symptoms which were later associated with their HIV diagnosis. At times, other people picked up the visible signs and symptoms of illness: "*my employer saw me acting strangely, seeing a lot of weight loss and thing and not being the person that I was before*" (Richards). The physical manifestations of HIV are obvious warning signs to persons who are knowledgeable of HIV/AIDS, which makes it difficult to hide being unwell and could expose some men to societal stigma and judgment.

Some men were surprised at the outcome of their HIV tests, having not perceived themselves to engage in behaviors that placed them at risk of contracting HIV. Jay commented, "*every now and then [I] would go out and [I] meet someone and you might like them and they would like you, you and them make love and so forth, but you're not running up and down*"—a phase used to describe men who are hypersexual, promiscuous and unfaithful. Others assumed that being in a serious relationship would protect them from the risk of HIV; "*a serious relationship… I am talking long term, years. But I was with a partner that cheated, a lot, and I knew that he had cheated and I got a STD… HIV was the last thing on my mind…. I forgave him and he said it won't happen again. Stupid me*" (Dan). There was also the belief that the general, though inconsistent, practice of safe sex was sufficient to protect men from contracting the virus. Therefore, some men grappled with the knowledge of a HIV diagnosis as they perceived themselves to "*always practice safe sex. I always try to have sex with a condom*" (Que).

Learning of a positive HIV diagnosis for most men was a shock. Some perceived that their life dreams and aspirations were destroyed, whilst others lost the will to live. In each instance, men contemplated the implications of living with HIV as a stigmatized and incurable illness that would alter their social identities and relationships with others. Troy expressed, "*I got tested and then the guy said to me, 'You know your test came back and it's positive'. And I was like, 'What!' And you know I was devastated*". According to Richard, "*it was like my whole life came shattered in front of me when I found out*". For many men, the diagnosis was "*a nightmare… a really devastating thing and I think it can also lead to suicide if you are not strong*" (John).

The realization of HIV being an incurable illness meant the introduction of a permanent sick identity that required continuous treatment and interactions with the health professional. Some men reported shifts in their masculine identities, from being independent, financially stable and respected, to becoming unemployed, dependent on others for care and subjected to social ridicule.

> *I always said I'd want to get married and have a family one day. Now I have to put that on hold, or just forget it completely… It's not easy for me to meet you and like you; it's not easy to talk to you and say, "you know say I'm HIV positive" or something. I might turn you off and you might not talk to me after that. (Bird)*

Men's experiences of being diagnosed with HIV were shaped by intersections of their identities, socio-cultural norms, and social structural processes such as HIV-related stigma. The personal and social experiences around learning of an HIV positive diagnosis determined men's ease of accepting their diagnosis and progress into initiating ARV treatment.

Acceptance: Renegotiating self and identity

"*The biggest obstacle I had in my life… was acceptance*" (Troy). Diagnosis was followed by a period of becoming ready to initiate and maintain ARV treatment. Participants had to accept their HIV diagnosis and make the choice to move on, alongside accepting the realities and implications of living with a chronic illness. By accepting their HIV diagnosis, men acknowledged that their test results were accurate, and that HIV was now an aspect of their selves. For some, acceptance of their HIV test results hinged on becoming symptomatic.

> *I started noticing that I started to tremble and started getting high, high, feeling like high fever and then extremely cold temperature. My body just changing temperatures like rapidly and then I'm blanking out… and then I came to the doctor… the doctor said 'You know, you're HIV positive? We need to tell you, you were tested and it seems you are HIV positive'. I said 'I know I'm HIV positive'* [laughs]*. Well at that point I finally accepted it, 'wow I am HIV positive'. (Troy)*

Acceptance of a positive HIV diagnosis was facilitated by men becoming better informed on the implications of living with HIV; including surpassing the myth that HIV is a death sentence.

