THE IMPACT OF MASCULINITY ON PRE-EXPOSURE PROPHYLAXIS (PREP) UTILIZATION AMONGST MEN WHO HAVE SEX WITH MEN (MSM) IN SOUTH AFRICA

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DECLARATION

I declare that this Masters research report is my own unaided work. It is submitted for the degree of Master of Art in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

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30th of April 2021

DEDICATION

This work is dedicated to my late mother, a domestic worker who had no education but sacrificed so much to ensure that I got one. My only wish is that you were here to witness it all mama. Continue to rest in eternal peace, I miss you every day.

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I would like to sincerely thank my best friend for pushing me and supporting me through all the emotional and tearful times, thank you so much my dear, your support motivated me to keep going. All I can say is "Look at me now!!"

Lastly, I would like to thank my partner for being my biggest cheerleader, thank you for believing in me and cheering me up every step of the way, you believe in me more than I believe in myself sometimes.

ABSTRACT

Although major strides have been achieved in HIV prevention in recent years, MSM still bear the greatest disease burden when it comes to HIV. Biomedical preventative strategies such as PrEP have been developed to reduce HIV burden amongst MSM. This study sought to respond to the research question, 'what is the impact of masculinity on utilization of PrEP amongst MSM?' A qualitative research methodology was adopted, and a sample of twenty-one MSM was interviewed through purposive sampling using snowballing. The enactment of masculine norms coupled with the stigma and discrimination experienced while accessing healthcare services, places many MSM at risk of HIV infection. Barriers to PrEP access need to be addressed not only to cater for MSM's needs at individual level but also at structural and institutional level through policy related interventions as recommended by social-ecological model, in order to expand access to healthcare and improve MSM's wellbeing and health outcomes.

Keywords: hegemonic masculinity, heteronormativity, MSM, PrEP utilization, sex role, gender performance, knowledge about PrEP, MSM specific services, stigma and discrimination, sensitivity training

CONTENTS

ABBREVIATIONS

AIDS Acquired immunodeficiency syndrome

ARV Anti retro viral

ART Anti-retroviral treatment

CDC Centre for disease control

DL Down low

HCPs Healthcare Providers

HIV Human immunodeficiency virus

HPV Human papillomavirus

KZN KwaZulu - Natal

MSM Men who have sex with men

NGO Non-governmental organization

PEP Post-exposure prophylaxis

PrEP Pre-exposure prophylaxis

SDT Self-determination Theory

SEM Social – Ecological Model

SOGI Sexual orientation and gender identity

TasP Treatment as prevention

US United States

USA United States of America

Chapter 1 – Introduction

1.1 Introduction

Men who have sex with men (MSM) are disproportionally affected by the Human Immunodeficiency Virus (HIV) in comparison to the general population, in spite of all the progress and developments made in HIV prevention in recent years. HIV prevalence amongst MSM in South Africa, and the world over, still remains high. Innovative biomedical technologies such as Pre-Exposure Prophylaxis (PrEP) have been developed as a prevention strategy to reduce HIV infection rates amongst MSM. However, little research has been done to examine the impact of gender norms on PrEP uptake and the health outcomes associated with it. This study was premised to discover the impact of masculinity on PrEP use by MSM in a South African township. In addition, this study aimed to evaluate MSM's awareness, knowledge of, and willingness to use PrEP. Gender performance and sexual identity, and sex roles were also reviewed as these cultural and traditional norms that MSM ascribe to shape how they negotiate their identity, interact with society, and ultimately traverse and access healthcare.

This research adopted a qualitative research methodology. It was primarily centred around MSM's experiences and personal narratives which were collected through semi-structured in-depth interviews, from a sample size of twenty-one MSM from the township of Vosloorus in the east of Johannesburg, who were purposively sampled through snowballing. Three MSM experts were also interviewed to provide their professional perspective on provision of MSM services. Thematic content analysis was used to analyse research findings, which were clustered according to four main themes to unearth how masculinity shaped MSM's utilization of PrEP. This study determined that the definition of masculinity is individually constructed and fluid in nature (Mahalik, 2014), and it is also embodied and enacted differently through individualized behaviour that becomes apparent in numerous aspects of MSM's lives, in society, and in how they navigate and interact with the healthcare system. This study concluded that masculinity makes it challenging for MSM to utilize PrEP and to adhere to treatment. Enactment of masculine norms such as the reluctance to access health

services, having multiple sexual partners, low levels of perceived risk, and risky sexual behaviours puts MSM at risk of HIV infection.

When examining sexual orientation and gender identity, it became clearly evident that within MSM, classifications and meanings of masculinity and femininity are highly individualistic and personal, and these imply different things for different MSM. These identities further have implications for how those affiliating with a specific masculine or feminine identity, identify themselves, interact with society in general, and access healthcare services. Regarding knowledge of PrEP and willingness to use PrEP, the study discovered that there is an increasing knowledge of PrEP amongst MSM and those who have a better knowledge and understanding of its potential benefits have some willingness to use it to protect themselves from HIV infection. On the other hand, those who perceived themselves not to be at risk of HIV infection showed low levels of interest in utilizing PrEP. In addition, issues of access, in terms to location and availability still plays a critical role in determining whether MSM can ultimately use PrEP or not. Challenges such as negative attitudes from healthcare professionals dissuade MSM from disclosing their sexual orientation, for example, which could enable them to get quality healthcare services which would improve their health outcomes. This research demonstrated the importance of taking individual, social, and structural factors into consideration, as well as the socio-cultural drivers of HIV vulnerability and bringing them back into prevention to provide sensitive and comprehensive prevention services for MSM.

1.2 Background and context to the study

Despite significant improvements made in HIV prevention, HIV transmission among MSM in both developed and many developing countries still remains high. It is important to reduce HIV disease burden amongst MSM as this will contribute immensely to eradicating HIV epidemic. Previously, preventative measures such as “100% condom use, voluntary HIV testing and counselling services, HIV treatment as prevention (TasP) have been widely promoted amongst MSM. Lately, newer interventions such as pre-exposure prophylaxis, will also need to be widely adopted” (Peng et al., 2018, p. 1063) as PrEP has shown to reduce HIV

infections drastically if adhered to appropriately. Men who have sex with men, (MSM) is a term referring to biological born males who have sex with other biological born males regardless of their gender or sexual orientation. This term includes men who identify as gay, bisexual, transgender and those who do not , as long as they engage in sexual activities with other men (Rispel et al., 2011).

MSM are disproportionally affected by HIV (Al-Tayyib et al., 2014) in comparison to the general population. In many parts of the world, increased levels of HIV infections have been widely reported amongst MSM (Beyrer et al., 2012). MSM are characterized by involvement in high-risk sexual practices, such as unprotected anal intercourse, transactional sex, and multiple sexual partners (Maleke et al., 2017). MSM are further considered to have limited knowledge about HIV and this lack of knowledge makes them vulnerable to HIV. PrEP was introduced as a prevention strategy to protect at risk populations such as MSM, female sex workers, and transgender individuals. In some trial studies, the daily intake of oral PrEP provided significant efficacy in reducing the risk of HIV infection. South Africa became the second country after the United States to offer PrEP (Nideröst et al., 2018) to its citizens as a ground-breaking HIV prevention package in 2017. PrEP is recommended for HIV negative MSM, and transgender people and others who are at high risk of being infected with HIV (Bekker et al., 2016).

Lessons have been learned on numerous occasions regarding many diseases where the simple access to medical interventions would slow the spread of the disease; however, this does not necessarily guarantee their uptake, or their use in efficacious ways (Hugo et al., 2016). The efficacy of PrEP in reducing HIV risk transmission has been proven in various clinical studies. Although these studies confirmed PrEP's efficacy amongst several populations such as MSM, the general population, and amongst people who inject drugs, this efficacy differed largely across trials and is mainly associated with adherence of daily doses of the treatment (Jenani et al., 2016). In addition, some studies have discovered that in order for PrEP to be effective in preventing HIV, awareness of PrEP, acceptance of PrEP, and individual behaviours such as adherence and change in risk behaviours are dependent factors (Al-Tayyib et al., 2014). Peng

et al. (2018) also support this assertion by outlining that, in spite of its high efficacy, acceptance of PrEP use differs widely across diverse cultures, ethnic groups, geographical locations, and amongst MSM themselves.

