

Sexual behaviours and HIV protective practices amongst men who have sex with men (MSM) and
men who have sex with men and women (MSMW) in Soweto

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partial fulfilment of the requirements for a Degree in Master of Public Health

Submitted by: Sibongile Hillaray Dladla (Student number: 0711503X)

Supervisors: Dr Nicola Christofides, University of Witwatersrand, School of Public Health

Ms Helen Struthers, Director, Anova Health Institute

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Declaration

I, Sibongile Dladla, declare that this research is my own work. It is submitted in partial fulfilment of the degree of Master in Public Health in the field of Health Systems and Policy, at the Witwatersrand, Johannesburg. This research has not been submitted for any examination or degree at this or any other university.

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Abstract

Background: there is a growing body of research on men who have sex with men (MSM) and risk factors for HIV in South Africa. However, in order to develop more appropriate and relevant interventions to reduce the transmission of HIV amongst MSM and MSMW, there was a need to deepen our understanding of sexual risk behaviour and protective practices. The aim of the study was to explore the sexual risk and protective behaviour of men who have sex with men and women in Soweto, South Africa.

Methods: In-depth interviews were conducted with twelve men who self-identified as MSM from the Health4men clinic, a men's clinic situated at the Perinatal HIV Research Unit, Chris Hani Baragwanath Hospital. The interviews were conducted by the researcher in the counselling room to ensure privacy and confidentiality was assured. The interviews were taped, transcribed verbatim and thematic analysis conducted.

Results: The study found that the 10 gay-identified and two bisexual-identified men had knowledge on HIV transmission and how to protect themselves from infection but having knowledge did not necessary translate to consistent safer sex practices. High partner numbers and concurrency were described by study participants. Condoms were used but not consistently with different partners. Alcohol abuse played a critical role in engaging in sex with once-off partners, often with using condoms. Participants reflected on the lack of HIV prevention messaging that addressed their lives.

Conclusion: The study found that gay and bisexual men in Soweto are vulnerable to HIV as there are no sufficient prevention effort put into their health by the government and other stakeholders. HIV-related stigma, alcohol use, partner numbers and homophobia were perceived to contribute to HIV prevalence. Behaviour-change strategies, embedded in broader social change, remain an important HIV prevention strategy in the MSM community.

Table of contents

Declaration.....	ii
Acknowledgements.....	iii
Abstract.....	iv
Table of contents.....	v
Acronyms.....	viii
Definition of key terms.....	ix

Chapter 1: Background and Introduction

1.1 Introduction.....	1
1.2 Statement of the problem.....	2
1.3 Justification.....	2
1.4 Aims and objectives.....	3

Chapter 2: Literature review

2.1 The extent of HIV in South Africa.....	4
2.2 HIV and MSM Global perspective.....	5
2.3 HIV and MSM in South Africa.....	6
2.4 HIV Risk Factors among MSM.....	7
2.4.1 Unprotected anal sex.....	7
2.4.2 Condom use.....	8
2.4.3 Partner numbers.....	8
2.4.4 Concurrency.....	9
2.4.5 Risk and Protective behaviour.....	9
2.4.6 HIV, Alcohol and Drug use.....	10

2.4.7 HIV knowledge.....	11
2.4.8 Perception of Risk among MSM.....	11
2.4.9 Homophobia.....	12
2.4.10 HIV Protective Factors amongst MSM.....	12

Chapter 3: Methodology

3.1 Study design.....	14
3.2 Study site.....	14
3.3 Study population.....	14
3.4 Study sample.....	14
3.5 Data collection.....	15
3.6 Data management and Analysis.....	16
3.7 Ethical considerations.....	17

Chapter 4: Findings.....

4.1 Perceptions of HIV and HIV risk.....	18
4.2 HIV knowledge and transmission.....	20
4.3 Non-disclosure of HIV status.....	21
4.4 Multiple and concurrent partners.....	22
4.5 Partner numbers.....	23
4.6 Where sex takes place.....	23
4.7 Condom use with different sexual partners.....	25
4.8 Alcohol use & sexual risk behaviour.....	27
4.9 Homonegativity and discrimination.....	28
4.10 Perceptions of HIV messages.....	30

Chapter 5: Discussion	33
5.1 Knowledge of HIV & risk perception	33
5.2 Sexual behaviour, risk and protective practices	34
5.3 Awareness of HIV prevention campaigns and key messages	35
5.4 Homonegativity & discrimination	36
5.5 Limitations	37
Chapter 6: Conclusion and Recommendations	
6.1 Conclusion	39
6.2 Recommendations	39
6.2.1 Venue	41
6.2.2 Homonegativity	42
6.2.3 HIV messages	43
References	44
Appendix A	46

Acronyms

AIDS:	Acquired Immune Deficiency Syndrome
ART:	Anti-Retroviral Treatment
MSM:	Men who have sex with men
MSMW:	Men who have sex with both men and women
HIV:	Human Immunodeficiency Virus
NSP:	National Strategic Plan
STI:	Sexually Transmitted Infection
VCT:	Voluntary HIV Counselling and Testing
UAI:	Unprotected Anal Intercourse

Definition of key terms

MSM:

Men who have sex with men (MSM): is an abbreviation used for Men who have sex with men or males who have sex with males. The term describes males who have sex with males, regardless of whether or not they have sex with women or have personal or social gay or bisexual identity (UNAIDS., 2011).

Gay:

The term gay can refer to same-sex sexual attraction, same-sex sexual behaviour, and same sex cultural identity. The expression 'men who have sex with men' should be used unless individuals or groups self-identify as gay (UNAIDS., 2011).

Bisexual:

Bisexual is defined as a person who is attracted to and/or has sex with both men and women and who identifies with this as a cultural identity. The expression 'men who have sex with both men and women' or 'women who have sex with both women and men' should be used unless individuals or groups self-identify as "bisexual" (UNAIDS., 2011).

Heterosexual:

An individual who is attracted emotionally and physically to people of the opposite sex/gender. Heterosexuals do not necessarily have to have sexual experiences with people of the other sex/gender in order to identify themselves as being heterosexual (UNAIDS., 2011).

Homosexual:

An individual who is attracted sexually, emotionally and affectionately to people of the same sex/gender (UNAIDS., 2011).

Homophobia:

Has been an umbrella concept used to describe a varied range of social phenomena related with prejudice, discrimination and violence against homosexuals (UNAIDS., 2010).

Internalised homophobia:

Reflects a lack of positive beliefs about being gay, about valuation of large gay community, and about the morality of being gay (Steven., 2009).

Safer sex:

The term 'safer sex' reflects the idea that choices can be made and behaviours adopted to reduce or minimize the risk of HIV transmission, these include consistent and correct condom use for vaginal or anal intercourse (UNAIDS., 2011).

Sexual orientation:

The term 'sexual orientation' refers to each person's profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of different, the same, or both sexes (UNAIDS., 2011).

Sexual health:

WHO describes sexual health as part of one's mental and physical health. It is defined as: 'the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhances personality, communication and love' (WHO., 1995).

Chapter 1: Introduction

1.1 Introduction

Since the beginning of the HIV/AIDS pandemic in the 1980s, almost 60 million people have been infected and 25 million people have died of HIV related causes (UNAIDS., 2009). In the UNAIDS report on the Global AIDS Epidemic (2010) it is reported that in 2009, there were estimated 2.6 people who became newly infected with HIV. In 33 countries, the HIV incidence has fallen by more than 25% between 2001 and 2009. Of these, 22, are from the sub-Saharan Africa (UNAIDS., 2010).

Sex between men was identified as a significant route of HIV transmission in the 1980s (UNAIDS., 2008). Sex between men happens in every part of the world, in all societies and between men of all ages and there is a worldwide misconception that sex between men occurs only among men who self-identify as gay (UNAIDS., 2006).

Globally, less than one of 20 men who have sex with men (MSM) has access to HIV prevention and care (UNAIDS., 2006). This is evident in much of the developing world and in Africa in particular where the stigmatisation, discrimination, and criminalisation of homosexuality persist (UNAIDS., 2006). In Africa, recent studies reported that 25% of MSM in coastal Kenya and 22% in Dakar, Senegal are HIV positive (UNAIDS., 2006). In South Africa, recent evidence suggests that HIV prevalence among MSM may be even higher with estimates between 14.7% and 36.6% (Lane., Fisher., et al 2009; Rispel & Metcalf., 2009).

Other studies in Africa documented high proportions of MSM reporting recent sexual relationships with women and bisexual men, indicating that the sexual networks of MSM extended to the general population (Population Council., 2009).

In the generalised HIV epidemic and high-prevalence zone of southern sub-Saharan Africa, there is little evidence of the epidemic control especially amongst MSM (Beyrer., 2010). While southern sub-Saharan Africa has long been the most HIV/AIDS affected region globally, it has been arguably the most understudied for the risks of HIV associated with male to male sexual contact (Baral., et al 2006). The highest rates of HIV infection overall reported by various studies have been seen in sub-Saharan Africa where heterosexual intercourse is the main transmission path for the spread of HIV (Baral., et al, 2006). The

studies report that African MSM's are at risk of HIV infection, and that they have been markedly underserved and marginalised (Baral., et al 2006).

1.2 Statement of the problem

MSM from low and middle-income countries are in urgent need of prevention and care, and appear to be both understudied and underserved (UNAIDS., 2006). There is a large body of knowledge from the United States about the prevalence and incidence of HIV and the associated risk factors among MSM (Herrick., et al 2011, Jacobs., et al 2010, Nicole., et al 2006). There is also growing evidence of the prevalence of HIV and sexual risk behaviours of MSM and protective measures with different sexual partners in South Africa and in particular among African MSM (Cacers., et al 2009, Kiene., et al 2006, Sandfort., et al 2008, Saharaj., et al 2008). In order to be able to address these challenges, more research and a deeper understanding is required to understand perceptions of risk among MSM.

1.3 Justification for the study

Men who have sex with men and men who have sex with men and women (MSM & MSMW) are still hidden in most communities. Several studies across sub-Saharan Africa suggest that unprotected anal sex between men is an important factor in the epidemic (Baral., et al 2006). There is growing research from South Africa that describes the perceptions of HIV risk and protective behaviour among men who have sex with men and women (MSMW). However, this research has not focused on how current HIV prevention messages mostly targeting the heterosexual population are perceived by MSM and MSMW.