> *I don't see HIV as a death sentence. I honestly see it as a restart button. It may sound weird but it is really a reset button for me and because I cannot deny that I am HIV positive. I can't say, why? I just have to move on. It really is reset. And it is ah now is your chance. Cause there is no cure right now so what options do you have? You either get worse or get way better, and way better sounds good. (Dan)*

Marcus likened his experience of living with HIV to his grandmother's experience as a diabetic, "*It reminds me of my grandmother who have diabetes. She has to take her medication… so put it as I have sugar or diabetes and just work with it*". Similarly, Dan stated "*if you take your meds it becomes almost like a person living with diabetes taking their pills every day*".

Men generally feared the negative repercussions of others learning of their HIV status due to the stigma associated with being HIV positive. Dan stated, "*you are trained that it is chronic but everyone else thinks it's life ending. It is a very stigmatized illness. People think that you are a walking dead*". Thus, social acceptance, despite a known HIV status, was important in enabling some men to accept their diagnosis and progress into their treatment phase, especially where they obtained the support of family members and peers: "*Your family is so important. It is crucial. I can't tell you how light I feel that I was able to tell my mom and my sister. It was as if an entire weight has come off my shoulders*" (Dan).

Accepting being HIV infected as an aspect of their selves was a continuous process that involved men reconstructing their perception of HIV as a chronic and thus livable condition as they encountered varying issues pertaining to their illness, identities, and social contexts. For some, acceptance was reinforced through the value they placed on their social roles such as father, son, and partner. For Bones it was thinking about his daughter: "*Mi have a likkle 6-year-old baby me can't leave. Me keep think bout her you know*". Recognising their values was important in empowering men to move forward, regaining a sense of normality in the pursuit of their goals and aspirations.

Adjustment: Moving from diagnosis to treatment

Adjusting to an HIV positive diagnosis affected men's self-perceptions and their social identities. Fearing social reproach, due to the awareness of the stigma and stereotypes attached to an HIV identity, some men were forced to hide their HIV status. The decision to treat HIV as a hidden part of men's sense of self was, at times, compounded by other dimensions of their social identity that invited further social disapproval. Thus, being an HIV positive MSM was seen to attract intensified social antagonism and stigma that could aggravate the social dissent towards men whose identities comprised both dimensions. When asked how he adjusted, Marcus explained:

> *I adjust in the fact that I change my features in walking. So instead of walking like I'm in a nine inch heels and strutting the run-way I walk like I'm bouncing like a man, and when I go in I just shake it off cause that's not me; [it's done] in order to survive and cope.*

Men were, at times, required to navigate or reinforce a representation of hegemonic masculinity in an effort to protect their true identities and maintain a sense of belonging within their social groups. For some, the performance of masculinity emerged as a useful strategy to protect their MSM or transgender identities and ensure their well-being within selective social spaces. The emphases placed on social norms that prescribe the social identities of Jamaican men were found to impact how men chose to identify themselves personally and within the context of others. The findings also revealed a new dimension of masculine identities not previously documented in the Jamaican health literature. A few men introduced the delineation between a masculine and feminine MSM identity that adopts a gender-role divide for MSM, comparable to the traditional gender-role behaviors of men and women.

> *Masculinity in Jamaica has to take a cultural definition… masculinity here is so cultural. It's based on sexuality and also based on who is at bottom and at top [referring to the sexual roles of MSM]… and if you're gay, if you even have a tups [slight indication] of gayness, there goes masculinity (laughs)… They don't see my masculinity because I'm gay. (Dan)*

These introduced dimensions highlight the multidimensional nature of men's identities and the confluence that can lead to blurred lines of distinction. The dilemma of conflicting selves arises where dimensions of a man's identity prove incongruent given the emphasis on conformity to social norms and expectations of others. Pressure to conform meant men often felt the need to prioritize their socially determined roles as heroes and leaders at the expense of pursuing optimal health; whilst others navigated these social benchmarks to ensure their continued access to their treatment and care which they deemed important in maintaining their health.