1.2.1 Study significance and rationale

Existing HIV prevention programs have significantly failed to sufficiently address HIV in Southern Africa. HIV incidence amongst MSM remains high, with an estimate of "between 10% and 33% in South Africa" (Jobson et al., 2013, p. 12). Results from the 2012 Soweto Men's Study discovered that HIV disease burden is unevenly distributed amongst MSM and MSM are at risk of further infection. Amongst self-identified MSM, prevalence of HIV sat at 33% which was three times higher than that of bisexual and straight identifying MSM (Lane et al., 2011, p. 8). This difference is a reflection of the complexities involved in partner identity and sexual roles in MSM partnerships. A lot of research on HIV prevention efforts commonly employ the use of the epidemiological grouping of MSM without taking into consideration the complex internal diversity within MSM. As a result, it is important to address the diversity in gender and sexuality, power inequalities, and masculinities within this diverse group (Garcia et al., 2016) in order to solve the challenges that MSM face in accessing and utilising HIV prevention services such as PrEP. In other studies, masculinity has proven to perpetuate HIV transmission, yet it has been under researched in MSM studies in terms of HIV/AIDS epidemiology studies (Zeglin, 2015). In addition, limited research has been conducted to study the influence of masculinity, especially in connection with PrEP uptake amongst MSM and associated health outcomes (Zissette, 2015).

It is imperative to recognise how masculinity can be operationalised in interventions that aim to transform masculinities (Connell, 2005, as cited in Gibbs et al., 2019). In addition, looking at masculinity from a homogenous lens amongst excluded yet diverse men such as MSM is restrictive, and more investigation is required concerning characteristics of masculinities that affect sexual health and behaviour in relationships. Furthermore, it is important to explore how the diversity of masculinities is connected to sexual behaviours that encourage HIV risk (Fleming et al., 2016, as cited in Closson et al., 2019). Finally, subordinated masculinities

cannot, as a matter of fact, attain hegemonic masculinity and hence may generate significant gender-role strain and extend hyper-masculinity (Eguchi, 2009; Fields et al., 2015, as cited in Zeglin, 2015). It is imperative to understand the dynamics that cause and are caused by this strain, amongst MSM.

1.3 Main Research Question

What is the impact of masculinity on the utilization of PrEP amongst MSM?

1.3.1 Sub-questions

- How do gender norms amongst MSM affect utilization of PrEP?
- How does the sex-role/position affect MSM utilization of PrEP?
- What power relations within MSM affect PrEP utilization?
- What is the acceptability of oral PrEP as a prevention pill for HIV by MSM?

1.4 Research Objectives

This study aimed to provide new insight into how gender norms, especially masculinity, influence MSM's awareness and knowledge about PrEP. The study further intended to document MSM's experiences in relation to PrEP, that is how masculinity influences their journey towards utilization or non-utilization of PrEP.

i) In addition, the study investigated whether MSM perceive sexual orientation disclosure to healthcare providers as a barrier that challenges their masculinity and explored MSM's readiness to reveal their sexual orientation to their health care providers.

ii) Findings from the study potentially make a significant contribution for project implementers in designing and implementing programs that not only take into account the biomedical aspect of HIV prevention but also enable the critical examination of gender norms and how these can be incorporated into prevention activities to improve health outcomes for MSM.

iii) The study explored the complicated nature of the relationship between MSM and female healthcare workers from MSM's perspective to highlight the role women nurses play in MSM's use of PREP and the female nurses' exercising of power over MSM in the space of healthcare.

iv) Moreover, the study aimed to contribute to understanding masculinity from the MSM perspective to come up with a more nuanced theorization of masculinity specific to MSM. Finally, the study determined how MSM negotiate social and health spaces and assert themselves within South African society.

1.5 Organization of the remaining Chapters

Chapter 2 outlines the existing literature crucial in grounding the arguments made in the study. Topics discussed, amongst others, comprise of sexual orientation and gender identity, origins and application of masculinity, and knowledge of and willingness to use PrEP. Chapter 3 then summarizes the research methodology adopted whilst undertaking the research. This section of the report deliberates and justifies the research methods chosen; a choice directed by qualitative methodology. The purposive sampling technique of snowballing was adopted as this is one of the best methods to sample hidden or hard-to-reach populations such as MSM. Data was collected through in-depth interviews and analysed through thematic content analysis. Chapter 4 then presents a combination of both the findings and analysis of the study which are outlined as four main themes, sexual orientation and gender identity, awareness and knowledge of PrEP, gender performance, sexual identity and sex roles, and finally delves into PrEP and the healthcare context. These findings provide a descriptive outline of how masculinity affects MSM's use of PrEP, the impact of traditional gender roles on MSM, and how their enactment affect MSM's access to healthcare services. Finally, Chapter 5 completes the study, by formulating the conclusions and providing recommendations to improve MSM's access to health and healthcare.

Chapter 2 – Literature Review

2.1 Introduction

This chapter on literature review discusses critical areas that assist in grounding the arguments presented in this research report. As discussed in chapter 1, MSM have a higher prevalence of HIV and AIDS despite the progress that has been made in HIV prevention and research in recent years. PrEP was introduced as an HIV prevention pill that HIV negative MSM can utilise to protect themselves from being infected with HIV. In spite of wealth of literature available assessing several social, individual and structural risk factors directly linked with HIV transmission amongst MSM, comparatively, little remains known in terms of the individual-level role that masculinity plays in influencing PrEP use amongst MSM (Zeglin, 2015).

This chapter will systematically review literature on masculinity, including the knowledge of and willingness to use PrEP amongst MSM. In addition, this literature review will also explore the challenges that MSM face in general when accessing health services such as PrEP. These challenges are experienced at both the individual and structural level. According to Zeglin (2015) at the individual level, perceived social norms in terms of gender identity, sexual roles, internalized homonegativity, condom efficacy, drug use, sensation seeking, and sexual desires are identified as potential individual risk factors. At the structural level, factors involved include poverty, social norms, education, stigma, and discrimination. MSM's lived experiences due to stigma and discrimination from healthcare workers will be further explored as these have a bearing on MSM's access to sexual health services.

This literature review is separated into six sections. Section one focuses briefly on the origins of the concept of masculinity and its application, with a particular interest in sexual orientation and gender identity, it conceptually zooms in on how men who have sex with men define themselves, and how they identify and solidify their stance in society. The section further reviews masculinity in relation to heteronormativity, and the implications of such for men's access to HIV prevention services, such as PrEP. The second section specifically examines MSM's knowledge of PrEP and their willingness to utilize PrEP, followed by the third

section that deliberates on questions of gender performance, sexual identity, sex roles, and the impact these have on MSM and their willingness to use PrEP. Section four evaluates barriers to PrEP use whilst section five briefly looks at enabling factors that facilitate PrEP use. The review of the literature concludes in section six by presenting the theoretical framework used in this study. The key concept of hegemonic masculinity from Gender Theory is used to understand what beliefs and practices MSM ascribe to, which define (for them) what it is to be a man. In addition, the Social-Ecological Model is applied to understand the complexities of health seeking behaviour by MSM and provides strategies to address issues related to their access to health care.

This upcoming section discusses the concept of masculinity, its origins and application. It will also review masculinity and femininity in terms of sexual orientation and gender identity. Finally, masculinity and heteronormativity will briefly be discussed.

2.1.1 Origins and application of Masculinity

Masculinity is a social construct and is part of the collective gender identity (Morrell, 1998). It is attributed to the roles and behaviours that are prescribed for men in any society. Although, it appears as though there is a 'dominant' or hegemonic masculinity that all men aspire to, there is no singular existence of one universal masculinity, and subservient masculinities do occur amongst marginal groups, these may oppose the dominant masculinity (Morrell, 1998). Masculinity as a concept first appeared in reports from a field study of social inequality in Australian high schools (Kessler et al., 1982, as cited in Connell & Messerschmidt, 2016) and other related discussions of the creation of masculinities and the understanding of men's bodies (Connell, 1983, as cited in Connell & Messerschmidt, 2016). These early stages of masculinity theorizing criticised the male sex role and suggested a prototype of various masculinities and power relations. The notion of a hierarchy of masculinities emanated from the experience of homosexual men who experienced prejudice and violence from heterosexual men.

Studies on men and masculinity in the late 1980s and early 1990s were mainly within academia and education studies, seeking to understand the constant change in the classroom and to confront bullying amongst boys. It also discovered the relationship people had to the syllabus and the complications of gender-neutral teaching (Martino, 1995, as cited in Connell & Messerschmidt, 2016). Masculinity was further used in broadcasting where the representation of men typically focused on sports and war images (Jansen & Sabo, 1994), the homophobia often present in sports was also documented in sociology (Messner & Sabo, 1990, as cited in Connell & Messerschmidt, 2016). Finally, masculinity was employed increasingly to understand men's health practices including risky sexual practices. The concept helped to comprehend the difficulties men faced in dealing with injuries and disability as well as their general exposure to health risk (Gerschick & Miller, 1994, as cited in Connell & Messerschmidt, 2016).