This research will help fill gaps in information needed for monitoring of the National Strategic Plan on HIV, STIs & TB (NSP) 2012-2016, as well as help to provide information on HIV risk behaviours among MSM as part of the United General Assembly (UNGASS) monitoring requirements (NSP 2012-2016). Results from this study could help shape prevention messages and programmes targeted towards MSM an MSMW.

1.4 Aim and objectives

The overall aim of this study was to explore the sexual risk and protective behaviour of men who have sex with other men (and women) attending Health4Men services in Soweto, South Africa. The data were collected from September 2009 and ended in March 2010.

The specific objectives were:

1. To describe and analyse the perceptions of HIV risk among men who have sex with men, and men who have sex with men and women attending Health4Men services in Soweto for the period September 2009 to October 2010.
2. To explore the sexual risk behaviour and protective practices among MSM and MSMW including where and with whom men were having sex, condom use, lubrication use, alcohol and drug use.
3. To describe awareness of HIV prevention campaigns and perceptions of key messages among MSM and MSMW.

Chapter 2: Literature review

2.1 The extent of HIV in South Africa

South Africa is recognised as one of the countries most severely impacted by the HIV/AIDS pandemic (UNAIDS., 2006). An estimated 5.6 million people were living with HIV and AIDS in South Africa in 2011, the highest number of people in any country(UNAIDS., 2010).

HIV infection levels differ substantially by age and sex and also show a very uneven distribution among the nine provinces (Shisana., et al 2008). The country is experiencing a maturing generalised HIV epidemic in which heterosexual sex is the predominant mode of HIV transmission followed by mother-to-child transmission. Young adults, particularly females, are at greatest risk of acquiring HIV. Almost one-in-three women aged 25-29, and over a quarter of men aged 30-34 are living with HIV in South Africa (Shisana., et al, 2008). New indications show a slowing HIV incidence amid some signs of shift towards safer sex among young people. The annual HIV incident among 18 year olds declined sharply from 1.8% in 2005 to 0.8% in 2008, and among women 15–24 years old it dropped from 5.5% in 2003–2005 to 2.2% in 2005–2008 (UNADIS., 2010)(4).

According to the Shisana, et al (2009) South African HIV prevalence, incidence, behaviour and communication survey 2008, MSM are now categorized under the Most at Risk Population (MARPs). MARPs are defined as those populations that are found to have a higher HIV prevalence when compared to the general population (UNAIDS., 2006). In the generalised epidemic of Southern African the definition of MARPs is not clear cut, as higher than average prevalence may apply to large populations and sub-populations. Some MARPS are not necessarily stigmatised or marginalised to the same extent as others, it remains true that their risks are higher (Shisana., et al., 2009). In HIV for example, there are groups that are marginalised, i.e. men who have sex with men, commercial sex workers, truck drivers and many more) who are excluded from policies benefiting the wider public – in some cases there are laws against MSM. Other at-risk populations are often among the most marginalised and most likely to be stigmatised. In the National Strategic Plan on HIV, STIs and TB 2007-2011 the point is made that there is very little known about HIV prevalence and incidence among the

MSM population while noting that this population is particularly susceptible to HIV infection (Department of Health., 2007).

2.2 HIV and MSM: Selected international literature

The use of the term “MSM” has been used to describe the behaviour of biological males having sex with other biological males, but that does not address issues of sexual and gender identity and how identity and behaviour interact (Caceres., et al. 2009).

The Joint United Nations Programme on HIV/AIDS (UNAIDS) notes that faced with legal or social sanctions, men having sex with men are either excluded from, or exclude themselves from, sexual health and welfare agencies because they fear being identified as homosexuals (UNAIDS.,2008). MSM who disclose their orientation, through choice or necessity, report family rejection, public humiliation, harassment by authorities and ridicule by health care workers (Smith., et al 2009) Unprotected anal intercourse is the primary risk factor for HIV infection for MSM. Sex between men frequently involves anal intercourse, which if unprotected, carries a high risk of HIV transmission for the receptive partner, and a significant risk for the insertive partner (Magda., 2008). At least 5-10% of all infections worldwide are due to sexual transmission between men (UNAIDS., 2008).

Sex between men occurs in every culture and society though the extent and public acknowledgement vary from place to place (UNAIDS., 2008). In the USA, MSM continue to be the group most impacted by the human immunodeficiency virus (HIV) epidemic (Robin., Isabel., et al 2010). They account for nearly half of the approximately one million people living with HIV in the USA and 53% of all new infections (CDC., 2009). A survey conducted in Senegal and Voluntary Counselling and Testing (VCT) data from Kenya, found that HIV prevalence for MSM was higher than the national prevalence estimates (Wade., 2005).

Researches from recent studies in sub-Saharan Africa indicate the existence of groups of men who have sex with men and high levels of HIV infection among them. Up to 20% of new HIV infections in Senegal (23) and 15% of those in Kenya (20) and Rwanda (24) could be linked to unprotected sex between men (UNAIDS., 2010) Available evidence suggests that in sub-Saharan Africa, as elsewhere in the world, the majority of men who have sex with men also have sex with women (UNAIDS., 2010).

Several studies have been conducted in America that looked at the age and race at which MSM become infected with HIV. One of the studies was conducted by CDC was a closed cohort study of young gay men at the age of 18, none of whom were infected at age 18, the incidence rate of infection was estimated to be 2.4% per year as these men moved from age 20 to age 40 (CDC., 2008). Another study conducted by Centre for disease control (CDC), and published in June 2011 that investigated HIV and young MSM in the United States revealed similar findings as Lane and colleagues study from South Africa. They reported an estimated 56,300 Americans are infected with HIV each year. Of these, 34% are adolescents or young adults aged 13-19 years. Young MSM especially black MSM were at the highest risk (CDC., 2011).

2.3 HIV and MSM in South Africa

HIV prevalence in the population of men who have sex with men in South Africa is consistently higher than the general population (Lane., et al 2007). Lane and colleagues (2011) reported that the HIV prevalence among men who have sex with men in Soweto was 13.2%. Rispel and colleagues found that HIV prevalence among MSM was 49.5% in Johannesburg and in Durban was 27.5% (Rispel., et al 2011).

The study by Lane., et al (2011), found that HIV prevalence estimation amongst self-identifying gay men is 33.9%, which is three times greater than that of bisexual and straight identified MSM whose respective estimates were 6.4% and 10.6%. Baral (2006) reported HIV rates, where available, have been higher than among other men of reproductive age in the same populations. Several studies appear to confirm this, with rates between 14.1% and 38.3% (Lane., et al 2011; Sandfordt, 2008).

Recently published data from the Soweto Men's study on HIV prevalence and risk behaviours suggest that young gay and bisexual men continue to place themselves at considerable risk of infection with HIV and other sexually transmitted diseases (Lane., et al 2011). The study confirmed that HIV prevalence among self-identifying gay men to be three times greater than that of straight identified MSM whose respective estimates of 6.4% and 10% are comparable to the 11.7% HIV prevalence found among South African men aged 15-29 in the 2005 National Survey (Lane., et al 2011; Shisana et al., 2009). Other studies report that HIV rates have been higher than among other (straight) men of the reproductive age in

the same population, yet the MSM tend to have limited knowledge of health related risks of anal intercourse (Baral., et al 2009). Data collected from Cape Town, Durban, Johannesburg and Soweto, have all consistently yielded results showing that the HIV prevalence rates among MSM range between 14.15% and 38.3% among different subpopulations i.e. gay-identified, straight-identified and bisexual (Barrel., et al 2009; Lane., et al 2011; Rispel and Metcalf 2011). There seems to be inequalities on HIV prevalence in the general population that are associated with age and race which can also be found in MSM population (Jobson., et al 2010)

Lane., et al (2011) found that MSM who are aged 19 have a prevalence rate that was similar to that of women of the same age group rather than that of men in the general population. Lane and colleagues findings were compared with the 2005 National HIV Survey conducted by Shisana and colleagues at the HSRC. Shisana., et al found that the age at which most women become infected with HIV was between ages of 15-24, which was similar to MSM in Lane., et al, study. The study also looked at the trend of HIV spreading and they compared their findings to that of the HSRC on both men and women and it appeared that HIV is spreading more quickly among MSM than women (Lane., et al 2011). HIV infections are likely to be increasing at the fastest pace among young, black MSM and the increase is more dramatic if gay identifying (Lane., et al 2011).

2.4 HIV Risk Factors among MSM

2.4.1 Unprotected Anal Intercourse

Individual-level risks of HIV infection among MSM are similar in high-and-low-income countries (Beyrer., 2007). Risk behaviours contributing to this risk include unprotected anal intercourse, frequency and number of sexual partners, intravenous drug use (IDU)-related risks, and use of non-injection drugs (Nardone., et al 1998; Girault., et al 2004; Wade., et al 2005; van Griensven., et al 2005; Cloete., et al 2006; Herbst., et al 2007; Dodds., et al 2007; Rawstorne., et al 2007). The trend of unprotected sex among MSM appears to have increased since the 1990s and a steadily growing number of Sexually Transmitted Infections (STI) in this population has been observed in the United States (Richard., 2011). A study conducted in a sample of 802 MSM on factors associated with risk of UAI in men aged 40

and older revealed that most participants reported having anal sex in the past six months and 87% reported not using condoms (Robin., 2010).

2.4.2 Condom use

Studies conducted in Brazil (2000) suggest that the MSM population had low rates of consistent condom use. They reported that of 658 participants enrolled in the study, 30% were estimated to have had unprotected receptive anal sex in the last two months with one partner and 7% with more than one partner (de Mello., Adriana., et al 2000). Despite these low levels of condom use, 50% of MSM perceived themselves to be at low risk for HIV infection (de Mello., Chinaglia., et al 2000). A study conducted in New York presented results on why some MSM engage in *barebacking* despite knowledge of risk (Alex., 2011). *Barebacking* is defined as the practice of intentional condom less anal intercourse among MSM in circumstances in which there is risk of HIV transmission (Berg., 2009) Study participants reported that condom-less sex increased pleasure and satisfaction, provided more emotional intimacy, and could sometimes act as an expression of love (Alex., 2011). In much of the world, some MSM also have sex with women, and there is low prevalence of condom use with both their male and female partners, this may lead to underestimation of transmission from men to their female partners (Caceres., 2009).

