

**HEALTH AND HIV RISK ASSESSMENT OF MEN WHO HAVE SEX WITH MEN (MSM)  
IN THE JOHANNESBURG INNER CITY**

by

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MASTER OF ARTS

in the subject

SOCIOLOGY (SOCIAL BEHAVIOUR STUDIES IN HIV/AIDS)

at the

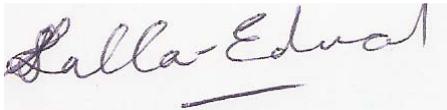
UNIVERSITY OF SOUTH AFRICA

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JUNE 2010

DECLARATION

I declare that **HEALTH AND HIV RISK ASSESSMENT OF MEN WHO HAVE SEX WITH MEN (MSM) IN THE JOHANNESBURG INNER CITY** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



26 August 2010

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S T Lalla-Edward (Mrs)

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Date

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## DEDICATION

This dissertation is dedicated to:

*1. My parents, Vijay and Chan Lalla*

My deepest appreciation and gratitude to you for the sacrifices you have made to educate us. Thank you for giving us wings to soar.

*2. The MSM population who have had negative experiences in their lives because of their sexual preferences*

At the beginning of my tertiary study career my parents shared the following famous wise words with me. Hopefully they have the same impact on your approach to dealing with life.

*If ~*

If you can keep your head when all about you are losing theirs and blaming it on you,  
If you can trust yourself when all men doubt you, but make allowance for their doubting,  
too;

If you can wait and not be tired of waiting, or being lied about, don't deal in lies, or being hated don't give way to hating, and yet don't look too God, nor talk too wise:

If you can dream and not make dreams your master and if you can think and not make thoughts your aim,

If you can meet with Triumph and Disaster and treat those two imposters just the same;

If you can bear to hear the truth you've spoken twisted by knaves to make a trap for fools, or watch the thing you gave life to, broken, and stoop and build 'em up with worn out tools:

If you can make one heap of all your winnings; and risk it on one turn of a pitch and toss,  
And lose, and start again at your beginnings and never breathe a word about your loss;

If you can force your heart and nerve and sinew to serve your turn long after they are gone, and so hold on when there is nothing in you except the Will which says to them  
"Hold on!"

If you can talk with crowds and keep your virtue, or walk with Kings nor lose the common touch,

If neither foes nor loving friends can hurt you, if all men count with you, but none to touch;

If you can fill the unforgiving minute with sixty seconds' worth of distance to run,

Yours is the Earth and everything that's in it, and which is more – you'll be a Man, my son!

Rudyard Kipling (1865–1936)

## **SUMMARY**

By gathering information from a volunteer sample of men who sleep with men (MSM) in the Johannesburg inner city, the study aimed to discover those decisions and behaviour that influence their health decision-making and health-seeking behaviour, particularly as far as HIV and their sexual health was concerned.

Eleven in-depth interviews were conducted by three interviewers using a semi-structured interview guide which asked questions on demographics, health-seeking behaviour, sexual orientations and behaviour, knowledge of HIV/AIDS and community support.

During analysis, collected data was classified into the themes of access to health care, personal and general MSM HIV risk perceptions, sexual behaviour, alcohol and unprotected sex, prostitution, religion and stigma, violence and discrimination.

This study was the first qualitative study researching MSM in the Johannesburg inner city and provides useful baseline information for further qualitative MSM studies in the geographical area and for the development of MSM aligned interventions.

## ACRONYMS AND ABBREVIATIONS

|        |   |
|--------|---|
| AIDS   | Acquired immunodeficiency syndrome              |
| ART    | Antiretroviral therapy                          |
| ARV    | Antiretroviral                                  |
| CHP    | Centre for Health Policy                        |
| HIV    | Human immunodeficiency virus                    |
| HSRC   | Human Sciences Research Council                 |
| IDU    | Intravenous drug users                          |
| IEC    | Information education communication             |
| LGBT   | Lesbian gay bisexual transgender                |
| MARP   | Most at risk population                         |
| MRC    | Medical Research Council                        |
| MSM    | Men who have sex with men                       |
| NGO    | Nongovernmental organisation                    |
| PHC    | Primary health care                             |
| PHRU   | Perinatal HIV Research Unit                     |
| PLWHA  | People living with HIV/AIDS                     |
| RHRU   | Reproductive Health and HIV Research Unit       |
| STIs   | Sexually transmitted infections                 |
| TB     | Tuberculosis                                    |
| VCT    | Voluntary counselling and testing               |
| UNAIDS | Joint United Nations Programme on HIV/AIDS      |
| UNGASS | United Nations General Assembly Special Session |
| UNISA  | University of South Africa                      |

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# CHAPTER 1: INTRODUCTION

## 1.1 INTRODUCTION

In South Africa, HIV/AIDS was initially diagnosed in the 1980s among white gay men, however, a decade later the pandemic emerged in the heterosexual population (Lane, Mogale, Struthers, McIntyre & Kegeles 2008:430). In 2007, South Africa had an estimated population of 48 577 000. Of this, 5.7 million people have been estimated to be living with HIV (UNAIDS 2008). South Africa is ranked with the countries (predominantly African) that have a high HIV prevalence rate. Certain HIV prevalence studies conducted in Africa, including research done in South Africa, reveal that HIV prevalence in men who have sex with men (MSM) is higher than that of the general adult male population. MSM HIV prevalence has been reported to be in excess of 30% (McIntyre 2010: 82).

Whilst MSM research has been of interest for some time, the majority of such research on the African continent has only been conducted in the last decade. This could be attributed to the still existing criminalisation and severe legal punishments attached to sodomy and consensual homosexual sex in approximately 70% of African countries – making MSM a hard-to-reach population for both health care and research purposes. In most of the research conducted and the literature published to date, researchers acknowledge the fact that MSM HIV research has been largely overlooked and MSM are excluded from local and national public health responses and policy making (Smith, Tapsoba, Peshu, Sanders & Jaffe 2009:416). In the South African context, this lack of research on and omission of MSM in prevention and policy programmes means that, currently, South African statistics cannot ascertain the “number of men engaging in sex with other men” (Rispel & Metcalf 2009:135). Neither can the statistics account for how many MSM are living with HIV (Cloete, Simbayi, Kalichman, Strebel & Henda 2008b:1105). What is known about the South African population (limited to geographical

areas where a few MSM research studies have been conducted) is that HIV infection could be associated with being older, self-identification as being gay, transactional sex (especially for the purchase of alcohol and drugs), consumption of alcohol and drugs, and unprotected anal and vaginal intercourse (Lane, Raymond, Dladla, Rasethe, Struthers, McFarland & McIntyre 2009). It is also known that MSM engage in multiple concurrent relationships with males and females (McIntyre 2010:83) and that they experience stigma and discrimination when accessing health care (Lane *et al* 2008:430–432; Cloete *et al* 2008b:1105–1110).

Currently, the majority of MSM studies being undertaken are trying to determine MSM HIV prevalence in different geographical areas. However, in addition to HIV prevalence, the Declaration of Commitment of the 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicators ask for response-to-risk knowledge and behaviour, and access to care (Smith *et al* 2009:418). Rispel and Metcalf (2009:133) point out that right until 2009, UNGASS indicators related to MSM have not been included in the South African country reports submitted to the Joint United Nations Programme on HIV/AIDS (UNAIDS). This highlights the need for increased focus on clinical and behavioural MSM research in South Africa.

## 1.2 DESCRIPTION AND PURPOSE OF THE RESEARCH

The current health and HIV risk-assessment study was conceptualised to address the lack of studies on men and MSM within the Johannesburg inner city and Hillbrow in particular. It was also deemed to be a useful pilot study for possible larger studies that could be conducted to respond to the South Africa MSM UNGASS indicators.

The problem statement encompassing the aims and objectives described below provides an explanation of what the study is about and what it set out to achieve.

### 1.2.1 Problem statement

As mentioned in the introduction, in the last decade there has been more focus on MSM HIV prevalence studies. As part of addressing the imbalance in MSM HIV research, it was considered appropriate to conduct a qualitative study in the Johannesburg inner city (where no prior MSM research beside a count-recount study of MSM sex workers was done) which would provide baseline information on access to health care, sexual behaviour and HIV risk perception on the MSM population in the Johannesburg inner city.

#### 1.2.1.1 Research question

What factors are associated with the health-seeking behaviour, personal HIV risk perception and sexual practices of MSM in the Johannesburg inner city?

#### 1.2.1.2 Aim

As a descriptive study, the proposed investigation aimed to describe, from the perspectives of a volunteer sample of MSM in the Johannesburg inner city, those decisions and behaviour that play a role in their health decision making and health-seeking behaviour, particularly as far as HIV and other sexually transmitted infections (STIs) are concerned. In order to meet this aim, the following specific objectives (listed in 1.2.1.3) were set.

#### 1.2.1.3 Objectives

1. To describe the biographical features of the volunteer sample of MSM, such as age, socioeconomic status, educational level, racial, cultural, ethnic, sexual and religious identities, place of residence, migration status, marital status, social and support networks, and issues related to living as MSM
2. To determine the factors that hinder MSM's health-seeking behaviour and propensity to access (or to avoid) voluntary counselling and testing (VCT) for HIV
3. To gain insight into the personal risk assessments of MSM

4. To gain insight into the sexual practices of MSM in the Johannesburg inner city

### 1.3 RATIONALE

In their discussion on the results of their community-based survey dealing with HIV testing, Sandfort, Nel, Rich, Reddy and Yi (2008:429) highlight that whilst there is little knowledge about HIV testing and HIV results in the South African MSM population, there are no South African studies that investigate the “structural, cultural, interpersonal and individual factors” of risky sexual practices among South African MSM. Insights gained from this study are thus useful for shedding light on the reasons for risky sexual behaviour and to provide baseline information from which interventions can be afterwards developed that address issues which prevent MSM from accessing public health services.

The risky sexual practices of MSM, which include unprotected sexual intercourse, multiple concurrent sexual partners, a reluctance to go for HIV-testing, nondisclosure of an HIV-positive status to a partner, a reluctance to initiate treatment and the low numbers of MSM engaging in positive health-seeking behaviour, are significant drivers of the HIV epidemic (Baral, Trapence, Motimedi, Umar, Lipinge, Dausab & Beyrer 2009:2–6; Cloete, Simbayi & Kalichman 2008a; Dladla, Struthers, McIntyre & Lane 2008; Rispel, Metcalf, Cloete, Reddy, Townsend & Zembe 2009; Saavedra, Izazola-Licea & Beyrer 2008; Smart 2009:3). Other factors like the criminalisation of homosexual intercourse in certain countries, social stigma associated with being an MSM, negative experiences with health care workers, community harassment and violence perpetrated against MSM contribute to such men being afraid to be open about their sexual practices and health care needs (Lane *et al* 2008:430–432, Sandfort *et al* 2008:425, Saavedra *et al* 2008). From a public health perspective, this does not facilitate positive health promotion and contributes to the concealment of the HIV/AIDS epidemic among the MSM population.

The HIV Management Cluster of the Reproductive Health and HIV Research Unit (RHRU) collaborates with the City of Johannesburg Health Department facilities in the Johannesburg inner city to provide sexual and reproductive health services to the people in this geographical area. MSM have been identified as one of the most at-risk populations (MARPs). To respond to the HIV epidemic in this at-risk population, RHRU's Men and HIV project has identified MSM as one of their key focus areas. However, success in increasing the numbers of MSM accessing health care services has been low. This, coupled with the lack of masculinity research conducted by the RHRU, has contributed to the need to conduct more research in order to gain knowledge and insight on MSM in the Johannesburg inner city.

#### 1.4 RESEARCH APPROACH AND METHODOLOGY

A descriptive, qualitative research design was appropriate for the aim of this proposed study as the study intended to use data obtained through immersion in the life worlds of the research participants to find answers to the stated research objectives (Madison, 2005: 6). In this regard, the decisions, intentions and practices of MSM regarding their sexual health are seen as socially constituted, which means determining the relationships (i.e. meaningful, constraining and/or enabling) between situational, biographical and social issues and the sexual health behaviour of MSM. Applying this to the study conducted, meant a commitment to describing, in the words of MSM themselves, the choices, constraints and strategies they face and draw upon to practise sexual agency in a context rife with HIV and HIV-related stigma.

##### 1.4.1 Ethical clearance

Prior to embarking on the study, permission and a series of ethical approvals had to be obtained. One of the clinics used as a recruitment site for this study is a clinic that is supported by the RHRU. In addition, staff attached to the RHRU assisted in the fieldwork component of the study (for reasons explained in Chapter 3). Based on this

association with the RHRU, the first step was to gain institutional permission. This was obtained in June 2009 (see Appendix A).

This research was conducted in the context of the public health care setting in the City of Johannesburg and in fulfilment of the requirements for a master's degree. This meant that permission and ethical clearance procedures relevant to the Gauteng Provincial Government's Department of Health, the University of Witwatersrand Ethics Committee and University of South Africa's (UNISA) Ethics Committee had to be complied with.

The relevant ethics and permission applications were made between July 2009 and January 2010. In July 2009, ethical clearance was received from UNISA's Ethics Committee (see Appendix B) and, in October 2009, ethical approval was received from the University of Witwatersrand Ethics Committee (see Appendix C). The Policy Planning and Research Directorate (Gauteng Department of Health and Social Development) office gave permission for the study in February 2010 (see Appendix D in this regard). Reasons for the delayed timelines with respect to the latter application and approval are provided in Chapter 3.

#### 1.4.2 Study design and procedures

Given the difficulty of accessing MSM for peer education and outreach activities, it was decided that a purposive sample of between ten and twenty men would be ideal to meet the objectives of the study. Two male fieldworkers were hired to assist with participant recruitment, data collection and, where necessary, translation of the collected data. These fieldworkers were trained in the study procedures and the qualitative data collection techniques. A semi-structured interview guide, which was tested (via mock interviews during training sessions) prior to the commencement of data collection, was used to gain information on demographics, health-seeking behaviour, sexual orientation and behaviour, knowledge of HIV/AIDS and community support. In addition to this semi-

structured interview, participants were asked to complete a short demographic questionnaire.

Using purposive and snowball sampling, eleven men were recruited into the study and were interviewed either by myself, one of the male fieldworkers or by both a fieldworker and myself (depending on the research participant's preference in terms of interviewer and the availability of the research participant).

Prior to starting the interviews, all men were provided with information about the study. They were then taken through the consenting process. At various points in this information sharing and consenting process, the men were asked if they understood what was being said and whether they had any questions. They were then asked to consent to their participation in the interview, as well as to having the interviews recorded, to which all the men consented.

Completed consent forms, the interview schedules that were completed during the interviews and the hard copies of the transcripts were stored in a secure cupboard. All the electronic information was stored on my computer and is accessible only by means of a password known only to me.

The information collected from the interviews yielded a vast amount of data – some of which were not directly linked to the study objectives. All this data was coded; classified into themes and critically analysed. The analysis is explained in Chapter 4 (as described in section 1.5 below).

An explanation of research results dissemination has been included in Chapter 3. It is important to note that dissemination has already commenced. In May 2010 a poster presentation on one subtheme of the results was presented at the 4<sup>th</sup> International

Workshop on HIV Treatment, Pathogenesis and Prevention Research in Resource Limited Settings in Maputo, Mozambique.

## 1.5 OUTLINE OF DISSERTATION

Chapter 2 is divided into two parts. The first part describes concepts of masculinity and the formation and evolution of hegemonic masculinity. In addition, it contains examples of research on gender, masculinities and hegemonic masculinity. The second part of this chapter contextualises the health and HIV risk assessment of MSM study through the literature review.

In Chapter 3 the study methodology is detailed. This chapter will give the reader an indication of what was done to achieve the objectives. Chapter 3 includes discussions on qualitative research methodology, ethical considerations, interviewer recruitment, quality-checking procedures of the interview schedule and the interview process, sample selection and inclusion criteria, participant recruitment, data collection and participant reimbursement. The chapter ends by discussing data storage, data analysis and the dissemination of the study outcomes.

Chapter 4 presents a comprehensive analysis of the research findings. These findings have been grouped according to the major themes and subthemes and, where applicable, the information in these themes and subthemes is linked to the literature on other research studies. The major themes discussed are access to health care; personal and general MSM HIV risk perceptions; and sexual behaviour. Each of these major themes comprised subthemes. The subthemes for access to health care include general access to health care, examples of positive health care experiences and examples of negative health care experiences. General knowledge about HIV and AIDS, personal risk assessment and opinions about the MSM contribution to the pandemic, condom usage and the reasons for condom usage, as well as myths about HIV acquisition, form

the body of the discussion under the theme of personal and general MSM HIV risk perceptions. The theme of sexual behaviour involves a discussion on sexual identities, age at sexual debut, sexual activity and frequency, number of partners and condom usage, HIV status and experience with STIs. In addition to these major themes and subthemes, the four themes of alcohol and unprotected sex; prostitution; religion and stigma; and violence and discrimination are elaborated on. Although these four themes do not provide information directly related to the objectives of this study, there was sufficient data related to these four themes to justify their inclusion in the data analysis, leading to their discussion in the results of this study.

Lastly, Chapter 5 provides a cohesive picture of the dissertation by weaving together the threads of each chapter. It provides a reflection on what the research set out to investigate (as outlined in Chapter 1), reiterating the major points from Chapters 2 (theoretical framework and literature review), 3 (methodology) and 4 (results), and making recommendations for further research and public health service delivery in the Johannesburg inner city, as suggested by the men who participated in this study.

## 1.6 CONCLUSION

Chapter 1 set the foundation for the dissertation by describing the need for the research study and what the research set out to achieve, as well as giving a brief overview of how the research was planned and introducing the readers to what they can expect in the subsequent chapters.

## **CHAPTER 2: MASCULINITY THEORIES AND A LITERATURE REVIEW**

### **2.1 INTRODUCTION**

In Chapter 1, it was stated that the research objectives for the Health and HIV risk assessment of MSM study were to gain information on the biographical features, factors associated with health-seeking behaviour, personal HIV risk perception and sexual practices of a sample of MSM in the Johannesburg inner city.

### **2.2 CONTEXTUALISING GENDER AND MASCULINITY RESEARCH**

Given that the research focuses on men and MSM in particular, the first section of this chapter (section 2.2) will discuss the masculine identity, hegemonic masculinity, critiques of masculinity and masculinity research.

#### **2.2.1 Masculine identity**

Gibbs (2005:287) describes applications of masculinity theories in health contexts by demonstrating that there is no single model of masculinity, but an array of possible masculinities that a male can identify with. This identification is shaped by social constructs and the definition of what an acceptable masculine position is at that point in time. The constructionist perspective informs us that men act in the way that they do because of the concepts of masculinity that they take on from their culture (Courtenay 2000:1387).

A concept that was mentioned and sometimes detailed in almost every excerpt on masculinity and masculinity research and theories that I read was that of hegemonic masculinity (Cheng 1999; Connell 1995; Demetriou 2001; Gibbs 2005) and hence an in-depth discussion on the term follows.

Before the discussion on hegemonic masculinity commences, it is important to note that I will be making a fair amount of reference to homosexuality and being gay for the purposes of comparison to the definitions of hegemonic masculinity only. Most of the masculinity research that has already been conducted and publications on masculinities do not cater for MSM (who may be homosexual or bisexual), therefore I consider a discussion on homosexuality as being the closest to my research.

Whilst hegemonic masculinity forms the basis of the discussion, it should be remembered that Connell also developed the terms “subordinate”, “marginal” and “complicit” masculinities in conjunction with hegemonic masculinity (Connell 1995:77–81). These terms will also be touched on in the following discussion.

### 2.2.2 Hegemonic masculinity

Hegemonic masculinity, a concept which originated approximately fifteen years ago (Connell & Messerschmidt 2005:829), is a composition of currently accepted gender practices that facilitates patriarchy and general male supremacy and female inferiority (Connell 1995:77). The concept of hegemonic masculinity, as formulated by Connell, is an influential and popular component of the author’s work and has provided a foundation and explanation for many masculinity theories, masculinity research and overall male behaviour (Demetriou 2001:337).

Two pairs of opposites form the core definition of hegemonic masculinity, that is, male and female (gender) and dominance and subordination (power). The power pair is actually the more important of the two as hegemonic masculinity directly simplified is a reference to male dominance or being a dominant male. Based on this, hegemonic masculinity is not only a reference to power relationships between males and females, but also power relationships between males and other males who perhaps do not portray the currently desirable male characteristics or behaviour. Demetriou (2001:341) distinguished distinguishes this inter and intra gender hegemony by labelling male–

female dominance as external hegemony and male–male dominance as internal hegemony.

In explaining subordination, Connell (1995:78) states that there are different levels of dominance between groups of males. The example used to illustrate male subordination in the context of America and Europe was the dominance of the heterosexual male over the homosexual male. Heterosexuality is extremely important in the maintenance and reproduction of patriarchy (Demetriou 2001:344), hence the subordination of homosexuals.

MSM is a behavioural concept and not a sexual-orientation identity as it encompasses the sexual orientations of homosexuality and bisexuality. Nevertheless, the underpinning sexual practices and sexual acts primarily align MSM with men who are homosexual. Despite its non-criminalisation in South Africa, homosexuality is still very much stigmatised (Sandfort *et al* 2008:425). The combination of hegemonic masculinity and stigma has negative ramifications in the sexual reproductive health care contexts, particularly as it relates to HIV. Both Dladla *et al* (2008) and Lane *et al* (2008) suggest stigma and discrimination as reasons for low uptake of HIV test results and treatment services. According to Jewkes and Morrell (2010:8), the ideals of hegemonic masculinity force men to ignore their risk of HIV acquisition. The 2008 National AIDS Survey reported that more women (57%) than men (43%) had ever accessed HIV counselling and testing. Coupled with this lower uptake of HIV counselling and testing in men are the higher mortality outcome rates given that initiation into antiretroviral treatment takes place when the CD4 counts<sup>1</sup> are relatively low and there are high viral loads (Jewkes & Morrell 2010:8).

Irrespective of where a particular type of masculinity lies within the hegemonic structure (e.g. homosexual at the bottom or the dominant or sexually successful heterosexual at

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<sup>1</sup> An indication of the quantity of CD4 lymphocytes in the blood of HIV-infected persons. People with CD4 counts less than 200 cells per cubic millimetre are eligible for initiation onto ARVs.

the top), practices related to hegemony place all categories of men at risk with respect to their health and personal safety. Jewkes and Morrell (2010:5, 8) describe two instances where the practices that stem from hegemonic masculinity place males at risk. Firstly, hegemony is associated with risk taking, like consuming large volumes of alcohol, driving dangerously, being violent and engaging in risky sexual behaviour. Secondly, susceptibility to illness is ignored. Within the context of HIV, this means that the hegemonic male could (or to an extent should) engage in unprotected sexual activity (either under the influence of substances or not) and unknowingly get infected or infect others with HIV and sexually transmitted infections. Further, he will not acknowledge the need for HIV testing or accessing health care in general where he would be presented with the opportunity to have illnesses (including sexually related ones) treated and to find out his HIV status. Thus, the male who is at the bottom of the hierarchy (like openly MSM and gays) would not access health care because of the stigma and negative experiences they have had or expect to have at the health care facility (especially if they have a rectal STI) because they do not conform to the notion of the ideal man. It is often the case that men present at the health care facility when they are extremely ill and, if they are HIV positive, the treatment outcomes are low, resulting in higher mortality on treatment rates (Jewkes & Morrell 2010:8).

Hegemonic masculinity comprises a hierarchy of masculinities as a means of maintaining gender relations (Lusher & Robins, 2009:387). Gayness, together with receptive anal pleasure, is associated with femininity thereby placing homosexuality at the bottom of this hierarchy (Connell 1995:78). As mentioned earlier, gay masculinities have been subordinated because the object of their sexual desire opposes heterosexual norms – a feature of prime importance in the reproduction of patriarchy (Demetriou 2001:344).

### 2.2.3 Critique of hegemonic masculinity

Connell's concept of hegemonic masculinity evolved from his critique of role theory started in 1979. He found and believed that role theory neglected to theorise both power

and change. In his later works, Connell criticised the inability of sex role theory to conceptualise power as a facet of inter- and intra-gender relationships (Demetriou 2001:337–338). Connell's second criticism of sex role theory revolved around the theory's inability to grasp change. Based on these two major criticisms, Connell then offered the idea of hegemonic masculinity which encompassed the complexities of masculinities, femininities, inter- and intra-gender power and the possibilities of internally generated change (Demetriou 2001:339).

Between the early 1990s and 2005, debates on hegemonic masculinity yielded five primary criticisms which are discussed below (Connell & Messerschmidt 2005:836–845).

#### 2.2.3.1 The underlying concept of masculinity

The definition of masculinity is said to be flawed and to have been argued from the realist view (i.e. masculinity is unclear and does not accentuate power and domination) and the poststructuralist view. A fair number of masculinity studies (sometimes with female subjects) have been done since the conceptualisation of hegemonic masculinity, therefore Connell and Messerschmidt (2005:836) argue that masculinities are configurations of practices which are socially achieved and can differ according to the gender relations in a specific social setting.

#### 2.2.3.2 Ambiguity

One of the first criticisms under this heading is the issue as to who it is that represents hegemonic masculinity. Some men who are powerful in society do not necessarily possess the ideal hegemonic masculine traits and there are also instances where the men identified by researchers as hegemonic models do not possess masculine traits. Martin, as cited in Connell and Messerschmidt (2005:838), criticises the concept for being inconsistent in that at times it refers to a fixed type of masculinity and at others it refers to the dominant type of masculinity in that particular setting.

### 2.2.3.3 Reification

There have been debates on the concept of hegemonic masculinity reducing masculinity to a reification of power. Holter, cited by Connell and Messerschmidt (2005:839), believes that hegemonic masculinity constructs masculine power from direct experiences of women, as opposed to constructing power from the subordination of women. Holter further states that there is a need to distinguish between patriarchy and gender. Connell and Messerschmidt (2005:839) agree with Holter and suggest that the institutionalisation of gender inequalities, the role of culture and the interplay of gender dynamics with ethnicity, socioeconomic status and geographic location be considered when making deductions about masculinity relations.

Collier's (also cited by Connell & Messerschmidt 2005:840) dissatisfaction with hegemonic masculinity is that it portrays negative behaviour in men as opposed to highlighting some of the positive aspects, such as serving the interests of women (e.g. providing financial assistance) instead of suppressing them.

### 2.2.3.4 The masculine subject

Wetherell and Edley (in Connell & Messerschmidt 2005:841) suggest an understanding of hegemonic norms as defining a subject position in discourse that is taken up by men in certain circumstances. This implies that men will adapt and adopt the hegemonic masculinity that is applicable to the setting they are in at that particular point. This therefore places masculinity as a way that men position themselves through discursive practices (Connell & Messerschmidt 2005:841).

The concept of hegemonic masculinity is contained within the historically dynamic view of gender in which the subject cannot be erased. It homogenises the subject only when reduced to a single dimension of gender relations and if it is regarded as the condition of a norm. When gender relations are viewed as multi-faceted with the possibilities of crisis

tendencies being present, it becomes difficult to recognise the individual within the relation as unitary (Connell & Messerschmidt 2005:843).

#### 2.2.3.5 The pattern of gender relations

Within social theories of gender there has been a tendency towards functionalism (Connell & Messerschmidt 2005:844). This tendency has been visible in modern theories of gender. Male dominance and the suppression of women are not self-reproducing systems; the maintenance of hegemony in a particular social setting requires the policing of men and the exclusion or subordination of women. Demetriou's (2001:339) explanation of internal and external hegemony as described at the beginning of section 2.2.1 also falls into this category of criticism. There is no clear understanding of the relationship between these two types of hegemony. Non-hegemonic masculinities exist but do not affect hegemonic masculinities. Irrespective of the relationship or lack thereof, there still is dual representation of masculinities.