2.1.2 Sexual orientation and gender identity

Understanding sexual orientation and gender identity is important in healthcare provision. Gender and sexual minorities encounter health disparities at higher rates than their heterosexual counterparts (Pebody, 2015). Sexual and gender minorities experience health inequalities because these individuals are denied their human and civil rights, and are subjected to discrimination, and societal stigma. Often health care providers disregard the relevance of sexual and gender identity in patient care and try to maintain professional neutrality. In as much as healthcare professionals may attempt to not express any negative perceptions or judgement, suboptimal treatment or health outcomes often still arise (Aleshire, 2016). Sexual orientation and gender identity are diverse attributes of human identity that occur within every individual and separate from one another. Sexual orientation and gender identity typically and essentially involves who one has a romantic attraction to (emotional and/or sexual) and is used in determining how MSM identify themselves. There are MSM who identify as gay, bisexual, and/or transgender. For those who identify as gay, they have romantic feelings for other men whilst those who identify as bisexual have romantic feelings for both men and women.

Historically, tensions around bisexuality have always existed. The context of bisexuality demonstrates the fluidity that exists in terms of sexual classification and meaning. Many scholars have been constrained to locate bisexuality in relation to heterosexuality and homosexuality (Fahs, 2009). There are debates that there has to be a distinction "between homosexual behaviour, deemed universal, and homosexual identity, which is historically specific" (Weeks, 1990, p. 3). Although bisexual behaviour has persistently existed as a fact of human life, bisexual identity represents a cultural creation that changes in meaning as it could be associated with both heterosexuality and homosexuality, and changes as a concept (Fahs, 2009). The struggle about bisexuality as an identity is commonplace and Moore and Norris (2005) discovered that bisexuals themselves were also more conflicted about their sexuality compared to their heterosexual counterparts. In addition, bisexuality has been distinguished by people who want "to deconstruct traditional models of sexual identity, as bisexual takes on a more fluid and malleable quality than heterosexual identity" (Blumstein & Schwartz, 1990, p. 310). These components are not simply dichotomous, instead, they are complex and multidimensional and have a great variation and fluidity (Aleshire, 2016).

Self-acceptance of one's sexual orientation is highly recommended as it is an integral part of positive self-identity development. Additionally, being more self-accepting is linked to other significant positive development processes such as reduced levels of internalized heterosexism, and a greater sense of self, disclosing one's sexuality to others and free participation in society (Camp et al., 2020). The process of acceptance and disclosure can be a challenging one for individuals identifying as non-heterosexual because of chronic experiences of homo-negativity and heterosexist attitudes, prejudice, and discrimination (Meyer, 2003). Furthermore, the probability of gender nonconformity experienced in childhood may imply that some individuals who in their later life identify as non-heterosexual, are likely to experience heightened victimization and prejudice (Camp et al., 2020). Wagner et al. (1994) also revealed that accepting one's sexuality from a younger age, is positively correlated with lower internalized negative attitudes towards one's sexuality in adulthood. Finally, positive feelings towards one's sexual orientation and positive identity affirmation contributes to pride in one's sexual identity (Camp et al., 2020).

2.1.3 Femininity

Some MSM classify themselves as 'feminine', and by so doing, these men are not looking to recreate symbolic patterns related to 'normative femininity', however, they instead highlight a transgressive form of femininity, which is regarded as a violation of accepted norms of prohibited female sexuality (Garcia et al., 2016). Furthermore, gender transgression is dual in the sense that it involves biological males acting as females, and prescriptive female sexual behaviour is changed into transgressive female sexuality. These types of identities that MSM adopt disclose how ideas of gender and sexuality are interconnected. As a result, as opposed to looking at these identities as fixed or independent of each other, they are correlated and fluid, and this fluidity and interconnectedness is obvious in MSM partnering strategies (Garcia et al., 2016). However, it is imperative to note that traditionally, masculinity and femininity are conceptualized as binary, and as a result, men who do not adhere to these stereotypical norms of masculinity are often equated with femininity but such MSM position and identify themselves differently. Although, this is done through the enactment of behaviours and attitudes that are associated with femininity, MSM themselves identify as men, not as women.

2.1.4 Masculinity

In order for a man to undertake any single positive health behaviour, they may end up having to reject various constructions of masculinity. As a way of aligning to this, studies have outlined that men likely to conform to masculine norms are highly unlikely to participate in positive health behaviour (Zeglin, 2015). This existing relationship between masculinity and health demonstrates the importance of examining the role masculinity plays in behaviours associated with health such as adhering to treatment and testing, and condom use (Zeglin, 2015). Other subordinated masculinities such as those enacted by MSM, cannot attain hegemonic masculinity and may lead to enactment of hypermasculinity. Masculine norms are affected by the intersectionality between sexual orientation and masculinity, and can end up creating significant gender role strain, influencing these men to reveal masculine identity via different ways (Zeglin, 2015).

In societies that require strict compliance to heteronormativity, deviation from sexual norms is condoned only as long as the person adapts to other normative gender characteristics such as portraying themselves as normatively male or female or undertaking socially and culturally appropriate gender roles (Lynch & Clayton, 2017). Some gay men decide to take part in cultural practices such as traditional circumcision in an attempt to repair their compromised gender identities in order to closely align with the heteronormative idealised masculinity that awards them manhood and complete citizenship in their communities (Lynch & Clayton, 2017).

Sexual performances and related risk-taking have been associated with masculine identity (Halkitis et al., 2004). Constructing gay masculinity has been challenging and numerous gay men have opted to stick with the heterosexual standard of what a masculine man is. From this finding, it is apparent that developing masculine identities distinct from heterosexual standards has been an ongoing challenge for MSM. This could be in part due to homophobic attitudes and stereotyping men who have sex with men and as a result, perpetuating them as 'weak' or 'not man enough', hence weakened efforts to classify a clear distinct gay masculinity. And this group of men who have embraced this hegemonic masculinity identity also excercibate this reality (Halkitis et al., 2004).

Fleming et al. (2016) attest that there is evidence in sub-Saharan Africa that men enacting characteristics of hegemonic masculinity such as stubbornness, fear of being on medication hinders them from accessing HIV Testing Services. In addition, health seeking behaviour is often itself deemed unmanly (Graaff & Heinecken, 2017). South African men access treatment less often and normally later on, their rates for HIV testing are lower in comparison to women, because masculine norms make it more difficult for men to get essential care as this is regarded as feminine and deemed a sign of weakness (Gittings, 2016). Moreover, health behaviour patterns associated with norms of masculinity lead to poorer health outcomes in men, and in South Africa where on average, women live five years longer than men, hegemonic masculinity ideals intensify the risk of HIV infection in men and decreases health-enabling behaviour like testing and adhering to treatment (Gittings, 2016).

2.1.5 Heteronormativity, masculinity and MSM

In his argument, Connell (2005, as cited in Closson et al., 2019) states that there is one or more types of hegemonic masculinities at any present context. These masculinities are largely viewed as an aspired-to version according to which all masculinities should be structured. In South Africa, for example, MSM negotiate gender identity mainly in heteronormative contexts which entitles a certain version of masculinity (Lynch & Clayton, 2017). This, they argue, is centred on assertive heterosexuality… cultural ascendency and support for male promiscuity. For example, fathering a child seems as a recurrent theme in modelling normative masculinity in Africa, in this manner, heterosexual sex and procreation become significant traits of socially valued masculinity, which gay men cannot generally meet (Lynch & Clayton, 2017).

Szymanski and Carr (2008) illustrate that most traditional families exhibit a lot of heterosexism, the acceptable dominance that heterosexuals are superior to homosexuals, and as a result, they are entitled to more rights than homosexuals. Set and Altınok (2016) moreover, assert that this belief leads to many children being subjected to anti-gay judgements from a young age by their parents and other family members and society at large. Pro-heterosexuality messages are dominant in many families, schools, and from the media which socialize children from an early age. Heterosexism makes life difficult for sexual minority groups as they are denied their rights and the majority of cultures are predicated on the assumption that everybody is heterosexual. Therefore, non-heterosexuals have an invisible status and when they become noticeable, they are termed abnormal and unnatural and are generally discriminated against and stigmatized (Set & Altınok, 2016). The cultural and traditional association with heteronormativity, was documented by Maleke et al. (2017) who found that traditional value systems in the rural context prized heteronormativity such that it shaped intimate MSM relations. MSM relationships were aligned with heterosexual stereotypes of male and female, and these stereotypes were also associated with intimate partner violence. As a result of uneven power dynamics MSM who identify as feminine in relationships could face difficulty in condom negotiation, for instance (Maleke et al., 2017).

Even though South Africa became one of the first African countries to pass laws on the protection of its citizens based on sexual orientation and gender identity in the Constitution, the lived experiences of those not conforming to heteronormative and masculine standards especially in men, far contradicts this legal equality. Homophobia and transphobia repeatedly reveal themselves through violence (Lynch & Clayton, 2017). Public discourse creations of homosexuality being 'un-African' fuel discrimination and stigma against gay, bisexual, and transgender persons. In societies that require strict compliance to heteronormativity, deviation from sexual norms is condoned as long as the person adapts to other normative gender characteristics such as portraying themselves as normatively male or female or undertaking socially and culturally appropriate gender roles (Lynch & Clayton, 2017).