2.4.3 Partner Numbers

While risk of HIV infection increases as a product of having many sexual partners, it is particularly risky to have concurrent sexual partners as this creates multiple pathways (more possibilities) for HIV transmission to occur in the general population (Shisana., et al 2009). Latkin (2011) discovered that many black MSM have female partners and that they talk to network members (the other MSM who have female partners) about their same sex behaviour, but do not talk about condom use. These results are similar to those of a study conducted in Brazil 2008, which reported that 16% of MSM had sex with both men and women in the last two months. Among those who had vaginal or anal sex with female partners, it was estimated that 75% had practised unprotected anal or vaginal sex with female partners (de Mello., Chinaglia., et al 2008).

2.4.4 Concurrent Sexual Partners

Concurrent sexual partnerships, where sexual relationships overlap in time are noted to be a major factor contributing to the rapid growth of HIV infections, and qualitative research illustrates that such partnerships are normative in South Africa (Parker., et al 2007). A study done with MSM in Southern Africa revealed that the issues of concurrency and bisexuality are also common in men in different countries (Beyrer., 2010).

Concurrency of sexual relationships has been posited by several groups as a key driver of the high rates of prevalence in the southern African region (Chen., 2007). Concurrency of same and opposite sex partners has been little studied, and may play an important role as well (Baral., et al 2009). A report on partnership patterns and HIV prevention amongst (MSM) conducted by the national aids trust in the UK, 2010 concluded by stating that both the number and very probably the concurrency of sexual partners have a significant impact on HIV transmission amongst MSM in the UK (National AIDS Trust., 2010). They reported that multiple partnerships increase transmission of STIs amongst MSM- and these increasingly prevalent STIs also increase transmission of HIV (National AIDS Trust., 2010).

2.4.5 Risk behaviour

A study conducted among HIV positive men who have sex with men (MSM) in Cape Town South Africa reported that a high percentage of men engaged in unprotected anal sex and did not disclose their HIV status to their partners (Cloete., et al 2006). Over 50% of participants reported having anal sex with more than one partner without informing them of their HIV positive status (Cloete., et al 2006). Several studies of MSM in Africa have noted high rates of reporting sex with both female and male partners in the past (Beyrer., et al 2008). Thirty percent indicated that they had unprotected vaginal sex more than once in the previous three months (Cloete., et al 2006).

The Soweto men's study identified the importance in self-identification to explain the sexual behaviours of MSM (Lane., et al 2011). In the study, 199 men who participated, 44.4% of men who reported having a regular female partner also reported unprotected anal intercourse with men (Lane., et al 2011). In a study conducted in Kenya, 69% of MSM interviewed reported having sexual relations with a woman at least once in their lives (Johnson., et al 2007). Of those respondents in Nairobi who reported having had sex with

women, 20% reported engaging in vaginal sex with women in the past month with less reporting condom use with female partners (Johnson., et al 2007).

4.6 HIV, Alcohol and drug use among MSM

The dynamic of alcohol use, centred around the places where people drink and socialize, are important with regard to the spread of HIV (Kalichman., et al 2008). Kalichman., et al (2008) also found that 28% of participants in their study had met at least one sexual partner at shebeens, participants who met sex partners at shebeens drank more heavily, had more sex partners and had higher rates of unprotected sex compared to participants who did not meet partners at shebeens (Kalichman., et al 2008).

Alcohol and drug abuse are a significant risk factor for HIV infection in the MSM community (Irwin., et al 2006). While alcohol is widely recognised as a risk factor for HIV infection among MSM, it is also important to understand how alcohol use may serve different “functions” for insertive and receptive partner respectively (Irwin., et al 2006). Other functions that alcohol play in MSM community is to be more social and open about their sexuality. Grant., et al (2011) reported that there continues to be a high prevalence of substance use among MSM and that non-injection drug use is associated with increased HIV risk.

Lane., et al (2008) reported 78% of participants reported alcohol as their most commonly used drug with 29% reporting marijuana use. However their results did not highlight the relation between alcohol consumption and HIV infection, instead the study noted the alcohol traded in exchange for sex. Levels of alcohol use in South Africa are high, as well as levels of risky alcohol use. Another study found that alcohol use in the sexual context was associated with unprotected anal intercourse (UAI) among MSM who used the internet to meet partners (Berg., 2008).

Sexual risk behaviour among MSM is increasing in many countries and some of it has been linked with alcohol and drug use (UNAIDS., 2006). The interaction between sex and drug use by MSM is described differently in the research that is currently available. Drugs are used in a social context where MSM socialize, because they increase acceptance by others, boosts self-esteem and gives more energy (Parry., et al 2008). Lane and his colleagues (2008) found

that unprotected anal intercourse (UAI) was associated with both regular alcohol use and intoxication. Rispel and Metcalf (2009) reported that 73% of MSM, participating in their study, reported having sex after consuming alcohol in the last 12 months.

To date, studies that have reported the relationship between alcohol consumption and HIV in the region have focused only on heterosexual transmission, with the exception of one study of MSM in Senegal (Wade., et al 2005) which did not find a significant association between alcohol use and HIV infection.

2.4.7 HIV Knowledge among MSM

A report by Parry and colleagues (2008) stated that MSM were well informed about HIV and how to protect themselves but when they were under the influence of drugs or alcohol, they lost control and put themselves at risk. He further reported that in his sample, MSM were well informed about HIV/AIDS, knew where to access VCT services and some indicated that they were tested regularly. The views about risk behaviour that individual's choices regard to engaging in risk behaviour are based on their knowledge of and attitudes towards these risk behaviours (Barnett & Whiteside., 2002).

2.4.8 Perception of risk among MSM

Johnson., et al (2007) argues that there are low perceptions of risk among MSM in Nairobi because of misconceptions about the risks associated with same-sex sexual behaviour. These include that HIV and STI cannot be transmitted through anal sex or through sex between men and that only the receptive partner in anal intercourse is at risk of contracting STI. These misconceptions may increase individual's vulnerability to HIV infection and transmission. In addition, even when MSM are aware of general HIV prevention interventions, low perceptions of risk of their own sexual practices may preclude them from accessing health services (Caceres., et al 2009).

2.4.9 Homophobia

Homophobia is a phenomenon where lesbians, gay and bisexual individuals face prejudice due to their sexual orientation (Meyer., et al 2003). Homophobia is pervasive and impacts all members of society (Herrick., Smith., et al 2011). MSM experience high rates of mental

health issues such as depression, and substance use as a result of stigma and discrimination from the homophobic society where they live. There are studies that suggest that social oppression and substance use may be the factors that affect the HIV risk behavior among MSM (Poppen., et al 2004). Other authors state that gay-identified people often experience internalised homonegativity, in which they internalise anti-gay attitudes and experience “negative views of self” (Weber., et al 2008).

The effects of exposure to homophobic environments, stigma and discrimination, may also be as important influence on individuals risk behaviour. Cloete (2008) notes that internalised feelings of shame and guilt have negative effect on the health status of individual’s living with HIV. Steven (2009) describes internalised homophobia as reflecting a lack of positive belief about being gay, about valuation of the larger gay community and the morality of being gay. They continue to report that in MSM and MSMW internalised homophobia correlated with low self-esteem and high-risk sex.

2.4.10 HIV harm reduction among MSM

Research on HIV protective factors among MSM have been limited with the exception of few studies on sero-sorting and sero-positioning. Even though this practice of identifying partners with the same sero-status is seen as a prevention method that MSM can engage in, it still does not guarantee safety. UAI between two partners who are both HIV positive can pose health risks for HIV-positive MSM themselves if such behaviours lead to co-infection with another STI or HIV - super infection (Nicole., et al 2006).

Chapter 3. Methodology

3.1 Study design

This was a qualitative study, which was descriptive and exploratory in nature. A qualitative approach was used because of the exploratory nature of this study. Additionally MSM(W) in Soweto are a hidden population because of stigma and social prejudice.

3.2 Study site

The study was conducted at Health4men clinic situated at the Perinatal HIV Research Unit at Chris Hani Baragwanath Hospital, Soweto. Soweto is a township southwest of the metropolitan of Johannesburg. The Health4men clinic is a clinic that caters for men's health which includes MSM and non-MSM identifying men. The clinic offers services such as VCT, Sexually transmitted infection (STI) screening and provides treatment for those who are on wellness programmes and those who require antiretroviral therapy (ART). The services are free which addresses some of the barriers for MSM who are unemployed to receive appropriate health care. Patients are mostly black men who cannot afford to visit private doctors for health care services. Health4men provides health care services to MSM and MSMW who resides, socialize and work in Soweto.

3.3 Study population

The study population was all MSM and MSMW who lived or socialised in Soweto and attended the Health4men clinic. To be eligible to take part in the study, men were required to be over the age of 18 and have had oral and/or anal sex with a man in the last six months.

3.4 Study sample

A purposive sample of twelve men was recruited to participate in the study. All participants were men who reported having sex with another man in the last six months. The study participants were self-identified MSM and MSMW, who identified as straight (heterosexual) or bisexual or gay (homosexual). The participants were recruited from the clinic waiting room and they were screened for eligibility in a separate counselling room. Ten participants were gay identifying and two were bisexual. The men were selected to ensure maximum variation on age and gender identity. Men who were waiting in the waiting area of the clinic

were given information leaflet about the study to read and if they wanted to take part in the study to come to the researchers/counselling room. About 50 men were approached to take part in the study and 20 agreed to participate. Men were provided opportunity to ask questions first before agreeing to participate in the study. All men who were interested in participating in the study were given appointments to return for the interviews. Of the 20 who agreed to participate, 12 returned for the interview. Eight men who were scheduled to take part in the study did not show up for the interviews citing other commitments such as work.

3.5 Data collection

Data were collected using in-depth interviews which explored participant's perceptions. The interviews lasted approximately one hour, were audio taped and professionally transcribed by a colleague who does transcriptions for the Perinatal HIV Research Unit.

Interviews were scheduled Monday to Friday during working hours. On the day of the scheduled interview two informed consent forms (i.e. tape recording and agreeing to take part in the study) were read to participants in the language of their choice. Participants were asked whether they had any concerns before beginning with the interview. When participants were satisfied that they understood the study procedure, they signed the consent form. No remuneration or benefits was provided to the men who agreed to participate in the study.