#### 2.2.4 Hegemonic and marginalised masculinities

For the purpose of Cheng's (1999:295) article on marginalised and hegemonic masculinities, he refers to inter- and intra-gender marginalisation as being unequal membership and receiving disparate treatment.

Cheng (1999, 295) promotes the rejection of the essentialist view of the sexes as being male and female only and, after explaining that gender and sexes are not equal, he suggests that gender researchers take cognisance of the existence of multiple versions of masculinity and femininity by accurately referring to masculinities and femininities.

When Connell (1995:81) defined marginalisation, he emphasised that it does not refer to relationships between masculinities in subordinate or dominant groups, but is rather always relative to the authorisation of the dominant group's hegemonic masculinity.

### 2.2.5 Rethinking the concept of hegemonic masculinity

Although hegemonic masculinity has presented a link between masculinity studies and sociological models of gender, it has been criticised by psychological, sociological, post-structuralist, materialist and non-academic fields. Over time it has also been opposed by many women's liberation movements and ethnic, social and class movements (Demetriou 2001:342). Therefore, Connell and Messerschmidt (2005:830) embarked on a comprehensive re-examination of the concept.

#### 2.2.5.1 Components retained

Throughout the many research studies conducted since the formulation of the concept, two key components have held true, that is, the hierarchy of masculinity and the idea that there are multiple masculinities. Another feature of the concept that was supported through the research was the fact that the hierarchy of masculinities is a pattern of hegemony and not a pattern built on force. Lastly, research findings have supported the ideas of the historical construction and reconstruction of hegemonic masculinities (Connell & Messerschmidt 2005:846).

#### 2.2.5.2 Components rejected

There are two components of the original concept that have been highly criticised and some would even argue that they should have been eliminated from the underpinnings of the concept. These comprise the model of the social relations surrounding hegemonic masculinities and the transcendence of the essentialist concept of masculinity and the trait approach to gender (Connell & Messerschmidt 2005:846–847).

#### 2.2.5.3 Components reformulated

Taking into consideration the critiques of the hegemonic masculinity concept, Connell and Messerschmidt (2005:847–853) concluded that the concept needed reworking in terms of gender hierarchy, the geography of masculine configurations, the process of social embodiment and masculinity dynamics.

#### 2.2.5.3.1 Gender hierarchy

A more holistic approach to gender hierarchy should be incorporated into the understanding and explanation of hegemonic masculinity. This is achieved by seeing the action/standing of the subordinated groups in the same light as the power of the hegemonic group, as well as the mutual condition of gender and social dynamics. The advantage of doing this would be to increase the focus on gender dynamics and the way they relate to problems (Connell & Messerschmidt 2005:848).

#### 2.2.5.3.2 Geography of masculine configurations

Connell and Messerschmidt (2005:849) suggest the following framework for analysing hegemonic masculinities:

- Local: constructed in the arenas of face-to-face interaction of families, organisations and immediate communities, as typically found in ethnographic and life-history research
- Regional: constructed at the level of the culture or the nation-state, as typically found in discursive, political, and demographic research
- Global: constructed in trans-national arenas such as world politics and trans-national business and media, as studied in the emerging research on masculinities and globalisation

#### 2.2.5.3.3 Social embodiment

The relationship between the representation and use of men's bodies to hegemonic masculinity has been recognised but not theorised. Masculine embodiment as a means of identification is evident in many contexts (e.g. youth and sport, eating unhealthily, engaging in risky behaviour). Health promotion or health-seeking behaviour is seen as non-conforming to the normative hegemonic masculinity model (Connell & Messerschmidt 2005:851).

According to Connell and Messerschmidt (2005:851), the role of bodies in social construction has increased significantly with time and the body actively participates in producing social practice. Thus, hegemonic masculinity not only needs to be understood as embodied, but the relationship between embodiment and social contexts also has to be considered. An example of the complexity of embodiment that Connell and Messerschmidt (2005:851) draw attention to is that of transgender practices, which cannot easily be understood from a simple social model perspective. This example forms the impetus for a reformulated, more in-depth inclusion and interpretation of embodiment in hegemonic masculinity.

#### 2.2.5.3.4 Masculinity dynamics

Masculinity has evolved to masculinities and the complexities of masculinities forces one to recognise their multiple layers or multidimensional composition. Masculinity cannot and should not be viewed as unitary. Another factor to consider in masculinity dynamics is that masculinity is an organisation of practices that is constructed, deconstructed and reconstructed over a life span. This is a direct association of masculinity with change. Finally, masculinities are associated with gendered power thereby linking them with emotional conflict and internal divisions (e.g. father–son relationships). One should take cognisance of the fact that it should be recognised that subscription to and practising of hegemonic masculinity does not naturally imply a gratifying life or way of living (Connell & Messerschmidt 2005:852).

Reviewing the concept of hegemonic masculinity has resulted in the retention of the components of multiple masculinities and the hierarchy of masculinities. It has also resulted in the rejection of the model of social relations surrounding hegemonic masculinities and the transcendence of the essentialist concept of masculinity and the trait approach to gender (Connell & Messerschmidt 2005 846–847).

### 2.2.6 Masculinity research in South Africa

In 1998, Morrell (1998:605) pointed out that little was known about masculinity in general. In 2010, Hamber (2010:4–5) states that the study of masculinity in Africa is still in its infancy despite the phenomenal growth in the South African literature on masculinities.

This section will contain a brief discussion on Morrell's (1998:605–630; 2002:309–327) literature on masculinity and gender in Southern African studies. In his publication on *Masculinity and gender in Southern African studies*, Morrell (1998:605–630) provides an in-depth explanation of the importance of discussing masculinity, the concept of masculinity (citing the likes of Connell), the history of masculinity, the relationships between race and masculinity, men and masculinity, masculinity in South Africa, colonialism and white masculinities, African masculinities, black masculinities and convergent masculinities.

From his discussions on all of the above-mentioned areas, Morrell (1998:605, 630) concludes that men have been viewed in essentialist terms and that when they are studied through the lens of masculinity there is a move away from this essentialist treatment and sex role theory. Morrell (2002:322), citing Mama, states that in order to understand gender in the South African context, it is imperative that the relationship between race, subordination and marginalisation be understood. Morrell (2002:322) further speaks about the gender impact (emasculating) of class and race oppression on black men. Colonialism contributed significantly in this oppression and the shaping (not destruction) of the black masculine identity (Morrell 1998:616–621). The Second World War and apartheid catalysed urbanisation and resulted in the emergence of a black masculinity which used violence to compensate for the emasculation experienced (Morrell 1998:630).

### 2.2.7 Masculinities and health care

Gibbs (2005:287–300) describes the applications of masculinity theories in a chronic illness context. Chronic illness is associated with pain, weakness, exhaustion and general deviations from the acceptable standards of strength and independence. If a man has a chronic or terminal illness which hinders his ability to function as a hegemonic male, then society's perception of him may change and he may move into the subordinate classes of masculinity (Gibbs 2005:288). I think researchers and medical professionals generally may be of the opinion that people do not want to test and seek treatment for HIV and sexually transmitted infections because of the stigma associated with being positive. In reality, however, stigma is just one part of the issue. I would argue that males may also not want to engage in health-seeking behaviour because of the challenges to their masculinity. It is not just about the shame of being HIV positive but also about the implications of being HIV positive on their health, physical abilities and social standing.

### 2.2.8 Risky health behaviour

Health behaviour is frequently predicted by socio-demographic variables. Sexual orientation and race have shown links to health behaviour. Sexual minorities (e.g. MSM) engage in a higher amount of risky health behaviour than heterosexuals (Mahalik, Burns & Syzdek 2007:2202). Further, studies have shown that men engage in many health risk behaviours, including not seeking medical care (Mahalik *et al* 2007:2202; Courtenay 2000:1389). Mahalik *et al* (2007:2202) suggest that one way of decreasing health risk behaviour is by increasing health promotion activity by first identifying reasons for engaging in health risk behaviour and health promotion behaviour.

Having reviewed research on masculinity and perceptions of normative masculinity, Mahalik *et al* (2007:2201–2209) investigated the contributions of masculinity and men's perceptions of normative men's and women's health behaviour in predicting men's self-reported health behaviour. They hypothesised that men are more likely to report health

risk behaviour and decreased health promotion behaviour and would tend to act in the same way as they perceived other men's behaviour (i.e. health risk or health promotion) and, lastly, that men's behaviour would be related to their perceptions of women's behaviour. Study results supported their hypotheses on masculinity and perceptions of other men's health behaviour influencing the research participant's own health behaviour. Evidence did not, however, support the last hypothesis about relating to perceptions of women's behaviour. Mahalik *et al* (2007:2207) conclude that traditional masculine socialisation does have an influence on men's putting their health at risk. One suggestion that came out of this study was that of conducting further research on men who are not white and who come from other (non-heterosexual) sexual orientations. The health and HIV risk assessment of MSM in the Johannesburg inner city study is an example of this.

#### 2.2.9 Immigrant access to health care

When HIV surfaced, it exposed a variety of sexual identities and sexual practices. A study on the experiences of the heterosexual African man was spurred on by the researchers' feelings that much HIV research has been focused on women, bisexual or gay men and that there was no interest in the heterosexual HIV-positive male experiences (Doyal, Anderson & Papparini 2009:1901–1903). These authors attributed this extreme focus on gay or bisexual men to the fact that HIV was first identified in gay men. It can be argued that MSM is still an under-researched population, despite Doyal *et al's* view that there is an abundance of knowledge and research on homosexual and bisexual men and HIV. The sample for this study on HIV-positive heterosexual male experiences was African males who were residing in London. These males (immigrants from African countries) had greater access to health care in London than in their countries of origin, however they did not access health care in London. This was attributed to perceptions of masculinity norms and men's feeling that they would be entering a woman's space (clinic) if they sought medical attention for illnesses. The Health and HIV risk assessment of MSM in the Johannesburg inner city study comprised

a similar study population as Doyal *et al*'s (2009) London study in that the men are African (because of geographic location of the study area) and it included men who are outside of their place (province or country) of birth (see details in Chapter 4 below). Contrary to the views of those African men in London, as explained by Doyal *et al* (2009:1903–1906) some of the non-South African men in the Health and HIV risk assessment of MSM in the Johannesburg inner city study did access health care. They did so because they felt that the health care system and facilities in South Africa were better than those that they had in their countries of origin. They also felt that some health care workers and South Africans in general were open to their sexuality as opposed to their fellow country men. One of the non-South Africans in the MSM study did not access health care because, being new to South Africa at the time of the interview, he had limited knowledge of the health care services available to him and he came from a country where MSM were not allowed to freely access health care, let alone be openly homosexual or MSM.

### **2.3 AN OVERVIEW OF MSM AND HIV/AIDS**

This second part of the chapter will contain information on definitions, research conducted, laws, viewpoints and population descriptions as it relates to MSM and HIV/AIDS.

Having been recognised as one of the worst pandemics to affect the world, HIV/AIDS has forced public health authorities in many countries to undertake multi-strategic approaches to decrease the incidence of new HIV infections and to respond to treatment issues among those already HIV-infected. Embedded in these multi-strategic approaches is the identification of HIV entry points into communities and the populations most susceptible to HIV infection. Such entry points or risky behaviour/milieus comprise

intravenous drug users (IDUs), commercial sex workers and men who have sex with men (United Nations, UNAIDS, [sa]).<sup>2</sup>

MSM is a term that first appeared in the 1990s (Saavedra *et al*, 2008) in reference to men engaging in sexual activity with other men. It is a behavioural concept and not a sexual orientation identity, as it encompasses the sexual orientations of homosexuality, heterosexuality and bisexuality. It also serves to describe men who engage in situational sexual intercourse (e.g. in prison) with other men. The construct does not impose restrictions on the types of sexual act, the minimum number of sexual acts, the minimum number of male partners and the minimum period of time a man should engage in sexual activities with another man or men

### 2.3.1 A brief historical overview

Differing views on the origins of homosexuality in Africa exist. One view is that of Epprecht (2008:24), who is of the opinion that same-sex sexual activities in Africa date back to the Khoi and Bushmen people. Regardless of how far ethnographic research can uncover same-sex sexual practices, it is well documented on the mines and in prisons that same sex sexual practices are very much a part of Africa and that colonisation merely facilitated and provided the means to encourage and catalyse the frequency of same sex (particularly MSM) sexual behaviour (Epprecht 2008:64).

Currently, male homosexual intercourse is known to take place all over the world; however, irrespective of the context, unprotected anal sex accounts for approximately 5 to 10% of HIV infections globally (United Nations, UNAIDS, 2006a; United Nations, UNAIDS, 2006b). In South Africa, the HIV/AIDS pandemic was initially diagnosed in the

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<sup>2</sup> Note that the terms “at-risk behaviour” or “risky environments” are used here as some commentators feel that the notion of risk groups results in the process of **othering** in the social construction of HIV/AIDS and that this was fuelled by the fallacy that HIV infects **others** – that is, people who are other than white, heterosexual or non-drug users. This coincided with an attempt to blame these “others” for the spread of the disease (Bury 1994; Herdt 1992). It is not intended to unify MSM as an “at risk” group. The point is that risk remains socio-culturally defined and social scientists grappling with these issues have come up with alternative notions such as risk milieus (Voeller, Reinisch & Gottlieb 1990; Zenilman 1988).

1980s among white gay men but a decade later the pandemic erupted in the heterosexual population (Lane *et al* 2008: 430). Another decade down the line there is the identification and acceptance of the need for establishing the role and impact of MSM community on HIV/AIDS.

#### 2.3.1.1 HIV surveillance

In 2007, South Africa had an estimated population of 48 577 000. Of this, 5.7 million people were estimated to be living with HIV (United Nations, UNAIDS, 2008). South Africa is ranked with the countries (predominantly African) that have a high HIV-prevalence rate. Given that the South African HIV debuted in MSM (Lane *et al*, 2008: 430), it is expected that there would be a significant focus on this population and its contribution to HIV. In effect this was not the case and no initial effort was put into exploring this section of the population further. The heterosexual transmission of HIV, predominantly among the black South African population in the 1990s, received greater attention and mobilised the country in terms of recognising the need to address HIV in the country.

In the recent past, South African organisations such as the Human Sciences Research Council (HSRC), the Centre for Health Policy (CHP), the Medical Research Council (MRC) and the Perinatal HIV Research Unit (PHRU) have undertaken HIV-status surveillance studies in Johannesburg, Soweto, Durban, Cape Town and Tshwane (Dladla *et al* 2008; Lane *et al* 2009; Rispel *et al* 2009). These studies revealed that the HIV pandemic is spreading rapidly (measured by incidence) among young, gay-identified MSM and that there is low VCT uptake by this group.

In the United States, HIV prevalence and incidence in MSM is highest in the black population (Millet, Peterson, Wolitski & Stall 2006: 1007). In rural Vietnam, MSM are at high risk of HIV infection as a result of low condom usage, decreased risk perception and multiple partners (Colby, Tan Minh & Toan 2008:439). Sentinel surveys in Kenya

revealed a 10.6% infection rate in MSM where the adult prevalence is 6.1%. Infection rates were 21.5% and 9.3% for Dakar and Khartoum respectively where the adult HIV prevalence was 0.9% and 1.6% respectively (Van Griensven 2006:1361).

#### 2.3.1.2 South Africa vs. global research settings

In many countries being openly gay is forbidden by law. Thirty-seven of 54 African countries have criminalised consensual gay or male-to-male sex with the latter carrying the death penalty in at least four of the countries (McIntyre 2010:82; Smith *et al* 2009:419). The practice of MSM is hidden for various reasons including criminalisation and stigma (Saavedra *et al* 2008; Smart 2009:2). Engaging in bisexual sexual practices can potentially increase the parameters through which HIV can spread. Therefore, the prevention of HIV in MSM becomes valuable to all such communities and countries at large (United States, USAID, 2006:2).

Iraq, Zimbabwe, some areas in Brazil, Burundi and Uganda all have an intolerant stance on MSM and thus little such research has been done in these countries on MSM and HIV (Bearak & Cowell 2010; Frayssinet, 2009; Human Rights Watch 2009a; Mungisha 2009; Neyuf & Al-Iraq 2009). MSM in such countries are disadvantaged in that there is no government urgency or support for research to determine their needs as far as HIV is concerned.

South Africa is the only African country to prohibit discrimination on the basis of sexual orientation, gender, race, class and age (Lane *et al* 2008:430, Morrell, 2002:309). Based on population counts the Johannesburg inner city (research setting) is one of the 100 largest cities in the world and comprises an array of inhabitants including refugees, migrants, transitional residents and the local long-term residents (Pleaner 2009:15). These people come from various political, socioeconomic and cultural contexts.

To some extent, the chosen research site can be compared to Laos, Senegal and certain parts of Brazil, where people are equivocal in their stance about MSM and prefer

to keep their orientation on the “down low” or hidden (*Mail & Guardian* 2009; Plus news, 2009). Mombasa, Kenya also displays similar characteristics (Tlhwale 2009). This possibly indicates two issues. Firstly, stigma, discrimination and, to an extent, harassment may be preventing people from being open about their same-sex sexual practices or from advocating for societal and governmental acceptance of homosexuality and MSM. Secondly (from a research perspective), recruiting MSM into research studies is not always an easy task.

### 2.3.2 Descriptions of viewpoints and research findings

#### 2.3.2.1 Government

The South African government recognises MSM activities as a driver of the HIV/AIDS pandemic and that their (MSM) sexual health needs can no longer be overlooked. In this regard, the *HIV and AIDS and STI National Strategic Plan 2007–2011* acknowledges the lack of information on MSM and their exclusion from national HIV and AIDS interventions (South Africa, Dept. of Health 2007:38). Results from all the smaller provincial studies undertaken in South Africa indicate that HIV prevalence in this marginalised population is high and on the increase – even though the national HIV prevalence rate among the MSM population is unknown (Dladla *et al* 2008; Reddy & Sandfort 2008).

The United States of America, Europe, Vietnam, Cambodia, India, China and Australia have also started addressing the relationships of MSM to HIV (United Nations, USAID 2006c:26; United States, CDC 2007:5, United Nations, UNAIDS, 2006a). Studies in Australia based on the mathematical modelling of HIV/AIDS data from their national registry are already showing that the average life expectancy of an HIV-positive man who has sex with men will exceed 44 years due to the increased uptake of antiretroviral treatment. According to the Australian HIV statistics, since 2001, estimated deaths among the MSM population from other causes have exceeded AIDS-related deaths (Murray, McDonald & Law 2009:83).

On the other side of the spectrum there are countries like Malawi, Namibia, Uganda, Burundi, Iraq, Zimbabwe and Senegal where same-gender sex acts are illegal. Governments in these countries have not conceptualised the amount of HIV surveillance data lost by not acknowledging the reality of same-sex sexual behaviour. A population and its activities, which contribute to the overall picture of the HIV situation of these countries, are thus being ignored and omitted. This leads to missed opportunities for HIV prevention. The Asian Pacific governments are reluctant to inject country resources into MSM programmes possibly due to the stigma surrounding MSM, as well as a lack of research data to support the development of MSM prevention programmes (United States, USAID 2006:1).

At the XVII International AIDS Conference held in Mexico City in August 2008, Ban Ki-moon, the Secretary General of the United Nations, made the following statement:

In countries without laws to protect sex workers, drug users and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us (Smart 2009:2).

The effect of the impact and meaning of this statement is evident in the legislature change in India. On 2 July 2009, the Delhi High Court ruled adult, consensual, private sex between men as legal (Carter 2009). This should have a positive effect on reaching MSM with prevention strategies in that country. Furthermore, MSM can now freely access health care. For example, previously an MSM who had a rectal STI would have

been hesitant to consult a health care professional as he could have faced charges for engaging in anal intercourse.

The previously ignored impact and contribution of MSM on HIV in Vietnam gained recognition in 2006 when the Vietnam National Assembly passed a revised HIV/AIDS law which prioritised the sexual health needs of homosexuals among other at-risk behaviour (Colby *et al* 2008: 439).

In direct contrast to the above positive developments, in October 2009, the Ugandan government proposed the Anti-Homosexuality Bill which would broaden the criminalisation of homosexuality by introducing the death penalty for people who have previous homosexual convictions, are HIV positive, or engage in homosexual sex acts with people who are younger than 18 years of age. It also proposes penalties for people and organisations that support lesbian, gay, bisexual and transgender (LGBT) human rights (Human Rights Watch 2009b). The bill received widespread criticism including comments from the United States president, Barack Obama, and United States Secretary of State, Hilary Clinton (Sokari 2010). Donor countries like Sweden also threatened to withdraw funding after the Anti-Homosexuality Bill was proposed. This forced the Ugandan president to commission a committee to review the ramifications of the bill. In May 2010, this committee recommended that the Anti-Homosexuality bill be withdrawn (Human Rights Watch 2009b; Sokari 2010).

#### 2.3.2.2 Research

Despite government recognition of the need to focus on MSM, it is agreed across the board that stigma is a huge barrier to taking larger strides in combating HIV in the MSM population. The UNAIDS best practice report on MSM in Asia and the Pacific calls for universities and research institutions, among many other organisations, to conduct research so that there can be updated MSM behavioural information. However, they have cautioned that researchers need to take cognisance of the fact that MSM are

active role players in the response to HIV and not mere research subjects or participants (UNAIDS 2006c:20). Researchers also agree that there is limited research on MSM and that more should be done (Lane *et al* 2008:430, Sandfort *et al* 2008:425). For the researchers, the HIV vulnerable populations are generally harder to reach (Geibel, van der Elst, King'ola, Luchters, Davies, Getambu, Peshu, Graham, McClelland & Sanders 2007:1349), thereby making general information gathering and research difficult tasks to execute. Smart (2009:2) adds that the study of MSM populations is complicated owing to intolerance; discrimination and criminalisation. He elaborates on this saying that MSM are excluded from national HIV surveillance efforts and that in some instances governments (e.g. Togo) do not encourage independent research on this topic.

### 2.3.3 Research and the South African MSM population

Studies conducted in South African areas, such as Soweto, Cape Town and Tshwane, reveal high HIV-prevalence rates (Lane *et al* 2008), low disclosure rates (Cloete *et al* 2008a) and limited general knowledge of HIV and poor motivation to practise safe sex (Reddy, Sandfort, Maimane, Yi & Dolezal 2009). The MSM population has a low uptake of HIV counselling and testing and antiretroviral treatment. The PHRU collaborative Soweto men's study revealed that of the 300 men who did pre-test counselling, 40% declined to receive their test results. Of this 40%, 36% were HIV positive (Dladla *et al* 2008). The HSRC, the CHP and the MRC conducted a survey with 266 men in the Johannesburg and the eThekweni areas. Their results revealed that 40% of MSM are HIV positive and that 46% of the men had unprotected sex in the previous year (Metcalf 2009). Both Dladla *et al* (2008) and Lane *et al* (2008a: 431) suggest stigma and discrimination as reasons for low uptake of results and treatment services. Results from an HIV-testing study conducted in the South African provinces of Gauteng, Western Province and KwaZulu-Natal show that those men who were younger, black and from KwaZulu-Natal were less likely to test for HIV (Sandfort *et al* 2008:425).

Lane, Shade, McIntyre and Morin (2008b:S80–82) have published the results of their study, which, among other factors, investigated the relationship between alcohol and risky sexual behaviour in MSM. The study conducted with approximately 200 men in Gauteng Province townships found that 78% of the men consumed alcohol. They also found that the MSM were at high risk for HIV infection by engaging in unprotected anal intercourse. In most instances, unprotected anal intercourse only took place when the MSM were under the influence of alcohol, thus making alcohol consumption a strong predictor of risk behaviour (Lane *et al* 2008:S80–83). Chersich, Rees, Scorgie & Martin (2009:5) indicate that consuming alcohol has been associated with increased sexual activity, inconsistent condom usage, condom accidents and increased STI infection. They have also indicated that, in sub-Saharan Africa in particular, there is evidence of associations between drinking alcohol and unprotected sex. In their review article, Woolf and Maisto (2009:774) state that there is adequate evidence of alcohol use and unprotected anal intercourse among MSM.

In keeping with HIV risk and substance use, Parry, Petersen, Dewing, Carney, Needle, Kroeger and Treger (2008:45) conducted an assessment of drug-related HIV risk among MSM. They found several linkages between drug usage and sexual behaviour. Firstly, in many instances drugs were taken before having sex, as being inebriated enhanced the sexual experience (Parry *et al* 2008:48). They also found a definite relationship between drugs and transactional sex. Many of the drug users had to engage in sexual activity to get money to pay for the drugs that they were using (Parry *et al* 2008:47). Irrespective of the circumstances of drug usage or engaging in sexual activity, all MSM acknowledged that there was an element of risky sexual behaviour associated with drug use as they were less (or not) careful about their sexual behaviour after having taken drugs. This poses a significant HIV risk to MSM. Examples of risky behaviour reported included inconsistent condom usage, having sex with strangers, taking part in orgies, having multiple partners and ejaculating in someone (Parry *et al* 2008:49).

Despite its non-criminalisation in South Africa, homosexuality is still very much stigmatised (Sandfort *et al* 2008:425). Based on this, men presenting at clinics for the treatment of rectal STIs often find themselves being lectured on the “immorality” of anal sex by health care workers who frame such issues as “God’s punishment” for practising “unnatural sexual acts” (Lane *et al* 2008:431). For those MSM who still choose to access health care services despite potential poor treatment, one strategy to deal with this is to seek out more tolerant and open-minded health care workers (Lane *et al* 2009:431–432).

South Africa has no policies that directly address the poor uptake of sexual health services by MSM. According to the national strategic plan, the activity linked to increase the rollout of prevention to at-risk populations is: “Incremental roll-out of a comprehensive customized HIV prevention package for MSM, lesbians and transsexuals including promotion of VCT and access to male and female condoms, and STI symptom recognition” (South Africa, Dept. of Health 2007:69). Furthermore, it strives to “ensure a supportive legal environment for the provision of HIV and AIDS services to marginalized groups” (South Africa, Dept. of Health, 2007:119). The absence of South African policies on health care for MSM can be attributed to the fact that there is limited information on the proportion of MSM in South Africa, as well as a lack of wide-scale surveillance and prevalence data on South African MSM (Rispel & Metcalf 2009:135). Rispel *et al* (2009:138) strongly recommend the conducting of policy research to ascertain why leadership has been inactive in its response to the prejudice and stigma directed at most at-risk populations, as well as in its inability to understand the drivers and barriers to change.

## 2.4 CONCLUSION

Gender is a socially created characteristic of men and women (Bird & Rieker 1999:752) and has often been interpreted in different ways to suit the type of research being done. Masculinity multiplicity has been identified, recognised and incorporated into understanding masculinity (Gibbs 2005:287). Through extensive research, Connell developed the concept of hegemonic masculinity (together with subordination, complicity and marginalisation), which provided and provides the foundation for masculinity theories and masculinity studies, and a basis for interpreting the results of masculinity research. Hegemonic masculinity involves male dominance over the female as a means of reproducing patriarchy and other males who are perceived to be deviating from the normative, hegemonic behaviour deemed acceptable at that time (Connell 1995:77). The concept of hegemonic masculinity originated approximately fifteen years ago and like many new things came under review and criticism as masculinity studies were conducted. Based on this, Connell and Messerschmidt (2005:829–859) re-looked at the concept and made suggestions of elements that needed to remain because they worked well, to be rejected because they did not work so well, and concepts that needed to be reformulated.