Ozbay (2010) demonstrates that there is a strategy adopted by men who identify as heterosexual and have had sex with other men, whereby they exaggerate heteronormative characters as a way of securing their male identity (Lynch & Clayton, 2017). MSM are generally vulnerable to social exclusion due to heteronormative and heterosexist perspectives and conforming to these dominant standards gives them access to a sense of belonging and social integrity (Lynch & Clayton, 2017). There is an understanding amongst some men that competent gender performance partly comprises sexuality. Owing to that, they seem to deem their homosexuality as a shame or exhibit feelings of guilt. Their comprehension of societal expectations of a man extends beyond heterosexual appearance nonetheless, to include having children, providing for their families and solving problems or asserting themselves in society through anger and violence (Garcia et al., 2016). These men's identity seem to oscillate between their heteronormative social appearance and their homosexual behaviour.

2.1.6 Heteronormativity and religion

The application of heteronormative gender identity takes place in numerous ways in societies, especially in established religion. Churches endorse a patriarchal world view that supports and favours sexual dualism where men are in charge. It is often argued that male/female only exists in the Christian Bible and nothing else. This is accompanied by careful cherry-picked scriptural references that build on theological views that push forward the agenda of

heteronormativity at the total exclusion and ignorance of homosexuality (Mitchem, 2018). Questioning one's sexuality in Biblical terms seems to be an expression rooted in deterministic understanding of gender. Men essentialize gender identities to try to understand the various assumed necessity of gender and expectations. This pursuit of a deeper understanding of gender, and what it means to be male specifically, brings gender confusion for men who have sexual relations with other men, as this is considered as deviation from their 'natural' expression of masculinity, as their 'natural' born gender identity (Graham & Mphaphuli, 2018).

In addition, the Bible defines homosexuality as sin, a demonic act that people need to repent from and that should not be flaunted. Homosexuality is considered morally wrong and the church uses a few Biblical passages to condemn homosexuality, to view homosexuals as unnatural, and homosexuals are instructed to pray for forgiveness (Subhi & Geelan, 2012). At the core of Christian faith is the belief that to follow Jesus Christ who has been sent by God, his father to save the world, is to save people from sin and hell. Therefore, members of this religion have to adhere to these theological beliefs, and gender and sexuality are used as weapons to bind everyone to this self-righteousness (Mitchem, 2018). Men who experience religious homophobia have high levels of internalized homo-negativity, heightened levels of shame, low self-esteem and reduced necessary social support. Messages that have homo-negative connotations in religious contexts can weaken the health and spiritual benefits of religion for MSM in comparison to their heterosexual counterparts (Foster et al., 2015).

In conclusion, these structural drivers conceptualised as social, economic, organization and policy/political factors contribute to social inequalities and unequal access to health (Baral et al., 2013) and have both a direct and indirect influence on how MSM construct their masculinity and influence PrEP utilization. Factors affecting MSM construction of masculinity and subsequent use of PrEP occur at three different levels: micro level, meso level and macro level. At micro level, factors such as peer victimization, family support, and social support may influence how MSM construct their masculinity. At Meso level, homophobia and discrimination, gay community norms, peer norms, economic disparity, religion, ethnicity and

lack of prevention programs. At Macro level, history, culture, societal norms, institutional discrimination and stigma are involved (Mustanski et al., 2011). The hegemonic discourse about heteronormativity at macro level propagated through policies that discriminate MSM propels many MSM to construct their masculinity in alignment with heterosexist and heteronormative cultural norms, to foster a sense of belonging. These macro-political factors lead to institutional dominance at meso level whereby MSM experience institutionalized stigma from healthcare providers for example, which may either lead to MSM not disclosing their sexual orientation to their healthcare provider, (Mirandola et al., 2017) for example, because of fear of stigma and discrimination, and this may be a missed opportunity for them to receive quality client-centred care specific to their healthcare needs because of interpersonal experience of stigma experienced at micro level, or this may lead to MSM misrepresenting themselves at healthcare facilities and this could have a negative impact on them in the sense that the healthcare provider may misdiagnose MSM and fail to offer appropriate treatment. In addition, meso level systems such as religion further exert institutional dominance, (Holle et al., 2021) through discrimination and judgmental discourses about MSM which may also lead to poor health seeking behaviour by MSM due to fear of experiencing religious and moral judgement from the healthcare providers as well, who usually impose their own religious beliefs on MSM with the intention of influencing their gender identity and sexuality.

The next section provides a review of knowledge of PrEP and the willingness amongst MSM to use PrEP. This will be followed by HIV risk perception and its association with risky sexual behaviours amongst MSM.

2.2 Knowledge of and willingness to use PrEP

Hugo et al. (2016) speculated that there is little evidence of MSM's willingness to take PrEP in South Africa. However, existing evidence is limited to specific geographic locations and over 65% of the sample constituted white participants who have higher education qualifications. This is a gap in the literature hence the need to undertake this study in the South African township context targeting men who do not possess similar educational background. Garcia

et al. (2016, p. 1039) iterated that very few men would use PrEP and condoms for the added protection against contracting HIV. From their study findings, men who identified as 'real' were reflexive about how masculinity and femininity would affect the acceptance of PrEP. Several likened taking Truvada daily to the 'pill for contraception' and even suggested messaging to call it 'The Pill for Men'. Therefore, these men avoided being equated to being 'on the pill' like women and rather opted to not take PrEP.

According to findings from a study by Al-Tayyib et al. (2014), PrEP knowledge amongst MSM (as people who may benefit from its potential preventative benefits) remained low. Additionally, a study by Jenani et al. (2016) also discovered that MSM had low knowledge about PrEP. However, the majority of those with some education and knowledge about the effectiveness of PrEP showed a high interest in using it. Believing that PrEP was effective in reducing the risk of transmission of HIV was an important factor influencing willingness to be on PrEP. Furthermore, the perception of risk plays a significant role in influencing adherence to PrEP and therefore the efficacy of PrEP as a prevention strategy (Jenani et al., 2016). Health experts in a study by Krakower et al. (2014) were well informed about adherence challenges which could lead to suboptimal utilization of PrEP. They had reservations regarding adherence and logistical threats as challenges to implementing PrEP successfully. They predicted that patients are highly likely to utilize PrEP intermittently, in spite of counselling to use it daily, and this could decrease or eliminate its protective benefits. Additionally, experts' previous knowledge of HIV positive patients not adhering to antiretroviral treatment and those not infected with HIV not adhering to PrEP regimens caused concern that patients may not adhere to PrEP.

Generally, MSM contemplate considering PrEP for a couple of reasons, including PrEP's long term health effects. Latino MSM in the study, who were not on PrEP presently, stated that they are unlikely to think about being on PrEP owing to "potential side effects such as nausea, dizziness, vomit, diarrhoea, or stomach pain, liver damage and kidney damage" (García & Harris, 2017, p. 8). Lin et al. (2021) research results showcased that peer education was positively linked with accessing HIV services amongst MSM This discovery established and

contributed to prior meta-analysis that exhibited that peer education was positively associated with promoting the uptake of HIV services by MSM. Peer education, firstly, can create awareness of accessing HIV services and give information of where services are available and thus increase health seeking behaviour by MSM. Secondly, peers can offer social support, and service referrals. Finally, emotional support shared amongst peers can help MSM as the key population to overcome certain barriers to gaining access to HIV services. Krakower et al. (2014) found out that healthcare providers (HCPs) in USA were willing to recommend and prescribe PrEP to MSM. They outlined patient motivation as the number one facilitator in prescribing PrEP and PrEP guidelines. This motivation was not associated with any gender performance within MSM relations. Thus, HCPs believed they would prescribe PrEP to every MSM regardless of his gender performance. However, negative perceptions amongst MSM themselves that PrEP is only for bottoms may derail HCP's intention.

2.2.1 Risky sexual behaviours

Hugo et al. (2016) found that rates of continuous condom use amongst MSM are low hence there is need for further biomedical interventions to prevent new infections. In addition, Stahlman et al. (2017) reiterated that many HIV prevention studies have discovered that in terms of individual determinants of HIV infection among MSM, condomless sex, high frequency of casual male partners, and other drug use present increased opportunity for HIV exposure. There are some studies that have explored the influence of emotions in formal partnerships and the risk associated with it (Goldenberg et al., 2015). Intimacy and sexual gratification were adversely correlated with sexual risk taking. One of the many reasons MSM engage in unprotected anal sex was as a result of emotional reasons, that is, trust and a desire to connect with their partner - this also depended on the length of the relationship. These findings imply that romantic or intimate emotions exist and are significant for MSM. These emotions bring about complexity in sexual decision making and a degree of influence on risky sexual behaviours (Goldenberg et al., 2015). Love, intimacy, and trust inhibited perceptions of risk, hence an increased willingness to engage in condomless sex. On the other hand, there are men who claim control of their lives and refuse to embed their behaviour within the idea of individual vulnerability as sexual behaviour has a direct link to being vulnerable to HIV.