The in-depth interviews were guided by an interview guide (see appendix D). The guide used open-ended questions in order to encourage discussions around issues of key interest in this study. The scope of inquiry included exploring preventive and risky behaviour of MSM and MSMW. The dimensions are presented below:

- Perceptions of HIV/AIDS and HIV prevention
- Perceptions of HIV prevention messages
- Sexual experiences and circumstances surrounding their experience.
- Alcohol use
- Concurrent partners

The researcher conducted all the interviews. She is a social worker by profession and was employed as a clinic manager during the time of the study. She was known by many of the participants which may have facilitated the rapport with participants. Since there was a high refusal rate to participate in the study, it is unlikely that her position at the facility played a role in participation or non-participation. As a woman asking MSM questions about sexual behaviour, it is possible that some participants did not disclose all their experiences and perceptions. However, participants did share intimate details so if there was an element of withholding, it was minimal. Being a woman may have affected negatively the participation of men who have sex with men and women. Some self-identified bisexual men who agreed to participate in the study at recruitment later missed their appointments suggesting that they may have changed their minds about participating. The sexual behaviour of MSM (W) is still a very sensitive topic especially in the black communities.

The researcher is conversant in isiZulu, Sesotho and English. She invited participants to choose the language that they wanted to be interviewed in. Participants preferred to be interviewed in English and used colloquial terms in their mother tongue IsiZulu or Sesotho, both common local languages. These were translated during the verbatim transcription that was made of audio-recording. All interviews were audio taped and were transcribed in English as soon as they were completed.

3.6 Data management and analysis

The audio-taped in-depth interviews were translated, transcribed verbatim, and stored in a computerised word processing program. The data were then imported into MAX QDA2 for coding. The data analysis began simultaneously with the data collection process. This process was conducted using a grounded theory approach and both inductive and deductive codes were applied. Preliminary data analysis informed the subsequent data collection and emerging themes were explored in more depth. Memos were used throughout to describe connections between codes and emerging theories.

The text segments were coded inductively. Codes perceptions and behaviours related to HIV, sexual self-identity, condom use, drug and alcohol use, homophobia, and exposure to HIV prevention activities. Such an open process is typical for data analysis based on grounded theory (Gibbs., 2007). An independent coder reviewed transcripts identifying data

that fell under this code. Comparisons were made until consensus was reached, definitions and examples were developed. The codes were developed into themes.

3.7 Ethical considerations.

Ethical approval was granted by the Wits ethics committee and the clearance certificate number is M10123 (See appendix B). Participating in the study was voluntary and participants were able to withdraw from the study at any time. All men were informed in detail about the study and were offered opportunity to ask questions. Participants were assured that if they chose not to participate in the study it would in no way affect the services that they received at the Health4men clinic.

Written consent for both the interview and the audio-recordings were obtained. Participants could terminate the interview at any time and were encouraged to ask questions throughout the interview. If respondents required assistance in terms of social and/ or health services, they were referred to the appropriate service within Health4men clinic. Respondents did not receive any financial incentive for the time spent in the study. Each participant was provided a unique study number and no personal identifiers were recorded on any of the study materials. The master list of names and unique identifiers were securely stored separately from other study materials. Tape recordings and consent forms are stored in a locked filing cabinet/cupboard at Health4men clinic. The transcripts are stored in a password protected file. All data would be kept for two years after the end of the two years it will be destroyed in accordance with the University Ethics Guidelines.

Chapter 4. Findings

A total of 12 men who have sex with other men were interviewed. They ranged in age between 18 and 45 years. Five of the men were employed, one was still a student in matric and six were unemployed. Eleven were African men and one was coloured. Five of the men were employed, one was still a student in matric and six were unemployed. Some were currently in “steady” relationships. Ten participants self-identified as gay and two identified as bisexual. The participants expressed that they had an average of two to three sexual partners in the last six months with one of the sexual partner being a life partner. They reported unprotected anal intercourse (UAI) with their “steady” partners and sometimes used condoms with their other partners.

Table 1: Socio demographic characteristics and pseudonyms of participants

	Pseudonyms	MSM/MSMW	Age	Race	Employment status	Gender identity
1	Thabo	MSM	33	Black	Employed	Gay
2	Katleho	MSMW	18	Black	Student	Bi-sexual
3	Magician	MSMW	31	Coloured	Employed	Bi-sexual
4	Sipho	MSM	25	Black	Employed	Gay
5	T-man	MSM	32	Black	Employed	Gay
6	Tebza	MSM	19	Black	Employed	Gay
7	Mandla	MSM	19	Black	Student	Gay
8	Lerato	MSM	27	Black	Employed	Gay
9	Vuvu	MSM	32	Black	Employed	Gay
10	Tshepo	MSM	32	Black	Unemployed	Gay
11	Dumi	MSM	35	Black	Employed	Gay
12	David	MSM	29	Coloured	Unemployed	Gay

4.1 Perception of HIV and HIV risk

The majority of respondents knew their HIV status as they attended Health4men clinic. While not asked directly about their HIV status, many of the men freely disclosed their HIV status during the interview. Eight participants who were interviewed disclosed that they were HIV positive, and three were receiving ARV treatment at the clinic. Participants shared that they believed that knowing their HIV status was important but did not consistently influence their sexual practices. They reported that at times they found themselves in situations, such as clubbing and drinking alcohol with friends, and felt less able to engage in safer sex.

The participants described their perceptions of how HIV spreads amongst their community and what they could do to prevent infection, or re-infection among those who are already HIV positive. The participants, especially the gay-identified men, were aware that they were part of a sexual network that put them at risk. Sipho, a gay identified man, explained that he was part of a very small gay community. He was aware of who was having sex with whom. Most of the men in his community were HIV positive. He went on to say that news travelled very fast within his community and as a result, there was no confidentiality or trust among them.

“ Uhm! My community i.e. the gay community is very small community and we know each other and out of 10 people you know, 6 or 7 out of us have dated each other. Seeing the HIV prevalence amongst them maybe 7 or 4 of them are already HIV positive” (Sipho, 25 year old, gay identified)

Other participants reported that individual choices and behaviours played an important role in their health. One man David stated that non-disclosure of their sexual orientation resulted in sex being hidden and that this puts MSM/MSMW at risk.

“ The straight community, they have these perceptions that gay people are very promiscuous and I share their sentiments that they are telling the truth. Gay people are rough; they are living another lifestyle especially when it comes to sexual issues” (David, 29 year old, gay identified)

Katleho stated that the link between unprotected sex and HIV is well-known. He believed that not using protection knowingly put men who have sex with men at risk of HIV infection, and the only circumstances he believed were beyond their control to use condoms was if sex was forced.

“it is stupid, like to get HIV in 2010, like willingly having unprotected sex. It takes conscious decision to have sex without a condom because you know the risks. It’s been said everywhere, it not a secret. We know what HIV is and we know how we get it. Unless if you have been forced into something” (Katleho, 18 year old, bisexual).

4.2 HIV knowledge and transmission

The participants demonstrated that they had good knowledge of how HIV is transmitted and how to protect themselves from becoming infected. Most participants reported that UAI happened in circumstances in which they were aware and they should have used condoms. In general, there was no single reason that led to UAI but a combination of factors. For example, participants who were gay identifying reported arousal, emotional involvement, and pleasure, as reasons that led to UAI and bisexual men reported curiosity, heat of the moment and not having condoms with them. Those who reported not using condoms with their steady partners expressed views that HIV was no longer a death sentence since there is treatment available. Dumi explained that HIV is a virus that cannot be seen through a naked eye. He further explained that people get to know their HIV status when they become ill from the virus.

HIV is like a virus that you get through sex (unprotected) and then you cannot see it when you get it. You will be able to see it after a certain time when you start experiencing health complications. And you find that because you see that you are becoming sick and you are having symptoms, you still don’t want to go for HIV testing because you are afraid. You will wait until you get worse maybe now you are losing weight and you see that they symptoms are starting to show outside and that’s when you start to seek help” (Dumi, 35 year old, gay identified).

““ the most common risk that may occur will be not using a condom, obviously. And then again not lubricating your anus before penetration because your anus is tight and guys comes in different sizes of penis and if your anus is not lubricated it will be by luck if you don't get cracks. But most people get cracks if not lubricated and they end up bleeding and if one is bleeding the risk of getting an infection is very high” (Thabo, 33 year old, gay identified).

Despite high levels of knowledge of HIV transmission, participants shared that there were times when they found themselves not doing the “right” thing when it came to protecting themselves and their partners, for example having unprotected anal intercourse.

“ I can say that the most common way of one ending up being infected with HIV is when one doesn't practice safer sex or doesn't take any precautions of preventing himself against contracting any body fluid from his partner” (Lerato, 27 year old, gay identified).

4.3 Non-disclosure of HIV status to sexual partners.

Non-disclosure of HIV status was also seen as something that could hinder practicing safer sex. Participants reported that it was difficult to inform their sexual partners of their HIV status, especially if it was a new partner.

“Especially in our gay life, there are many things happening. Like for example, we are not honest, if we meet a person for the first time, we won't tell them that we are HIV positive and we don't [know] whether they are HIV positive as well” (Tshepo, 32 year old, gay identified).

Men also perceived that if they disclosed their HIV status that information would be spread and that they will be unable to control who knows. Vuvu expressed fear that his family might find out his HIV status before he was ready to disclose to them if he were to be open about his status. The participant reported that if his family could find out his HIV status before he was ready to disclose to them, it would make things difficult for him as he also had a difficult time when disclosing his sexual orientation. He chose not to inform anyone about HIV status.

“ Just coming out will lead to my family knowing and that person will tell other people about my status and he will be doing that when I am not ready to come out myself. You know how it’s like in our townships and in the society when it comes to HIV issues” (Vuvu, 32 year old, gay identified).

4.4 Multiple and concurrent sexual partners.

Participants expressed that it was not easy to stick to one partner even though awareness of multiple partners was a known deterrent of HIV risk. They described that even when they had a main partner, they were also attracted to other men. Sexual desire was sometimes described as something very compelling. Some participants described how they would have a casual sexual encounter with someone because of their looks. T-Man, a gay identified man who is in a long-term relationship stated that he would encourage others to stick to one partner even though “faithfulness” was hard. He went on to describe that “there are handsome men out there” and that sometimes he could not resist.