A variety of masculinity studies were done. In this chapter research related to men's accounts of masculinity and their influence on health-seeking behaviour and health risk behaviour, as well as exploring the experiences of masculinities among HIV-positive heterosexual African males (Mahalik 2007:2201–2207; Doyal *et al* 2009:1901–1097) was discussed. It has been found that hegemonic masculinity influences health behaviour (i.e. both health promotion and health risk). This may help to explain gender differences in health and life span. Courtenay (2000:1386) cites Koop by bringing to the fore the idea that efforts aimed at improving health behaviour can have a positive impact on reducing mortality and morbidity. Achieving this reduction can only have positive meaning for health care systems and the human race as a whole.

It can be argued that in

... the generalized epidemics of HIV in southern Sub-Saharan Africa, men who have sex with men (MSM) have been largely excluded from HIV surveillance and research. Epidemiologic data for MSM in Southern Africa are among the sparsest globally, and HIV risk among these men has yet to be characterized in the majority of countries (Baral *et al* 2009:e4997).

This was reiterated by the erstwhile South African Health Minister, Barbara Hogan, at the 4<sup>th</sup> South African AIDS Conference in 2009 when she thanked those organisations conducting MSM research in South Africa and called for further surveillance and research in this area. This would facilitate reporting on MSM UNGASS indicators – which would then help to show the way forward when dealing with the AIDS pandemic in the MSM community.

Research on South African MSM populations is limited and most of the studies have surveillance, prevalence and incidence measurement as their core objective, highlighting the need for complementary behavioural research. Research in many African countries is also limited, which may be attributed to the legal stance on male-to-male sex in those countries (37 of 54 African countries have criminalised consensual gay or male to male sex with the latter having death penalty implications in at least four of the countries [McIntyre 2010:82; Smith *et al* 2009:419]).

Rispel *et al* (2009) highlight the fact that MSM are continuously faced with stigma, discrimination and decreased societal acceptance – this includes health care workers. According to these authors, this may affect those accessing health care and providing health care facilities/workers with full, accurate medical histories when they do access health care

Whilst it has been acknowledged on numerous occasions that there is a lack of research in the area of MSM, we can clearly deduce from surveillance data that MSM significantly contribute to the AIDS pandemic as well as to the response to the pandemic (Saavedra *et al* 2008:2; Smart 2009:4).

Most research findings indicate that MSM engage in risky sexual behaviour. This may be attributed to factors like stigma, non-disclosure of sexuality and criminalisation of homosexual intercourse. Irrespective of the reasons for risky sexual practices and sexual activities in general, it is imperative for MSM to seek health care and make decisions that have a positive impact on their health (including knowing their HIV status). Lane *et al* (2009:430) note health-seeking behaviour as a worthy research focal point based on the findings of their studies conducted in peri-urban Gauteng townships.

## **CHAPTER 3: METHODOLOGY**

### **3.1 INTRODUCTION**

A qualitative research approach accentuates the importance of looking at the issues being studied as they exist in their natural setting. It encourages the close examination of the relationship between the issues (including behaviour, perceptions, motivations and opinions) as a means of gaining an understanding of them. This study aimed to gain insight into the lives of MSM as it pertains to their health and sexual practices; therefore a qualitative, descriptive research approach was taken.

Ethical considerations, including the researcher's attention to research ethics, ethical clearance procedures and research participants' consent, will be described before defining qualitative research and the discussion on the chosen study design. Within this comprehensive discussion there are sections on fieldworker recruitment and training, quality control of the interview process, sample selection, participant recruitment, data collection and participant reimbursement. The chapter ends with a discussion on data storage, data analysis and dissemination of study outcomes.

### **3.2 QUALITATIVE RESEARCH APPROACH**

Generally research studies fall within two broad research categories, that is, qualitative research and quantitative research. Both research methodologies have clear, distinguishable characteristics, and come with their own sets of advantages and disadvantages. Although researchers often choose to follow one particular methodology when conducting research, the mixed methodology approach is also becoming popular (Trochim 2006).

Quantitative research is a rigid, numerical and highly structured research approach that seeks to confirm hypotheses about phenomena. Qualitative research, on the other hand, is a flexible, iterative, text-rich, semi-structured approach which is more aligned to describing and explaining relationships and experiences as they occur in particular research settings (Mack, Woodsong, MacQueen, Guest & Namey 2005:3).

Mack *et al* (2005:1) explain qualitative research as a type of scientific research which sets out to answer questions using predefined systems or procedures. The evidence collected produces findings that were not predetermined and which may extend beyond the study group. In addition to this, qualitative research seeks to understand a research problem from the local population's perspectives. The qualitative research approach thus becomes useful in obtaining culturally specific data on the values, behaviour, perceptions and social contexts of the researched population.

A qualitative research design makes allowance for flexibility in the data collection process, hence data collection tools are generally semi-structured. This permits the data collector to adapt the questions and the flow of the data collection tools in reaction to the research participant's responses. In most cases a large amount of textual data is obtained (Pope, Ziebland & Mays 2000:114) which can take the form of transcripts and field notes (as was the case in this MSM research study).

Ladner (2008) uses a flow diagram (Figure 3.1) to illustrate the above-mentioned flexible, non-linear and iterative nature of the qualitative research process.

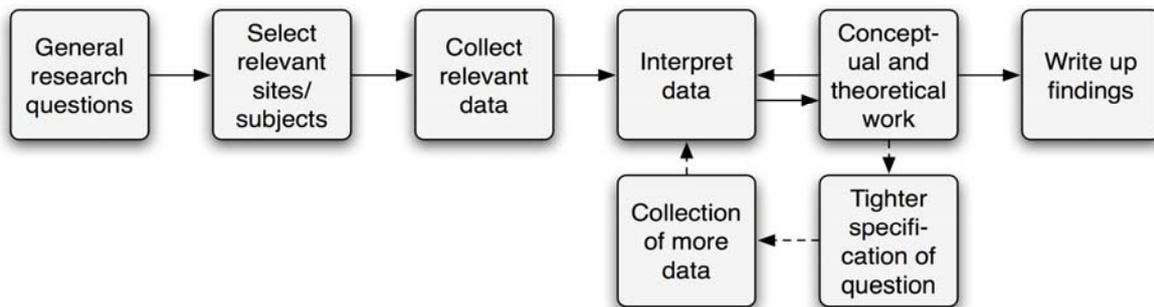


Figure 3.1 Diagrammatic representation of the qualitative research process

### 3.3 ETHICAL ASPECTS

In research, especially that which involves human participants, it is imperative that ethical aspects are given careful thought in the research design phase. There are three areas of ethical consideration, namely research ethics knowledge related to the researcher, the area which focuses on permission by the ethical review boards and the involved institutions and the area of ethics as it relates directly to the research participants.

This section comprises a detailed description of the researcher's research ethics training, institutional and ethical review board applications processes as well the information sharing and informed consent process that was completed prior to the data collection of the study.

#### 3.3.1 Researcher training on research ethics

Having worked on social science studies embedded within clinical trials, I completed many research ethics courses between 2006 and 2009. The ethics research training I have participated in includes the Human Participants Protection Education for Research Teams online course, the CITI Good Clinical Practice, the Responsible Conduct of

Research CITI test (Biomedical Responsible Conduct of Research), the Responsible Conduct of Research CITI test (Social and Behavioural Responsible Conduct of Research), the Family Health International Online Ethics training and the Medical Research Council's Good Clinical Practice training. This wealth of training ensures that I possess the knowledge required to conduct research in a responsible manner, upholding morals and values and not compromising the safety of the research participants.

### 3.3.2 Institutional permission and ethical clearance

Gaining permission and ethical clearances for this study was a lengthy process. This research was conducted in the context of a public health care setting in the City of Johannesburg and in fulfilment of the requirements for a master's degree. This meant that permission and ethical clearance procedures relevant to the Gauteng Provincial Government's Department of Health, the University of Witwatersrand Ethics Committee and University of South Africa's (UNISA) Ethics Committee had to be complied with.

The RHRU works in collaboration with the City of Johannesburg's Health Department in 14 primary health care (PHC) facilities. Esselen Street Clinic is one of these PHC facilities and was anticipated to be the primary site of recruitment since the RHRU's Inner City Programme's Men and HIV Project operates from this clinic. In June 2009, the director of the RHRU's Inner City Programme was approached for permission to conduct this study with the assistance of staff from the Men and HIV Project and clients from the Esselen Street Clinic. Given the absence of MSM research in the RHRU and the possible benefits of the research findings to the Inner City Programme, the director granted her permission (attached as Appendix A).

Ethical clearance was then required from two university ethics committees, namely the UNISA College of Human Sciences ethical review committee and the University of Witwatersrand's Human Ethics Committee (medical). Once the institutional permission

(RHRU) had been received, the research proposal was submitted to UNISA's College of Human Sciences ethical review committee. Ethical clearance was received from UNISA in July 2009 (attached as Appendix B). In September 2009 the University of Witwatersrand's Human Ethics Committee (medical) reviewed the ethics application and study proposal. In October 2009, ethical clearance (attached as Appendix C) was received.

There were a few unsuccessful communication attempts between myself and the Policy Planning and Research Directorate office between October 2009 and December 2009. In order to meet the ethical review boards' timelines and the timelines for the degree, I was advised by the RHRU to proceed with the research study while still making attempts to contact the relevant personnel at the Policy Planning and Research Directorate office. The study commenced in December 2009. In January 2010, I was able to submit the proposal with the permission letter and ethical clearance certificates to the Policy Planning and Research Directorate (Gauteng Department Health and Social Development) office and their approval for the study was granted in February 2010 (included as Appendix D).

### 3.3.3 Informed consent

Before starting the interviews, all research participants were given comprehensive explanations of the study procedures and were taken through an information sheet detailing the aims, objectives, sampling procedures and ethical considerations of the study. At various points in the consenting process and again before they signed, all men were asked whether they understood what was being explained to them and whether they had questions about the study procedures. Once all the questions had been answered, they were asked to sign the informed consent sheet. They were also asked whether they required copies of the information sheet and consent forms for themselves. In addition to the informed consent form for the study (included as Appendix E), all participants were asked to sign a consent form permitting the voice recording of their

interviews (attached as Appendix F). All participants were satisfied with the consent processes and none of them asked for copies of the documents. I conducted all the informed consent processes and the interviewers (when applicable) then proceeded with the interviews.

At the outset and during the interview, participants were reminded that they were not obligated to participate in the interview and could decline to answer any questions which made them feel uncomfortable. Further, they were reminded that all the information shared during the interview would remain confidential and anonymous when disseminated and that their interviews, experiences, beliefs and opinions would not be traceable back to them by people who were not the interviewers or me.

### 3.4 INTERVIEWER RECRUITMENT, TRAINING AND COMPENSATION

Fieldworkers/interviewers were hired for research volunteer recruitment and data collection. One of the reasons for the creation of the Men and HIV Project at the RHRU with an all-male staff complement was a request from male patients to have a male-friendly environment in which they would be comfortable to speak. For this reason and the fact that MSM is a sensitive discussion topic, I believed that as an Indian, English-speaking female, I would not be the best person to conduct the interviews. I was of the opinion that valuable information could be lost if research participants were to feel uncomfortable answering questions related to sexual activity and sexual health when posed by me (reactivity in a sense, i.e. a threat to external validity because participants are aware they are in a research study [Neuman 2006:265]).

The Special Services Programme (of which the Men and HIV Project is one component) at the RHRU has 50 peer educators. As part of capacity development these peer educators have been trained in research methodology and data collection. Some of them have worked on operations research studies to gain practical experience and

develop research skills. All the male peer educators who indicated that they would like to be a part of this study were interviewed. They were asked questions on previous research experience, languages spoken and willingness to ask sensitive questions. Their knowledge of HIV and AIDS, research methodology and ethical research conduct was also explored. One fieldworker/interviewer was chosen from these interviews. When he left the organisation, the same interviewer recruitment process was followed to recruit the second field worker/interviewer.

Training was provided on the following:

- general background on MSM
- the study background and objectives of the study
- interviewing and focus group discussion moderation techniques
- the study interview schedule and the focus group discussion schedule
- informed consent and ethical guidelines

Training took place using formal PowerPoint presentations and the fieldworkers/interviewers were issued with handbooks/manuals. Once the formal training had been done, mock interviewee recruitment scenarios and interviews were done. Interviewer styles were commented upon and the necessary training/retraining was provided. Detailed notes on these procedures were kept for report back should this be required.

Fieldworkers were paid R150 per day worked. The funding for their salaries was provided by the RHRU HIV Management Cluster's budget. For this reason, the fieldworkers/interviewers signed the RHRU contracts applicable to fieldworkers. Fieldworkers/interviewers completed funder/donor timesheets and were paid by the Wits Health Consortium's finance department.

Debriefing sessions took place after every data collection process where the interviewer and I gave feedback on our experiences. Voice recordings were listened to and the strengths and weaknesses of the session were identified. These were communicated to the fieldworker/interviewer.

### 3.5 QUALITY CONTROL OF THE INTERVIEW PROCESS

I was present at the first interviews conducted by each of the interviewers. During this time I observed the interviewers and the interviewees. Detailed notes were taken about the interview process and these were discussed with the interviewer immediately after the interview. Given that the interviewers were trained on the interview schedule (as explained in section 3.4) there were few areas for improvement on the interviewing styles.

There were instances of leading the participant in the first parts of the first interviews conducted and the references to gay men instead of MSM. This was pointed out to the interviewers and they were more cautious in the following interviews. In the first three interviews conducted the research participants were asked for their opinion on the interview and the nature of the questions asked. Fortunately, all the men felt that, despite some of the questions being sensitive, other MSM would still answer them. The interview schedule therefore remained unchanged.

Research participants were given the opportunity to speak freely and interviewers were skilled enough to direct the interview in such a way so as to still gain information on the areas required for the objectives without necessarily following the sequence of the interview schedule.

### 3.6 SAMPLE SELECTION AND INCLUSION CRITERIA

A purposive sample of eleven MSM was recruited (see section 3.7 below) for face-to-face interviews. Inclusion criteria were the following:

- The men had to be 18 years and older so that they could be asked to give informed consent to participate in the study.
- They had to have engaged in sexual activity<sup>3</sup> with another man/men in the last year.
- They had to reside in the Johannesburg inner city for the duration of the study period.
- The respondents had to choose to participate in the study voluntarily, be willing to be interviewed and be willing to have the interviews voice recorded.

### 3.7 RECRUITMENT AND SAMPLING

Once ethical clearance had been obtained, one male fieldworker/interviewer (attached to the RHRU) commenced with recruitment in mid-December 2009. He recruited two men but, in January 2010, joined another organisation. I then had to source another fieldworker/interviewer. This second fieldworker/interviewer, who is employed by the RHRU as a peer educator (Youth Friendly Services Project), used his knowledge of the geographical area to assist in recruiting five other men for the study. Two of the recruited men are peer educators for one of the RHRU's projects. Both the fieldworkers recruited one peer educator each. One of these peer educators then assisted with recruiting three men through his peer education activities at a clinic. One of the men recruited by the second fieldworker enquired about his friend accompanying him, and this was how the eleven-man sample was obtained. During the recruitment process all

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<sup>3</sup> Sexual activity includes protected anal intercourse, unprotected anal intercourse, individual and mutual masturbation and oral sex. There is no minimum number of sexual acts that the research participant had to have engaged in and there is no minimum number of partners required.

men were given information about the study. Recruitment was completed in mid-January 2010.

There was little success in recruiting male sex workers, as they felt that the amount being reimbursed was not worth their time. There was also little success in recruiting men who were married to females and engaged in extramarital activities with men. In addition, none of the partners of the men who participated in the research study were willing to be participants.

When the study was designed it was planned to use purposive sampling as the recruitment strategy. As mentioned in Chapter 2, MSM is a hard-to-reach, at-risk, population group, thereby making them an under-researched population. Further, the health-seeking behaviour of MSM in the Johannesburg inner city has not been researched before. When considering this and Neuman's (2006:222) definition of purposive sampling (i.e. a non-random sample which uses many methods to locate possible cases of a highly specific and highly difficult to reach population), purposive sampling becomes the most appropriate sampling method for this study.

However, when one reads the explanation of how the eleven men were recruited it becomes apparent that the recruitment process was more of a snowball sampling process where the study started with two men who then brought in other men from their networks and this chain referral or reputational sampling (Neuman 2006:223) facilitated the sample size being reached in a very short space of time. Castillo (2009) highlights three disadvantages of snowball sampling: the researcher has little control over the sampling method (I could relate to this strongly because after the first three interviews I had people either asking me or coming to the clinic to find out if they could participate in the men's study they had heard about); the sample is not necessarily representative; and, finally, there could be sampling bias (since the research participants tend to nominate people that they know well, it is highly possible that the subjects share the

same traits and characteristics, therefore it is possible that the sample that the researcher will obtain is only a small subgroup of the entire population).

Once people had expressed a willingness to participate in the study, they were asked about their availability to complete the informed consent form and the in-depth interviews. Interviewees were asked to come to the RHRU offices in Hillbrow to be interviewed (see 3.8.1).

### 3.8 DATA COLLECTION

Qualitative research methods were used to explore information on being MSM and health-seeking behaviour. It was decided that a semi-structured in-depth interview coupled with a short demographic questionnaire would be the most suitable to meet the objectives of the study. The semi-structured interview guide provided the flexibility to adapt the questions to the research participant and the direction of the interview while simultaneously gathering the information pertinent to the study objectives. The participants were made to feel comfortable because they were encouraged to speak freely thereby transforming the interview setting into less of a formalised interview and more of a casual conversation.

The interviewers for the face-to-face interviews were male colleagues attached to the RHRU (elaborated on in section 3.4) and myself.

#### 3.8.1 In-depth, face-to-face interviews

In-depth, face-to-face interviews were conducted with all eleven recruited volunteer study participants. The in-depth interviews were conducted by two male colleagues from the RHRU and myself, using a semi-structured interview schedule (attached as Appendix G). This schedule had been compiled in English but, before interviewing commenced, a training session was conducted with the interviewers in which

translations of the questions in the vernacular were discussed and noted to ensure equivalence. Research participants had the choice of answering in English or their vernacular – depending on the language they felt most comfortable in expressing themselves. All participants initially felt comfortable with English, however, at certain points in three of the interviews there were translations of questions into Zulu. One interview was conducted in English and Sotho.

As mentioned above, eleven interviews were conducted by three interviewers using a semi-structured in-depth interview guide. The interview guide was developed to obtain information on six broad areas, namely:

1. Demographic information: This was used to contextualise the rest of the interview and as a cross check for information supplied in the demographic questionnaire. The demographic questionnaire was completed at the end of the in-depth interview.
2. Health seeking behaviour
3. Programme-specific questions – as they apply to the PHC services offered at the Esselen Street Clinic as well as the RHRU's Men and HIV Project's Men's Clinic operating on the first floor of Esselen Street Clinic
4. Sexual orientation and behaviour
5. Knowledge of HIV and AIDS
6. Community support and integration with NGOs

I was present at eight of the eleven interviews. I was not present at one of the interviews because the research participant was uncomfortable with my presence in the room, nor was I present at the remaining two interviews because the research participants came to the offices early and the other interviewer and myself conducted the interviews concurrently so as to accommodate the research participants' schedules. Had these men come at the agreed interview times, I would have been involved in ten out of the eleven interviews, given that when the men had a choice of interviewer they were

comfortable with both of us (the male interviewer and I) conducting the interview. I had not anticipated this, as I had expected the majority of the men to prefer the male interviewers over me. Irrespective of their reasons (unknown to me), the research participants felt comfortable with me interviewing them and were open to answering all the questions asked. One participant acknowledged that even though the questions were sensitive, he did not mind answering them as the flow and sequence of the questions enabled him to understand the value of the questions that were being asked.

I conducted three interviews on my own. Although these men were all fluent in English, they were reminded several times during the interview that they were welcome to answer in the vernacular should they be struggling to convey their answer properly in English. The remaining five interviews were conducted by me together with the male interviewers present to accommodate instances where the answers were in vernacular or if the need arose for the questions to be translated. To an extent, this pairing of interviewers worked well because the other interviewers and I have different cultures and knowledge sets. This means that there were some instances when we both assumed the insider or the outsider roles and there were other instances where there was a lack of congruence in the roles assumed. The fluidity of the insider/outsider roles (Rabe 2003:150) prompted us to probe different areas during the interviews. This facilitated us in obtaining comprehensive data and adequate explanations, which eliminated ambiguity and confusion when analysing the data.

### 3.8.2 Demographic questionnaire

At the end of the in-depth interview, research volunteers were asked to complete the demographic questionnaire (Appendix H). This questionnaire contained simple, predominantly closed-ended questions which the research volunteer either completed by themselves or with the assistance of the interviewer. Consent for completion of this demographic questionnaire was included in the study consent form (attached as

Appendix E) and research participants were informed that they were not obligated to complete the questionnaire.

The demographic questionnaire consisted of fifteen questions which facilitated a simple profiling of the research participants. In-depth interview guides and demographic questionnaires were paired. Each pair was then allocated a number from one to eleven which was used as the identifier for that particular research participant.

### 3.9 REIMBURSEMENT

Participants were required to come to the RHRU offices in Hillbrow for the interviews. Participants who took part in the face-to-face interviews were given R50 to cover their travel expenses. This reimbursement was provided by the RHRU. For audit purposes, the participants were asked to sign as acknowledgment of receipt of the reimbursement.

The research participants were also given beverages to sustain their energy levels.

### 3.10 DATA STORAGE, ANALYSIS AND DISSEMINATION

The final section of this chapter will explain the procedures that were followed with respect to data storage, how the data were analysed and interpreted (Chapter 4) and the dissemination of the study results.

#### 3.10.1 Data storage

All interviews were voice recorded. After the interviews, the voice files were transferred onto a password-protected computer. I transcribed the voice recorded interviews and all areas that required translations were marked with the recording times in the transcripts and the interviewer translated these parts of the interview. These translations were verified by two of the RHRU's operations research staff. Transcripts were stored on the

office computer at the RHRU which is secure and password-protected. Once I had transcribed the interviews, and the completed transcripts had been checked for quality, the transcripts were transferred to CD-ROMs (which have been secured in a locked safe along with the informed consent forms and all notes and documentation pertaining to this study) and the files stored on the desktops were deleted.

Transcription of the interviews yielded transcripts of 350 pages of information-rich data. Based on this, and for the sake of emphasis and validation, excerpts from the transcripts have been included in Chapter 4. These excerpts convey rich meaning and thick descriptions as opposed to only being referenced in the thematic discussions in the next chapter.

### 3.10.2 Data analysis

It is characteristic for qualitative data analyses to involve the identification and extraction of themes which, once critically analysed, present a coherent picture of the research study findings. The conceptualisation of categories of data or themes was initially done when conducting the interviews, and hearing for the first time the voice recordings of interviews that I did not conduct. Although the interview guide would have placed information into five major themes, this conceptualisation process facilitated the grouping of other information into themes which were not covered by the interview guide. Four competencies are generally relied on for researchers to be able to recognise themes in the data, that is, recognising patterns in the data, having all the relevant information, having comprehensive background knowledge and, lastly, thinking in terms of systems and concepts (Neuman 2006:461).

Data in the transcripts were manually coded. Coding involves breaking down the text in labelled meaningful phrases, with the aim of then categorising the small codes or phrases under code headings. Information under these code headings are either

compared with each other or information under other code headings (Terre Blanch & Durrheim 1999:143).

Coding of the transcript data was done in three steps. Initially *open coding* was done. Open coding is the first phase of coding qualitative data in which the data are condensed into preliminary units of analysis after careful and thorough examination. This was a time-consuming process because even though there was previous exposure to the data, this initial phase forces scrutiny of the data to identify critical information, key concepts, broad categories and so forth. Once the open coding was completed, the next step was *axial coding*. Where open coded was centred on the data and the code/label assignment for the themes, axial coding was more focused on the themes and less on the actual data. Axial coding prompted thoughts about how the themes and the information link to one another and, to an extent, enabled the identification of the major themes and the subthemes. The coding process ended with the *selective coding* phase. Here, the data were revisited for information relevant to the major themes. The information extracted during selective coding enabled the themes to be presented in a comprehensive manner since the selective codes provided the information that was compared and contrasted (Neuman 2006: 460-464).

When considering the thematising and coding processes for this research study, another point highlighted by Terre Blanch and Durrheim (1991:143) held true, that is, that themes and codes blend into each other and themes change as coding proceeds, contributing to the development of subthemes. It was anticipated that the information could fit into four broad themes each with two to three subthemes. After coding and analysing all the data, the product was three primary themes with two to five subthemes each. In addition, there were four secondary themes.

### 3.10.3 Dissemination

This dissertation of limited scope was compiled for submission to UNISA in compliance with requirements for the Master's degree in Social Behavioural Studies in HIV/AIDS. On approval of this dissertation the results of this study will be disseminated to all stakeholders and in appropriate journals. In May 2010, a poster presentation on one subtheme of the results was presented at the 4<sup>th</sup> International Workshop on HIV Treatment, Pathogenesis and Prevention Research in Resource Limited Settings in Maputo, Mozambique. In June 2010, abstracts will be submitted for the University of Witwatersrand Research Day and the African Masculinities and Family Planning in Africa Conference. Abstracts will also be submitted for presentations at other national and international conferences.

### 3.11 CONCLUSION

This chapter discussed the study methodology, including the qualitative research methodology, ethical considerations, interviewer recruitment, the quality checking processes of the interview schedule and the interviews, participant recruitment, data collection, data storage, data analysis and the dissemination of the findings.

The six broad areas listed in section 3.8.1 provided information pertinent to the four objectives of the study (as listed in chapter 1) and created the opportunity for additional information to present itself which, although not related directly to the objectives, provided insight into the lives and worldview of an MSM. This information was grouped according to its relevance to the objectives and other major themes (in instances where information did not directly relate to the objective but was frequent enough to be included). This thematic information forms the content of the next chapter where it is discussed comprehensively.

## CHAPTER 4: RESULTS

### 4.1 INTRODUCTION

The information obtained using the six broad areas highlighted in Chapter 3, was initially grouped according to the major themes of *access to health care*; *personal and general MSM HIV risk perceptions*; and *sexual behaviour*. However, because a substantial amount of information was shared in the interviews, four other themes were identified and these three major themes had to be broken down into subthemes.

Information that was collected on access to health care was categorised into the subthemes of general access to health care, examples of positive health care experiences and examples of negative health care experiences. General knowledge about HIV and AIDS, personal risk assessment and opinions around MSM contribution to the pandemic (*Have you ever used a condom and why?*), and myths about HIV acquisition were all subthemes of the personal and general MSM HIV risk perceptions. Questions on *sexual behaviour* collected the most information and this theme was thus broken down into five subthemes. These subthemes are sexual identities; age at sexual debut; sexual activity and frequency; number of partners and condom usage; and HIV status and experiences with STIs. Alcohol and unprotected sex, prostitution, religion and violence, discrimination and stigma were additional themes identified in the data. All of the themes provide a piece of the puzzle of the life, the experiences and the worldview of the eleven research participants.

This chapter will begin with a description of the demographic characteristics of all the men in the research sample, including their knowledge of and experiences related to social and support networks and living openly. Following this will be a discussion on the major themes (*access to health care*, *personal and general MSM HIV risk perceptions* and *sexual behaviour*) and their subthemes. The chapter will end with a discussion on

the additional themes that came out of the interviews, namely alcohol and unprotected sex, prostitution, religion and violence, discrimination and stigma.