Treatment initiation and continuation: Navigating clinical and social spaces

HIV positive men's treatment experiences in clinical and social contexts highlighted the pivotal role the clinic plays in determining when and how they access treatment. In a system of control, the clinic was positioned as central to men's treatment approaches and extended care. Rather than providing a space for men's input in their treatment design, men were provided with the generic message to take their ARV medication on time each day. John III perceived that the absence of treatment preparation contributed to his default in treatment and further deterioration of health: "*I start to break down and so on and then my CD4 start to fall… I think that was basically it, cause I didn't really get no pre- nothing, no counseling really*". The process of preparing men to initiate ARV treatment predominantly focused on advising them to "*always take the medication and on time*" (Dante); a health message that largely focused on the efficacy of the ARV medication which ideally requires consistency in both dosage and timing. It also communicates an image of the ideal patient who is both compliant and adherent of this message. However, the message fails to capture and address the unique and complex situations of patients.

Prescription renewals and access to ARV medication hinged on the men maintaining their clinic visits; thereby reinforcing the regime and schedule of the clinic and patients needing to comply.

> *When it comes on to the stage where my medication is running out, I have to go back to the doctor and I have to get a prescription before it ends. Because if it ends before the date of the clinic date, I basically have to skip my medication. (Whitey)*

The absence of dialogue between physician and patient reflected both a top-down authoritative process, as well as men's fear of being judged or punished if their doctors learned of their modified treatment approaches. Paul shared the experience of feeling silenced after attempting to ask his doctor a question.

> *There was something me want to see on my file and me say [to the doctor], 'Tell me 'bout this no doc'. And he was like, 'you have to wait until I look through the file first'. Me say 'but no not about this'. [The doctor interjected] 'You hear what I said? You have to wait'. Now me did a get up and come out you know because me did a get upset… and me say you know what happen, easy*

> *[relax]. You want your prescription, you want your medication, [you have to] grin and bear [endure]… That was the worse I ever felt from a doctor. (Paul)*

Whereas the clinic should ideally represent a safe space, it appeared to also represent a symbol of judgment, evaluation and, perhaps, sentencing, whereby some persons are granted or denied access to services.

> *This particular clinic has a problem with MSM people, people who they know to be MSM and people who they know to be very active in MSM advocacy and also HIV advocacy. They honestly, they are not sensitive, and they do not see us as partners but see us as combaters, as people to be squashed as nuances. (Dan)*

Some men revealed their fear of being noticed attending the clinic; potentially exposing their HIV identity: "*You don't know who you will see or who might see you. You there hoping nobody don't see you coming in this building or find out what it's for*" (Bird). Maintaining HIV as a hidden identity required men to identify safe spaces that allowed them to take their medication without inviting the curiosity or interrogation of others who may not be accepting of their HIV illness. Many participants made a conscious effort to either disguise their medication or take it in hiding.

> *When I go to work in the morning and I eat, I have to find way, hide out go in the bathroom or somewhere private cause it was so much medication and I had a pill container, I just put them in there so I go to work now I just go somewhere private and take them. (Ritchie)*

The clinic, as with other social institutions, acted as an enforcer of socio-cultural rules that assessed men's social identities and, subsequently, impacted men's health outcomes.

DISCUSSION

"Men's lives and health are rooted in opportunity structures that are shaped by race, ethnicity and other characteristics that have important social, political, economic and cultural meaning" [31, p.106]. Findings highlight the multiple junctures along the treatment trajectory that were influenced by the men's identities, related norms, values and ideologies and a range of social structural processes deeply embedded in the socio-cultural, political and historical contexts of the Jamaican society. HIV remains largely stigmatized in Jamaica [4,32], contributing to the experience of emotional trauma due to the fear of being isolated or socially ostracized [16]. Acknowledging the stigma attached to being HIV positive impacts how men incorporate their HIV status and ongoing treatment as a defining aspect of their personal and social identities as negotiated against the benchmark of socially approved representations of a masculine self.

Initiating and adhering to ARV treatment proved beneficial in restoring a number of men to a physically healthy status, further enabling them to reclaim their pre-existing masculine selves and identities [33]. The hegemonic representation of Jamaican masculinity is often predicated on the need to show sexual prowess, strength and resilience. Accepting their HIV diagnosis was important for men's reconstruction of their social identities and combating societal stigma. Understanding the role and efficacy of ARV helped men transition into their self acceptance [34] and subsequent treatment initiation and retention [35,36].