“for me, it’s because men are handsome out there. (Both laughing). People are attractive out there; I mean even if you have a cute or handsome boyfriend, there’s still that thing that, I want that one. I won’t say no to him” (T-Man, 32 year old, bi-sexual identified).

Most of the concurrent relationships described by participant were casual sexual encounters. These sometimes occurred in the context of consuming alcohol. Tshepo explained that in that moment of desire for sexual satisfaction he did not care about “what will happen in the future”.

“ Yah, I think because you are under the influence of alcohol, you don’t think of taking this thing anywhere, you just want to shag and that’s it. You don’t put your mind in it, you just want to get satisfied and you just want to satisfy the guy and that’s it. You don’t even care about what’s happening or what will happen in the future”. (Tshepo, 32 year old, gay identified)

“Eish! It just happen, you find yourself having a relationship with someone for a long time but there’s this other person whom you just feel like you could just have sex with him. And you end up having an affair with that person in secret. You know, these things happen most of the times” (Thabo, 33 year old, gay identified).

4.5 Partner numbers

Participants interviewed discussed their perceptions of the high number of sexual partners among the “township” MSM and MSMW. This was seen as playing a role in the increasing HIV transmission among this group. Participants acknowledged that most MSM/MSMW in Soweto were still in the “closet” as some might be married or have female partners to conform to cultural or community norms. These men were viewed to be more vulnerable to HIV as they are not practising safer sex especially with both their female and male partners.

“because as people we meet different people and I do not commit to those people but I only have sex for that time and enjoy it the after a while I will meet someone then it will be the very same thing with that one as well” (Lerato, 27 year old, gay identified)

Some men talked about casual sex partners who are always available when they are called. They refer such partners as “Abagasi” which literally means “on call”. This is well-known gay lingo in Soweto referring to men whom they call when they want to have sex without their partners knowing. “Abagasi” is not considered to be a steady partner or one night stand partner as they are available to them anytime their service is required.

“Yah that’s the person who would come when he sees that you around and if you invite him to come, he will come. So it is a no strings attached relationship, we just do what we do and that’s it” (Vuvu, 32 year old, gay identified).

4.6 Where sex takes place

The places where sex occurred are important to explore in terms of HIV prevention. Participants described where they usually had sexual encounters. Participants reported numerous places where sex took place and these places varied according to sexual orientation. They described that when sex took place between straight identifying men and

gay men it would occur on the open field, clubs, abandoned buildings and in the toilets. Clubs, with special reference to gay clubs, were seen as places to go to have fun and meet potential sexual partners other than steady partner. Some clubs were described as having dark rooms where the men could have sex immediately without having time to find an alternative venue.

“To be honest, we as gay people, we most of the times meet our partner in clubs or shebeens” (Vuvu, 32 year old, gay identified)

“Uhm! It can happen outside the premises: it can be on a passage of the house where it’s dark or in a toilet. You understand “(Thabo, 32 year old, gay identified).

One participant stated that most of the time when he went to clubs, his main purpose was to get sexual partners. He described that sex “just happen any time” , at one of the clubs he frequented there are rooms with leather sofas where men can have sex which allowed for instant gratification.

“Nowadays I go to South Gate clubs, in those clubs there are dance floors, there are private rooms and dark rooms, and especially there is one which I cannot call by name which has other rooms with big leather sofas, containing condoms and lubrication. So sex just happen any time there because there are pornography movies playing all the time, so it’s easy for sex to happen because if you feel like it, you just grab him and do your thing. So you would take whoever you want and go to the rooms then after that come back to the dance floor, then grab another one again” (Vuvu, 32 year old, gay identified).

The majority of participants mentioned that they did not have specific places where they had sex with other partners, but with their steady partners they would either go his place or partner’s place.

“ I meet someone on the road and then that person would approach me and I would sometimes go to his place or we would find an alternative” (Tebza, 19 years old, gay identified.)

“Say for instance there’s a building and it is at night, nobody can see us then we would utilize that building” (Tebza, 19 year old, gay identified).

Other participants mentioned that they take their partners to where they stay.

“Normally I take them to my house, I don’t like to play far away from home. If it happens that we go far from home, I go with my friend who’s got a car and he would drive us around. Or sometimes we take our partners to my friend’s place, and we spend the night there. You find that we are four, my friend and his partner and I and my partner at his place” (Thabo, 33 year old, gay identified).

Not all men interviewed were interested in having casual sex. Sipho described how he had never had sex in a club. He believed in getting to know a partner first before engaging in sex and was not into what he called “a one night stand”.

” Hum! I have never had sex in a club. I have never had experience of meeting a person and have sex with that person at that moment but that would happen after we have met 3 or 4 times and I wouldn’t call that a relationship that will brings pleasure, a one night stand” (Sipho, 25 year old, gay identified).

Dumi, a gay identified man, reported that he met casual partners at his place of work. He mentioned that he worked in a country club and there were always co-workers who were potential sexual partners.

“Mostly I meet them where I am working because we are serving clients and we have facilities which are squashed, we have some cleaners squad and on the other hand have the golf course, we have waiters at the bar and waiters at the conference centre plus they are good looking guys” (Dumi, 35 year old, gay identified).

“I: so if you meet someone at work, where would you often have sex?

“No oh yah, it would happen mostly in the changing rooms” (Dumi, 35 year old, gay identified).

4.7 Condom use with different sexual partners

Participants reported that they were aware of the protective ways that condoms can be used for HIV prevention. Despite their awareness, there was still inconsistent use of condoms as described by different participants. Men who had a main partner reported that they did not usually use condoms with them but sometimes used condoms with other types of partners.

Men described that their condom use not only differed with different partners but more importantly it was linked to situations they found themselves in, especially in the moment of wanting to have sex. Tshepo, 32 year old gay identified man, explained that even having condoms in his pocket did not mean that he would use them. This was especially true when in a public space where there was a risk of being caught. Using condoms he said “will kill the mood”.

: can you explain what you mean by hectic?

P, I mean by then you were drinking and kissing on the other hand, so everything is just happening fast. Even though you will be having condoms in your back pocket, it will be very rare to use it because everything is fast. And you feel like it will kill the mood and you find that you want a quickie so on the other hand you scared that people might catch you doing that. Things are fast in that situation and chances of using a condom are very slim. And then you will realize afterwards that you didn't use a condom (Tshepo, 32 year old, gay identified)

Other participants shared examples of how there were circumstances when they intended to use a condom but did not. This was influenced by many factors including the use of alcohol prior to having sexual intercourse and availability of condoms at the venue. Most participants reported that under those circumstances not having a condom was not a reason to delay the sexual encounter. As Mandla, gay identified man, said “if we don't do it now, we won't get another chance again”.

“when we are in a club and that chemistry takes place and you find that there's nowhere where I could take that person, what I am going to do. It's obvious we are going to look for a corner that we can do our thing because if we don't do it now

then maybe we won't get another chance. And you find that time you don't even have a condom. And you wanted this guy for a long time, what can you do, you are going to say once and for all, you do it today. And when you see an opportunity you have to seize it because if you don't use it then there are chances that you might no longer see him, so why not cease the moment, even if it is riskier"(Mandla, 32 year old, gay identified)

While many participants described that condoms were available everywhere they go, others mentioned that in some places, like the clubs, condoms ran out very fast and when you needed them they were not available. They further described situations that resulted in having sex with "one night stand" partners without using a condom.

"where I hang out condoms run out very fast and then after that there's nowhere where you can get them. Condoms are taken very fast at around twelve midnight and towards the early hours of the morning. By then you won't get a condom"
(Tshepo, 32 year old, gay identified)

Although a majority of participants had knowledge about condoms, some reported they were not keen on using them. Dumi stated that he "hates" condoms as they lessen his level of performance.

"hay! And the erection of a condom is so... I don't understand. I think there's nothing nice about condoms" (Dumi, 35 year old, gay identified)

4.8 Alcohol use and sexual risk behaviour

Alcohol use was reported by most participants. Participants' narratives contained many descriptions of "forgetting" to use condoms when drunk. Alcohol use often was combined with socialising at clubs and having casual sexual encounters. Clubs were also identified by participants as an environment that was conducive to having casual unprotected sex as everyone was looking to have a good time. It was evident that condom use, alcohol use and unprotected anal intercourse with casual or once-off sexual partners were strongly inter-related. David, explained that when he drank alcohol "you don't think straight" and that he forgot about using a condom.

“ as I have said that alcohol can sometimes make you wild and lead you to say that forget about using a condom. It is not the same when you are sober and when you are not because if you used alcohol you do not think straight, you just think for now and whatever you think is right even though it is wrong” (David, 29 year old, gay identified)

“Mostly it was alcohol. When we are under the influence of alcohol we use to compete with friends about the number of partners that we hook up. And when you are alone you start to realise that they behaviour would lead you into trouble” (Lerato, 27 year old, gay identified)

The main risky behaviour reported by participants was unprotected anal intercourse which was often linked to alcohol use. However, one participant Mandla, described how he believed that the antiretroviral (ARVs) that he was taking combined with alcohol use increased his libido.

“it can only be when I’m drunk. There’s something that I have realised with these drugs (ARVs) that I’m taking, when you have taken them and you happen to drink alcohol, they make you have a sexual hype. They make you to have a very high sexual need even if you did not mix them with alcohol” (Mandla, 19 year old, gay identified)

Some men described feelings of guilt or shame after engaging in unprotected sex while under the influence of alcohol. Men sometimes labelled having casual sexual encounters while under the influence of alcohol as “wrong” and judged themselves harshly.

“ I think most of the thing begin to go wrong when one is under the influence of alcohol. Because when you are drunk, you do not know what is wrong or right, you just go with the flow of being in love and you end up going to sleep with someone.

When you’re sober you can be able to feel guilty and blame yourself by saying that you know what you’re about to do is wrong which is something you cannot do when under the influence” (Lerato, 27 year old, gay identified)

4.9 Homonegativity and discrimination

Although the men did not use the word “homophobia” explicitly, many described fears and thoughts that could be characterised as homonegativity or internalized homophobia and fear of discrimination in their community. The narratives encompassing homophobia were particularly prominent when the men were gay identified. Participants described how they struggled to disclose their sexual identity often denying it to themselves and expressing fear of discrimination. One participant linked the negative feelings he had about being gay with his risky sexual behaviour.