## 4.2 DESCRIPTION OF THE SAMPLE

The first part of objective one of the study was to describe *the biographical features of the volunteer sample of MSM, such as age, socioeconomic status, educational level, racial, cultural, ethnic, sexual and religious identities, place of residence, migration status and marital status*. These features will now be focused on to provide a description of the sample in which the subsequent themes can be analysed.

### 4.2.1 Characteristics of the sample

The information from the demographic questionnaire is presented in Table 4.1 below. Information included in this table is represented as it was given in the interviews with the help of the demographic questionnaires.

**Table 4.1 Demographic details of research participants**

| INTERVIEWEE ALLOCATION | PSEUDONYM | AGE | RACE    | LANGUAGES SPOKEN | PROVINCE OF BIRTH | AREA OF RESIDENCE IN JIC                        | YEAR MOVED INTO JIC | REASON FOR MOVING TO JIC                 | EMPLOYMENT STATUS  | EDUCATIONAL LEVEL                        | RELIGION  | MARITAL STATUS | GENDER OF PARTNER IF COHABITATING | CHILDREN |
|------------------------|-----------|-----|---------|------------------|-------------------|---|---------------------|--|--------------------|--|-----------|----------------|-----------------------------------|----------|
| 1                      | Abe       | 32  | African | English and Zulu | KwaZulu-Natal     | Berea   | 2005                | 1. Cheaper rent<br>2. Seeking employment | Un-employed        | Completed secondary schooling (Grade 12) | Christian | Single         | N/A                               | 0        |
| 2                      | Blythe    | 22  | African | English and Zulu | Mpumalanga        | Hillbrow Johannesburg Central Business District | 2006                | Seeking employment                       | Un-employed        | Completed secondary schooling (Grade 12) | Christian | Married        | Male                              | 0        |
| 3                      | Johnson   | 31  | African | English          | Mpumalanga        | Braamfontein                                    | 2002                | Seeking employment                       | Self-employed      | Completed secondary schooling (Grade 12) | Christian | Co-habiting    | Male                              | 0        |
| 4                      | Dale      | 39  | White   | English          | KwaZulu-Natal     | Braamfontein                                    | 2008                | Studying at Witwatersrand University     | Full-time employed | Completed undergraduate degree           | Christian | Co-habiting    | Male                              | 0        |
| 5                      | Eugene    | 24  | African | English          | Limpopo           | Parktown  | 2005                | Studying at Witwatersrand University     | Student            | Completing undergraduate degree          | Christian | Single         | N/A                               | 0        |
| 6                      | Moses     | 27  | African | Xhosa            | Eastern Cape      | Hillbrow Johannesburg Central Business District | 2004                | Seeking employment                       | Part-time employed | Post matric                              | Christian | Single         | N/A                               | 1        |
| 7                      | Michael   | 33  | African | English          | KwaZulu-Natal     | Braamfontein                                    | 2007                | Seeking employment                       | Part-time employed | Post matric                              | Christian | Co-habiting    | Male                              | 0        |

| INTERVIEWEE ALLOCATION | PSEUDONYM | AGE | RACE    | LANGUAGES SPOKEN | PROVINCE OF BIRTH | AREA OF RESIDENCE IN JIC | YEAR MOVED INTO JIC | REASON FOR MOVING TO JIC                       | EMPLOYMENT STATUS  | EDUCATIONAL LEVEL                        | RELIGION  | MARITAL STATUS | GENDER OF PARTNER IF COHABITATING | CHILDREN |
|------------------------|-----------|-----|---------|------------------|-------------------|--------------------------|---------------------|--|--------------------|--|-----------|----------------|-----------------------------------|----------|
| 8                      | Themba    | 34  | African | English          | Swaziland         | Newtown                  | 2009                | To be with family                              | Unemployed         | Post matric                              | Christian | Divorced       | N/A                               | 2        |
| 9                      | Neo       | 19  | African | Ndebele          | Zimbabwe          | Hillbrow                 | 2009                | 1. Seeking employment<br>2. Practice sexuality | Unemployed         | Completed secondary schooling (Grade 12) | Christian | Single         | N/A                               | 0        |
| 10                     | Eddie     | 23  | African | English          | Zimbabwe          | Yeoville                 | 2008                | Seeking employment                             | Full-time employed | Completed secondary schooling (Grade 12) | Christian | Co-habiting    | Male                              | 0        |
| 11                     | Vuyo      | 27  | African | Sotho            | Free State        | Berea                    | 2009                | Seeking employment                             | Self-employed      | Completed secondary schooling (Grade 12) | Christian | Single         | N/A                               | 0        |

South Africa's main population composition was rigidly divided into four racial categories during the apartheid years, namely, black, white, coloured and Indian. This racial categorisation still plays a role in present-day South Africa but, for the purposes of describing the sample and the racial references made throughout the chapter, the classifications of black and white will be used. The sample comprised ten black men and one white man. Based on how the men answered the question about languages spoken, it appears that the most frequently spoken language among them is English. However, throughout the interviews it became apparent that there were different levels of fluency in English, as was also evident in the verbatim quotations included in this chapter. One man is a traditional healer. All men share a belief in Christianity. All of the men had some form of formalised education and had completed at least Grade 12. Four men had obtained further qualifications and one man is currently completing a university degree.

Three of the men were non-South Africans – one from Swaziland and two from Zimbabwe. The original provinces of residence or places of birth of the eight South Africans in the study can be listed as three being from KwaZulu-Natal, two from Mpumalanga and one each from Limpopo, Free State and Eastern Cape. On relocation to the Johannesburg inner city in Gauteng, the most commonly found areas the men live in are Hillbrow, Berea and the Johannesburg central business district.

Albeit eight of the men cited seeking employment as one of the fundamental reasons for moving into the area, only four are successfully employed by organisations in either full- or part-time positions and two are self-employed. Self-employment in this instance includes being involved in commercial sex work.

Five of the men identified themselves as single, four as cohabitating, one as divorced and one as married. In addition to the information on marital status provided in Table 4.1, other information related to marital practices is also

pertinent to this study. Blythe, for example, is currently separated from his partner who is also male. They were married according to traditional SiSwati rites. Blythe assumed the role of the female in the relationship, which means that a *lobola* (bride wealth) was paid to his family for his hand in marriage. Currently, Blythe is cohabitating with another male who has three wives and many children (who all reside in another province and are completely unaware of what is happening in Johannesburg, Gauteng). It is unusual to learn that *lobola* was paid for this participant as it is generally understood that bride prices are only paid for female brides. The payment of *lobola* for males (particularly young boys), however, was common practice in the early twentieth century (from 1903) on the coal and gold mines. Families either left the young boys on the mines or men who were going to the mines would take young boys with them. In both instances *lobola* was paid to the elders and the young boys would act as the female partner of the older male miner (Epprecht 2008:67, 69, 70).

Further matters relating to partners include the case of Themba, who indicated that he is divorced, was married to a woman and has two children with her. Another exceptional case is Neo, who is in a steady relationship with a male and also has a steady relationship with a female. According to Neo, this female is aware of the relationship her boyfriend and Neo share. All the other men, irrespective of whether they are single or cohabitating, are currently involved in sexual interactions or relationships with males. Eddie is an interesting example since he is in a steady relationship with a male whose primary means of earning income is through involvement in criminal activities and who was imprisoned at the time of data collection.

In general, some men are not openly MSM because they are married and not gay/homosexual. These men are not completely hegemonic neither are they subordinates. They passively subscribe to hegemony either by having girlfriends or getting married and having families. In examining the above two paragraphs it

can be seen that Blythe's partner, Neo's partner and Themba can be categorised as having complicit<sup>4</sup> masculinities.

Neo and Eddie are self-reported transvestites. Their attire includes make-up, female jewellery, hairstyles and hair pieces. Abe and Vuyo said that they liked to use some female outer garments (e.g. tight pants or tight blouses) but did not use make-up, wigs or high-heeled shoes. Neo, Eddie and Vuyo also identified themselves as female. This identification as being a female has a different interpretation for Blythe who assumed the female role in his past marriage. Neo, Eddie and Vuyo believe that they are women even though they are not biologically and physiologically feminine, whereas Blythe assumed the passive and domestic (the one who cooks, cleans, tends to the family) roles of the female in his description. Eddie and Vuyo together have had links to commercial sex work with other males at some point in their lives.

Abe, Blythe and Moses are directly involved in and exposed to the PHC system in their roles as peer educators or trained health care workers (counsellors and junior nurse). Eight of the eleven research participants know their current HIV status with five of these eight men voluntarily revealing their HIV status as being HIV positive and two out of the eight voluntarily revealing their HIV status as being HIV negative. Of the remaining four research participants, one male does know his current HIV status but chose not to disclose his status in the interview and the other three are completely ignorant of their current HIV status, with two having never accessed VCT.

The following two sections further address the first objective by focusing on *social and support networks* and the *question of living openly*.

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<sup>4</sup> Those men who do not totally subscribe to the hegemonic model but still realise and maintain the patriarchal divide are said to have complicit masculinity (Cornell 1995:79).

#### 4.2.2 Social and support networks

In order to determine whether social and support networks exist, the men were asked questions about their knowledge of other organisations in their areas that provide health care. This question was supplemented with questions on awareness of the peer educators and health talks/education done at the Esselen Street clinic. The intention was to gain information on formal (and in a sense more controlled, stable networks like organisations offering MSM support); however, it was found that there were more social and informal networks (information sharing between friends and peers) present as will be seen below. The responses fell in the two distinctive categories of research participants who did not have knowledge about NGOs and participants who had some knowledge. This is detailed below.

##### 4.2.2.1 Research participants who had no knowledge about NGOs

Of the men asked about NGOs, there was only one person (Eddie) who had no knowledge about the existence of any NGOs in the area. In addition to Eddie indicating that he had no knowledge about the existence of any NGOs in the area, he was of the opinion that even if there are NGOs, MSM would not access them. When asked what he thought stops MSM from going to the NGOs, he said *I think its embarrassment or something you won't be heard talking about*. Eddie's response was indicative of a sense of MSM being embarrassed about their sexuality and given that accessing services of NGOs may require them (MSM) to be open about their sexuality or their sexual behaviour MSM will not go to NGOs. According to him it is not the norm for MSM to speak about such things. His perception of MSM is that *speaking out is not normal*.

Eddie was, however, aware of the peer educators and health talks given at the Esselen Street Clinic waiting rooms, but he, together with the friends that he brought to the clinic (indirectly indicating an informal social network in which health and sexuality are discussed), all feel that the peer education was not relevant to them as it focused on the heterosexual acquisition of diseases. Eddie

recalled his friends saying, *How can you bring us to such a place? They discuss about men and women and I want a clinic that discusses about men and men.* At this point, Eddie's feedback not only answered the question he was asked but also highlighted a programmatic design flaw with respect to awareness and education.

Johnson, Neo and Vuyo were not specifically asked about NGO knowledge since it transpired from their interviews that they did not have knowledge about NGOs. Understandably, Neo and Vuyo, being relatively new to the area (having relocated from areas outside Gauteng in late 2009) had no knowledge of any public health and support service providers in the area. Johnson, on the other hand, is only interested in accessing the services of private practitioners as he felt that it was more convenient and was adequate, so he has never made an effort to find out what is available to support him beyond a private facility.

Neo and Vuyo were therefore not asked about their knowledge of the peer education programme as they were so new to the area. Neo was asked about the peer education programme and although he did not know about it, he had an understanding of what a peer educator was and knew one of the peer educators as he (the peer educator) had approached and invited Neo to come to Esselen Street clinic for VCT. On two separate occasions Neo had agreed to come to the clinic; however, he did not put in an appearance on either occasion. The peer educator followed up on Neo in both instances and Neo said that he felt comfortable with the peer educator and would readily approach him for knowledge on MSM health care issues.

Despite neither having knowledge about NGOs that could offer them support as MSM nor awareness of the peer education programme and health talks conducted at the Esselen Street clinic, all three men (Johnson, Vuyo and Neo) have friends with whom they discuss HIV, sexual practices and health issues. Johnson even said *I have a friend living with the virus and we talk about*

*everything. Sometimes he tells me that he didn't use protection. I would ask him why you would do that. I think even though they (referring to his friend and other MSM) know their status, they don't always use condoms.*

When Johnson was probed about his feelings around his friend's inconsistent condom usage he proceeded to say: *It makes me feel very sad because he is the only person that I know who got the virus who I'm close to. I'm learning a lot from him. On the other hand he is giving me advice about safe sex and on the other he is not practising it at the same time so it makes me feel very very angry.*

Interested in ascertaining how in-depth these HIV-related conversations between Vuyo and his close friend are, the interviewer continued to probe as indicated in the excerpt below:

*Interviewer: Do you talk to him about your feelings? Do you tell him what you think about him not using protection?*

*Johnson: I tried to*

*Interviewer: Does he listen?*

*Johnson: No he doesn't. He tells me he didn't use protection and then three weeks down the line he tells me the same story. It makes me really really mad because he is always telling us to always use protection. It makes me really mad.*

*Interviewer: I am glad that you discuss HIV or sexual health issues with your friend. How do you use what he tells you to better your life?*

*Johnson: He has been living with virus for quite a while now. Whatever he tells me I take it very seriously.*

Neo's responses to ever having contracted an STI and the diagnosis thereof, was: *Ya I have it but my friend got tablets in the house. My gay friend at Esselen he gives us STI tablets. STI tablets at his house. I did not go to the clinic. I just took it in my house. Just drink tablets, drugs, whatever. Now I don't know whether*

*it is finished or its inside. But now I'm fine and; I just ask my friend about what it feels. He told me that it's STI.*

For Neo and Eddie, it becomes evident that their support systems extend beyond discussions around their sexual behaviour and its relation to HIV. They are supported by their peers in terms of accessing health services, self-diagnosis and sharing medication in the cases where they do not go to the clinic (e.g. for STIs).

#### 4.2.2.2 Research participants who had some knowledge about NGOs

Seven of the research participants had some awareness of the existence of NGOs in Johannesburg. HIVSA, The AIDS Consortium, New Start, New Life Centre and Ipegeleng were the most common NGOs identified. The services offered at these facilities include VCT, STI treatment, peer education and support groups. Although some men spoke about condemnation by the church, one participant spoke about a gay church as an NGO that provides men with spiritual and medical support and information, especially when it comes to issues of HIV and STIs.

Of the seven men that were aware of NGOs, two were peer educators themselves, two were oblivious to peer educators and peer education and three were aware of and had had previous interactions with peer educators. Five men had been in the audience of the health talks conducted at the Esselen Street Clinic and three men had their own social networks and support groups in the form of their friends who also engage in male-to-male sexual activities. This came out very positively in one of the interviews when Themba was asked about whether he engaged in discussions about STIs and HIV/AIDS with his friends:

*Themba: I think the most common one is HIV because some of my friends they do disclose because we have been friends for such a long time. We do discuss especially HIV. The main topic we discuss about is HIV, the way*

*you have to handle yourself if you have a partner. You have to tell your partner about your status.*

*Interviewer: Ok when you discuss is everybody free to talk about it? Mostly when it comes to STIs and as you mentioned earlier piles and stuff like that do you guys feel free about that?*

*Themba: Yes we do discuss about things like that like piles and I think that that is the most common one piles.*

From the above it is clear that even though some men may not access health care or formal health education sessions, they still discuss issues related to STIs and HIV/AIDS. However, whilst awareness may be one of the first steps to prevention and safer living, it must also be remembered that, if people only discuss health issues among themselves, it is easier for incorrect information or myths to spread

#### 4.2.3 Questions about living openly

When asked questions about their sexual preferences and living openly with the sexual identities they have chosen, all men indicated that they are currently strictly gay with only three men indicating that they had ever had relationships with females. Nine men indicated that they are completely openly gay, that is, their families, society, their communities and anybody else who may know them are aware that they are gay.

Even though parents and families became aware of the men being gay upon their disclosure, not all parents were receptive to the idea. One set of parents took their son to a traditional healer.

*Neo: My mother and father go with me to the traditional healers to ask about gays. Maybe it's some spirit or something. The traditional healers will say they can't do anything because it is in the blood not spirits.*

Eugene and Moses indicated living an openly gay life in Johannesburg, but when they go back home or to their province of birth, they are in the closet. Both do not engage in male-to-male sexual intercourse when they are at home. Eugene said that he was open *only to (his) friends and some of (his) friends and family don't know* and that he *hasn't really told them*. He said *because they wouldn't approve of it and their faith and my faith. Their belief in God and Christianity does not really approve of such behaviour*. This prevents him from living completely openly.

The fact that the majority of research participants are openly gay probably contributed to the open and frank discussions during the research interviews.

#### 4.3 ACCESS TO HEALTH CARE

Information that was collected in response to the objective: *To determine the factors that hinder MSM's health-seeking behaviour and propensities to access (or to avoid) voluntary counselling and testing (VCT) for HIV* extended beyond the geographical location of the Johannesburg inner city. A considerable amount of information on participants' overall access to health care, as well as their views on the health care service provision in the Johannesburg inner city and their original areas of residence (in instances where they were new to the Johannesburg inner city and had not accessed health care in the area in the period leading up to the interview) was obtained. The aspects that are elaborated on in this section will extend beyond the scope of the objective to include information on health care service providers, health care services accessed and positive experiences with accessing health care.

##### 4.3.1 General access to health care

All participants had access to health care. Owing to the sensitivity of the information shared in this section, facilities will be referred to by indicating only the classification and not their names in order to preserve their reputation and not

to defame particular health care facilities. Six categories/combinations of facilities were accessed at least once by the men, namely, a PHC clinic, a community clinic, a wellness centre, a combination of the PHC clinic and community clinic (dependant on service required), traditional healers and private doctors.

With the exception of the private doctors, the PHC clinic, community clinic and wellness centre are located in the Johannesburg inner city.

Vuyo, a more recent inhabitant of the Johannesburg inner city, had not accessed any health care beyond his routine CD4 and viral load blood draws. This routine testing was conducted at a national laboratory in the area. However, he had accessed health care in the area where he resided prior to the Johannesburg inner city and shared his experiences of this. This is elaborated on in section 4.3.3.

Dale and Johnson had experience only with private doctors. Dale said that he was brought up in a culture where they were not exposed to public health care systems and it was therefore natural for him to visit his general practitioner when he was ill. He had even done his HIV testing at another national laboratory, through the facilitation of his general practitioner. Of importance is that whilst this HIV test was voluntary there was no counselling that accompanied it. Dale spoke to his doctor, the doctor referred him to the laboratory, Dale went to the laboratory, blood was drawn and he received his results at a later stage from his general practitioner. In my opinion counselling is a vital step in HIV testing and entry into HIV care as a whole. The process of VCT was explained to Dale by the interviewer (who did this not as an advocate of VCT but rather as somebody who had knowledge of VCT protocols in the PHC setting). Dale found this information useful and realised that he had not experienced one of the more appropriate models of testing for HIV. Johnson said that private doctors were his preference owing to the frequent drug shortages at facilities and the incompetence of facility

staff. Having never accessed public health care, or drawn on the experiences of his colleagues, it is not clear how Johnson arrived at his deductions.

Moses, Neo and Michael had been to the community centre for non-sexually related illnesses. Vuyo frequents this facility as it is near his home and he can access condoms easily, without harassment (he is one of five participants to frequent the PHC clinic and the community centre to obtain condoms). Neo initially went to the facility because he had tonsillitis. Given his mannerisms and appearance (he is a cross-dresser) it was apparent to the attending medical officer that Neo could be homosexual or an MSM. The doctor enquired about Neo's sexuality and sexual history and referred him for an HIV test. Neo has yet to perform the VCT but has indicated that he was supposed to go to the PHC clinic for the test on a planned day but woke up too late (midday). At the time of the interview he still had not taken the HIV test.

Michael went for treatment at the community centre for a continuous nose bleed. The doctor enquired whether he had tested for HIV before and Michael responded that he had tested a while back. He was then directed to a blood draw room in which he was informed he would be tested for HIV. The blood was drawn and he was told that the blood would go to the laboratory and that he should return to the clinic on a particular date (3 weeks later). Michael received no pre- or post-test counselling. He was later told that he was HIV positive with a CD4 count greater than 200 cells/mm<sup>3</sup>, making him ineligible for ART.

Themba, Blythe and Abe accessed health care at both the PHC clinic and the community centre.

Themba is an HIV-positive man who was initiated on to ARTs in Swaziland. On his relocation to Johannesburg he had to collect his ARVs from a facility in the area. Themba did not come to South Africa with a transfer letter from the initiating facility in Swaziland, accordingly he was told at the community centre that he

should choose a facility that was most accessible to him for receiving his ARVs. Once Themba had identified such a facility, the PHC clinic, he was down referred<sup>5</sup> to that facility. At the community centre his vital health indicators (weight, blood pressure, etc) were taken and blood was drawn for the CD4 count and a viral load determination was done. This information was handed in at the PHC clinic on the day of his appointment at that facility and he was registered for the ARV down referral programme. Themba did not experience any difficulties when collecting his medication and had not had any health care related needs which forced him to access any other health care facilities.

Blythe initially accessed health care at the community centre until he met a particular health care worker at the PHC facility. He was comfortable with this health care worker's approach and thereafter only sought health care at the PHC facility. In comparing his experiences at the PHC facility and the community health centre, Blythe indicated having negative health care experiences at the community health centre and more positive experiences at the PHC facility (this positive experience is explained in detail in section 4.3.2).

Abe accessed the community centre initially for mild STIs and VCT. He had an extremely negative experience at this facility and therefore moved to the PHC clinic for health care (this negative experience is detailed under section 4.3.3). Although he had recommendations for the PHC clinic he nevertheless had positive opinions of and comments about this facility.

Themba, Blythe and Abe all indicated having positive health care experiences and preferences for the PHC facility. Themba did not indicate having a negative experience at the community health centre but both Blythe and Abe did. Relating

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<sup>5</sup> Down referral is process of transferring stable, adherent initiated patients to a PHC clinic to continue their treatment (decentralising care). Down referral is a means of decongesting ARV initiation sites to make resources available to HIV-positive patients who still need to go onto ARVs.

his experience at the community health centre was difficult for Abe and after a certain point he became too emotional to speak any further about it.

Moses accessed health care in both the provinces of his residence prior to his relocation. At these facilities he accessed services relevant to STI treatment and VCT and when he had flu and headaches. In Gauteng Province, his first experience with the City of Johannesburg public health care system was when he went to the community health centre after breaking out into a rash and was diagnosed with Herpes Zoster. He had exposure to a VCT campaign conducted by another NGO and wanted to access VCT in the Johannesburg inner city but refrained from going to that particular NGO because of the fact that his acquaintances worked there. Instead, he went to the community centre for VCT and rated the counsellor's knowledge as lacking and the VCT process as poor. This rating was informed by the fact that Moses was a trained HIV counsellor who worked in a similar facility in another province. Unhappy with the services received at the community health centre he went to the PHC clinic where again he accessed VCT but this time rated the counselling services as being of a higher standard than that of the community health centre.

Eddie had only been to the PHC clinic where he initially went for VCT and tuberculosis (TB). Eddie works night shifts and his partner frequently engaged in sexual intercourse with male commercial sex workers during Eddie's working hours. Eddie's partner had high STI acquisition rates and also transferred the STIs to Eddie. Based on this Eddie found himself going to the PHC clinic for STI treatment on a regular basis – until he eventually opted for having protected sexual acts with his partner again. The condoms for these protected acts were obtained from the PHC clinic. Eddie was always treated by a female nurse and was satisfied with the services and treatment that he received.

Eugene went to a doctor in private practice when he was ill. Since Eugene is a student this doctor advised him to access the Wellness Centre on the campus as

it would be more economically viable. Eugene then went to this Centre and, although he did not have any problems with the service offered, he felt it did not cater for his specific needs. He then made use of the VCT and STI services of the PHC clinic. Again he did not have a problem with the services he received, but he was embarrassed and uncomfortable when answering questions about sex as they were asked by a female nurse.

To summarise – the recurrent reasons given for either expressing little desire or not wanting to go to any health care facility at all when ill are discomfort in being attended to by a female health care worker and the health care worker's lack of tolerance, knowledge and interpersonal skills when consulting MSM. All participants felt that there was inadequate literature and health information for MSM. Some of the men mentioned experiences of discrimination which are detailed below (see section 4.6.4).

Only Abe, Blythe, Neo and Eddie had accessed traditional healers and in addition to these four, Vuyo is a traditional healer himself. Abe and Blythe went to the traditional healer for the treatment of shingles. In both cases, the men reported having been given an ointment which they applied to the shingles resulting in them being healed within a few days. Neo was taken to a traditional healer because his parents attributed his homosexuality to the presence of bad spirits. Eddie only went to get lucky charms and never sought medical assistance from a traditional healer. He did, however, mention that men went to traditional healers for a powder which can be eaten with porridge. This powder assists men to vary the size of the anus to suit the size of their partner's penis. All men regarded traditional healing practitioners as being unqualified and incompetent to treat HIV. They were uncomfortable with the methodologies of slashing hands with non-sterile blades to interpret the blood from the resulting cuts for causes of illnesses, as well as the use of *imbizas* (usually a liquid herbal remedy which is taken orally) which activate the vomit reflex so that the illnesses can come out of the

body. They viewed HIV as a condition which can only be controlled in medical/clinical facilities with laboratory formulated drugs.

When reviewing the concept of hegemonic masculinity, one of the components that received renewed attention was that of social embodiment. Included under the concept of social embodiment was a discussion on health promotion or health-seeking behaviour, which was viewed as non-conforming to the normative hegemonic masculinity model (Connell & Messerschmidt 2005:851). Irrespective of the men in this study's health care experiences, they all display going against masculine embodiment (specifically here with respect to health-seeking behaviour) as a means of identification.

#### 4.3.2 Examples of positive health care experiences

Blythe had accessed health care (for VCT, STI and flu) at a variety of PHC clinics in the Johannesburg inner city and the Gauteng East Rand, but has stopped going to the PHC facility because his favourite health care worker retired. Blythe had an expression of contentment while recollection his experiences with her. The following is a section of one of his descriptions of their interactions:

*Blythe: As I told you when Sister Agnes (pseudonym) was there I recommended her as someone who is good for me on my side. Normally for CD4 staging you see that one she used to ask, my child is there any problem, what happened, do you know about the re-infection? All those things – she will spend time with you even if you spend 45 minutes with her or what. .... They help people bona eService is good because they help people. They don't chase people away or say come tomorrow or go where ever they treat. But not like Agnes, the way she used to treat me and she doesn't even know me. She used to ask me, mntwana wami, do you use condoms? What do you take? Are you on vitamins? Now, you see your CD4 count is high. All those things she used to talk - you feel comfortable. She don't tell me how shame or no – the way she talks to you, you are like other persons. The way*

*she talks now you will feel comfortable. Because she is the old one, she was friendly. By the time that Agnes was there I was comfortable.*

Most men preferred a male-friendly clinic with male staff as they felt uncomfortable with being assisted by a female nurse or doctor. However, Eddie, like Blythe, also had a positive experience with a female health care worker. He said: *She was very good. I really admired her. She was so open. She was free ... there wasn't any tension between us. She was just cool ... She is very good. I never want to leave her.*

#### 4.3.3 Examples of negative health care experiences

Both negative and positive health care experiences have a great influence on a person's decision to subsequently access health care. Vuyo had a negative experience at a health care facility in Sasolburg. Although this is not a facility in the researched geographical area, it has been included because experiences like these contribute to perceptions of, and accessing health care overall.