They prefer to adopt safe sex practices such as use of condoms to avoid HIV infection (Da Fonte et al., 2017).

A study by Ewing and Bryan (2015) posited that both pragmatic and emotional worries affect condom use in adolescent relationships. Adolescents who frequently engage in sexual activities, had difficulties in consistently having condoms on hand when needed and to always consider using one before sexual engagement. This challenge may be worsened by social constructions that link the use of condoms to unfaithfulness, promiscuousness, and the absence of trust and love in a relationship. Young people may transition into beliefs that using condoms is not necessary as they start to love and trust their partners. In addition, they may consider this as a barrier to the strong emotional and physical connection they yearn for in intimate relationships (Ewing & Bryan, 2015).

2.2.2 HIV risk perception amongst MSM

Anyone can be affected by HIV irrespective of their sexual orientation, or where they reside. Nonetheless, there are specific groups of people more likely to be at risk/vulnerable to infection or to be infected by HIV than others due to factors such as the communities they come from, subpopulations they are affiliated to, and their individual risk behaviours (HIV.gov, 2020). There are some MSM who hold the belief that MSM are not the only subpopulation at risk of HIV, and that because HIV has been identified as having been spread through heterosexual transmission routes, some MSM believe they are not at risk. However, MSM as the key population subpopulation are adversely affected by HIV. A 2018 study by the US Centres for Disease Control (CDC) revealed that MSM contributed to 69% of HIV diagnoses in the USA and that unprotected anal sex and or vaginal sex were key contributors with unprotected anal sex being the chief risk-behaviour (HIV.gov, 2020, p. 1). In South Africa, MSM are also at high risk of being infected with HIV and the prevalence of HIV amongst MSM, according to numerous studies, is estimated to be between 10.4% and 34.5% (Maleke et al., 2017, p. 32).

A recent study by Lin et al. (2021) revealed that only half of key populations, including MSM, perceive themselves to be at risk of HIV globally. The connection between risk perception and HIV health uptake in key populations such as MSM has been assessed in a range of studies. Nonetheless, findings are conflicting. For instance, a cross-section study done in China suggested that individuals who perceived themselves to be at risk of HIV infection were inclined to test for HIV. However, those who deemed themselves not to be at risk or to have low risk of being infected were highly unlikely to test for HIV (Lin et al., 2021). Moreover, other research done in sub-Saharan Africa, Germany, and India also discovered that HIV risk perception is a facilitator for HIV testing among MSM…since they may be interested in knowing their status if they think they are at risk. Contrary to this finding, a study done in Peru demonstrated that those who perceive a higher HIV risk, were unlikely to test regularly (Lin et al., 2021).

The following part of the literature reviews gender performance and dimensions of sexual identity and sex roles. This will be discussed in relation to socialization, gender roles, and MSM. Hybrid masculinities and egalitarian relationships will further be deliberated, and the section will be concluded by looking at dimensions of sexual identity and sex roles.

2.3 Gender performance and dimensions of sexual identity and sex roles

2.3.1 Socialization, gender roles and MSM

Due to socialization and stigma related to homophobia, MSM's exhibiting masculine characteristics prefer to maintain the traditional gendered division of labour in their partnerships. MSM in relationships, who exhibit effeminate characteristics are linked to hegemonic femininity similar to heterosexual women according to traditional gender roles and are typically associated with a preference for anal receptivity (Johns et al., 2012). Masculine MSM adopt normative 'male' gender characteristics and undertake socially and culturally appropriate gender roles (Lynch & Clayton, 2017), this adoption allows them to align with stereotypical heteronormativity and as such, to expect the same from their partners. Moskowitz and Hart (2011) emphasize that a heterogeneity of sexual behaviour exists within the subpopulation of MSM. However, the normative conceptualization of gender roles largely

guide their sexual practices. Traditional gender roles impact on MSM's conceptualizations of their sexual relations and sexual decision making. Given the fact that traditional gender roles have a potential to contribute to the inequitable distribution of power in heterosexual contexts, it is important to be aware that the prescriptive utilization of gender roles may similarly generate unequal power relations amongst MSM themselves (Johns et al., 2012). Furthermore, it is paramount to understand that due to the power and dominance that masculine MSM possess, receptive or feminine MSM's sexual decision-making/agency maybe be adversely affected as a result of adherence to the gender roles expected by their dominant masculine partner.

2.3.2 Hybrid masculinities and egalitarian relationships

Although gender is frequently discussed and distinguished from biological difference (sex) as opposed to social difference, it is still important not to reduce gender to simply male or female. Instead, it is preferable to look at how gender is enacted and continuously performed (Garcia et al., 2016). Garcia further illustrates that some MSM, especially younger MSM, emulate hybrid masculinities whereby they blend masculine and feminine gender norms and beliefs independent of sexuality or biological sex. Shechory and Ziv (2007) demonstrate that same-sex couples had more liberal attitudes toward gender roles. There is an assumption that liberal or modern gender role attitudes are linked with an egalitarian role/division of labour, particularly among same-sex couples. In same-sex relations, the absence of a sex/gender difference is thought to eliminate the possibility of gender hierarchy. This potentially creates a more egalitarian relationship regarding role division and responsibilities in those unions (Shechory & Ziv 2007). Research by McPherson (1994, as cited in Shechory & Ziv, 2007) found this to hold true, and that among gay couples, there is a more equitable division of labour and that same-sex couples held more liberal attitudes regarding gender roles. This heterogeneity is identified in the Northern context, and it will be important to explore if this is the case in South African context.

2.3.3 Dimensions of sexual identity and sex roles

Within the subpopulation of MSM, multiple identities are at play. Some MSM identify as gay, straight, bisexual, discreet, or after-nines since they do not self-identify as gay and act straight during the day but also engage in sexual intercourse with other men at night (Mantell et al., 2016). Other men are more comfortable identifying as gay. The majority of MSM who identify as straight and bisexual have girlfriends in long-term relationships, while they have casual sexual relationships with other men. Those who identify as discreet, or after-nines emphasize 'not being out of the closet' as the major trait of their sexuality and see this as only a part of their identity. There is a story to these sexual identity labels about these men's social and self-representation (Garcia et al., 2016, p. 1031). This self-ascribed identity by those discreet may put MSM at a vulnerable position to being infected with HIV because this identity may be directly linked to conceptualization and endorsement of masculinity (Morrell, 2003). The enactment of hegemonic masculine norms places men in a position where they engage in risky sexual behaviours such as being reluctant to test for HIV and having multiple concurrent sex partners and this emphasizes the connection between men and their masculinity as ways of preventing HIV (Zeglin, 2015). MSM generally prefer labelling themselves when negotiating sexual intercourse with firm ideas of what sexual position they prefer, such as total tops (insertive in anal sex), total bottoms (receptive in anal sex) and power bottoms[1]. Others are eager to be equal tops and bottoms during anal sex to differing degrees, for example, versatile-tops, versatile-bottoms and generally versatile (Dowsette, 1996, as cited in Ambrose, 1997, p. 29). Often times, men's preference of a sexual role creates boundaries of the gender performance they expect. That is men looking for partners who are only receptive during anal sex often portray themselves to be more masculine.

In a study conducted to assess perceptions amongst Dutch MSM and their willingness to use rectal microbicides (RM) and oral PrEP (pills) to reduce HIV risk, both the survey and in-depth interview findings suggested that Dutch MSM would prefer RM to oral PrEP if proven equally effective (Marra & Hankins, 2015). Rectal microbicides are a topical PrEP containing ARV for rectal administration (Marra & Hankins, 2015). This study concluded that willingness to utilise

[1] "A receptive partner in anal sex that exhibits control/dominance in intercourse" (Garcia et al., 2016, p. 1034).

oral PrEP was lower than expected despite the view that pills are more effective than creams. MSM who identify as masculine and are total tops think PrEP is a great idea but for other MSM, for instance, for serodiscordant couples, because "taking a daily pill is crazy and a big commitment" (Garcia et al., 2016, p. 1038). Others in the same category allude that PrEP is for *bottoms* or those people who are having unprotected sex (Garcia et al., 2016). Straight and bisexual men switch between heterosexuality and homosexuality interchangeably, especially when accessing health services since for them, going for routine health check-ups is seen as a sign of weakness and femininity, and not their responsibility. These ideas are borne out of perceptions about gender role and expectations that men accessing health services are considered feminine. As a result, bisexual and straight men can present themselves as straight men while accessing health services so that they are not considered weak or feminine.

2.4. Barriers to PrEP use

MSM experience barriers to PrEP use at individual and structural level. At the individual level, perceived risk, gender identity, sexual roles, and internalized homonegativity are barriers to PrEP use. Following Garcia's review of individual level factors, the next section discusses barriers experienced at the social or structural level, and these include stigma and discrimination in relation to access to health care services, institutional and medical mistrust, power dynamics, 'slut-shaming'[2], sexual orientation disclosure, and negative attitudes from healthcare workers.