“denial that I am gay and I don’t want to come out of the closet. And they fear that people will discriminate against me, and insult me if I come out, they will call me names. Especially when I was at school, I will fear that if I came out, I will be insulted, so there are lots of factors which are negative that contributed to us behaving in this manner” (Thabo, 33 year old, gay identified)

“ the community have this notion that says it is taboo to love another men. That how can a man love another man, what prompts a man to have feelings for another man, so for them that does not exist” (Sipho, 25 year old, gay identified)

Some of the participants explained how they experienced stereotypes like “gay men are promiscuous”. Participants talked about being gay as isolating as they did not believe that they can discuss their sexual issues with family members. This made it harder for them to get support. The exposure to homophobic environments, discrimination and stigma may lead to internalized homonegativity for some of the participants. This is what one participant description of his situation:

“ because gay people follow a culture and so they cannot discuss sexual issues with their brothers or sisters and they end up discussing it with outsiders. It doesn’t mean that when you are gay, you have to be promiscuous. I don’t think being gay is about having sex all the time, there are lots of better things that are associated with being gay than having sex, after all we are all human beings” (Thabo, 33 year old, gay identified).

However, the gay identified men were open about their sexuality in some circumstances, such as among their gay friends and at the Health4men centre but they still did not feel free to disclose their sexual orientation without being judged by some people. Many men spoke of assumptions based on being gay which is different from the men who have sex with both men and women.

“ when a person approaches you and says to you that, you look different and you say that you are gay, what comes up to their mind or what they say is oh! You are having sex with other men. That’s what they say; they don’t know that being gay is not just being sexual but a whole lot about me, my personality. Or what I do out there, it’s not all about having sex with other men only” (Sipho, 25 year old, gay identified).

4.10 Perceptions of HIV messages

HIV messages that are being aired on our televisions, radio and print media mostly did not tackle the issues of the gay and bisexual community. Participants reported not seeing any messages that spoke to them directly as gay or bisexual identified men. They perceived that the ads aired whether on radio or television only focused on heterosexual relationships. Some respondents specifically mentioned the “Scrutinize” advert, which they said talked about multiple partners and alcohol in the context of heterosexual men with female partners. Scrutinize was a Youth HIV Prevention Addressing Multiple and Concurrent Partnerships in South Africa. The prevention intervention utilized audio, visual and print media. This is what some participants said:

“ NO, normally it’s always heterosexual. Even the ads when they show them, it’s always heterosexuals who are used in them. I don’t think there’s enough information that is related to MSM’s. (Tebza, 19 year old, gay identified).

Even though the messages were not targeting MSM, some of the participants reported that they converted the message around to make it relevant to them as gay men. One participant stated that one of the adverts spoke to the lifestyle of the gay community that was why he liked it.

“to be honest I have never seen an ad or any poster or pamphlet that speaks about prevention messages that is related to MSM. Most of the information that is

conveyed is for heterosexual community and so one has to twist the whole information and make it to be relevant to him so that he can be on a safe side” (Lerato, 27 years old, gay identified).

“ normally I like the one that is on TV, the one called Scrutinize. That says reduce the number of partners but for me I think the best option is to abstain. Because in any level of living. “A” is a distinction. (Mandla, 19 year old, gay identified).

When asked about what they would like to see being advertised, the majority of participants reported that they would like to see adverts that are inclusive of all different sexual orientations. They reported that advertising could also be used as a vehicle to teach the community about homosexuality.

“ no, not on TV and not on radio. Things like that do not get much public time. Like in our country it’s not a norm for them to show bi-sexual and gays. It’s like they don’t relate things like that to gays and bi-sexual, it is more heterosexual people that can get the programmes that they can relate to. (Katlheho, 18 year old, bi-sexual).

The participants felt that the media needed to teach people about homosexuality, that the gay lifestyle was not only about having sex, but there was more to it than that.

“we are not just sexual, people think that gay people are just sexual, there’s still communication you know, and there are still committed people who are gay out there and so I would like them to show a steady relationship that shows that there’s commitment in that relationship. And there is commitment enough to that person to the point whereby they want to take an HIV test together. (Sipho, 25 year old, gay identified).

The study also discovered that having HIV knowledge does not always translate to practising safer sex. Almost all the participants were aware of their HIV status as they were attending health4men clinic but they reported inconsistent and correct use of condoms with their partners. Venues were highlighted as “high risk” places since they facilitate sexual partnership which is not in this study as one element that puts gay identifying men at risk. Another important element that was raised in the study is around HIV messages. As much as there is information on HIV acquisition and transmission, the focus largely on heterosexual

relationships. The venues where the gay and bisexual men who participated in this study are closely linked with alcohol use and finding partners.

However, the men who actively participated in this study were gay identifying, than bi-sexual identifying. The study found that most men, who identified as gay, had difficulties when it came to disclosing their HIV status to their families and/or partners. This might be one of the reasons they find themselves at risk of HIV. As they noted in the interviews that at times they do not want to lose their partners hence not disclosing the HIV status.

Multiple and concurrent partners were also reported by the participants of this study, with reports of unprotected anal intercourse with both steady partners and casual partners especially when having consumed alcohol.

Chapter 5. Discussion

The findings presented here were based on a purposive sample of MSM and MSMW attending Health4Men clinic in Soweto. The study recruited men who were comfortable with their sexual orientation and many had disclosed their sexual orientation to the staff at health4men clinic. The men who participated in this study acknowledged that their behaviour at times put them at high risk of HIV infection. A narrative of risky sexual behaviour often was accompanied by disclosure of binge drinking of alcohol. The use and abuse of alcohol by MSM was an integral part of socialising for many men and played a role in getting sexual partners. This highlighted the state of MSM in Soweto. Their state of HIV infection was much high when they find themselves using and/or abusing of alcohol as they will not be thinking straight or thinking of using protection when approaching or being approached by a potential partner.

5.1 Knowledge of HIV and risk perceptions

The participants in the study had all attended HIV counselling and testing at Health4men and some were attending the ARV clinic. These services would all have provided opportunity for information and education on HIV. The men spoke knowledgeably about the transmission of HIV and about behaviour that increased risk of transmitting HIV, such as having unprotected anal intercourse. A study by Fay and colleagues conducted in multiple sites in Southern Africa reported that 93% of men who have sex with men had accurate knowledge that unprotected anal intercourse increased risk of HIV transmission (Fay et al, 2011). These studies supported the findings of this study that MSM in Soweto have knowledge on HIV and how it was transmitted from one person to the other. The participants related that HIV has been there for years and it is unlikely that people do not have knowledge of transmission and safer sex.

Rispel and colleagues found that men who perceived that they were at high risk of HIV infection were twice as likely to be infected with HIV (Rispel et al, 2011). Among the men who participated in this study, who were mostly HIV positive, perception of risk for HIV was high. A study by Lane, et al (2011) found that MSM perceived themselves to be HIV negative (57.2%) prior to being tested in the study.

5.2 Sexual behaviour, risk and protective practices.

Almost all participants interviewed reported having multiple and concurrent partners at one point in their life, with most reporting having had UAI. There was a complex interplay between sexual desire and inconsistent condom use. Sexual desire led some men to have sex with casual or once-off partners without condoms. Sexual desire was described as a force that men could not, or did not want, to control and that sometimes condoms were not used even if available. Participants expressed feelings of regret about not using condoms with their sexual partners while they were under the influence of alcohol.

MSM frequently reported having unprotected anal intercourse with steady or main partners. It could be that the men who reported UIA with their steady partners had built up trust so they did not feel the need to use condoms.

A study done in Nairobi reported that not all MSM engaged in high risk behaviours, and they should not be uniformly be labelled as “high risk” group. In their study, 75% of MSM reported condom use during their last anal sex act and 21% reported having only one male sexual partner during the past year (Population Council 2009). It was important to note that in this study, although most participants reported not using condoms consistently, there were some who reported consistent condom use. These men were not engaging in risky sexual behaviour and messages need to reinforce and maintain their low risk.

Other studies had found that participants reported not thinking about condoms and having safe sex or being happy to forgo condom use when they had been drinking alcohol (Parry, 2008). Behaviours such as unprotected anal intercourse, alcohol use and concurrent partners were prevalent among MSM interviewed in the Soweto men’s study (Lane, et al 2008). Like most participants in this study, they reported not thinking about condoms and safer sex and that sexual satisfaction was the primary factor affecting their decision about sex. Another important finding was the association of alcohol use and abuse that played a role in reducing inhibition in settings where sexual desire was highest such as clubs. Lane, et al, 2008 found that alcohol was the most commonly used substance among MSM, with 87.9% reporting that they drank at least once per month and 54.5% reporting 10 or more drinks on a typical day of drinking.

Several studies had also noted the association between alcohol consumption and sexual risk behaviour (Kalichman, et al 2007, Baiocco, et al 2010, Parry, et al 2008). A study by Baral and colleagues found that African MSM were more likely to have UAI if they regularly drink alcohol or did not know that HIV can be transmitted via anal intercourse (Baral, et al 2009). A study conducted by WHO 2005 in eight countries on alcohol use and sexual risk behaviour revealed that alcohol use occurred in association with sexual behaviour for a variety of social, cultural and other reasons. Their report highlighted that alcohol-sex linkage has serious implications for the health of populations due to the risk of HIV infection, irrespective of sexual orientation. They reported that people were less likely to adopt safe sex procedures when under the influence of alcohol; including the MSM population. They stated that the perception that alcohol has a disinhibitory effect propels some individuals to consume alcohol in order for them to engage in behaviours they would not normally participate in. The use of alcohol should therefore be recognized as a risk factor in the transmission of HIV and other sexually transmitted infections (WHO, 2005).

Alcohol was the dominant or commonly used drug mentioned by participants. There was not any mention of the use of drugs such as marijuana, ecstasy and “tic”. “Tic” is drug that is locally manufactured, and is a combination of different drugs mixed together (crystal methamphetamine) UNODC 2008.

5.3 Awareness of HIV prevention campaigns and key messages.

South Africa has the highest number of people living with HIV in the world. The South Africans National Strategic Plan on HIV & STI of 2012-2016 aimed to address the dual epidemic of HIV and TB. Through this document, the government has expanded their program to be inclusive of “key populations “including MSM and MSMW (NSP on HIV, STI’s & TB 2012-2016). The NSP stated that men who have sex with men are at higher risk of acquiring HIV than heterosexual males of the same age, with older men (<30 years) having the highest prevalence. It is estimated that 9.2% of new infections are related to MSM (NSP on HIV, STI’s & TB 2012-2016). Despite the recognition of MSM as a key population, there have been limited prevention messages targeting this population.