*Vuyo: So when I go there they say okay – what are you doing here? You thought you are going to have a baby. Or did you come to have an abortion? Stuff like that. And they know very well that I don't have a baby.*

Abe shared his experience at the community health care centre. He came to the centre for VCT and instead of providing confidential, individual post-test counselling, the counsellor disclosed the results/status of the participant in the waiting room. From his narration it is apparent that this was a very traumatic experience for him.

*Abe: ... because she said to me, you said that you don't do sex but how come you are positive. You are positive. I don't want to talk about this because it reminds me of something bad. And I know that counsellor. I used to see her at the community health centre.*

Lane *et al's* (2008: 430–433) study shared participants self-experienced and witnessed reports of health care workers homophobic displays towards gay-identified and gay-labelled men. The men in Lane *et al's* study (2008) differed from the men in the health and HIV risk assessment of MSM study in that they managed to develop coping mechanisms and still attend the same clinic. These coping mechanisms included lying about their identity, denying health care workers information about their sexual identity and seeking out tolerant health care workers. The more confident men challenged the health care workers and demanded that they assist them with their presenting health problem. The men in the health and HIV risk assessment of MSM study on the other hand chose to change facilities when they had negative health care experiences.

For me as the researcher who only listened to or read about the negative health care experiences of these men, I must admit being traumatised by some of them. I was sometimes overwhelmed with empathy and filled with anger and could not completely understand why these men may choose to avoid the public health care system.

#### 4.4 Personal and general MSM HIV risk perceptions

The interviews focused on men's opinions, thoughts, familiarity with and perceptions of HIV and AIDS and therefore they provided insight into the personal risk assessments of MSM. They were also asked what they thought an MSM's contribution to the HIV pandemic was. To an extent the interview then forced men to reflect on their sexual behaviour, answer the question of how at risk they thought they were for HIV acquisition (infection or re-infection) and their role in HIV transmission. I will also touch on reasons for condom usage in terms of their outlook on their personal risk.

#### 4.4.1 General knowledge about HIV and AIDS

The research participants' general knowledge about HIV and AIDS was varied, with Neo on one side of the field having absolutely no knowledge about the virus besides the fact that it is *not for animals*, and Blythe on the other side having all the essential knowledge related to HIV and AIDS. He explained what the virus was, the staging of the virus, how it can be acquired and transmitted, and what people should do when they are HIV positive in terms of health care, personal hygiene and routine testing. Despite all this knowledge his actions spoke a different language – one that was riddled with risky behaviour (especially taking into consideration his HIV-positive status) as elaborated on in section 4.6.1.

The majority of the men mentioned HIV being a virus that attacks humans, with four men specifically referring to the immune system. They described HIV as being transmitted through unprotected sex, blood in the form of ulcerations on the penis and cuts in the anus, and from blood transfer when helping people involved in accidents. Abe weighted transmission in 99% of cases as resulting from unprotected sex with an HIV-infected person and 1% when helping people who have cuts. Michael mentioned transmission through blood transfusion and sharing needles during drug use. Only Neo thought that ARVs cause HIV (as elaborated upon in section 4.4.3).

#### 4.4.2 Personal risk assessment and opinions around MSM contribution to the pandemic

Perceptions of risk were inversely proportionate to length of relationships. More than half of the sample stated that if they are in a homosexual relationship for three months or longer, it is expected (and even automatic) that sex will no longer involve the use of a condom. A relationship of three months or longer is considered to be a stable relationship in which both partners are committed and there is little chance of transmission or of acquiring diseases or viruses. In practice, this commitment is generally not there as some of the men in the sample and the majority of their partners were involved in multiple partnerships. It

is unknown what the specific condom usage practices are within the sexual networks, but in some cases there is evidence suggesting that condom usage was inconsistent or condoms were not used at all. An example of this is Eddie's partner who contracted an STI and passed it on to Eddie.

Only three of the men, Blythe, Moses and Eugene, provided information on their personal risk of HIV infection or re-infection. Two of these three men, Moses and Eugene, are HIV negative. Eugene felt that he was not at risk because his relationship was monogamous and Moses viewed himself as being 98% at risk for HIV infection because he does engage in bouts of unprotected anal sex. Blythe is HIV positive and is aware of the risks of re-infection and transmission but indicated that the sex was *good and nice*. In response to a direct question, he admitted that he was consciously engaging in risky sexual practices. Research participants in Parry *et al's* (2008:49) study on the links between drug usage and HIV risk also reported consciously engaging in unprotected sex for sexual pleasure. They further reported instances of forgoing condom usage if it provided them with the opportunity to obtain money for drugs.

All the men had an opinion on the contribution of MSM to the HIV pandemic. It was unanimously echoed that MSM and gay men contribute to the spread of HIV with Michael going so far as to quantify MSM and gay men's contribution to the pandemic as being 100%.

A common mode of transmission that was drawn attention to was that the research participants believed that many MSM led double lives in the form of having female partners (wives and girlfriends). These men often engage in unprotected anal sex with men and may transfer STIs (including HIV) to women with whom they have unprotected heterosexual sex, who, in turn, could transfer illnesses to other male partners. The transmission path is bi-directional however, since, as mentioned in section 4.4.3, MSM also contract STIs and other infections from other men who were originally infected by their female partners.

Abe, Michael and Eugene mentioned cases of HIV-infected men purposely infecting others. Abe knew two other men residing in the same building as him who are of the opinion that everybody is going to die anyway so there is no need to use condoms and so *what if somebody got infected?* Abe was asked whether he used his knowledge and skills as a peer educator for outreach and education with such men. According to Abe, he had tried to educate these men but all his efforts were in vain. Michael spoke about gay men having unprotected sex with bisexual men, who then have unprotected sex with their wives or girlfriends thereby increasing the transmission network. Eugene said that some men will not tell somebody who they have just started dating/courting that they are HIV positive and will engage in unprotected sex. These men are either caught up in the moment or do not feel comfortable enough with the new partner to reveal their HIV status to them so they just engage in unprotected sexual activities with the partner.

At least five men attributed HIV transmission by MSM to other MSM and their female partners and to clubbing, drinking and total loss of control of common sense and logic. Blythe said that *the feeling loses you* and Eddie said *that time your brains you don't remember. Most of the time, these good looking guys, they mess you so badly that you just give in to anything.* After all, in the words of Abe: *we don't worry about tomorrow – just live for the day.* Whilst not conforming to the characteristics of the ideal, hegemonic (dominant and powerful) male, Blythe, Eddie and Abe definitely conform to Jewkes and Morrell's (2010:5) explanations about risky practices that stem from hegemonic masculinity.

A third of the men felt that the high frequency of partner change and lack of stability in monogamous relationships were contributors to the expansion and maintenance of the HIV pandemic. They drew comparisons with heterosexual relationships in which they felt couples stayed together for longer periods of time and were more committed to being monogamous than male homosexual

relationships which were underpinned by partner (and indirectly infection and disease) hopping and swopping, thereby confirming the perception that gays are the main source of HIV transmission.

Eugene's view was different from the other research participants in that he felt that MSM play a key role in spreading HIV simply because in the African culture homosexuality is wrong and unacceptable. More than half of the men concurred that HIV spreads at a rapid rate among MSM but especially among gay people because they had lost many gay friends to HIV.

#### 4.4.3 Have you ever used a condom and why?

Whilst some men reported inconsistent condom usage (see section 4.5.5), only one out of the nine men who were asked about current condom usage reported no condom usage at all. The reasons given for using condoms included contraception and protection against HIV infection, HIV re-infection, STI infection and scratches. Partner unwillingness to engage in protected sex was the main reason given for not using condoms.

Protection against HIV infection, re-infection and transmission coupled with protection against STI acquisition were the main reasons for men using condoms during anal and/or oral sex. Moses, the participant who had a long-term relationship with a female, was the only man to supply contraception as a reason for using condoms. Moses has one child, however, and it is not clear from the timelines discussed whether the family planning/contraception motivation for condom usage came before or after the birth of that child. The participant who had the least exposure to male-to-male sexual practices, Eugene, was the only one who listed having used condoms to prevent getting scratches during insertive anal intercourse. Blythe, the man who said that he does not engage in protected sex with his partner, is the one who said that his partner did not want to use a condom although Blythe is HIV positive. He said that his partner is a Zulu male and Zulus don't like to use condoms. Further, because he takes care of himself

and ensures that he is always healthy; his partner does not believe that he is HIV positive. He described himself as being *fresh* since he is healthy looking and that others do not see *fresh* people as people who are living with the virus.

Although most of the men in this study possessed the necessary knowledge of the need for condom usage and its protective functions, condom usage was inconsistent. Sexual activity between Blythe and his partner is carried out irresponsibly since they engage in unprotected sex even though Blythe is openly HIV positive. Blythe's partner's refusal to use condoms could be attributed to him not thinking that he could get HIV infected or re-infected (his status was not revealed in the interview) or that he was willing to take risks and engage in unprotected sex.

#### 4.4.4 Myths about HIV acquisition

There is a strong overlap between personal risk assessments and sexual practices in terms of the myths or eccentric beliefs that were shared in the interviews. The information obtained here relates to the third objective – *To gain insight into the personal risk assessments of MSM*. Whilst it pertains to sexual practices it does not necessarily reflect the actual sexual practices of the men who participated in this research study and would therefore be inappropriate to discuss under sexual behaviour.

In a significant number of the interviews men highlighted the reasons that men have sex with other men. The most common reason given for men to have sex with other men (and more especially unprotected sex) was that there is a belief among African men that a man cannot get HIV from another man. This means that men who are not attracted to other men will go and have sex with men because they need to relieve their sexual frustrations in unprotected acts which they feel unsafe doing with a female. The men who believe this will even resort to transactional sex. This myth stems from South African beliefs in the early 1900s where it was said that men engaged in sex with other men (even though there

was access to females) because they were afraid of ill health related to the penis. In the times of no penicillin they feared contracting syphilis from females and suffering with the infection as a result of a lack of medical care (Epprecht 2008:60). They further believed that women are loose and with time the penis would fall off (Epprecht 2008:69).

Another misperception that came across was that in a homosexual relationship the man who is on top (anal insertive), and loosely referred to as the giver, cannot get HIV. The only partner at risk for HIV in anal intercourse is the person at the bottom (anal receptive), who is termed the receiver. The terms “giver” and “receiver” play a pivotal role in this misperception since their meanings have been taken literally to imply a giver gives HIV and a receiver gets HIV.

While trying to remain non-judgemental, the most horrifying misperception for me was that HIV is transmitted through ARVs. Neo had indicated that he did not have much knowledge of HIV and all the information he obtained was from his friends. He had said that he knew that there was a relationship between gay men and HIV because many of his gay friends were HIV positive when they died. When asked: *How do you think that those gay men who died of HIV, got HIV?* Neo said *other gays tell us. They give you tablets, drugs for HIV – ARVs something like.* For clarification of this statement I asked Neo to explain what the relationship between the ARVs and HIV was. I received a similar explanation and I asked: *Please clarify what you are saying. Are you saying that they told you, you can get HIV from taking the tablet – the ARVs?* And Neo responded: *Ya. They told us after they are taking drugs ARVs they got HIV.* These responses forced me to go back against one of the things I said at the outset of the interview that there are no right or wrong answers. Neo’s idea about HIV acquisition from ARVs was incorrect and as a person working in the public health sector and more especially within an organisation which is striving to achieve the objectives as set out in the South African National Strategic Plan 2007–2011 and the Millennium Development Goals, I felt compelled to explain a little about the role of ARVs in

an HIV-positive person's life. This information sharing was done at the end of the interview once the voice recorder had been switched off.

## 4.5 SEXUAL BEHAVIOUR

The following sections elaborate on current sexual identity, sexual debut ages, the numbers and gender preferences of partners, condom usage, HIV status and whether the men had ever had STIs. The latter aspect is important since having an STI is a proxy indicator of the condom usage, risk-reduction behaviour and sexual practices of these men's partners.

### 4.5.1 Sexual identities

All the men identified themselves as being gay (not just MSM) currently – some of them are openly gay and others are only openly gay in geographical areas away from their hometowns and families. As mentioned previously, three of these men, Dale, Moses and Themba, have had relationships and sexual interactions with both males and females (two of whom have children). The remainder of the men have only engaged in sexual activities with males. Of the three who indicated that they had had both heterosexual and homosexual relationships, Moses, stated that he was practising bisexuality in the period of “being in the closet” about being gay; Themba had moved from a heterosexual relationship to becoming completely gay and Dale (up until his current relationship) had engaged in gender swapping – depending on his emotional and sexual needs at the time. Despite once having had relationships with females, all the men have currently found comfort in *who* they are and engage strictly in homosexual relationships and sexual interactions.

### 4.5.2 Age at sexual debut

Only ten participants gave information about their age at the first sexual engagement which varied between eight and twenty-two. Two of the men lost their virginity at 18 years of age and two of them lost their virginity when they

were 16 years old. When asking the question *how old were you when you started having sex?* it was discovered that the phrase “having sex” was not always interpreted as it was intended to be (i.e. penetration – vaginal or anal). The men’s answers of very young ages prompted interviewers to clarify their interpretation of the question in each interview. Michael, who gave the answer of being eight years old at the time of his first sexual experience was repeatedly asked what he thought he was being asked and it was explained what the interviewer was actually asking. When the interviewer was satisfied that Michael’s and his interpretations of the question were the same, he no longer probed the question. Michael did mention that he was in Grade 3 when he had his first sexual experience but was not aware at that time of what was taking place. Without being asked he also mentioned that this was in 1985 (when he was indeed eight years old). A mental verification provided a means of getting over the shock and internalising the fact that voluntary (albeit unconsciously) sexual debut can be at such a tender age.

Moses had his sexual debut at 16 years of age with another man of 18 years of age. Themba, who had his first sexual experience at 18 years of age, had his MSM sexual debut when he was 24 years old. Dale who had his heterosexual debut at 21 years of age had his homosexual debut when he was 22 years old. The average age for homosexual sexual onset was 17.7 years with almost two thirds of the sample population having started to engage in sex with other males from the age of 18 years onwards.

Going back to Michael whose sexual onset was when he was eight years old – this was with his male friend (whose age was not shared in the interview) and they were playing a game. He would pull his pants down and the friend would penetrate him. Even though he could not understand what was happening he enjoyed the feeling. They pursued this interaction for the remainder of that calendar year until his friend’s family moved away from the area. Based on the

pleasure he had experienced with this friend, all Michael's sexual experiences to date have only been with men.

Eddie who started having sex at 12 years old has an interesting background and sexual history – parts of which will be elaborated at different points in this section. He was in a boarding school in Zimbabwe for his entire school career. Both Eddie's parents were South African and did not have much of a family life as he never came home during his school holidays but rather stayed with his brother in their flat in Zimbabwe. His first sexual experience was with an 18-year-old boy who was a boarder at the same school. Because that boy was in Grade 12 he had his own room and this would provide the setting for all sexual interactions between these boys. The first anal receptive incident that Eddie encountered left him sick and bleeding for a while. Eddie's mother had a private doctor who treated him. It is at this point in the interview that Eddie indicates that his mother was white which according to him, meant that she understood about being gay. His father, who was black, did not know and was never told about the incident because, according to Eddie, he would never understand or accept what had happened. After Eddie's first sexual experience, he went on to have many relationships and one night stands with boys and men for his entire school career (this will be elaborated on in section 4.6.2).

#### 4.5.3 Sexual activity and frequency

In response to the questions about the main sexual activities the men were involved in, oral sex, a combination of insertive and receptive anal sex, insertive anal sex and a combination of receptive anal sex and oral sex (in ascending order) were listed. The most common sexual activity among this sample of men was receptive anal sex with the receptive anal sex–oral sex combination forming the core activities of seven of the men. This high percentage can be attributed to many factors that became evident in the interviews. Two out of the seven men (Eddie and Vuyo) were involved in transactional sex and their clients were all interested in being dominant in the sexual interactions. In terms of service

provision in this world it is always said that the customer is correct and should ideally receive the service that they request. Another three of the seven men identified themselves as female. If the sex is aligned to vaginal intercourse then the lady is always the recipient and in these cases it would make sense for the men to become the receptive partner during anal intercourse. It was further found that oral sex featured so highly for two reasons: firstly, it served as foreplay and set the mood for what was to progress and, secondly, it was used as an alternative to anal sex, especially in relationships where there was high sexual activity frequencies. Three men indicated that it would be too tiring to have anal intercourse more than three times a week so sometimes they alternated between anal intercourse and oral sex. Also in the event of rectal STIs, anal bleeding and bruising, oral sex formed the substitute.

Frequency of sexual activity was only obtained from nine of the men. It seems that it is the norm for men to engage in sexual activities three to four times a week. Vuyo reported having sex five times a week. He is a commercial sex worker who operates on weekends only and on average sees two clients a night. This substantiates his reported weekly frequency of five times. Eddie, who had sex four times a week, is currently involved in two relationships. The remainder of the men (two men who reported having sex four times a week together with all three men who reported having sex three times a week) have one steady partner. Risk-reduction behaviour seems to be most apparent in the group of the three men who reported having had sex three times a week, as two know their current HIV status is negative and the third had accessed VCT a few years ago where he tested negative. His current HIV status is unknown. Two of the three had never had STIs. They were all in committed relationships and use condoms consistently (i.e. condom usage at every penetrative sexual instance). They reported not engaging in any intimate contact with other males aside from their partners and even though they have differing opinions and practices of condom usage during oral sex, they all disapprove of penetrative sexual intercourse without a condom.

#### 4.5.4 Number of partners

Partners referred to in the interviews and in this section include both males and females. These are people with whom the participants engaged in some form of sexual activity (i.e. vaginal, anal intercourse or oral sex). A person was not considered a partner if the only exchanges between them were just holding hands and some kissing.

All of the men gave an indication of how many partners they had ever had whilst only ten of the men said how many partners they currently have. The outlier by a significant amount of partners is Themba who reported having been with in excess of five hundred men. Initially, when he was asked how many partners he had, he responded that he could not answer as he did not know. On probing and approaching the question at a later point in the interview, Themba said that he had been with so many men because once he became openly gay and had ended his relationship with his wife, he started going out to bars and clubs and involving himself in numerous one-night stands. Initially he did not know that many were going to be one-night stands as he had hoped to have relationships with some of the people who he had sexual intercourse with, only to experience feelings of rejection when he saw those men with other men shortly afterwards. Experiencing this repeatedly taught him about how the dating and nightlife of a gay person or MSM worked in his residential area and he moved on to do the same. He then went on to mention reading an interview in an international magazine where the gay interviewee reported having slept with over six hundred men. This made it justifiable for him to report his number of partners as more than five hundred. In his mind it is not impossible to have slept with so many men. Based on other information he gave in the interview it appeared that he had slept with many men but more than five hundred seemed to be an exaggeration. Themba's introduction to and initial experiences of the *gay lifestyle* were similar to those of one of the men (Alan) that Connell (1995:152) describes when he talks about identities and relationships associated with being gay. Alan, like Themba, went through phases of development and exploration of hetero- and

homosexual relationships before he accepted and let people know that he was gay. Alan's first sexual experiences were not pleasurable for him for two reasons. One, he was inexperienced at anal sex and, two, he was looking for affection and love (like Themba) where his male sexual partners were looking for sex. However Themba and Alan reacted differently when each of them realised what had been happening. Themba chose to do to others what was done to him (i.e. have sex without love) and Alan chose to be more discrete with his flirting and homosexual engagements (Connell 1995:152).

Both the men who were linked to commercial sex work reported having been with more than 20 partners each. A little less than half of this sample has had more than ten partners in the history of their sexual activity. From an HIV prevention perspective, a positive thing to note is that currently more than two thirds of the sample only has one partner. Dale acknowledged the ethics and morals that accompany a monogamous relationship and felt that infidelity did indeed have negative effects on a relationship. Three participants (Abe, Blythe and Eddie) reported currently being in multiple concurrent relationships with Eddie having two partners and the other two being in partnerships with three men each. Blythe's one partner also has three other partners (all of whom are females). It was not clear whether his other two partners were involved in multiple concurrent partnerships. Michael and Neo are also both involved with men who have female partners. Michael's partner is married (as a cover up of his sexual preference for males) and Neo's partner has a girlfriend. Johnson did not give his current number of partners.

#### 4.5.5 Condom usage, HIV status and experience with STIs

Consistent condom usage for the purposes this study was taken to mean using condoms at every sexual intercourse session (vaginal or anal). It did not include oral sex even though there were participants who reported using condoms during oral sex. Current is a reference to the last calendar year.

There is not much difference between consistent and inconsistent condom usage in these eleven men, however, six of the eleven men reported inconsistent condom usage. Two of these six men are HIV positive. As mentioned in the beginning sections of this chapter, three of the men did not know their current HIV status. Of the men who did not know their current HIV status, Dale did access VCT seven years prior where he tested HIV negative. Dale, through consistent condom usage, is one of the men who reported never having an STI. Johnson was the other man who reported never having an STI; however, he started engaging in male to male sex a year ago and has also reported using condoms consistently. Eugene balances his sexual activity between anal intercourse and oral sex. From information on condom usage and STI acquisition it can be concluded that consistent condom usage has assisted in decreasing the number of new STI cases.

Interesting to note was that four of the research group thought piles was an STI. The other common STI identified was drip (gonorrhoea). STI acquisition was primarily from partners who had other partners. Up until the point of STI acquisition many men were oblivious to the fact that their partners were involved in multiple partnerships because they (certain men in the research group) were being faithful in the relationship and assumed the same of their partners. From this it can be seen that multiple concurrent partnerships does have a relationship with STI transmission.

#### 4.6 VICES AND COPING STRATEGIES OF MSM

In the section on data collection in *Chapter 3*, the six research areas that the study set out to investigate were listed. Immersed in the information gathered related to these six areas were pieces of information that could eventually be grouped into themes of alcohol, prostitution, religion, violence and stigma. The sections below provide descriptions of all this additional information that was obtained.

#### 4.6.1 Alcohol and unprotected sex

According to Woolf and Maisto (2009:758) MSM choose to meet potential sex partners in places where drinking occurs thereby allowing alcohol to be highly associated with sexual activity in MSM. The majority of the research participants in this study listed clubs and bars as the prime hotspots for picking up men although parties were also mentioned. Alcohol is common to all these settings. Taking the literature on alcohol, unprotected sex and HIV risk into account, it is expected that these MSM in the Johannesburg inner city are also at high risk for HIV infection or re-infection. The two men who had a fair amount of knowledge, Abe as a peer educator and Blythe as a trained nurse and counsellor, seemed to have the least amount of risk reduction behaviour and attributed their nonchalant lifestyle and attitude to HIV re-infection and transmission to alcohol. When Abe was asked to confirm whether he was saying that he had multiple partners, he said *because many are one night stands, you see*.

This prompted the interviewer to ask a question on the circumstances surrounding Abe having so many temporary partners. Abe's response was *drinking and clubbing. So we don't worry about tomorrow just live for the day. We enjoy our life like that. One partner – no*.

As mentioned in *Chapter 3*, interviews were conducted by the male interviewer alone, by myself alone or by both of us together. Blythe's interview one of those interviews which was facilitated by both the male interviewer and myself. Below is an excerpt of the exchange of information amongst the three of us.

Me: *...I think that you have a phenomenal amount of knowledge and would be a good counsellor – very educated. But having all that knowledge and you said that you engage in a lot of unprotected sexual activity dependant on the mood, what are your thoughts around re-infection for you?*

Blythe: *All those things I know about re-infection for myself but if I am drunk there is nothing that I can do. There are people here who can promise you the heaven and if you are with that guy you can't say to him no or what.*

Later on in the conversation

Interviewer: *You said it only happens mostly when you are drunk. So would you say that it is because of the enjoyment of sex or is it because you have been drinking alcohol and that is why you find yourself in that situation?*

Blythe: *Especially if I am drunk I lose my network (referring to common sense). Everything that the person will say I will agree.*

Interviewer: *What happens when you are sober minded?*

Blythe: *People don't touch me. I say no – even if they force me. Even if you can make me a cup of tea or prepare lunch for me I will say no.*

Blythe's narration brings two other things to mind. Firstly that knowledge (and not just awareness) and training does not translate into a reduction of risky sexual behaviour and that sobriety for Blythe would lead to a decrease in his risk of getting re-infected and more importantly could prevent him infecting many men. In their men's study Lane *et al* (2008:S81) found that in the group of MSM who drank regularly till the point of intoxication 56% of the men experienced sexual coercion. Blythe did not share information about sexual coercion but when he says, *if I am drunk I lose my network. Everything that the person will say I will agree*, it is indicative that there could have been instances when he would have experienced sexual coercion.

Johnson and Vuyo indicated that they both consume alcohol. Both these men emphasized their responsibility and levels of consciousness when they engage in sex after alcohol. Vuyo said that he used the bar to get picked up by men. He would only have one drink – which he kept in his hand up until that point he got picked up. That drink would serve to make him seem like any other person in the bar who was there for a drink. Johnson said that whilst he would drink he would

never get to the level of intoxication where he would not be in control of his thoughts, decisions or actions. Hygiene and safety come first in sex and he would always make sure that he was sober enough to ensure that a condom was being used in both oral and anal sexual activities. Johnson and Vuyo show us that consciously avoiding excessive alcohol use facilitates responsible sexual behaviour.

#### 4.6.2 Prostitution

Early traces of transactional sex or male prostitution in South Africa was found in military camps that developed in the warring periods of 1900 to 1902 where male natives of Ladysmith in KwaZulu-Natal allowed soldiers to engage in insertive anal intercourse with them for a monetary fee (Epprecht 2008:55–56). Even though the employment sector is more established now than it was 100 years ago, lack of income now still drives men to source income in similar ways as it was done then. Vuyo indicated that he was a commercial sex worker. His family was overcome with poverty and in an attempt to overcome the helplessness of being a male who was unable to provide for the family, he decided on becoming a sex worker. This started while he was still at school. His family were unaware of what he was doing as they thought he was out studying. When his mother enquired about the source of the money that he was suddenly able to provide, he always answered that it came from his school teachers who liked him very much and who were aware of his family's living situation. Given the fact that his mother was elated at being able to put a meal on the table at the end of each day and that they could have electricity and water, she never did an in-depth exploration of the truth in her son's explanation.

In his explanation of his experience as a commercial sex worker, Vuyo recalled his encounters of how he deceived his male clients into believing that they were having sexual intercourse with a female. Given that his clientele were truck drivers (non-local people that could not recognise him during the day as he was not open about the sex work) the sexual activities would take place in the truck.

When he ascertained that the client was not MSM and thought that he (Vuyo) was a female, he would ask his client to switch the lights off. Since he knew what a man wanted he would start setting the scene with oral sex. It would then move on to receptive anal sex for him but his client would be of the opinion that they were engaging in vaginal sex from the back. It is difficult to understand how these truck drivers could not tell that they were not having vaginal intercourse. Vuyo had not indicated whether the clients were inebriated in any way which may help to explain his claims otherwise it may reflect that the judgement of the people can become clouded in the moment of sexual pleasure.