Some men engaged in gender performativity, where they exuded the defining qualities of masculinity that would ensure their safety, acceptance, and sense of belonging. Importantly, a number of men moved towards reconstructing new masculinities that supported their HIV identity and need for lifelong treatment. Nonetheless, some values pertaining to hegemonic masculinity such as being a leader, role model, father and breadwinner [19,37,38,39] were maintained or modified to suit their HIV status; enabling men to reconstruct their personal identities upon resumption of their regular social, recreational, relational and familial activities [39].

The use of an intersectionality-informed framework allowed an examination of how fluid, interrelated and mutually constituted dimensions of men's identities shape their treatment experiences at the micro level, and further interlocked with systems of oppression, inequality and privilege at the macro structural level. Findings revealed social institutions to be enforcers of many of the norms driving these social structural processes. This explicit linkage to social institutions allowed an interrogation of the role of the Jamaican healthy system and varying personal contexts, such as men's families and communities in shaping men's treatment experiences.

Jamaica has reported significant improvement in the longevity and quality of life of PLHIV, with a gradual increase in the number of persons receiving ARV treatment since 2004 [18]. Yet, data have shown that an increasing number of persons are defaulting care and treatment 12 months after initiation [2]. A number of participants raised concerns regarding the practicalities of services (e.g., rigid scheduling of appointments and lengthy delays in wait times). These factors act as barriers to treatment access and care, and fail to regard men's personal circumstances such as employment commitments. Heath accessibility ensures men's access to information, care and services at points deemed necessary by the men. Flexibility would address men's problematic approaches to their health such as medication rationing. Most participants identified the need to extend treatment beyond the narrow biomedical response. Jamaica's health system and health policies would benefit from adopting a more integrated approach in line with the WHO's [40, p.1-2] recommendation to implement holistic and person-centered approach that is "grounded in principles of human rights an health equity". There is a recognized need for legislation that effectively protects the rights of PLHIV from issues of stigma and discrimination—breaking down barriers to accessing an optimal standard of healthcare.

Limitations

Participants were recruited from one clinical setting, potentially limiting the diversity of men. Including men within the high-income grouping would enhance the complexity surrounding men's social identities. Further, given the focus of this study on ARV treatment experiences and adherence outcomes, it would have been useful to capture the voices of men who had opted to discontinue services at the clinic and who could, in turn, be defaulting treatment.

The lead researcher was female whose previous work with two HIV-related NGOs had heightened her awareness of the sensitivities and challenges of engaging persons living with a stigmatized illness; yet, reinforced the need to capture HIV positive Jamaican men's voices in order to facilitate new understandings and changes to treatment processes in the country. Her position was both a strength and limitation of the current study. Being a HIV negative woman meant that the researcher was unfamiliar with certain language cues that emerged during interviews (e.g., some males referred to their ARV medication as vitamins). It was thus necessary to consistently clarify these points of reference as some men were taking both ARV medication and vitamins. Such openness strengthened a sense of interest and collaboration with participants. However, the willingness of men to discuss masculinity, or sexual or HIV identity, would potentially be radically different if the interviewer was matched to the participants; thus altering the data captured and subsequent analyses.

CONCLUSION

Universal access to ARV treatment remains one of the main global targets towards ending the public health threat of HIV/AIDS, with UNAIDS [41] working towards a 95-95-95 target by 2030—95% of people will know their HIV status, 95% of people who know their status will receive treatment; and 95% of people on HIV treatment will have a suppressed viral load. Critical to the success of these targets in Jamaica is the identification of innovative ways to promote earlier diagnosis, as well as ensuring that persons in need are receiving and sustaining treatment. The study makes an original contribution to understanding a population and issue that remains integral in effectively addressing the HIV epidemic in Jamaica. The study reinforces the value of qualitative, intersectionality research as a means to engender a greater sense of awareness and combat perceived stigma that could inform how HIV positive Jamaican men proceeded with their personal sexual and reproductive health choices, as well as their treatment adherence.

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