In terms of HIV awareness campaigns, participants reported that they had heard different HIV prevention messages aired on radios, television and print media including how HIV is

transmitted, mother to child transmission, multiple and concurrent partnerships and condom use. However, the focus of these prevention messages was on heterosexual people or relationships rather than being inclusive of MSM population. They stated that the messages do not incorporate the use of condoms amongst the MSM population like encouraging the use of condoms together with water based lubricants. Participants reported that they would like to see HIV prevention messages that are inclusive of other groups as South Africa is diverse society and they perceived the absence of targeted messages as discriminatory.

The campaign most frequently mentioned by the participants was “Scrutinize”, an animated HIV campaign directed towards young people, produced by John Hopkins Health and Education in South Africa (JHHESA). They suggested that such animated campaigns can be produced for MSMs and those MSM’s who still have not disclosed their sexual orientation can feel safe.

5.4 Homonegativity and discrimination

Although homonegativity or internalised homophobia was not mentioned explicitly, it was evident in the feelings of shame, and self-blaming that men described. Gay-identified men did talk about experiences of discrimination and accompanying fear of being discriminated against by members of their family and community. This resulted in some men not wanting to disclose their sexual orientation to people outside of a very small circle. Men who have sex with men globally experienced high rates of psychological health problems such as depression, substance use and victimisation that may be in part the results of adverse life experiences to cultural marginalisation and homophobia (Herrick., et al 2011). Considering the links described by Herrick and colleagues, the abuse of alcohol by men in this study could be a consequence of homonegativity. There could be a cycle of men feeling shame and using alcohol to numb these feelings and having unprotected anal intercourse while intoxicated which in turn intensified feelings of shame.

A study by King, et al 2008, reported that gay men experience high rates of depression, which are in part explained by experiences of discrimination and homophobia. Participants in this study reported their experiences of social discrimination based on their sexual orientation especially the communities that they live in. These experiences caused stress to

the individual, there by not “coming out” lead to them not attending health care services in their communities but prefer going to private doctors. The evidence suggested that these stressors increase their risk for other health related diseases despite HIV. A study by Rebe and colleagues reported that MSM in South Africa experience mainstream state health sector services as unfriendly and prejudiced which is a barrier to MSM accessing such services (Rebe., et al 2011)

They further reported that the gay community in the township is small and they have close links with one another. They expressed fear of disclosing their HIV status to their families or their friends due to this. This fear was instilled by the fact that the circles of gay men in Soweto are closely connected and they do not operate on the value of confidentiality. Non-disclosure of HIV status may increase the exposure that MSM and they can continue with unprotected anal intercourse. There are numerous dynamics that can prevent MSM to practice safer sex even after knowing their HIV status. Belonging, acceptance and not wanting to be alone are some of the reasons. The National AIDS Trust (2010) list psychological and social issues which motivate multiple partnership amongst MSM. Those are drug and alcohol use, difficulties in establishing and maintaining longer term sexual relationships, wishing to avoid identification as gay (thus seeking sex in anonymous settings) and avoiding issues of HIV status disclosure (National AIDS Trust., 2010).

5.5 Limitations

The study purposively sampled patients who attended the Health4men centre. Participants were thus limited to MSM who have either participated in other studies or who have made use of the HIV services offered by PHRU or Health4men. This study reflects the views of men who have received pre and post HIV counselling and other information through these services. Men who do not access services may have different views and experiences than those presented in this report. However, the exploratory nature of this study can offer useful insights for further research and for the design of interventions addressing MSM in South Africa.

Although the study tried to include an equal number of MSM and MSMW in the study, this was not realised. The recruitment sample was targeted towards MSM and MSMW but the participants who actively participated in the study identified themselves as gay. MSMW

were hard to recruit. We therefore could not compare between the two groups of participants. Most of the participants were gay-identifying. We cannot therefore draw conclusions about MSM who do not identify as gay or bisexual.

The researcher worked as a clinic manager at Health4men at the time of the study. This may have positively influenced men's participation in the study as they were aware that the centre maintained confidentiality. Although the participants were reassured that the services that they received at the clinic would not be affected if they chose not to participate, some men who did not attend the scheduled interviews might have viewed participating in the study negatively as the interview had some personal questions that they would not like to disclose thus it may have influenced their decision not to participate. It should be noted that half of the men approached to participate in the study did refuse. Additionally, there were a number of men who agreed to participate who did not attend their appointments for the interviews they mentioned factors such as work and time of the interview as reasons for non-attendance.

Another limitation was that even though the study wanted to explore the risks and protective practices of both MSM and MSMW, the researcher ended up focusing more on the risks rather than the protective practices. As much as the researcher wanted to include many MSM and MSMW in the study, many men were unavailable to participate in the study.

Chapter 6. Conclusion and Recommendations

6.1 Conclusion

This study described the sexual behaviours and preventative measures of men who have sex with men (and women). MSM have knowledge about HIV and ways of preventing transmitting the virus. This research has identified a number of factors that affect MSM's vulnerabilities to HIV infection. Participants reported unprotected anal intercourse with main or steady partners, as well as with casual or once off partners. UAI with casual partners often occurred in the context of drinking alcohol and attending nightclubs.

MSM in this study were aware of condoms and in many cases intended to use of condoms. However, condoms were not used for different reasons, including lack of availability, not wanting to "kill the mood", being intoxicated, and because the partner was a steady or main partner. Some clubs created an environment that supported UAI as there were rooms where sexual intercourse could take place at the venue while pornography that was being screened. Among gay and bisexual men, and other men who have sex with men (MSM) this study suggests that being young, black and unemployed might increase the risk of exposure to HIV as young men do not necessarily have skills and resources to cope with issues of depression, anxiety, substance use and sexual risk behavior.

There was a lack of targeted interventions that addressed MSM. HIV prevention strategies need to address the needs of MSM and thus reduce existing inequities. The society, culture and the context where men live and socialise are important social determinants of HIV risk behaviour. These include societal and cultural norms which discriminate against gay and bisexual men as well as MSM regardless of sexual orientation. This is particularly true for MSM living and socialising in Soweto.

Even though the country is making progress on the rights of gay and other men who have sex with men, MSM are still marginalised, stigmatised and sometimes criminalised. Homophobia affects the entire response to HIV and AIDS; it undermines the prevention strategies geared towards the MSM population. Additionally the infection rates among young MSM in Soweto is the reflection of the extent to which they do not have access to the essential health and social support systems they need to avoid HIV infection.

6.2 Recommendations

MSM communities in Soweto are faced by multiple risk factors for HIV. HIV prevention strategies need to at least start acknowledging the complexity of HIV risk in this population. There are a number of challenges that make responding to the epidemic amongst MSM difficult such as the ability for MSM to obtain lubrication, HIV testing, homophobia and provider stigma within the society. There are still opportunities to improve HIV prevention knowledge and behaviour still abound. The Department of Health needs to sensitize public health care providers about MSM and different sexual orientations of clients to ensure the provision of quality, non-judgemental treatment of all patients.

Even if there are laws that legitimize same sex relationships in South Africa, more work still needs to be done to enable MSM to have control over their health and lives. MSM experience barriers accessing public health care facilities due to the fact that not all care facilities are receptive to their needs. The need to address discrimination against MSM should be directed at influential people including politicians, leaders of faith based organisations, media and medical professionals as well as the general public.

The goals of advocacy can include the review of the policies such as the National Strategic Plan on HIV, STI & TB 2012-2016 which only include MSM under the MARPs. The policy and programmatic responses to HIV prevention in South Africa have focused on interventions that target heterosexual and mother-to-child transmission (National Strategic plan on HIV, STIs and TB 2012-2016). Advocating for change in the guidelines will strengthen the effectiveness of national HIV prevention programs on HIV risk behaviour in MSM and ensure that MSM are included in the implementation of anti-discrimination laws and policies addressing MSM, and programmes that increase access to information and social and medical services. Comprehensive HIV prevention strategies for MSM need to focus on the factors affecting the MSM environment/community.

Coordination and integration between programmes need to be strengthened to effectively provide quality care to these groups. UNAIDS reports on comprehensive package to address HIV-related issues among men who have sex with men and transgender people and suggests that all interventions should be evidence-informed, developed with, and protect the rights of men who have sex with men and transgender people (UNAIDS., 2008).

A combination approach is required to be developed to address the challenges faced by MSM in townships including making PrEP part of a comprehensive HIV prevention policy so it can be provided to patients at high risk. According to South African HIV Society, the recent iPrEx trial of daily oral chemoprophylaxis was a watershed first multi-country phase III preventive intervention for MSM that demonstrated preventive efficacy (44% reduction in HIV acquisition) among MSM (The Global Forum on MSM & HIV (MSMGF) 2012). An MSM package that will address HIV testing, treatment, condom and lubrication use, psychological support and legal or human rights is needed. There are numerous factors that can contribute to the reduction of HIV incidence in a population like strengthening couples HIV testing, this will lift the burden of disclosure to partners and they will participate in preventing infection or re-infection as information will be proved to them as a couple.

6.2.1 Venues

While men who have sex with other men described a variety of places where they had sex, clubs were often mentioned as sites for having unprotected anal intercourse. Clubs are frequently identified as a primary source of social contact and therefore a determinant of drinking and finding partners among MSM. Mapping the existing venues used by men who have sex with men should be carried out, to ensure that there is effective and appropriate information, education and communication available. Distribution of condoms and lubricants at venues should be prioritised and supply should be consistent.

More visible outreach on alcohol use and abuse is required at these social venues. The involvement of the venues owners and staff should be nurtured and including them in the prevention programmes may be useful to create an environment that limits alcohol abuse through refusal to sell alcohol to anyone obviously intoxicated, and restricted opening hours. This recommendation might work closely with the department of transport theme of “Arrive Alive”, where they encourage people to call a taxi or a buddy to drive them home when they are intoxicated. The patrons in those venues might notice that the manager is looking after their wellbeing. As MSM attend these venues for multiple reasons such as looking for company, conversation or sex, engaging in unprotected sex whilst drunk, there are possibilities of inconsistent condoms use and multiple sexual partners. A different interactive prevention approach should be taken in addressing MSM risky behaviours, such

as having a champion at the venues who can distribute condoms and lubrication to the patrons.