Another person who was indirectly involved in prostitution from an early age is Eddie. His background was elaborated on when discussing sexual debut (see section 4.5.2). As indicated earlier Eddie was a border at a boy's school in Zimbabwe. He spent his entire schooling life in Zimbabwe and with little time spent with family, he was left with a fair amount of free time. Towards the latter part of his schooling, he decided to move a level up in his sexual exploration. From his family flat he would observe men that would come and conduct their business meetings at the nearby cafes and restaurants. He would then make attempts to pick these men up or draw enough attention to himself to facilitate these men picking him up. Since these men were wealthy and some quite influential (members of parliament or the local government), he was guaranteed to be taken to nice hotels and eating houses. These men further provided him with money and gifts – which gave him the impetus to carry on in this manner. When he left school he took this transactional sex to more of a formalised escorting service in which he would advertise on particular websites and in certain newspapers. Foreign men would book his services for the duration of their stay in Zimbabwe. He would quote them a rate, do all the accommodation and entertainment bookings according to his client's specification, spend the time with them as their companion and sexual partner and get paid at the end of their visits. This proved to be a lucrative business for him as he had many repeat clients. His family was completely unaware of what he was doing and was of the

impression that he was working for a company that dealt in gold. He would explain his periods of absence as business trips away from home.

On his coming to South Africa, Eddie met his boyfriend who is five years his junior and had just been released from prison at that time. This boyfriend sources his income from criminal activities and abuses Eddie because of jealousy. After the bouts of physical abuse Eddie was showered with gifts. It seems as if Eddie is content with the abuse since he is aware that the handbag or shoes he mentioned fancying in the weeks prior would accompany the slap or punch that he would receive. The boyfriend has been in jail since December 2009 and was due for release in February 2010. Eddie had been engaging in sexual activities with his neighbour for the period that his boyfriend was in jail and stood the chance of being blackmailed by this neighbour when the boyfriend returned from jail. A jealous, criminal boyfriend and a manipulative, blackmailing *mistress* do not spell a smooth ride for Eddie.

From the above experiences it is evident that poverty, idleness and the means to either afford or acquire nice things were some of the motivators for Vuyo and Eddie to do sex work. Further, it seems that Eddie is comfortable with being in multiple concurrent relationships and comes across as someone who requires a partner or needs to be in a relationship all the time.

#### 4.6.3 Religion

Issues concerning being gay, religion and Christianity manifested itself in many interviews. These issues came up at different points in the interviews and were not prompted by the interviewer asking direct questions about religion. This section discusses viewpoints related to Christianity as interpreted and shared by the research participants and is not meant to condemn or offend others who have differing interpretations and practices of Christianity.

Many participants had indicated that certain health care workers had subjected them to sermons on Christianity and even stated that their rectal STIs and their preference for having sex with other males was a direct affiliation to Satanism. Blythe was asked whether he was aware of *Sodom and Gomorra* and whether he knew that *God was going to punish* him. Blythe was further told that he would *go into the fire* when the Lord came. In the Bible Sodom and Gomorra were the two cities that were destroyed because of their sinful ways. The health care worker implied to Blythe that his sodomy is a sin and that he would be destroyed because of this sin – as in the case of the men from Sodom and Gomorra. In keeping with the discussion on punishment from God, one of the men in Lane *et al's* (2008a:431) study on MSM use of health services and experiences of stigma and discrimination narrated his observation of a HCW towards two gay men who presented with STIs. The HCW told them that getting STIs was punishment from God for sleeping around.

The specific faith beliefs of family members was one of the reasons that men cited for not being open about their sexual preferences with their friends and family. Eugene felt that his parents would never come to terms with his choice of sexuality as it was completely against his family's religious beliefs to engage in homosexual relationships. He also stated fear of rejection since his beliefs and the beliefs of the church he belonged to differed. The congregation he belonged to viewed homosexuality *as evil and people don't have to do it*. These homosexuals will have to repent and leave homosexuality or face being ousted from the church. Dale never revealed his sexuality to his closest friend because of the friend's strong association with the church and the friend's viewpoints on being homosexual.

Themba, who married and had a family with a female, stated that he went through that phase of marriage in his life purely because he was a devout Christian. He always knew that he was gay but chose to deny this because of his affiliation to the church and the church's standpoint around homosexuality. On his

relocation to Gauteng Themba was lucky that he managed to find a church that focused on gay people and he was happy that he could practice his faith again and ceremonially worship God in the way that he always had. He went further to say that he had never consulted traditional healers as he was a Christian and traditional healing was neither a religion nor a part of Christianity.

Michael goes to a church that does not cater specifically for homosexuals and he has never revealed to the congregation that he is gay. He believes this has worked out well for him although he does mention that he should start going back to the *gay* church in Eastern Johannesburg. This was a church he used to go to until he relocated from the area. This gay church functions like any other church in that people go there with their families and the rituals are performed according to the denomination (not given in the interview) followed by the church. The difference is that gay men and women are made to feel welcome in this church to the point that they can cross dress without the risk of being condemned or ousted from the church. Michael was taken a little aback by a follow up question which focussed on whether he had used this Church as a hotspot. Michael hesitated a bit when answering and it seemed like he attempted to provide an answer that would lead to him not being judged for using a place of worship as a site to pick up guys. Michael did eventually say that it would not be a direct pick up place. If he fancied somebody and knew somebody who knew the person that he fancied, he (Michael) would approach that person to make the introductions. He made it clear that this would happen after the set church meeting.

From the experiences shared by the men it is evident that the religious beliefs of family members and certain churches' views about homosexuality have stopped some of the men from disclosing their sexuality. These men feared rejection and expressed issues of coping with the conflict between their sexual preferences and their religious views.

#### 4.6.4 Violence, discrimination and stigma

Eddie spoke about the violence that cross dressers or transvestites faced. He mentioned that strong gangster types of men liked to engage in random sex. Cross dressers tend to wear makeup, full feminine attire including the wigs and place things in their chest area to resemble breasts. If these cross dressers are picked up by the gangster type of men, they run the risk of facing danger if the gangster men think that they are picking up a female. Eddie substantiated the information shared about violence towards cross dressers or drag queens by giving examples of his friends' situations. One of his friends that was in such a situation was paralyzed because he was thrown from the eighth floor of a hotel. Another of Eddie's friends was shot in the forehead and killed a week prior to his research interview being conducted. As mentioned in *Chapter 2*, hegemonic masculinity is fluid and contains multiple masculinities (hierarchy) thereby making the power and dominance components of hegemonic masculinity also applicable to relationships between males (termed by Demetriou 2001:341 as intra or internal hegemony). The gangster, macho men and the cross dressing men discussed here are portrayals of different masculinities. The gangsters represent the dominant, hegemonic masculinity while the cross dressers are a subordinate masculinity. Morrell (1998:608) pointed out that hegemonic masculinity silences other masculinities that have differing values to it. The violence committed against the cross dressers is done to promote the power and dominance aspects of hegemonic masculinity as constructed by the gangsters.

Discrimination in the health care setting came in a few forms. One example mentioned was Abe being left to sit in the waiting area of clinic, for a very long time, as soon as the receptionist or counsellor had established the reason for this MSM's visit to the clinic. He was not provided with assistance and told to come back another day because of the clinic closing or not being able to assist him.

Blythe spoke about nurses announcing their illnesses to other health care workers and asking them to come and see what *this man has because he is*

*sleeping with other men.* The entire clinic staff was then aware of the male's condition and his confidentiality was completely breached. Comments were also passed by the receptionist when he exited from the clinic. A third type of negative behaviour that was faced by some of the men (and mentioned previously) was the health care workers indoctrination of Christianity into the males (especially those who presented with rectal STIs) and the sermon about their Satanic behaviour. In all the consultation time – the men did not receive the health care that they sought at the outset. In keeping with the topic of religion, ousting from community churches was another example of discrimination.

Men gave examples of comments that were passed by community members about MSM who accessed health care. Communities tend to be familiar with the health care services being offered by health care facilities in their area. The PHC facility spoken about in various sections in this chapter is such an example. Generally if people go into that clinic, outsiders can narrow the person's health care needs to VCT, HIV wellness or ARV collection, and STI or TB treatment. All of these services are linked to HIV. People who then access the facilities are stigmatized or labelled. Blythe recalled men who were standing outside the facility making a comment about a man who was going into the clinic. The comment that was made about this man was, *you see - AIDS is boss.* In that particular case the man was HIV positive, however this is of course not the case with every MSM or every person in general who visits the health care facility.

#### 4.5 CONCLUSION

When conducting the interviews and analysing the transcripts, a large amount of varied information came to the fore. This could be attributed to the fact that all the men appeared honest and open to the questions that were posed to them.

In trying to streamline and organise the information into units that were comparable and contrastable the three major themes of *access to health care*,

*personal and general MSM HIV risk perceptions and sexual behaviour* were identified.

Access to health care was subdivided into a discussion on general access to health care and was supplemented with examples of positive and negative health care experiences of the MSM. All men had been exposed to the health care system with two men having never accessed public health care. Some men had positive health care experiences and some had extremely negative health care experiences, highlighting the strengths, weaknesses and gaps with health care service provision – especially in one PHC facility and a community health centre located in the Johannesburg inner city.

Personal risk assessment and opinions around MSM contribution to the pandemic, reasons for condom usage and myths about HIV and its acquisition formed the subthemes of the discussion around personal and general MSM HIV risk perceptions. There was a vast difference in the knowledge levels and risk perceptions of the males in this study but most could identify the main modes of HIV transmission and reasons for use and functions of condoms. There was no significant difference between the group of men who used condoms consistently and the group who used condoms inconsistently. The majority of the men had used the free government condoms and were happy with them, having never experienced any malfunction.

Sexual behaviour yielded the largest amount of data and this theme was divided into five discussion areas. These discussion areas were sexual identities, sexual debut ages, sexual activity and frequency, number of partners, condom usage, HIV status and experience with STIs.

The men in the sample have varied demographic information and backgrounds which provided insight into their choice of being an MSM. Although some men were either bisexual or heterosexual at some point, all presently identified

themselves not as MSM but rather as strictly gay men. The average age for the onset of sexual activity was sixteen years of age with the youngest person being eight years old and the eldest being 22 years old. When looking at the ages for the onset of MSM sexual activity, again the youngest age given was eight years (Michael) and the oldest was twenty-four years with an average age onset of MSM sexual activity being eighteen years.

With the exception of Neo, all the men had been sexually involved with more than three men in the span of their sexually active lives. Most men seemed to have been with between ten and twenty partners up till the point of their interviews. Whilst their current partners are males, the number of partners that they had ever been with included females. The combination of receptive anal sex and oral sex was the most common type of sexual activity that this group of men involves themselves in with majority of them reporting having sex three to four times a week. Condom use varied and in the last year there was no difference between the number of males that practised inconsistent condom usage and consistent condom usage. This is fairly alarming as a little under half of the sample are HIV positive and had sex on average three times weekly. Only two of the men had no experience with STIs.

An additional four themes of alcohol and unprotected sex, prostitution, religion and stigma, violence and discrimination also emerged.

Two HIV positive men portrayed themselves as *not in control* when they are under the influence of alcohol and showed little remorse for their actions (if they remembered what had happened when they were intoxicated) when they were inebriated. The two men have been trained in HIV education as part of their jobs. Another two men never abused alcohol when they drank and were completely in control of their senses and thoughts when they engaged in sexual activity.

Two of the research interviewees had/have involvement in male sex work and relayed their reasons for turning to sex work. Poverty, idleness and the sudden

means to afford nice things were some of the motivations for the sustenance of this sex work.

Christianity and religion surfaced in many interviews. Some men did not access health care because of the discrimination they faced due to them engaging in *non-Christian* activities. Christianity, family faith and certain churches prevented some men from disclosing or embracing their sexuality as they feared rejection or had coping issues with the conflict between their religious views and sexual desires. Some men did seek solace in finding churches that catered for their needs and allowed them to exercise their sexual preferences while practicing their religion.

Lastly, violence came in the form of a man describing him losing his cross dressing friends because they were mistaken for being females, discrimination in the form of negative health care experiences and stigma in the form of how people who access certain health care facilities are labelled by others who are outside watching them entering and leaving the health care facilities.

All men provided recommendations for the development of an MSM friendly clinic which will be discussed in the final chapter.

## CHAPTER 5: CONCLUSION

### 5.1 INTRODUCTION

By gathering information from a volunteer sample of MSM in the Johannesburg inner city, the study aimed to discover those decisions and behaviour that played a role in their health decision making and health seeking behaviour particularly as far as HIV and their sexual health was concerned. There were four objectives identified which facilitated achieving the aim. These objectives included 1) *To describe the biographical features of the volunteer sample of MSM such as their age, socioeconomic status, educational level, racial, cultural, ethnic, sexual and religious identities, place of residence, migration status and marital status; social and support networks; issues related to living openly as MSM;* 2) *To determine the factors that hinder MSM's health-seeking behaviour and propensities to access (or to avoid) voluntary counselling and testing (VCT) for HIV;* 3) *To gain insight into the personal risk assessments of MSM;* and 4) *To gain insight into the sexual practices of MSM in the Johannesburg inner city.* In this chapter these objectives will be related to the results of the study after which the conclusions and the recommendations from the study will be given.

In describing the layout in *Chapter 1* it was stated that this study would focus on masculinity research and provide a review of literature as it relates to MSM and their sexual behaviour which was presented in Chapter 2. Following this the specific methodology in conducting the health and HIV risk assessment of MSM in the Johannesburg inner city study was described (in Chapter 3) and thereafter an in depth discussion on the results of the study (in Chapter 4). In this final chapter an overview of the study is provided to form a composite picture of the qualitative study on MSM that was undertaken.

## 5.2 MASCULINITY RESEARCH AND MSM LITERATURE REVIEW

Gibbs (2005:287) demonstrated that there is an array of possible masculinities that a male can identify with. This identification is shaped by social constructs and the definition of what an acceptable masculine position is at that point in time. The constructionist perspective informs us that men act in the way that they do because of the concepts about masculinity which they take on from their culture (Courtenay 2000:1387).

Hegemonic masculinity, developed by Connell (1995), provided the foundation for masculinity theories, masculinity studies and a basis for interpreting results of masculinity research. Hegemonic masculinity involves the male dominance over the females as a means of reproducing patriarchy and other males who are perceived to be deviating from the normative, hegemonic behaviour deemed as acceptable at that time.

The research studies discussed above focussed on men's accounts of masculinity and its influence on health seeking behaviour and health risk behaviour and exploring the experiences of masculinities among HIV positive heterosexual African males (Mahalik *et al* 2007:2201–2207; Doyal *et al* 2009:1901–1907). Many of these studies found that hegemonic masculinity influences health behaviour with respect to health promotion and health risk.

In trying to align the information from the health and HIV risk assessment of MSM in the Johannesburg inner city study to the masculinity theories discussed, it can be argued that this study is a demonstration of how particular types of masculinity are undermined by certain health professionals that are in a position of power towards the patients when they access health care. Further it is highlighted that the men in this study defy current interpretations of social embodiment and actually seek health care and promote health care within their informal social networks.

Presently male homosexual intercourse is known to take place all over the world. Unprotected anal sex accounts for approximately 5 to 10% of HIV infections globally (United Nations, UNAIDS, 2006a; United Nations, UNAIDS, 2006b).

In many countries being openly gay is forbidden – 37 of 54 African countries have criminalised consensual gay or male to male sex with this male to male sex having death penalty implications in at least four of the countries (McIntyre 2010: 82; Smith *et al* 2009:419). South Africa is the only African country to prohibit discrimination on the basis of sexual orientation (Lane *et al* 2008:430). South African MSM studies revealed that the HIV pandemic is spreading rapidly (measured by incidence) amongst young, gay-identified MSM and that there is low VCT uptake amongst this group (Dladla *et al* 2008; Lane *et al* 2009, Rispel *et al* 2009). Further studies also revealed high HIV prevalence rates (Lane *et al* 2008b), low disclosure rates (Cloete *et al* 2008) and limited general knowledge of HIV and poor motivation to practice safe sex (Reddy *et al* 2009). This research has forced the South African government to recognise MSM activities as a driver of the HIV/AIDS pandemic and that their (MSM) sexual health needs can no longer be overlooked. The United States of America, Europe, Vietnam, Cambodia, India and China have also started addressing the relationships of MSM to HIV (United Nations 2006c:26; United States, CDC 2007:5).

Researchers (Lane *et al* 2008: 430, Sandfort *et al* 2008: 425) agree that there is limited research on MSM and that more should be done. For them (researchers) the HIV vulnerable populations are generally harder to reach (Geibel *et al* 2007:1349) thereby making general information gathering and research difficult tasks to execute. Smart (2009:2) also adds that it is complicated to study the MSM populations due to intolerance; discrimination and criminalisation. MSM are excluded from national HIV surveillance efforts and that in some instances governments (e.g. Togo) do not encourage independent research on this topic.

### 5.3 STUDY DESIGN

The health and HIV risk assessment of MSM in the Johannesburg inner city study was conducted in order to obtain information on MSM in this geographical area. It was anticipated that this information would not only provide a description of the MSM population in the area but would also assist in giving information that could be used to make programmatic improvements in some of the health care facilities in the Johannesburg inner city.

Once the study proposal was written, the procedures related to gaining permission and ethical approvals were followed.

### 5.4 MAJOR FINDINGS

All data that was obtained in the interviews were coded; classified into themes and critically analysed. Major points of the analysis are described in this section.

The major themes that were discussed are access to health care, personal and general MSM HIV risk perceptions and sexual behaviour. In order to make the large amount of data that was collected more meaningful and to ensure that as much of the information could be included in the results each of these major themes were broken up into subthemes.

*Access to health care* was subdivided into a discussion on general access to health care and was supplemented with examples of positive and negative health care experiences of the MSM. All men had been exposed to the health care system with two men having never accessed public health care. Some men had positive health care experiences and some had extremely negative health care experiences, highlighting the strengths, weaknesses and gaps with health care service provision – especially in one PHC facility and a community health centre located in the Johannesburg inner city.

Personal risk assessment and opinions around MSM contribution to the pandemic, reasons for condom usage and myths about HIV and its contraction were the subthemes discussed under *personal and general MSM HIV risk perceptions*. The men in this study had varied knowledge levels and risk perceptions. Most men could identify the main modes of HIV transmission and reasons for use and functions of condoms. There was no significant difference between the group of men who used condoms consistently and the group who used condoms inconsistently. The majority of the men had used the free government condoms and expressed satisfaction with the quality of the condom.

The largest amount of information was obtained on reported *sexual behaviour*. This theme was divided into five discussion areas. These discussion areas were sexual identities, sexual debut ages, sexual activity and frequency, number of partners, and condom usage, HIV status and experience with sexually transmitted infections.

The men in the sample have varied demographic information and backgrounds which provided insight into their choice of being an MSM. Although some men were either bisexual or heterosexual at some point, at the time of the interviews all men identified themselves as strictly gay men (and not just MSM). The average age for the onset of sexual activity was sixteen years of age with the youngest person being eight years old and the eldest being 22 years old. When looking at the ages for the onset of MSM sexual activity, again the youngest age given was eight years and the oldest was twenty-four years with an average age onset of MSM sexual activity being eighteen years.

With the exception of one, all the men had been sexually involved with more than three men in the span of their sexually active lives. Most men seemed to have been with between ten and twenty partners up till the point of their interviews. Whilst their current partners are males, the number of partners that they had ever been with included females. The combination of receptive anal sex and oral sex

was the most common type of sexual activity reported. The majority of the men said that they had sex three to four times a week. Condom use varied and in the last year there was no difference between the number of males that practised inconsistent condom usage and consistent condom usage. This has negative implications since a little under half of the men in the study are HIV positive and had sex on average three times weekly. Two of the eleven men reported that they had never contracted sexually transmitted infections.

Four themes, namely alcohol and unprotected sex, prostitution, religion and stigma, violence and discrimination, were identified from the additional information which was not directly related to the study objectives.

Two HIV positive men said they lost control when they are under the influence of alcohol and showed little remorse for their actions (if they remembered what had happened when they were intoxicated) when they were inebriated. These two men have been trained in HIV education as part of their jobs. Another two men said that they never over indulge in alcohol and were completely in control of their thoughts and actions when they engaged in sexual activity.

Two of the research interviewees had/have involvement in male sex work and relayed their reasons for turning to sex work. Poverty, idleness and the sudden means to afford nice things were some of the motivations for them to do sex work.

Christianity and religion were spoken about in many interviews. Some men did not access health care because of the discrimination they faced due to them engaging in *non-Christian* activities. Christianity, the religious beliefs of family members and certain churches stopped some men from disclosing or embracing their sexuality. These men either feared rejection or had coping issues with the conflict between their religious views and sexual desires. Some men attended

churches that catered to MSM and gays. These churches allowed them to exercise their sexual preferences while practicing their religion.

Lastly, one of the men described how he lost his cross dressing friends through violence because some gangster type of men mistook them for being females. Discussions on discrimination came in the form of negative health care experiences and stigma in the form of how people who access certain health care facilities are labelled by others who are outside watching them entering and leaving the health care facilities.

It has been repeatedly mentioned that a large amount of data was collected in this study. From the summary of the major findings detailed above, it is evident that this large amount of data not only facilitated getting information with respect to the objectives of the study but it also provided additional information on the experiences and practices of the MSM in the Johannesburg inner city. I therefore feel that the objectives of the study were met and the research question was answered. Given that this study was the first qualitative study researching MSM in the Johannesburg inner city, I further feel that the study provides interesting and more importantly useful baseline information for further qualitative MSM studies in the geographical area and for the development of interventions aimed at MSM.

## 5.5 LIMITATIONS

The first limitation of this qualitative study was that it had limited funding, little human resources and a tight study timeline. These limitations meant the study could only be completed if the sample size was small. This small sample size led to the second limitation where MSM in the Johannesburg inner city were underrepresented, making it difficult to generalise the findings to the entire MSM population in this area.

The study participants were recruited using purposive sampling techniques. Purposive sampling introduced the third limitation of possible selection bias. It was not intended to use snowball sampling however, men who participated in the interviews recruited their colleagues into the study without being asked to do so. This again could represent a bias in the data towards certain behaviour and opinions since the men and the friends they recruited into the study were most likely to have similar characteristics.

## 5.6 RECOMMENDATIONS

The interviewed men were asked if they had recommendations for the health care system. At the end of *Chapter 4* it was mentioned that these recommendations would be discussed in *Chapter 5*. In this section programmatic (as given by the MSM) and research recommendations will be discussed.

### 5.6.1 Programmatic and policy recommendations

There were two recommendations that were given by the majority of the men. One was the (re)training of health care workers on etiquette and how to deal with male homosexual clients presenting with rectal sexually transmitted infections. The other was the need to introduce information education communication (IEC) material that is strictly directed towards MSM. All the current written IEC material as well as the waiting room health talks were only targeting heterosexual sexual practices making it difficult for the MSM who is sitting in the waiting room or who is taking the educational material from the clinic to identify with the information. In particular MSM would like to see more information about STIs especially rectal STIs.

Some of the other recommendations made by the men included having more gay staff at the clinics and having MSM friendly clinics with male staff and regular support groups (so that MSM have people that they can consult without being judged). The last recommendation is not restricted to MSM only but pertains to all

people accessing health care at PHC facilities in the Johannesburg inner city. Most of the clinic flows are designed in such a way that pricking for HIV tests and blood draws for CD4 counts are done in particular rooms only. Men felt that having these clearly identifiable rooms introduced an element of stigma and to an extent breach of confidentiality for the person who walked into those rooms, because all the people in the waiting room can see who is going into those rooms and can deduce that a person who enters the CD4 count room is HIV positive. The recommendation was that pricking for HIV and blood draws for CD4 counts be done in all the consultation rooms so that people in the waiting room cannot recognise what services other people in the clinic were accessing.

It has been emphasized in some research publications (Rispel & Metcalf, 2009a: 139) that it is imperative to include MSM when planning health prevention programmes. The most logical way to design and implement an effective prevention programme or health care policy related to MSM is to include MSM in the designing, development and roll out phases. Jones, Gray, Whiteside, Wang, Bost, Dunbar, Foust and Johnson (2008:1043–1049) illustrated this in their Popular Opinion Leader intervention carried out in North Carolina, between December 2004 and December 2005. Evaluation of this intervention (adapted for black MSM) showed significant decreases in unprotected receptive and/or insertive anal intercourse. This was validated by the increases in reported condom usage. Jones *et al* (2008:1047) firmly believe that their study findings are indicative of the fact that interventions (or adaptations of existing interventions) developed for MSM can increase risk reduction among black MSM.

For the countries where homosexuality is criminalised, the first steps to addressing the hidden HIV epidemic in MSM would be to legalise homosexuality, educate health care workers about homosexuality and how to treat homosexuals and then make health care services open to all. MSM in South Africa are exposed to a better political and legal environment than MSM in most of the other African countries where MSM engaging in consensual anal intercourse could face

punishment as severe as the death penalty. For South Africa the recommendation would be to invest more in and place stronger emphasis on programmes that generate information about the MSM population in the country as a means of effectively responding to HIV among them.

#### 5.6.2 Research recommendations

Although the sample was small, the men shared a lot of their experiences, opinions and thoughts. The information gained was useful in providing a description of the MSM lifestyles in the Johannesburg inner city. Given the men's lack of HIV knowledge and the low risk perception (despite the high risk sexual behaviour) it is highly recommended that this study be conducted with a much larger sample size, using different methodologies to analyse the data.

In *Chapter 1* it was mentioned that in some studies conducted MSM were found to engage in multiple concurrent partnerships with both males and females. This study found that even though men were not aware of formal support networks (like community based organisations) they definitely were part of informal support and referral networks (in the form of friends and peers) and that some of them did have more than one partner or their partners had multiple partners. I would thus recommend that sexual mapping studies be conducted.

In *Chapters 2 and 4* literature and study findings on discrimination, stigma and violence are discussed. There is evidence to indicate that MSM face discrimination and harassment when trying to access health care – especially for treatment of rectal sexually transmitted infections. It may be useful to conduct research from the perspective of the health care workers as a means of finding out why they (the health care workers) react negatively to MSM.

## 5.7 DISSEMINATION

Aside from the compilation of this dissertation, other dissemination forums include RHRU research days, University of Witwatersrand research days, posters in the Esselen Street clinic, national and international conferences and publications in peer reviewed journals. In May 2010 a poster presentation on condom usage in MSM was presented at the 4<sup>th</sup> International Workshop on HIV Treatment, Pathogenesis and Prevention Research in Resource Limited Settings (Maputo, Mozambique).

## 5.8 CONCLUSION

The risky sexual practices of MSM, which includes having unprotected sexual intercourse, multiple concurrent sexual partners, a reluctance to go for HIV-testing, nondisclosure of an HIV positive status to a partner, a reluctance to initiate on treatment and the low numbers of MSM engaging in positive health-seeking behaviour, are significant drivers of the HIV epidemic (Baral *et al* 2009: 2-6; Cloete *et al* 2008b; Dladla *et al* 2008, Rispel *et al* 2009; Saavedra *et al* 2008, Smart 2009:3). Other factors like criminalisation of homosexual intercourse, social stigma associated with being a man who has sex with men, negative experiences with health care workers, community harassment and violence perpetrated against MSM contribute to such men being afraid to be open about their sexual practices and health care needs (Lane *et al* 2008:430–432, Sandfort *et al* 2008:425, Saavedra *et al* 2008). From a public health perspective, this does not facilitate positive health promotion and contributes to maintaining the HIV/AIDS epidemic as hidden amongst the MSM population.

All the men who participated in my study identified themselves as gay. Most of the men knew their HIV status but did not act responsibly in accordance with their status. When comparing the men's sexual behaviour practices (including condom usage) to their levels of HIV knowledge, it became apparent that education and

awareness is not having the influence on risk reduction behaviour that it should to be. The men did access health care but some of them had negative experiences with health care workers. Men also shared their opinions on being openly MSM, religion, prostitution, multiple concurrent partnerships and community support structures. Lastly men provided recommendations for making the health care system more MSM friendly.