2.4.1 Stigma and discrimination, and access to health care services

According to Stahlman et al. (2017) there are numerous types of stigma that MSM face which limit the provision, acceptance, and utilization of HIV prevention services. Being exposed to stigma as well as healthcare providers who are culturally insensitive can discourage MSM from HIV testing and using other prevention services, which may limit opportunities to

[2] A belief by some gay men that PrEP leads to reckless sexual behaviour and that PrEP is only used by sluts or whores, (Dubov et al., 2018).

diagnose and make them aware of their HIV status. MSM's reduced use of health and HIV services as a result of perceived discrimination, restricts their knowledge of the risk involved in condom-less anal intercourse and prospects in relation to prevention services (Stahlman et al., 2017). Moreover, most studies of MSM stigma have mainly been fixated on internalised stigma or internalised homo-negativity. Nonetheless, current studies indicating elevated levels of experienced and perceived stigma in many countries insinuate that internalised stigma is a result of the lived experience of stigma and a representation of mental health stressors associated with stigma (Stahlman et al., 2017).

Dubov et al. (2018, p. 1833) discovered a link between PrEP stigma and HIV stigma. In both situations, PrEP use to prevent seroconversion and/or having HIV gives rise to being labelled a "slut, whore, dirty, or irresponsible." HIV negative MSM are therefore also stigmatized for wanting to protect themselves from contracting HIV. PrEP stigma seems to trail along a similar path as HIV stigma leading to lack of motivation to use PrEP and social exclusion based on PrEP use. The result being that MSM are deterred from HIV testing and/or use of PrEP despite the fact that the medication could prevent them from seroconverting. HIV-related stigma is common in MSM communities including "enacted stigma (covert behaviour), perceived (awareness of stereotype), and internalized (self-stigma)" (Dubov et al., 2018, p. 1839). Findings from this study further revealed that for MSM to experience the following types of stigma, enacted stigma which may be experienced when MSM experience social exclusion by others is based on societal rejection of their (MSM's) sexual orientation. In other instances, MSM experience perceived stigma, when for example, they experience social isolation based on how their feminine behavioral traits are interpreted and understood by others within the community. In addition, MSM may experience internalized stigma when negative stereotypes of MSM produce feelings of, for example, being immoral or reckless within MSM themselves (Dubov et al., 2018).

There are some underlying causes of stigma amongst MSM regarding PrEP use. There is an assumption that seeking PrEP as a supplementary layer of protection against HIV is done by irresponsible and wild people. This pervasive stigma serves as a constraint preventing the

uptake of PrEP (Dubov et al., 2018). LeBeau and Jellison (2009) asserted the same issue that from the moment gay and bisexual men identify with their sexuality, they are subjected to numerous adverse social influences which range from rejection from family and friends to being threatened with violence, and countless types of discrimination. These undesirable societal attitudes coupled with widespread stigma have the potential to lead to psychological stress, which may lead to harmful mental health outcomes "such as the experience of distress, feelings of guilt, and suicidal tendencies" (LeBeau & Jellison, 2009, p. 57).

2.4.2 Institutional and medical mistrust

Issues related to institutional mistrust and distrust of medical providers generate extra barriers for governmental initiatives that support PrEP as an HIV prevention strategy for at risk populations such as MSM. Negative information regarding PrEP and medical mistrust could play a role in influencing decisions made by potential PrEP users (García & Harris, 2017). Medical mistrust has been recognized as a barrier to MSM's participation in regular health care. Attitudes about mistrust, especially in HIV treatment temper healthcare providers' ability to involve those needing medical support. Trust in clinicians has been associated with positive health outcomes like adherence to ARVs and improved mental health (Eaton et al., 2015), and lack thereof negative outcomes.

A study by Krakower et al. (2014) examining HIV providers' perceived barriers and facilitators to implementing Pre-Exposure Prophylaxis in care settings found that some health care providers had reservations about prescribing PrEP because of the belief that some people would engage in increased risky behaviours whilst utilizing PrEP, which may potentially increase their general risk of being infected with HIV. García and Harris (2017) also reiterated concern that PrEP users such as MSM could get a false sense of safety that could potentially promote an increase in risky behaviours. As a result, MSM who use PrEP may adjust their behaviour and take part in unprotected sex because of a perceived reduction in risk of HIV transference, termed PrEP optimism.

2.4.3 Power dynamics

Power dynamics within MSM relationships can have an impact on PrEP use. MSM who usually embrace heteronormativity and generally attempt to enact hegemonic masculinity may influence their feminine partner's use or non-use of PrEP. Poverty and severe economic circumstances can drive some younger men who are on the 'down low' (DL) or 'after-9s' to engage in sexual activities in exchange for monetary and other economic gains. These men engage in regular sexual relationships with women while also having transactional sexual relationships with men. Cultural norms relating to masculinity and associated male behaviour promote these men's decision to conceal their sexuality. After-9s or DLs' sexual encounters are usually brief, to quickly negotiate and engage in sex with partners met anonymously or over the internet (Icard, 2008). Maleke et al. (2017) also noted that power dynamics are at play in MSM relationships with 'after 9s'. These are men who were not ready to disclose their sexual orientation and were usually in concurrent relationships with or married to women.

MSMs relationships with 'after 9s' were particularly founded on heteronormative stereotypes (also associated with sexual roles preferred by individuals in that relationship), men enacting the insertive role in anal sex are regarded as possessing more power over those playing a receptive role. Power dynamics in MSM's relationships are also associated with whether or not partners were employed. The ability to financially support one's partner was directly connected with the power that partner has in the relationship (Maleke et al.,2017). Finally, Ricks et al. (2018) found that age, and economic motivations such as financial dependency exposes male sexual partners to vulnerability and these demonstrate underlying interpersonal dynamics between MSM which contributes to disparities in perceived relationship power that could also affect one's agency to negotiate PrEP use with their sexual partner.

2.4.4 "Slut-shaming"

On the other hand, discourses within MSM about PrEP have multiple instances of slut-shaming which are generally different from a simple misunderstanding or criticism. Slut-

shaming frequently arises from other gay men in the community who believe that PrEP promotes reckless sexual behaviour and that it is only utilized by sluts or whores (Dubov et al., 2018). This PrEP-related stigma is a deterrent for MSM to freely utilize PrEP without fear of being shamed. Buchbinder (2018), on the other hand, argues that PrEP's effectiveness is correlated with PrEP adherence. The lack of knowledge leads to many MSM being sceptical about PrEP and it's health benefits. Social factors (such as access to PrEP, lack of education, and stigma) together with pharmacodynamics (the effects or side effects of PrEP) also undermine this (Buchbinder, 2018). In order to advocate for PrEP use, it is important to know which context is applicable for MSM in South Africa.

2.4.5 Sexual Orientation Disclosure

In societies where homosexuals are exposed to discrimination and marginalization, MSM may have a tough time accepting and disclosing their sexual orientation. These processes impact on the feelings of emotional security and attachment which demonstrate liveliness and compassion towards self. Owing to that, MSM may experience internalized homophobia which may result in negative health outcomes such as mental health issues (Set & Altınok, 2016). A study in Uganda found that 72.9% of MSM were not comfortable disclosing their sexual orientation to healthcare providers while 81.1% felt that health providers did not respect MSM (Matovu et al., 2019, p. 2). In order to promote culturally sensitive service provision, care should be provided in a welcoming and supportive environment, which will facilitate sexual orientation and gender identity disclosure, by MSM, through advanced and effective communication and advocacy in the community and within the healthcare system (Aleshire, 2016), and equitable health care services and health systems that allow patients to openly share their sexual and gender identities should be created and be an integral part of holistic health service delivery.

Disclosure of sexual orientation by MSM is an important factor linked with positive health outcomes. Sexual orientation disclosure could be associated with improved health outcomes together with increased well-being (Watson et al., 2020). In addition, disclosure of sexual orientation is also associated with increased social support and this has potential to increase

MSM's self-esteem and psychological health and may also encourage access to health services and linkage to treatment services (Tang et al., 2017). It is worth acknowledging though that research has also proven that disclosure can also be connected to harassment and depression. As a result, evidence of mixed advantages and disadvantages exists in terms of sexual orientation disclosure and this often depends on the context of disclosure and the consequence of interest (Watson et al., 2020). Participants from a study by Rispel et al. (2011) stated that MSM were reluctant to utilize healthcare services from the public sector and to disclose their sexual orientation to healthcare providers in the public sector due to past negative experiences. Health care providers such as nurses and doctors as leaders in the ever-changing health care service, should implement strategies to eliminate inequalities in health and deliver an inclusive health care environment (Aleshire, 2016).