6.2.2 Homonegativity

Staying in an environment that is homophobic and discriminatory can be detrimental to an individual's mental health, and lead to low self-esteem and depression. HIV prevention needs to encourage positivity to build self-esteem and confidence of MSM. The MSM social support groups that are available in the townships need strengthening. Groups could support the use of safer sexual practices. Social support may also help moderate the effects of HIV-associated stress. MSM also suffer psychosocial and psychological factors such as depression, which are related to HIV risk taking. Stall et al (2003) found that the more psychosocial health problems an individual experienced, the greater their risk for both participating in risk behaviours and HIV infection. With this in mind, the interventions should represent both the clinical and psychosocial needs of the MSM. Social groups can also play a role in educating and the distribution of prevention materials such as condoms and water-based lubrication. Although alcohol use can be a coping mechanism to deal with feelings of internalised homophobia, it is still an important element of the MSM social life.

6.2.3 HIV messages

Information, education and communication materials should be developed for the community of MSM generally, as well as for use in venues that MSM use. Materials from other countries can be adapted and modified for the MSM in South Africa, this can save time and resources. The materials can be in print or audio-visual formats and language suitable for that community, safer sex videos can also be appropriate as the messages will be more easily understandable. It is also important to note that the information materials used do not increase the stigma or increased homophobic behaviour. Positive images of gay and bisexual men can be portrayed in the community. Such visibility will create debate in the communities and begin to address homophobia. Men who have sex with men self-esteem will increase and have a sense of "belonging". For the clinic such as Health4men to tackle the differences of MSM and MSMW is to create more open more such clinics in the communities which will MSMs prevention programs. Currently MSM do not attend the public facilities because face public humiliation.

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APPENDICES

Appendix A. Study Informed Consent

Appendix B. Information leaflet

Appendix C. Tape recording Informed consent for VCT

Appendix D. Interview guide

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Miss Sibongile Dladla

CLEARANCE CERTIFICATE

PROJECT

M10123

Sexual Behaviours and HIV Protective Practices
amongst Men who Have Sex with Men (MSM)
and Men who have Sex with both Men and
Women (MSMW) in Soweto

INVESTIGATORS

Miss Sibongile Dladla.

DEPARTMENT

School of Public Health

DATE CONSIDERED

29/01/2010

DECISION OF THE COMMITTEE*

Approved unconditionally

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

DATE

18/02/2010

CHAIRPERSON


(Professor PE Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : N Chrsitofides

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...

Sexual Behaviours and HIV Protective Practices amongst Men who have sex with men (MSM) and Men who have sex with Men and women (MSMW) in Soweto.

PARTICIPANT'S INFORMATION LEAFLET AND INFORMED CONSENT.

Good day, my name is _____ and I am a student at the School of Public Health at University of Witwatersrand. I am conducting some research to learn more about the issues that men who have sex with men experience. This knowledge may inform some services and programmes that are offered to men, I am going to ask you some questions about these things.

You are invited to participate in this research study that is being conducted in Soweto. You should not agree to participate in this study until you fully understand what is asked of you and are completely happy with all procedures involved. If you do not understand the information or have any other questions, feel free to ask the interviewer.

PURPOSE OF THE INTERVIEW:

The purpose of the study is to collect information so we can understand issues for MSM in the community. The research study will help us understand sexual behaviors and HIV protective measures that MSM undertake.

LENGTH OF THE STUDY AND NUMBER OF PARTICIPANTS:

The interview will take approximately 1hour 30 minutes (1h30). You have been asked to participate together with other 20 other men. In analysis, we will put the information from all the men participating together. This will ensure that no one will be able to identify you.

WHAT PROCEDURES ARE INVOLVED:

If you agree to volunteer for the study, the following will occur:

1. You will participate in the individual interview with the interviewer.

2. The interview will be in a secure and confidential room.
3. The interview will be tape-recorded.

RISKS AND DISCOMFORTS:

Much of the information we would like to share with us is of a sensitive nature. Some of the discussion will include sexual behavior, sexual practices with other men, use of alcohol and drugs. If anything we discuss causes you to be emotionally distressed, either during or after the discussion, we will refer you to a professional counselor within the study area.

BENEFITS:

There will be no direct benefit to you from participating in this study. However, the information that you provide may help community organizations such Health4men, researchers at PHRU, and health workers in this area to provide better services for men who have sex with men.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT:

Your participation in this study is voluntary. You can refuse to participate or stop at any time without giving any reason. Some of the questions are very personal. Please remember that you are free to skip over any question you do not want to answer and you are free to stop answering questions at any time.

CONFIDENTIALITY:

All the information obtained during the course of this study, including the discussion recordings and transcripts, will be kept strictly confidential. Should you wish to access the recordings of your discussion, you have the right to review, edit or erase those portions of the audio tape that have recorded your voice. Paper copies of consent and transcripts will be stored in a locked file cabinet at PHRU. Only the primary researcher (Ms Sibongile Dladla) will have access to these files. The recording of your discussions will be destroyed at the end of the analysis phase of the study. Your name will not be used in any reports or publications that may result from this study.

You will be identified by participant identifier codes and not by your names or identity numbers. All records will be held in secure filing system and will be available only to the researcher. You are encouraged to use pseudonym (false name) to identify yourself.

COSTS:

There will be no costs to you as a result of taking part in this study.

ETHICAL APPROVAL:

This study will be submitted to the University of the Witwatersrand, Human Ethics Committee (Medical) and the committee would grant written approval.

CONTACTS FOR QUESTIONS AND FURTHER INFORMATION:

If you want additional information regarding the study please feel free to contact Ms Sibongile Dladla at the following numbers (011)9899179 or 0847228435/0832630804.

If you want any information regarding your rights as a research participant, or complaints regarding this research study, you may contact the Chairperson of the University of the Witwatersrand, Human Research Ethics Committee (HREC), Professor PE Cleaton-Jones at (011) 717-2230/1. You can also contact the HREC secretary Anisa Keshav at (011) 717-1234.

INFORMED CONSENT

I hereby confirm that the person seeking my informed consent to participate in this study has given me information to my satisfaction. She explained to me the purpose, procedures involved, risks and benefits and my rights as a participant in the study. I have received the information leaflet for the study and have had enough time to read it on my own and ask questions. I feel that my questions regarding participation in the study have been answered to my satisfaction. I have been told that the information I give to the study will together with other information gathered from other people, be anonymous processed into a research report and scientific publications.

I am aware that it is my right to withdraw my consent in this study without any prejudice. I hereby, voluntary give my consent to participate in the study.

Participants name _____ **(Please print)**

Participant's signature _____ **Date** _____

Researcher's name _____ **(Please print)**

Researcher's signature _____ **Date** _____

Witness's name _____ **(Please print)**

Witness's signature _____ **Date** _____

As we talked earlier, please tell me if there are any questions that you do not understand. If you feel uncomfortable answering a question, please tell me so we can skip it. Your complete and honest answers will help us understand the preventative methods that are used in these communities.

If you want additional information regarding the study, please feel free to contact Ms Sibongile Dladla at the following numbers (011)9899179 or 0847228435/0832630804.

If you want any information regarding your rights as a research participant, or complaints regarding this research study, you may contact the Chairperson of the University of the Witwatersrand, Human Research Ethics Committee (HREC), Professor PE Cleaton-Jones at (011) 717-2230/1. You can also contact the HREC secretary Anisa Keshav at (011) 717-1234.

Consent to tape interview

I have read the project information sheet and I understand that it is up to me whether the interview is recorded. It will not affect the way in which the interview is conducted if I do not want the interview to be recorded.

I understand that if the interview is recorded that the recording will be destroyed once the study is completed.

I understand that I can ask the person interviewing me to stop recording, and to stop the interview at anytime.

I understand that the information I give will be treated in the strictest confidence without any identifying information, unless I have agreed otherwise.

I consent to the interview being tape recoded. _____ (initials)

I do not consent to the interview being tape recorded. _____ (initials)

Interviewees name _____ (Please print)

Signature _____ **Date** _____

Interviewers name _____ (Please print)

Signature _____ **Date** _____

Interview guide for in-depth interview with MSM

Thank you for agreeing to participate in this interview. Do you have any questions?
May I begin the interview?

1. Experiences (general):

Tell me about yourself

Probe: employment, where you live and age

Now I am going to ask you questions regarding what you know about HIV

1.1 Please tell me what you think about HIV/Aids? Why do you say that?

Probes: What do you think are some of the risks that may occur having sex with women and men? In what ways are these same or different?

Probe: In what ways might you be at risk of HIV, if at all?

2. Sexual health and HIV prevention

Sometimes we hear about HIV on the radio or TV or read about it. What are some of the messages about HIV prevention that you have heard?

Probe: which of these messages, if any, speak to you personally?

Where did you hear these messages (probe each one separately)

How do these messages address MSM issues if at all?

What would you like to see being addressed in these messages?

3. Sexual Experiences

I want to move on to a very personal topic-sex. Please feel free to say whatever comes to your mind. There are no right and wrong answers. No one will know what you share with me today.

What does sex mean to you?

Probe: Is it mostly physical pleasure?

Is it about emotional connection?

Can you tell me about the last person that you had sex with and circumstances?

Probe: was this typical of your sexual experiences? In what way was it/wasn't it typical?

Tell me more about your male partner(s) - where do you meet them?

Where do you most often have sex? Please describe the situation.

With whom do you have sex with at this place?

Do you at times find yourself having more than one sexual partner? Please describe these situations.

Probe: ask about one night stand

Ask about female partners

4. Condom and lubrication Use

How do you feel about using condoms?

Probes: In what situations or with which partners do you feel need to use them?

How easy is it to get condoms? Where do you usually get them?

How do you feel about using lubrication?

Probe: What kind of lubrication do you use together with condoms, if any?

How easy is it to get lube? Where do you usually get lube?

Has there been any time when you may have had unprotected anal sex with someone.

If yes, tell me about those circumstances when this happened?

5. Alcohol and Drug use

How often do you drink alcohol or use drugs?

Have you ever had sex while using alcohol or drugs?

Do you; use protection in the same way when having sex while using alcohol and drugs?

6. Conclusion

6.1 Is there anything that we did not talk about that you would like to tell us?

6.2 Any feelings about this conversation that you would like to express?