Being the first MSM behavioural study focussed on the Johannesburg inner city only, it is hoped that the information gained here will provide the motivation for such a study to be scaled up and combined with a surveillance component to give a more representative depiction of the MSM population in this geographical area. Having one of the larger sub district populations means that the information gained from a bigger study in this area could assist in influencing programmatic and policy change at a regional and provincial level in the least. The information gained from further MSM research, coupled with the introduction of HIV related interventions directed at MSM will be positive steps towards addressing HIV prevention and treatment in MSM.

## LIST OF SOURCES

Baral, S, Trapence, G, Motimedi, F, Umar, E, Lipinge, S, Dausab, F & Beyrer, C. 2009. HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS* 4(3): e4997. Available at:

<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0004997> (Accessed on 04/04/09).

Bearak, B & Cowell, A. 2010. *Zimbabwe shrugs off gay rights*. [O]. Available at: <http://www.nytimes.com/2010/03/27/world/africa/27zimbabwe.html> (Accessed on 08/06/10).

Beck, J. 2009. *United States: HIV infection rate still increasing among young black men who have sex with men*. [O] Available at: <http://my.ibpinitiative.org/ViewDiscussion.aspx?c=04899a23-4335-4db5-81f6-4a5fe7c0cdaf&i=b47f06d2-c782-44bf-9303-0cdcf9d0b01> (Accessed on 04/04/09).

Bird, CE & Rieker, PP. 1999. Gender matters: an integrated model for understanding men's and women's health. *Social Science and Medicine* 48:745–755.

Bowleg, L. 2004. Love, sex, masculinity in sociocultural context: HIV concerns and condom use among African American men in heterosexual relationships. *Men and Masculinities* 7:166–186.

Bury, J. 1994. Women and HIV/AIDS: Medical issues, in *AIDS: Setting a feminist agenda* edited by L Doyal, J Naidoo, & T Wilton. London: Taylor and Francis.

Carter, M. 2009. *India legalises sex between men*. [O]. Available at: <http://www.aidsmap.com/en/news/A86EA876-3569-4840-BD6A-B8CA201E803A.asp> (Accessed on 10/07/09).

Castillo, JJ. 2009. *Snowball sampling*. [O] Available at: <http://www.experiment-resources.com/snowball-sampling.html> (Accessed on 16/05/10).

*Casual sex among Cambodia's MSM an HIV time bomb*. [O]. Available at: <http://www.thebody.com/content/news/art43520.html?ts=pf> (Accessed on 01/05/09).

Cheng, C. 1999. Marginalised masculinities and hegemonic masculinity: an introduction. *Journal of Men's Studies* 7(3):295–315.

Chersich, M, Rees, HV, Scorgie, F & Martin, G. 2009. Enhancing global control of alcohol to reduce unsafe sex and HIV in sub-Saharan Africa. *Global Health* 17:5–16.

Cloete, A, Simbayi, LC & Kalichman, SC. 2008a. Disclosure decisions of HIV positive men who have sex with men (MSM) in Cape Town, South Africa. Paper presented at the XVII International Aids Conference, Mexico City.

Cloete, A, Simbayi, LC, Kalichman, SC, Strebel, A & Henda, N. 2008b. Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa. *AIDS Care* 20(9):1105–1110.

Colby, D, Tan Minh, T & Toan, TT. 2008. Down on the farm: homosexual behaviour, HIV risk and HIV prevalence in rural communities in Khanh province; Vietnam. *Sexually Transmitted Infections* 84:439–443.

Connell, RW. 1995. *Masculinities*. Cambridge: Polity Press.

Connell, RW & Messerschmidt, JW. 2005. Hegemonic masculinity: rethinking the concept. *Gender and Society* 19(6):829–859.

Courtenay, WH. 2000. Constructions of masculinity and theory influence on men's well-being: a theory of gender and health. *Social Science and Medicine* 50:1385–1401.

Demetriou, DZ. 2001. Connell's concept of hegemonic masculinity: a critique. *Theory and Society* 30(3):337–361.

Dladla, S, Struthers, H, McIntyre, J & Lane, T. 2008. HIV prevalence among MSM in Soweto: preliminary results from the Soweto men's study. Paper presented at Controversies in HIV Symposium, Johannesburg. Available at [www.hivsa.com/pact/pact2008/msm\\_joburg.pdf](http://www.hivsa.com/pact/pact2008/msm_joburg.pdf). (Accessed on 23/03/09).

Doyal, L, Anderson, J & Papparini, S. 2009. You are not yourself: exploring masculinities among heterosexual African men living with HIV in London. *Social Science and Medicine* 68:1901–1907.

Epprecht, M. 2008. *Unspoken fact: A history of homosexualities in Africa*. Harare: Weaver press.

Frayssinet, F. 2009. *Gay bashing murders up by 55 percent*. [O]. Available at: <http://www.ipsnews.net/news.asp?idnews=46596> (Accessed on 25/04/09).

Geibel, S, van der Elst, E, King'ola, N, Luchters, S, Davies, A, Getambu, EM, Peshu N, Graham, SM, McClelland RS & Sanders EJ. 2007. Are you on the market?: a capture–recapture enumeration of men who sell sex to men in and around Mombasa, Kenya. *AIDS* 21:1349–1354.

Gibbs, L. 2005. Applications of masculinity theories in a chronic illness context. *International Journal of Men's Health* 4(3):287–300.

Good, GE, Borst, TS & Wallace, DL. 1994. Masculinity research: a review and critique. *Applied and Preventive Psychology* 3:3–14.

Hamber, B. 2010. Masculinity and transitional justice: an exploratory study. *Peace Prints: South Asian Journal of Peacebuilding* 3(1):1–22. [O]. Available at: <http://www.wiscomp.org/peaceprints.htm> (Accessed on 31 May 2010).

Herdt, G. 1992. Preface and Introduction, in *The time of AIDS: social analysis, theory and method* edited by G Herdt & S Lindenbaum. California: Sage.

Human Rights Watch. 2009a. Repeal law criminalizing homosexual conduct. Discriminatory law violates basic rights, will hamper AIDS prevention. [O] Available at: <http://www.hrw.org/en/news/2009/04/24/burundi-repeal-law-criminalizing-homosexual-conduct> (Accessed on 25/04/09).

Human Rights Watch. 2009b. Uganda: anti-homosexuality bill threatens liberties and human rights defenders. [O]. Available at: <http://www.hrw.org/en/news/2009/10/15/uganda-anti-homosexuality-bill-threatens-liberties-and-human-rights-defenders> (Accessed on 08/06/10).

Jewkes, R & Morrell R. 2010. Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk perception. *Journal of the International AIDS Society* 13(6): 1–11.

Jones, KT, Gray, P, Whiteside, YM, Wang, T, Bost, D, Dunbar, E, Foust, E & Johnson, WD. 2008. Evaluation of an HIV prevention intervention adapted for black men who have sex with men. *American Journal of Public Health* 98(6):1043–1050.

Kong, TSK. 2008. Risk factors affecting condom use among male sex workers who serve men in China: a qualitative study. *Sexually Transmitted Infections* 84:444–448.

Ladner, S. 2008. Qualitative versus quantitative research, Part II. [O]. Available at: <http://copernicusconsulting.net/qualitative-versus-quantitative-research-part-ii/> (Accessed on 16/05/10).

Lane, T, Mogale, T, Struthers, H, McIntyre, J & Kegeles, SM. 2008. They see you as a different thing: the experiences of men who have sex with men with healthcare workers in South African township communities. *Sexually Transmitted Infections* 84:430–433.

Lane, T, Shade, SB, McIntyre, J & Morin, SF. 2008. Alcohol and sexual risk behaviour among men who have sex with men in South African township communities. *AIDS Behaviour* 12:S78–S85.

Lane, T, Raymond, F, Dladla, S, Rasethe, J, Struthers, H, McFarland, W & McIntyre, J. 2009. High HIV prevalence among MSM in Soweto: results from the Soweto men's study. *AIDS Behaviour*. [O] Available at: <http://www.springerlink.com/libproxy.lib.unc.edu/content/j28347774tm76217/fulltext.pdf> (Accessed on 19/01/10).

Lusher, D & Robins, G. 2009. Hegemonic and other masculinities in local social contexts. *Men and Masculinities* 11(4):387–423.

Mack, N, Woodsong, C, MacQueen, KM, Guest, G & Namey, E. 2005. *Qualitative research methods: a data collector's field guide*. United States of America: Family Health International.

Madison, DS. 2005. *Critical ethnography: method, ethics and performance*. London: Sage.

Mahalik, JR, Burns, SM & Syzdek, M. 2007. Masculinity and perceived normative health behaviors as predictors of men's health behaviors. *Social Science and Medicine* 64:2201–2209.

*Mail & Guardian*. 2009. Dakar court overturns jail terms for homosexuality. [O]. Available at: <http://www.mg.co.za/article/2009-04-20-dakar-court-overturns-jail-terms-for-homosexuality>(Accessed on 29/04/09).

McIntyre, JA. 2010. The need for HIV prevention interventions for men who have sex with men in Africa. *Sexually Transmitted Infections* 86(2):82–83.

Metcalf, C. 2009. The hidden HIV epidemic among men who have sex with men (MSM). Preliminary findings from the Johannesburg/Ethekwini Men's study (JEMS). Paper presented at the 4<sup>th</sup> South African AIDS Conference, Durban.

Millet, GA, Peterson, JL, Wolitski, RJ & Stall, R. 2006. Greater risk infection of black men who have sex with men: a critical literature review. *American Journal of Public Health* 96(6):1007–1019.

Morrell, R. 1998. Of boys and men: masculinity and gender in Southern African studies. *Journal of Southern African Studies* 24(4):605–630.

Morrell, R. 2002. Men, movement and gender transformation in South Africa. *The Journal of Men's Studies* 10(3):309–327.

Mungisha, F. 2009. *Ugandans propose new tougher laws against gay activist*. [O]. Available at: <http://www.mask.org.za/article.php?cat=uganda&id=2095> (Accessed on 29/04/09).

Murray, JM, McDonald, AM & Law, MG. 2009. Rapidly ageing HIV epidemic among men who have sex with men in Australia. *Sexual Health* 6(1):83–86. [O]. Available at: [http://www.publish.csiro.au/?act=view\\_file&file\\_id=SH08063.pdf](http://www.publish.csiro.au/?act=view_file&file_id=SH08063.pdf) (Accessed on 07/04/09).

Neuman, WL. 2006. *Social research methods: qualitative and quantitative approaches*. 6<sup>th</sup> edition. United States of America: Pearson.

Neyuf, H & Al Iraqi, A. 2009. *Bodies of 7 gays in Baghdad morgue*. [O]. Available at: [http://www.alarabiya.net/save\\_print.php?print=1&cont\\_id=71071](http://www.alarabiya.net/save_print.php?print=1&cont_id=71071) (Accessed on 29/04/09).

Parry, C, Petersen, P, Dewing, S, Carney, T, Needle R, Kroeger, K & Treger, L. 2008. Rapid assessment of drug related HIV risk among men who have sex with men in three South African cities. *Drug and Alcohol Dependence* 95:45–53.

Pleaner, M. (ed). 2009. *Towards best practice: programmes, projects and systems to expand HIV care in Inner City Johannesburg*. South Africa: Reproductive Health and HIV Research Unit.

Plus News. 2009. *Tackling a hidden epidemic*. [O]. Available at: <http://www.plusnews.org/Report.aspx?ReportId=83813> (Accessed on 29/04/09).

Pope, C, Ziebland, S & Mays, N. 2000. Qualitative research in health care: analysing qualitative data. *BMJ* 320:114–116.

Rabe, ME. 2003. Revisiting insiders and outsiders as social researchers. *African Sociological Review* 7(2):149–161.

Reddy, V & Sandfort, T. 2008. Regional MSM research initiatives: UNAIDS/UNDP research project. Paper presented at ICASA 2008, Dakar.

Reddy, V, Sandfort, T, Maimane, S, Yi, H & Dolezal, C. 2009. AIDS a death sentence? Paper presented at the 4<sup>th</sup> South African AIDS Conference, Durban. Available at: <http://www.MSMandhiv.org/documents/VASUREDDY.pdf> (Accessed on 15/05/09).

Rispel, L & Metcalf, C. 2009. Breaking the silence: South African HIV policies and the needs of men who sleep with men. *Reproductive Health Matters* 17(33):133–142.

Rispel, L, Metcalf, C, Cloete, A, Reddy, V, Townsend, L & Zembe, Y. 2009. Eish but the whites are scarce! JEMS research challenges. Paper presented at the 4<sup>th</sup> South African AIDS Conference: MSM Satellite Conference, Durban.

Saavedra, J, Izazola-Licea, JA & Beyrer, C. 2008. Sex between men in the context of HIV: The AIDS 2008 Jonathan Mann Memorial lecture in health and human rights. *Journal of the International AIDS Society* 11(9). [O]. Available at: <http://www.jiasociety.org/content/11/1/9>. (Accessed on 08/07/09).

Sandfort, TGM, Nel, J, Rich, E, Reddy, V & Yi, H. 2008. HIV testing and self reported HIV status in South African men who have sex with men: results from a community based survey. *Sexually Transmitted Infections* 84:425–429.

Smart, T. 2009. Appropriate prevention and care services for men who have sex with men and transgender people in resource limited settings. *HIV & AIDS Treatment in Practice* 138:1–8. [O] Available at: <http://www.aidsmap.com> (Accessed on 01/07/09).

Smith, AD, Tapsoba, P, Peshu, N, Sanders, EJ & Jaffe, HW. 2009. Men who have sex with men and HIV/AIDS in sub-Saharan Africa. *Lancet* 374(9687):416–422.

Sokari, E. 2010. *Uganda: Cabinet committee wants the Anti-Homosexuality Bill reviewed*. [O]: Available at: <http://www.blacklooks.org/2010/05/uganda-cabinet-committee-wants-the-anti-homosexuality-bill-reviewed/> (Accessed on 17/05/10).

South Africa (Republic). Department of Health. 2007. *HIV & AIDS and STI strategic plan for South Africa 2007–2011*. Pretoria: South African Department of Health.

Terre Blanche, M & Durrheim, K. (eds). 1999. *Research in practice: applied methods for social sciences*. South Africa: University of Cape Town Press.

Tlhwale, L. 2009. *Kenyan gays demand protection following lesbian bash*. [O]. Available at: <http://www.mask.org.za/article.php?cat=kenya&id=2104> (Accessed on 29/04/09).

Tobin, KE & Latkin, CA. 2008. An examination of social network characteristics of men who have sex with men who use drugs. *Sexually Transmitted Infections* 84:420–424.

Trochim, WMK. 2006. *The qualitative debate*. [O]. Available at: <http://www.socialresearchmethods.net/kb/qualdeb.php>. (Accessed on 10 May 2010).

United Nations. UNAIDS. [Sa] HIV prevention among key populations. [O]. Available at: <http://www.unaids.org/en/PolicyAndPractice/Prevention/HIVprevKeyPopulations/> (Accessed on 10/07/09).

United Nations. UNAIDS. 2006a *Policy brief HIV and sex between men*. Geneva. at:

[http://data.unaids.org/pub/BriefingNote/2006/20060801\\_Policy\\_Brief\\_MSM\\_en.pdf](http://data.unaids.org/pub/BriefingNote/2006/20060801_Policy_Brief_MSM_en.pdf) (Accessed 16/06/09).

United Nations. UNAIDS. 2006b. *The value of investing in MSM programs in the Asia-Pacific region*. Washington: Health Policy Initiative.

United Nations. UNAIDS. 2006c. *HIV and men who have sex with men in Asia and the Pacific*. Geneva. 1-69. [O]. Available at: [http://data.unaids.org/Publications/IRC-pub07/JC901-MSM-AsiaPacific\\_en.pdf](http://data.unaids.org/Publications/IRC-pub07/JC901-MSM-AsiaPacific_en.pdf) (Accessed 16/06/09).

United Nations. UNAIDS. 2008. *Epidemiological fact sheet on HIV/AIDS Core data on epidemiology and response South Africa*. Geneva. [O]. Available at: [http://www.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008\\_RSA.pdf](http://www.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_RSA.pdf) (Accessed 16/06/09).

United States. Centre for Disease Control. 2007. *HIV/AIDS among men who have sex with men*. [O]. Available at: <http://www.cdc.gov/hiv> (Accessed on 26/03/09).

United States. USAID. 2006. *HIV expenditure on MSM programming in the Asia-Pacific region*. [O]. Available at: <http://www.healthpolicyinitiative.com/Publications/Documents/MSM%20HIV%20Expenditures%20FINAL%20Formatted%206-11-07.pdf> (Accessed on 08/12/08).

Van Griensven, F. 2006. Men who have sex with men and their HIV epidemics in Africa. *AIDS* 21:1361–1362.

Voeller, B, Reinisch, JM & Gottlieb, M. 1990. *AIDS and sex: an integrated biomedical and biobehavioral approach*. New York: Oxford University Press.

Woolf, SE & Maisto, SA. 2009. Alcohol use and risk of HIV infection among men who have sex with men. *AIDS Behaviour* 13:757–782.

Zenilman, J. 1988. Sexually transmitted diseases in homosexual adolescents. *Journal of Adolescent Medicine* 9:129–138.

## APPENDICES

Appendices A, B, C, D, E, F, G and H are attached here after.

APPENDIX A: RHRU PERMISSION LETTER

APPENDIX B: UNISA ETHICAL APPROVAL

APPENDIX C: UNIVERSITY OF WITWATERSRAND ETHICAL APPROVAL

APPENDIX D: GAUTENG DEPARTMENT OF HEALTH APPROVAL

APPENDIX E: INFORMATION SHEET & CONSENT FORM

APPENDIX F: RECORDING CONSENT FORM

## APPENDIX A



19 June 2009

Mrs S T Lalla-Edward  
21 Aloe Place 1  
Greenstone Hill  
Greenstone Drive  
1609

Dear Mrs Lalla-Edward

### **Permission to conduct research within the Men and HIV Project of the RHRU's Inner City Programme**

Thank you very much for expressing an interest in conducting MSM research within the Men and HIV project of the RHRU's Inner City Programme.

I am satisfied with your research proposal and am supportive of your study. The study will complement the research that is currently taking place within the programme.

Please submit all ethical approvals to my office for our records.

Yours faithfully

**Winnie Moleko**  
Director: Inner City Programme  
HIV Management Cluster  
Reproductive Health and HIV Research Unit

RHRU Johannesburg National Office:  
University of the Witwatersrand,  
Hillbrow Health Precinct, Hugh Solomon Building,  
Esselen Street (Car Klein St), Hillbrow,  
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The RHRU is a division of WHO Health Cooperation (Pty) Ltd.  
Reg. 93/15443/07

RHRU Durban Regional Office:  
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## APPENDIX B

**OFFICE OF THE DEPUTY EXECUTIVE DEAN  
COLLEGE OF HUMAN SCIENCES**

31 July 2009

Mrs ST Lalla – Edward  
21 Aloe Place 1  
Greenstone drive  
GREENSTONE HILL  
1609

**Proposed title:** HEALTH AND HIV RISK ASSESSMENT OF MEN WHO HAVE SEX WITH MEN (MSM) IN THE JOHANNESBURG INNER CITY

**Principal investigator:** Mrs ST Lalla-Edward

**Reviewed and processed as:** Class approval (see paragraph 10.7 of the UNISA Guidelines for Ethics Review)

**Approval status recommended by reviewers:** Approved

The Ethics Subcommittee of the College of Human Sciences has reviewed this proposal and considers the methodological, technical and ethical aspects of the proposal to be appropriate to the tasks proposed. Approval is hereby granted to the principal investigator to proceed with the study in strict accordance with the approved proposal and the ethics policy of the University of South Africa.

In addition, the principal investigator should heed the following guidelines:

- To only start this research study after obtaining informed consent
- To carry out the research according to good research practice and in an ethical manner
- To maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy
- To record the way in which the ethical guidelines as suggested in the proposal has been implemented in the research
- To work in close collaboration with your supervisor(s) and to notify the Subcommittee in writing immediately if any change to the study is proposed and await approval before proceeding with the proposed change
- To notify the Subcommittee in writing immediately if any adverse event occurs.

Approvals are valid for ONE academic year after which a continuation must be submitted.



Prof Kuzvinetsa Peter Dzvimb  
Deputy Executive Dean: College of Human Sciences  
Tel: 012 429 4067  
E-mail: [dzvimkp@unisa.ac.za](mailto:dzvimkp@unisa.ac.za)

**APPENDIX C**

**UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG**

Division of the Deputy Registrar (Research)

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)**

R14/49 Samantha T Lalla-Edward

**CLEARANCE CERTIFICATE**

**M090935**

**PROJECT**

Health and HIV Risk Assessment of Men who have Sex with Men (MSM) in the Johannesburg Inner City

**INVESTIGATORS**

Samantha T Lalla-Edward.

**DEPARTMENT**

Reproductive Health and HIV Research Unit

**DATE CONSIDERED**

2009/10/02

**DECISION OF THE COMMITTEE\***

Approved unconditionally

**Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.**

**DATE** 2009/10/02

**CHAIRPERSON** .....

  
(Professor PE Cleaton-Jones)

\*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Ms A Jaffer

---

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**DECLARATION OF INVESTIGATOR(S)**

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10004, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

.....

**DEPARTMENT  
OF HEALTH**

Directorate: Policy Planning and Research  
(Research & Epidemiology)

|  |                                 |
|--|---------------------------------|
| <i>FROM: Kagiso</i>                    | <i>TO : Mrs St Lalla-Edward</i> |
|  |                                 |
| <i>TEL. NO.: 011 355<br/>3490/3500</i> | <i>TEL : 011 358 5438</i>       |
| <i>FAX. NO: 011 355 3007</i>           | <i>FAX. 086 645 4701</i>        |

**MESSAGES:**

*Please find attached research approval letter.*

**PAGES: Including Cover 08**

|                   |
|-------------------|
| <b>APPENDIX D</b> |
|-------------------|

**GDH RESEARCH PROPOSAL EVALUATION FORM**

For approval by Director: Policy, Planning and Research

**HEALTH AND SOCIAL DEVELOPMENT  
(GDHSD)****POLICY, PLANNING AND RESEARCH (PPR)**

Enquiries: Sue le Roux

Tel: +2711 355 3212

Fax: +2711 355 3675

Email: [Sue.LeRoux@gauteng.gov.za](mailto:Sue.LeRoux@gauteng.gov.za)**SECTION A**

|   |  |
|---|--|
| <b>Researcher Name</b>                      | Mrs. ST Lalla-Edward   |
| <b>Physical Address</b>                     | RHRU Johannesburg National Office, Hillbrow Health Precinct, Hugh Solomon Building, Esselen Street, Hillbrow, Johannesburg, 2001   |
| <b>Postal Address</b>                       | P.O. Box 18512, Hillbrow 2038  |
| <b>Telephone</b>                            | +2711 358 5438 or +2783 568 1350   |
| <b>Email</b>                                | Slalla-edward@rhru.co.za   |
| <b>Institution</b>                          | Reproductive Health and HIV Research Unit (RHRU)   |
| <b>Research Topic</b>                       | "Health and HIV risk assessment of men who have sex with men (MSM) in the Johannesburg Inner city"   |
| <b>Date Received by the Directorate PPR</b> | 22 January 2010  |
| <b>Date Received Reviewer</b>               | 09 February 2010   |
| <b>Final Review Date</b>                    | 15 February 2010   |
| <b>Date Submitted to Director of PPR</b>    | 15 February 2010   |
| <b>Research Site(s)</b>                     | Participants will be recruited at MSM "hot spots" in the inner city, the Men and HIV Project of the RHRU. MSM will also be informed about the study during the health talks conducted at waiting rooms on a daily basis at RHRU. Interviews will be conducted at Esselen Clinic or RHRU offices. |
| <b>Type of research</b>                     | Descriptive Qualitative, study design.   |
| <b>Supervisor</b>                           | Ms. A Jaffer   |

ONLY FOR APPROVAL OF THE RESEARCH STUDY ENTITLED "HEALTH AND HIV RISK ASSESSMENT OF MEN WHO HAVE SEX WITH MEN (MSM) IN THE JOHANNESBURG INNER CITY" TO BE CONDUCTED BY ST LALLA-EDWARD

## SECTION B- PROPOSAL REVIEW

|  | YES | NO | Comments  |
|--|-----|----|---|
| 1. Is this research project within the scope of the Department of Health key policy priorities/directives? | √   |    | <p>The NSP's goal of reducing new HIV Infections by 50% in 2011 is a priority to all provinces of the Republic of South Africa. In order to achieve this goal all possible strategies that will help reduce the rate of new infections should be explored. The field of Men that engage in sexual activities with other men (MSM) has not been adequately researched. Research that has been conducted suggests that there might be a number of reasons which prevent MSM from seeking health advice or disclosing their HIV status. Stigmatization and negative perceptions and behaviour by health care workers could be some of the reasons that prevent MSM from seeking help from public health facilities.</p> <p>The potentially risky health behaviour of this group which is not well understood may negate efforts of South African government to reduce HIV infection. This study will examine some of the pertinent issues pertaining to MSM health and HIV risk.</p> |
| 2. Content of Research:  |     |    | <p>The study will investigate and describe behaviours and decisions that play a role in health decision making and health seeking behaviour of MSM, particularly relating to HIV and other sexually transmitted infections (STI's).</p>   |
| ▪ Original work  | √   |    |   |
| ▪ New facts, Ideas   | √   |    |   |
| ▪ Confirmation of uncertain data   |     | √  |   |
| ▪ Repetition of known data and consequently of limited importance  |     | √  |   |
| ▪ Insufficient research information  | √   |    |   |
| ▪ Confusion of topics/questions  |     | √  |   |
| 3. Is the title of the research project suitable?  | √   |    | The title of the study is: <b>"Health and HIV risk assessment of men who have sex with men (MSM) in the Johannesburg Inner city"</b>  |
| 4. Are the objectives of the research project adequate?  | √   |    | <p><b>Objectives</b></p> <ol style="list-style-type: none"> <li>1. To describe the biographical features of the volunteer sample of MSM such as their age, socio-economic status, education level, race, cultural, ethnic, sexual and religious identity, place of residence, migration status, marital status, social and support networks as well as the question of living openly;</li> <li>2. To determine the factors that hinder MSM's health seeking behaviour and propensities to access or to avoid voluntary counseling and testing for HIV;</li> <li>3. To gain insight into personal risk assessments of MSM;</li> <li>4. To gain insight into sexual practices of MSM in the Johannesburg Inner city.</li> </ol>   |
| 5. Could the objectives be limited to better focus on the project's main objective?                        |     | √  |   |

| <b>SECTION B- PROPOSAL REVIEW</b>  |            |           |   |
|--|------------|-----------|---|
|  | <b>YES</b> | <b>NO</b> | <b>Comments</b>   |
| 6. Writing style   |            |           | Well written academic piece of work.  |
| ▪ The text of the proposal is clear  | √          |           |   |
| ▪ The nomenclature used is correct   | √          |           |   |
| ▪ The references used are relevant, comprehensive and accurate (corrected)                           | √          |           |   |
| ▪ The spelling and grammar are correct   | √          |           |   |
| ▪ The language needs improvement   |            | √         |   |
| ▪ The research proposal needs restyling and rewriting  |            | √         |   |
| 7. Are the research methods appropriate to the study   | √          |           |   |
| 8. Does the study have ethical approval? If yes, name the ethics committee                           | √          |           | <b>Yes</b><br>Officially granted ethics approval on 02/10/2009 by the Wits Human Research Ethics Committee (Medical). |
| 9. Is data collection method in line with study design?  | √          |           |   |
| 10. Is time frame of the proposal adequate to meet the objectives?                                   | √          |           |   |
| 11. Is it stated in the proposal the method of dissemination of the results of the research project? | √          |           |   |
| 12. Is the possible conflict of interests clarified?   | √          |           |   |
| 13. Are financial implications and financial support transparent?                                    | √          |           | There is no financial implication of this study for GDHSD.  |

## **SECTION C - SUMMARY OF THE RESEARCH PROPOSAL**

The proposed study by a UNISA registered Masters student associated with RHRU Mrs. ST Lalla-Edward will examine and describe behaviours and decisions that play a role in health decision making and health seeking behaviour of MSM, particularly relating to HIV and other sexually transmitted infections (STI's).