2.4.6 Negative healthcare worker attitudes towards MSM

The major barrier discouraging MSM to seek health services is stigma. Findings from a review by Ma et al. (2017) established that deep rooted social and internalized stigma towards homosexuality contribute to MSM's reluctance to seek healthcare services. Social stigma towards MSM adversely affect health care provision. Through their negative and stigmatizing attitudes, health care professionals neglect their obligation to protect their patients and to promote health by violating MSM's equal rights to health. Health care workers need to be equipped with enough knowledge to offer appropriate and sensitive services to MSM. It is imperative for health professionals to scrutinize their inherent values and perceptions about homosexuality and be aware of the right to health that all humans have. In addition, health providers need to undergo sensitivity training which can advance their knowledge and attitudes concerning marginalized populations such as MSM. One study found that a sensitivity training course in Kenya improved health care providers' knowledge regarding MSM's issues and reduced HCP's deeply held homophobic attitudes significantly (Ma et al., 2017). Owing to that, it should be a requirement for health personnel and health related students to undergo sensitivity training as part of their curriculum as this may reduce their bias and result in delivery of quality, friendly, and non-judgmental services.

In addition, in Uganda, MSM stated that they faced challenges in accessing HIV services because of negative healthcare worker attitudes (Matovu et al., 2019). A study by Kushwaha et al. (2017) in Ghana also revealed that healthcare providers did not understand MSM and MSM felt that healthcare providers did not care about them. In a similar light, some studies revealed that perceived and experienced stigma by MSM especially regarding sexual identity issues from the healthcare facilities, have contributed to delays in seeking care, travelling to other distant clinics, and missing opportunities for proper HIV services amongst MSM (Matovu et al., 2019). In one South African study exploring experiences of MSM with healthcare workers, MSM avoided accessing services where they faced stigma from health workers and numerous non-gay-identifying MSM refused or evaded discussing same-sex behaviour with health providers. In cases where health providers are inconsiderate of MSM's needs, or create barriers to care, ensuring use of prevention and treatment services for HIV becomes difficult (Rispel et al., 2011).

Due to experiences that MSM encounter because of an unresponsive healthcare system, being stigmatized and discriminated against, a mere 7% of participants in a study by Rispel et al. (2011, p. 148) preferred government health facilities. This may have come about as a result of past negative experiences with public sector health services, combined with overall perceptions of the sub-standard of public sector services.

The next part briefly discusses enabling factors that facilitate PrEP use, the human rights centred approach, collaboration with non-governmental organizations, and consideration of MSM-specific services.

2.5 Enabling factors for PrEP use by MSM

As discussed above, stigma, negative attitudes, and maltreatment are factors that dissuade MSM from using health services; however, there are a range of factors whose presence would greatly encourage MSM to access health services, including PrEP. MSM preferred to be "treated with respect, privacy, and empathy by health care providers who were non-

judgmental and had a positive attitude" (Ma et al., 2017, p. 2433). At the community level, MSM acknowledged that non-governmental organizations play a significant role in enabling MSM health seeking behaviour and advocating for more government involvement in MSM issues such as PrEP information dissemination. There is a need for targeted HIV prevention and treatment services for MSM. While Rispel et al. (2011) study suggested that MSM prefer attending facilities dedicated to their specific needs, they outlined that this was not likely to be achievable, across South Africa, as a result of present resource limitations and the prevailing challenges in the health system (Rispel et al., 2011).

The potential impact of PrEP in HIV prevention will be determined by a number of factors such "as knowledge of, access to, and adherence to daily medication" (Al-Tayyib et al., 2014, p. 6). A study by Hugo et al. (2016, p. 361) confirms that an estimated 75% of MSM confirmed that should PrEP be accessible to them, they would use it. A considerable number of MSM who participated in a focus group discussion by (Arreola et al., 2014) emphasized their enthusiasm in utilizing PrEP after hearing about its potential benefits. They outlined that if structural and social barriers regarding PrEP use were addressed, they would not only consider being on PrEP, but they would also recommend it to their peers. In addition, results from a study by Kim (2010) revealed that the incidences of anal cancer in MSM were much lower if HPV vaccines were administered early in life to MSM. These findings demonstrate the positive impact of targeted and appropriate healthcare for MSM to reinforce better outcomes. The next section concludes literature review by looking at theoretical framework. Gender Theory's key concept of masculinity and social- ecological model will be discussed.

2.6 Theoretical Framework

2.6.1 Gender Theory's key concept of hegemonic masculinity

2.6.1.1 Hegemonic Masculinity

Hegemonic masculinity is generally defined as the alignment of prominent and dominant masculine norms which function to disregard and put women and other men at subservient levels in society (Connell, 1995, as cited in Zeglin, 2015). When examining hegemonic

masculinity, discussions typically incorporate prized qualities like 'taking risks, ambition, heterosexuality' and so on. However, not a lot of men are capable of achieving this idealized form of masculinity, as a result, they experience gender role strain.

As a way of compensating for not living up to these 'ideals', men end up enacting hypermasculinity, that is, participating in intensified masculine norms such as 'denying weakness or pain or sexual promiscuity', (Connell & Messerschmidt, 2005, as cited in (Zeglin, 2015). These often have negative health outcomes for men, for instance, there is a connection between masculinity and poor help-seeking behaviour in men (O'Brien et al., 2007). According to Morrell (2003) features connected to hegemonic masculinity may also affect men who do not subscribe to hegemonic masculinity such as compulsory heterosexuality and the silence embedded in other gender identities due to homophobia, violence and cultural beliefs . As a result, perspectives and behaviour of men and dynamics related to gender, especially in relation to HIV, can be understood as a threat to aspired masculinity representations (Chikovore et al., 2016). In responses to HIV, hegemonic masculinity has been utilised to explore men's poor health seeking behaviour with a focus on the links between men's masculinity and health related behaviour (Gittings, 2016).

Masculinity standards create difficulty for men to access the required care, as this is seen as a sign of weakness. In South Africa, for example, life expectancy for men is five years less than women on average, and the norms of hegemonic masculinity increase the risk of HIV infection in men by deterring them from seeking health services like testing for HIV, accepting an HIV positive result, and following the nurse's instructions (Baker et al., 2014, as cited in Gittings, 2016). Because of supply related barriers from health institutions, men are unlikely to access HIV testing, treatment, and support services, and due to hegemonic masculinity practices that have an inclination towards equalizing illness to weakness and weakness to emasculation (Gittings, 2016). Fleming et al. (2016) assert that researchers investigating masculinity-related obstacles in HIV treatment show HIV stigma to be a contributing factor.

Alongside this, risky sexual behaviour is deemed manly, whereas health-seeking behaviour is viewed unmanly (Graaff & Heinecken, 2017). Recently, scholars have begun to investigate matters relating to masculinity in terms of HIV risks such as sexual behaviours, how masculine norms affect men testing for HIV and the outcomes for treatment and care. HIV testing was alleged to conflict with how men self-presented their masculinity because it was highly feminised (Fleming et al., 2016). Although there is an agreement to the existence of hegemonic masculinity, there is also acknowledgement of several masculinities (Connell & Messerschmidt, 2016) and from this point of view, there is criticism of whether a lone hegemonic masculinity exists. There is also an agreement that masculine identity is a fluid concept emanating from multiple available masculinities (Graham & Mphaphuli, 2018).

The concept of hegemonic masculinity will be useful in understanding if and how MSM enact this masculine norm when navigating health care services. Understanding how MSM individually conceptualize and enact masculinity will be a significant bridge between individual level factors and social or structural factors (Zeglin, 2015). If found to be relevant, counselling interventions that are focused on masculinity could be a vehicle to close the existing gap. By having a better understanding of the role of masculinity in HIV care, counselling professionals who work with MSM can be better informed to start providing services that are holistic and MSM specific to reduce HIV transmission (Zeglin, 2015).

2.6.2 Social-Ecological Model

The Social Ecological Model (SEM) has been broadly acknowledged and employed to better comprehend the health behaviours of individuals. It looks at the dynamic interconnections between people and their environment as determining factors of health-related behaviour (Baral et al., 2013). The social ecological model recognizes that an individual's behaviour is modelled through "multilevel factors that include the intrapersonal, interpersonal, institutional, community and policy levels" (Ma et al., 2017, p. 2413). SEM has been and is utilized in this study to provide a comprehensive understanding of MSM's health seeking behaviour and access to health. SEM is predicated on current frameworks exploring the multi-level context of HIV infection; it places individual risk factors within the broader network,

community, public policy setting and epidemic stage. The effectiveness of SEM is demonstrated in successful case studies that determine HIV infection risk amongst key populations such as MSM (Baral et al., 2013). A deeper understanding of the different levels of risk contributes to the acknowledgement that prevention measures have to be carried out as a form of basket of services that address HIV infection risk at each level (Auerbach et al., 2011). SEM encourages prevention efforts that focus on biomedical, behavioural, and structural components and demand a theoretical framework that monitors and characterizes HIV risk at all levels (Mahajan et al., 2008). SEM is a flexible model aimed at guiding epidemiological research amongst at risk populations of diverse social backgrounds. In order for HIV prevention interventions to be successful, the integration of sociocultural and structural evidence-based strategies is required since the focus of epidemiological studies has traditionally targeted individual-level risk factors at the expense of comprehensive research that takes into consideration multiple levels of risk (Baral et al., 2013).