The potentially risky health behaviour of this group which is not well understood may negate efforts of South African government to reduce HIV infection. There are suggestions in other studies that MSM's health seeking behaviour is affected by many social perceptions and behaviours which ultimately influence their decision to seek medical help from public institutions. This study will examine some of the pertinent issues pertaining to MSM health and HIV risk and hopefully the findings will help shed light on very important issues that are not known by policy makers and health care providers.

The specific objectives of the study are:

1. To describe the biographical features of the volunteer sample of MSM such as their age, socio-economic status, education level, race, cultural, ethnic, sexual and religious identity, place of residence, migration status, marital status, social and support networks as well as the question of living openly;
2. To determine the factors that hinder MSM's health seeking behaviour and propensities to access or to avoid voluntary counseling and testing for HIV;
3. To gain insight into personal risk assessments of MSM;
4. To gain insight into sexual practices of MSM in the Johannesburg inner city.

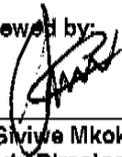
Participants will be recruited at MSM "hot spots" in the inner city, the Men and HIV Project of the RHRU. MSM will also be informed about the study during the health talks conducted at waiting rooms on a daily basis at RHRU. Interviews will be conducted at Esselen Clinic or RHRU offices. Ethics clearance certificate from Wits Human Research Ethics Committee (Medical) was obtained and the study is potentially not harmful to participants.

The research project has no financial implications for the GDHSD.

**SECTION D – REVIEW  
RECOMMENDATION AND APPROVAL**

**REVIEW**

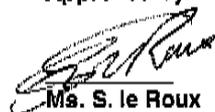
Reviewed by:



\_\_\_\_\_  
Mr. Siviwe Mkoka  
Deputy Director: Policy, Planning and Research  
Date: 15/02/10

**Approval**

Approved by:



\_\_\_\_\_  
Ms. S. le Roux  
Director, Policy, Planning and Research: Gauteng Provincial Department of Health and Social  
Development  
Date: 17/02/2010

**CONDITIONS OF APPROVAL OF RESEARCH CONDUCTED GAUTENG DEPARTMENT OF HEALTH AND SOCIAL  
DEVELOPMENT (GDHSD)**

For approval by Director: Policy, Planning and Research



**HEALTH AND SOCIAL DEVELOPMENT  
(GDHSD)**

**POLICY, PLANNING AND RESEARCH (PPR)**

Enquiries: Sue le Roux

Tel: +2711 355 3212

Fax: +2711 355 3675

Email: [Sue.LeRoux@gauteng.gov.za](mailto:Sue.LeRoux@gauteng.gov.za)

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**ONLY FOR APPROVAL OF THE RESEARCH STUDY ENTITLED "HEALTH AND HIV RISK ASSESSMENT OF MEN WHO HAVE SEX  
WITH MEN (MSM) IN THE JOHANNESBURG INNER CITY" TO BE CONDUCTED BY ST LALLA-EDWARD**

| CONTACT DETAILS OF THE RESEARCHER              |   |
|--|---|
| <b>Date</b>                                    | 15 February 2010  |
| <b>Tel number</b>                              | +2711 358 5438 or +2783 566 1350  |
| <b>Email</b>                                   | Slalla-edward@rhru.co.za  |
| <b>Researcher /Principal Investigator (PI)</b> | Mrs. ST Lalla-Edward  |
| <b>Supervisor</b>                              | Ms. A Jaffer  |
| <b>Institution</b>                             | Reproductive Health and HIV Research Unit (RHUR)  |
| <b>Research title</b>                          | <b>"Health and HIV risk assessment of men who have sex with men (MSM) in the Johannesburg inner city"</b> |

Approval is hereby granted by the Gauteng Department of Health and Social Development for the above research project to be conducted. Approval is limited to compliance with the following terms and conditions:

1. All principles and South African regulations pertaining to ethics of research are observed and adhered to by all involved in the research project. Ethics approval is only acceptable if it has been provided by a South African research ethics committee which is accredited by the National Health Research Ethics Council (NHREC) of South Africa; this is regardless of whether ethics approval has been granted elsewhere.

Of key importance for all researchers is that they abide by all research ethics principles and practice relating to human subjects as contained in the Declaration of Helsinki (1964, amended in 1983) and the constitution of the Republic of South Africa in its entirety. Declaration of Helsinki upholds the following principles when conducting research, respect for:

- Human dignity;
- Autonomy;
- Informed consent;
- Vulnerable persons;
- Confidentiality;
- Lack of harm;
- Maximum benefit;
- and Justice

2. The GDHSD is indemnified from any form of liability arising from or as a consequence of the process or outcomes of any research approved by HOD and conducted within the GDHSD domain;

3. Researchers commit to providing the GDHSD with periodic progress and a final report; short term projects are expected to submit progress reports on a more frequent basis and all reports must be submitted to the Director: Policy, Planning and Research of the GDHSD;
4. The Principal Investigator shall promptly inform the above mentioned office of changes of contact details or physical address of the researching individual, organisation or team;
5. The Principal Investigator shall inform the above office and make arrangements to discuss their findings with GDHSD prior to dissemination;
6. The Principal Investigator shall promptly inform the above mentioned office of any adverse situation which may be a health hazard to any of the participants;
7. The Principal Investigator shall request in writing authorization by the HOD via PPR for any intended changes of any form to the original and approved research proposal;
8. If for any reason the research is discontinued, the Principal Investigator must inform the above mentioned office of the reasons for such discontinuation;
9. A formal research report upon completion should be submitted to the Director: Policy, Planning and Research of the GDHSD with recommendations and implications for GDHSD, the Directorate will make this report available for the HOD

**AGREEMENT BETWEEN THE GAUTENG DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT (GDHSD) AND THE RESEARCHER**

  
 \_\_\_\_\_  
 Ms. S. le Roux

**Director: Policy, Planning and Research**

**Date:** 17/02/2010

**Signature:**  
 \_\_\_\_\_

**Name and surname of Principal Researcher**

**Research/Academic Institution**

**Date:**

**Signature:**  
 \_\_\_\_\_

## **APPENDIX E**

### **INFORMATION SHEET AND CONSENT FORM FOR IN-DEPTH INTERVIEWS ON HEALTH AND HIV RISK ASSESSMENT OF MSM IN THE JOHANNESBURG INNER CITY**

#### **Purpose of the study**

Hello, my name is \_\_\_\_\_. I work at the Reproductive Health and HIV Research Unit. I am talking to men who have sex with men to determine their health-seeking behaviour. The researcher of this study would like to find out whether you access health care services and the reasons for this.

#### **Procedures**

If you agree to participate, we will talk to you for about 60 minutes. At the end of the interview you will be requested to complete a demographic questionnaire. This will be administered by yourself or the interviewer should you require assistance.

Your participation in this interview process is completely voluntary (this means you, and only you, can choose whether you would like to join this study). You may refuse to answer any specific question if you feel uncomfortable with that question. You do not have to give me a reason for refusing to answer specific questions. You can also decide to stop participating at any time. If you decide you don't want to be part of this study, there will be no negative consequences for you and it will have no impact on your accessing health care services in this clinic or anywhere else. If at any time during the interview you decide that you don't want to be part of the study, you can stop by letting the researcher know, and the interview will be stopped. Take note that we have little to do with the clinic staff and the study does not concern the nurses and doctors. If you don't want to be part of this study, they will not know and you can come to this hospital/clinic as usual. There is no right or wrong answers to any of the questions. I only want to know your opinions and ideas.

#### **Confidentiality**

We don't record your full name in this study. To help us to remember what you say here today, the interviewer will take notes and will record today's session on audio-tape. Only our research team will review the tape. After transcription, the tapes will be destroyed and all personal identifiers will be removed from the transcript. Your name will not be recorded and a false name will be used (you can choose a name yourself). The only place your real name will be recorded is on this information sheet and informed consent form. These sheets are kept in a locked cabinet and your name will never be used in any of the research outputs.

#### **Discomforts and risk**

There is a slight risk that you may feel uncomfortable talking about some of these sensitive topics. We do not wish this to happen, and you may refuse to answer any question, or any part of a question, at any time.

#### **Reimbursement**

You will be reimbursed R50 to cover the transport costs you have incurred.

**Benefits**

There are no direct benefits to you, but your participation will help us find out more about why men who have sex with men come to the clinic or not. With the information gained from these interviews we can try to make health care more accessible to men who have sex with men.

**Offer to answer questions and freedom to withdraw from the study**

If you have questions about the study you may ask them now or you can call: Samanta Lalla-Edward on 011 3585438 / 083 5661350

If you don't have any questions and agree to participate in this study then we will go ahead and begin. But first, I will ask you to sign this form stating that I, the interviewer, have informed you of your rights as a participant and that you have agreed to participate in today's interview. This is the only place where your name will be entered. If you do not wish to sign your name, you may simply mark the space with an 'X'.

**Volunteer's statement**

THE INTERVIEW HAS BEEN EXPLAINED TO ME. I HAVE BEEN GIVEN A CHANCE TO ASK ANY QUESTIONS I MAY HAVE AND I AM CONTENT WITH THE ANSWERS TO ALL OF MY QUESTIONS.

I ALSO KNOW THAT:

MY RECORDS WILL BE KEPT PRIVATE AND CONFIDENTIAL;

I CAN CHOOSE NOT TO BE INTERVIEWED, NOT TO ANSWER CERTAIN QUESTIONS, OR TO STOP THE INTERVIEW AT ANY TIME;

IF I REFUSE TO BE INTERVIEWED, IT WILL NOT AFFECT MY MEDICAL CARE AT THE CLINIC.

I GIVE CONSENT THAT MY INTERVIEW CAN BE TAPE-RECORDED.

I UNDERSTAND THAT THE INTERVIEWS FROM APPROXIMATELY 19 OTHER VOLUNTEERS WILL BE ANALYSED WITH MINE AND REPORTED ON AS FINDINGS OF THE STUDY.

We thank you for your time. If you need to contact us to ask us any further questions after the discussion:

|           |                   |                      |
|-----------|-------------------|----------------------|
| _____     | _____             |                      |
| Date      | Name of volunteer | Signature or Mark of |
| Volunteer |                   |                      |

|       |                 |                                |
|-------|-----------------|--------------------------------|
| _____ | _____           |                                |
| Date  | Name of witness | Signature of Witness           |
|       |                 | (If participant is illiterate) |

**Interviewer's statement**

I, the undersigned, have defined and explained to the volunteer in a language that he understands the procedures to be followed, the risks and benefits involved, and the obligations of the interviewer.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of interviewer

Signature of interviewer

## APPENDIX F

**Title of Study: Health and HIV risk assessment of men who have sex with men in the Johannesburg inner city**

**Principal Investigator: Samanta Tresha Lalla-Edward  
Institution: Reproductive Health and Research Unit**

### **In-Depth Interview Recording Consent Form**

I will record the interview using an audio recorder to help me remember all the information from our conversation. This will only be done however with your consent. We will transcribe (write out) what you have said. Our discussion will be confidential and your name will not be recorded with the tape recording. There will be no way of linking what you say in this interview to who you are. Only the staff from the research study, from the Reproductive Health and HIV Research Unit will see this information.

The tape recordings will be stored in Johannesburg and the only people who will have access to the tapes will be the principle investigator of this study. Six years after the research has been finalised, the tapes will be destroyed.

Should you have any further questions regarding this research project please feel free to contact the Principal Investigator Samanta Tresha Lalla-Edward. The contact details are provided below.

**If you agree to this interview being audio recorded please provide me with your full name and signature.**

I, \_\_\_\_\_ have been explained and understand the reason for the audio recording. I agree to this in-depth interview being recorded.

Research participant:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Interviewer:**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Consent Form #: \_\_\_\_\_

### **Contact Details**

Principal Investigator: Samanta Tresha Lalla-Edward  
Monitoring and Evaluation Coordinator  
Reproductive Health and HIV Research Unit (RHRU)  
Tel: 0835661350  
Email: slalla-edward@rhru.co.za

## APPENDIX G

### IN DEPTH INTERVIEW SCHEDULE ON HEALTH AND HIV RISK ASSESSMENT OF MSM IN THE JOHANNESBURG INNER CITY

#### INSTRUCTIONS

1. This IDI is intended to be an informal conversation to collect information on the topics of health seeking behaviour, Esselen clinic services for men, sexual orientation and sexual behaviour, male knowledge, attitudes, perceptions and beliefs and community support.
2. Each IDI must be audio recorded ONLY after the informed consent form has been signed.
3. There are two levels of questions:
  - a. **# Main questions: the questions that the principal investigator want to get answers to**
  - b. **Probes: the questions that you as the moderator could ask respondent in order to get greater clarity on certain issues**
4. *Instructions/suggestions to the moderator are in italics.*
5. The IDI guide is divided into three columns.
6. **The left-hand column** contains the main questions and instructions. Much will depend on how the discussion develops.
7. **The middle column** suggests overall impression of the answer.
8. **The right-hand column** is for summarising the themes. These should be summaries of the general issues raised in connection with the question, NOT responses of individual men in response to particular points or questions. These summaries should be more than just yes/no, but not longer than a few sentences of bullet points. They do not need to be detailed, as we have the details on the recording.

Hello, my name is [MODERATOR] Welcome to the discussion and please make yourself comfortable.

Today I would like us to discuss your experiences of being MSM and accessing health care services at the Esselen Clinic.

Please note that we simply want to hear your views, and there is no right or wrong answer; everything you say is important to us. Please feel free to speak openly and use any language or words that best describe your experiences. Your real name will not be written anywhere, which means that no one will know it was you who said something. The voice files and notes will be kept private and safe. The discussion will take about 1 hour. After the discussion you will be asked to complete a demographic questionnaire. Again completion of this questionnaire is completely voluntary.

Do you have any questions at this point?

*Ice breaker*

Moderator to start session with light refreshments and allow the research participant to relax.

Interview schedule number:

Interviewer number:

Date of interview: .....

Where is the interview taking place? **(Tick one of the following)**

Esselen Clinic

Field (state which geographical area)  \_\_\_\_\_

**DEMOGRAPHIC INFORMATION**

|  |  |  |
|--|--|--|
| <p><b>1. Do you stay in the Johannesburg Inner City?</b><br/><br/>→Get the participant to discuss where they stay. You should cover the following points</p> | <p>Yes<br/><input type="checkbox"/><br/><br/>No<br/><input type="checkbox"/></p> | <p><u>DIFFERENT AREAS WITHIN JOHANNESBURG INNER CITY THAT RESEARCH PARTICIPANT MAY LIVE IN</u></p> |
|--|--|--|

|  |   |                          |
|--|---|--------------------------|
| <ul style="list-style-type: none"> <li>• Where did the person originally reside</li> <li>• Why did they move to the Johannesburg Inner City</li> </ul>     |   |                          |
| <b>2. Is research volunteer employed?</b><br>→Get the participant discuss their employment status. He should not reveal their actual jobs or workplaces. . | Yes<br><input type="checkbox"/><br>No<br><input type="checkbox"/> | <u>EMPLOYMENT STATUS</u> |

### HEALTH SEEKING BEHAVIOR

|   |   |   |
|---|---|---|
| <b>3. Do you access health care and what services do you access?</b><br><br>→Get the participant to discuss health care services focussing on: <ul style="list-style-type: none"> <li>• VCT</li> <li>• STI-care</li> <li>• TB or other services</li> <li>• Geographical location of clinics where health care is accessed</li> </ul>      | Generally VCT<br><input type="checkbox"/><br>Generally STI<br><input type="checkbox"/><br>Generally TB<br><input type="checkbox"/><br>Mixed<br><input type="checkbox"/> | <u>REASONS FOR ACCESSING HEALTH CARE (IF APPLICABLE)</u><br><br><u>MOST ACCESSED SERVICES (IF APPLICABLE)</u> |
| <b>4. What are barriers to accessing health care services?</b><br><br>→Discussion to focus on reasons for not accessing health care including <ul style="list-style-type: none"> <li>• Geographical location of health care facilities</li> <li>• Experiences when accessing health care (especially with health care workers)</li> </ul> |   | <u>REASONS FOR NOT ACCESSING HEALTH CARE FACILITIES</u>   |
| <b>5. What would make you go to clinics and health facilities?</b><br><br>→Get the participant to discuss what he would like the clinic to offer for him to come to that clinic   |   | <u>SUGGESTIONS FOR MAKING CLINICS MSM FRIENDLY</u>  |

|  |  |   |
|--|--|---|
| <p><i>(including male health care workers, special days for MSM etc). Please probe this in depth and get enough suggestions for programme development and improvement</i></p> <p>→ Discussion to also touch on</p> <ul style="list-style-type: none"> <li>• Clinic operating times</li> <li>• Clinic waiting times</li> </ul>  |  |   |
| <p><b>6. Do you think that stigma and discrimination against MSM presents a barrier in accessing health care services?</b></p> <p>→ Get the participant to discuss whether his sexual orientation stops him from going to the clinic because he may be embarrassed or health care workers may not want to assist him being MSM etc. One example to ask is how he would feel discussing contraction of an STI with a HCW</p>  | <p>Generally Yes<br/><input type="checkbox"/></p> <p>Generally No<br/><input type="checkbox"/></p> <p>Sometimes<br/><input type="checkbox"/></p> | <p><u> VIEWS ABOUT DISCRIMINATION AGAINST MSM IN HEALTH SERVICES</u></p>  |
| <p><b>7. Are there specific sexual health needs experiences by MSM which are not addressed by the clinic?</b></p> <p>→ Get the participant to discuss health care needs focussing on</p> <ul style="list-style-type: none"> <li>• What his health care needs are</li> <li>• What health care needs are addressed by the clinic</li> <li>• What health care needs need to be addressed by the clinic</li> <li>• Suggestions for improvement in the services offered by the clinic in this regard</li> </ul> | <p>Generally Yes<br/><input type="checkbox"/></p> <p>Generally No<br/><input type="checkbox"/></p> <p>Sometimes<br/><input type="checkbox"/></p> | <p><u> GENERAL VIEWS AROUND WHICH HEALTH CARE NEEDS ARE ADDRESSED AND WHICH AREN'T</u></p> <p><u> SUGGESTIONS FOR IMPROVEMENT</u></p> |

**PROGRAMME SPECIFIC QUESTIONS**

|  |            |                               |
|--|------------|-------------------------------|
| <p><b>8. Are you aware of the peer educators and health talks/</b></p> | <p>Yes</p> | <p><u> PEER EDUCATORS</u></p> |
|--|------------|-------------------------------|

|  |   |   |
|--|---|---|
| <p><b>education done in the clinic?</b></p> <p>→Get the participants to discuss</p> <ul style="list-style-type: none"> <li>• Whether they were ever approached by peer educators</li> <li>• If they attended health talks and which topics</li> <li>• How did they hear about the health talks</li> <li>• What other information they would like to be included in health education</li> </ul>                         | <input type="checkbox"/><br><br>No<br><br><input type="checkbox"/>            | <u>HEALTH TALKS</u>   |
| <p><b>9 Would you recommend the Esselen clinic to your friends/ to anybody in general?</b></p> <p>→ Participant discussion to focus around</p> <ul style="list-style-type: none"> <li>• Whether he would recommend the clinic</li> <li>• Why would he not recommend the clinic(probe thoroughly)</li> <li>• Are there positive things about the clinic that makes him come back (e.g. services &amp; staff)</li> </ul> | Yes<br><br><input type="checkbox"/><br><br>No<br><br><input type="checkbox"/> | <u>VIEWS AROUND RECOMMENDING THE CLINIC TO OTHERS</u><br><br><br><u>CLINIC SERVICES AND STAFF</u> |

**SEXUAL ORIENTATION AND BEHAVIOUR**

|   |   |  |
|---|---|--|
| <p><b>10. Are you openly MSM?</b></p> <p>→ Participant discussion to focus around</p> <ul style="list-style-type: none"> <li>• Whether he is openly MSM</li> <li>• Issues around being MSM (stigma, discrimination etc)</li> <li>• Do these issues prevent him from being openly MSM</li> </ul> | Yes<br><br><input type="checkbox"/><br><br>No<br><br><input type="checkbox"/> | <u>VIEWS AROUND BEING OPENLY MSM</u><br><br><br><u>SOCIAL ISSUES EXPERIENCED BECAUSE OF SEXUAL ORIENTATION</u> |
|---|---|--|

|  |  |  |
|--|--|--|
| <p><b>11. Do you use condoms?</b></p> <p>→ <i>Participant discussion to focus around</i></p> <ul style="list-style-type: none"> <li>• <i>Where condoms are obtained from (e.g. buy, clinics, public condotainers/ condom dispensers)</i></li> <li>• <i>With who condoms are used</i></li> <li>• <i>Frequency of condom usage</i></li> <li>• <i>Why condoms are used (checking whether condoms are used to prevent STIs /HIV acquisition or transmission)</i></li> </ul>  | <p>Generally Yes<br/><input type="checkbox"/></p> <p>Generally No<br/><input type="checkbox"/></p> <p>Sometimes<br/><input type="checkbox"/></p> | <p><u>IEWS ABOUT CONDOM AND CONDOM FATIGUE</u></p> |
| <p><b>12. Tell me about your sexual practices</b></p> <p>→ <i>Participant discussion to focus around</i></p> <ul style="list-style-type: none"> <li>• <i>When he first started engaging in MSM activities</i></li> <li>• <i>When he engages in the activities (e.g. at night only, only in another geographical location)</i></li> <li>• <i>“Hot spots” for picking up guys or getting picked up</i></li> <li>• <i>Frequency of MSM activities</i></li> <li>• <i>Number of partners</i></li> <li>• <i>Main activity engaged in e.g. UIA, oral sex</i></li> </ul> |  | <p><u>DESCRIPTION ABOUT SEXUAL PRACTICES</u></p>   |

**KNOWLEDGE OF HIV AND AIDS**

|   |   |   |
|---|---|---|
| <p><b>13. What are HIV and AIDS?</b></p> <p><i>→Direct the discussion around what the person thinks HIV and AIDS are and how it is acquired/ transmitted.<br/>Does research volunteer generally have knowledge around HIV and AIDS?</i></p>   | <p>Yes<br/><input type="checkbox"/></p> <p>No<br/><input type="checkbox"/></p>  | <p><u>SUMMARY OF DISCUSSION ON WHAT HIV/AIDS IS AND HOW IT IS TRANSMITTED</u></p>           |
| <p><b>14. What are your views about your personal susceptibility in contracting HIV? Do they think that they contribute to HIV/AIDS acquisition or transmission in any way?</b></p> <p><i>→Get the participant to discuss his views on what role he plays in transmitting HIV or getting HIV – especially by not regularly accessing VCT or STI treatment</i></p> | <p>Yes<br/><input type="checkbox"/></p> <p>No<br/><input type="checkbox"/></p> <p>Unsure<br/><input type="checkbox"/></p> | <p><u>SUMMARY OF DISCUSSION ABOUT NOT KNOWING YOUR STATUS AND BEING SEXUALLY ACTIVE</u></p> |

**COMMUNITY SUPPORT & INTEGRATION WITH NGOs**

|  |   |   |
|--|---|---|
| <p><b>15. Do you know of other organisations in your area that provide health care?</b></p> <p>→Discussions to get information on</p> <ul style="list-style-type: none"> <li>• Names of other NGOs</li> <li>• Do men access these NGOs' services</li> <li>• What other services men would like to have in their area</li> <li>• Do men access traditional healers</li> </ul> | <p>Yes<br/><input type="checkbox"/></p> <p>No<br/><input type="checkbox"/></p> <p>Unsure<br/><input type="checkbox"/></p> | <p><u>SUMMARY OF DISCUSSION AROUND NGOs IN THEIR AREA</u></p> |
|--|---|---|

*Conclusion (5 minutes)*

Thank you for your time and information.

Ask if there are questions and comments on anything about the study or this discussion. Discuss with participant what he thinks are the main points that you discussed. Address any outstanding questions that you may have postponed to the end during the discussion.

**APPENDIX H**

**DEMOGRAPHIC QUESTIONNAIRE FOR IN-DEPTH INTERVIEWS ON HEALTH SEEKING BEHAVIOUR IN THE MSM POPULATION IN THE JOHANNESBURG INNER CITY**

Questionnaire number: \_\_\_\_\_

Interviewer number: \_\_\_\_\_

Date of interview: .....

Where is the interview taking place? **(Tick one of the following)**

Esselen Clinic

Field (state which geographical area)  \_\_\_\_\_

**Demographic Information**

1. a) Language spoken .....

1. b) Age: .....

2. Place of birth (City, Province, and Country)  
.....

3. Neighbourhood of residence? **(Tick one of the following)**

|                 |   |
|-----------------|---|
| Hillbrow        | 1 |
| Yeoville        | 2 |
| Soweto          | 3 |
| Alexandra       | 4 |
| Other (specify) |   |

4. When did you move to this neighbourhood?  
\_\_\_\_\_Year

5. What is the main reason why you moved to this neighbourhood?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What is your current employment status?

|                    |   |
|--------------------|---|
| Full-time employed | 1 |
| Part-time employed | 2 |
| Unemployed         | 3 |
| Student            | 4 |
| Self employed      | 5 |
| Other (specify)    |   |

7. What is your highest educational level?

|  |   |
|--|---|
| Some primary school                          | 1 |
| Completed primary school                     | 2 |
| Some secondary school                        | 3 |
| Completed secondary school                   | 4 |
| Any tertiary education/post secondary school | 5 |

8 What is your race?

|                |   |
|----------------|---|
| Indian         | 1 |
| Coloured       | 2 |
| African        | 3 |
| White          | 4 |
| Other (Expand) | 5 |

9. Which religion, if any, do you identify with (e.g. Christianity, Hinduism, and Judaism)?

If Christian – ask which denomination (e.g. Anglican, Catholic etc)

.....

10. Which ethnic group do you identify with?

.....

...

11. Are you married?

|                              |   |
|------------------------------|---|
| Married                      | 1 |
| Single                       | 2 |
| Widowed                      | 3 |
| Cohabiting                   | 4 |
| Divorced                     | 5 |
| Other (please specify) _____ |   |

11.1 If “married” or “cohabitating” is your spouse/partner a man or a woman?

|        |   |
|--------|---|
| Male   | 1 |
| Female | 2 |

11.2 If “single”, “widowed” or “divorced” do you mostly date men or women?

|       |   |
|-------|---|
| Men   | 1 |
| Women | 2 |

12 Do you have children? (Own biological children)

|     |    |
|-----|----|
| Yes | No |
| 1   | 2  |

12.1 If “yes”, how many?

.....