SEM is used to explain the complexity of associations between, individual behaviours, social (social networks) and structural (access to care) factors, the physical environment and health (Poundstone et al., 2004). SEM takes into context the individual's practices through the use of intrapersonal (knowledge, attitudes and behaviour), interpersonal (social networks and social support), and community dimensions (relationships between organizations and institutions) and public policy (local, state and national laws) to deliver a framework that describes interactions between these levels (McLeroy et al., 1988). This model will be imperative in understanding the intersectionality between individual risk factors and the structural aspects perpetuated by masculinity.

Stahlman et al. (2017) adopted SEM and outlined that beyond risk factors at the individual level of HIV risk among MSM, at a network level, there is higher likelihood and probability of partner transmission of HIV from receptive anal sex than (for example) from vaginal sex. Furthermore, the probability of HIV infection for receptive condomless anal sex between MSM, compared to receptive condomless vaginal sex between men and women differs greatly depending on their biology, physiology, and immunology. Lastly, the rates of

transmission within MSM networks are likely to be higher as men can be both the receptive and insertive partner during sex and this sexual role versatility allows them to acquire and transmit HIV during rectal exposure. Structural risk factors for increased infection amongst MSM are related to their limited engagement and knowledge in sexual health education (Stahlman et al., 2017).

2.7 Conclusion

This chapter has deliberated on the literature and concepts that are central to the arguments and mechanisms that constitute and link the different sections of this Masters report. This chapter commenced by outlining sexual orientation and gender identity as used to define who MSM are and to differentiate them from heterosexual individuals. The identity of MSM plays a crucial role in how MSM assert themselves in society and navigate healthcare for example. MSM face challenges such as stigma and discrimination which they confront on a daily basis. This sometimes deters MSM from accessing health services and may lead to health disparities and poor health outcomes as a result of a high burden of disease. It is imperative therefore, to eliminate barriers to health care in order to improve their access to and ultimately improve their health outcomes. The following chapter outlines the methodology that was adopted in undertaking the study and the research methods and sampling procedures are discussed in-depth.

CHAPTER 3: RESEARCH METHODOLOGY

3. Introduction

This chapter outlines how the research was undertaken. It starts off by examining the study design, the methods used, and data analysis. The nature of the study focused on participants' experiences and personal narratives, as a result, the best study design to adopt was a qualitative research methodology. An account of the narratives and experiences were collected through semi-structured in-depth interviews, as the data collection method, from a sample of 24 participants who took part in the study. This group comprised of 21 MSM and 3 experts providing HIV prevention interventions targeted at Key Populations such as MSM. The description of the data analysis process, namely thematic content analysis follows. Ethical considerations were also taken into account where participants were assured confidentiality and anonymity throughout the data collection, analysis, and reporting process. Finally, the chapter concludes by taking into consideration the validity, credibility, and trustworthiness of the study and discusses issues involving researcher risks and vulnerability.

3.1 Qualitative Design

A qualitative design studies human behaviour, opinions, themes, and motivations (Mkhize & Njawala, 2016). Qualitative research considers the natural environment where people or groups operate in order to understand real-world problems in-depth. Generally, research questions are comprehensive and open-ended to produce unpredicted findings (Korstjens & Moser, 2017). This design was adopted because of its uniqueness as a research method to study what motivates or reinforces decisions, attitudes, behaviour, and phenomena (Ritchie et al., 2003, as cited in Mkhize & Njawala, 2016). Qualitative research is important in enriching our understanding of people's complex and diverse perspectives and experiences (Cooper et al., 2009). This qualitative study adopted a phenomenological methodology as a qualitative design which pursues uncovering meaning and the fundamental nature of a phenomena (Higginbottom, 2004). Phenomenological investigation is centred around interviewing and attaining insights and the meaning of experiences for participants. The main

goal of qualitative research is comprehending (that is, understanding) phenomena contrary to generalization of extrapolated data from the sample population (Byrne, 2001) . In addition, through phenomenology, qualitative researchers explore the manner in which individuals try to understand the world and to provide their perception of their subjective experiences. Finally, qualitative researchers have a responsibility of describing and accounting for 'rich' findings which could be applicable to other situations, rather than guaranteeing these (Byrne, 2001).

3.2 Research Methods

3.2.1 Sampling

In purposive sampling, it is important to understand the purpose of the research since this is a deciding factor for the qualitative sample to be selected. Moreover, as a means of providing credibility of the research findings, the decision-making process involved in qualitative sampling should be documented by the researcher (Byrne, 2001). For the researcher to attain the goal of concept and theory development, purposive sampling strategies can be employed, this is done through selecting 'information rich' participants, who are individuals capable of providing the greatest understanding and insight into the research questions. These participants are selected because of their lived experience and intimacy of the study subject being investigated (Devers & Frankel, 2000).

A sample size of twenty (20) MSM aged between 18 and 38 years was selected for this study. This age range was chosen to ensure all participants were male adults of consenting age, shared a similar sexual orientation (within the study investigation) and fell within the millennial age and experience category. This decision was made with the assumption that MSM of a similar age cohort were most likely to have comparable lifestyle experiences and were perhaps most sexually active. The study location was the South African township of Vosloorus in the East of Johannesburg. Vosloorus exhibits characteristics of a typical high-density urban township in South Africa with constrained and poor service delivery, ensuring participants were likely to experience a similar social and economic status.

Due to the progressive nature of South Africa's Constitution, various townships have gay-friendly bars which are vibrant and serve as meeting places for many gay men who want to have a good time and meet new potential partners. *Club Rainbow (the name of the bar where I met the Bar Manager) epitomises this forward thinking, accommodative nature, and oozes with both young and old, closeted and openly gay MSM, and after-9s who are ready to mingle. During the day, the place is usually serene and calm with sporadic fun-chasers congregating for a snack or a beer, but everything comes alive at night as partygoers go out and meet in large numbers. This venue attracts black working class and lower middle-income MSM, with high school qualifications. Most participants in this research reached Matric level, while several were still in high school, with just one possessing an honours degree. This intersectionality of race, class and education puts many MSM at risk and disempowers them due to their vulnerable position. The majority of studies on MSM in South Africa to date, has tended to focus on middle to upper class MSM. Owing to that, it was also important to document the experiences of working class to middle class MSM as well.

In addition to the purposive sampling procedure used, potential study participants were also located and identified through snowballing. I had an initial contact who assisted with the recruitment of study participants from his friends. We managed to have two interviews from his network. Unfortunately, he disappeared, and I could not get hold of him for weeks. So, I revised my approach, I approached the Bar Manager of one of the well-known and safe gay-friendly bars in Vosloorus and asked him if he knew any openly gay MSM who I could contact about my study. Fortunately, he gave me the contact details of a very friendly man who considers himself a Champion for MSM issues in the township. We set an appointment for our initial meeting, and I presented my study, and he was immediately available for an interview. He then referred and introduced me to two of his friends on the same day who took part in the research immediately as well. From that moment on, the second contact he introduced me to, was very friendly and then automatically became my key contact person. He was selfless and beyond helpful in referring me to his massive network of friends (both openly gay and in the closet) who participated in the study, and he even scheduled appointments on my behalf.

As a result of the sensitive nature of the study, the key contact was first given a letter detailing the aim of the study and selection criteria to distribute to his network of potential participants. Potential participants who were interested and comfortable to take part in the study, confirmed their willingness with him, he would then send me a WhatsApp text message with information about the number of appointments secured for the day, the time, and the place that the interviews would take place. When we had confirmed appointments, I would then pick him up from his house on Saturday mornings to go to the interviews with him. Due to the rapport and friendship that I built with this key contact, he accompanied me to all the interviews he had set up and made sure I was safe.

As Devers and Frankel (2000) note, for the research to take place, it is imperative for the researcher to develop, maintain, and properly end relationships with research subjects. The key contact was present at every single interview and what we normally did was he would introduce me to the contact to be interviewed and after introductions he would leave me with the interviewee so that we could have privacy during the interview. Immediately after the interview ended, he would then take me to my next appointment. Finally, a sample of three experts was selected, to share their knowledge and experience in the provision of health services for Key Populations such as MSM. These experts were selected because of their knowledge and in-depth experience of MSM service provision and additionally because they worked in the geographic coverage of the study. In addition, one of the experts was a professional contact from my previous work with MSM in Ekurhuleni and an MSM Activist who introduced me to his colleagues and professional networks in the same field who were also interested and participated in the study.

Study participants were between the ages of 18 and 38, with the majority having attained Matric as the highest level of education, several younger MSM reported that they were still in High School, whilst just one reported having a post-graduate degree (Honours). Nineteen (19) MSM self-identified as gay, whilst two self-identified as bisexual. The majority identified as “masculine” while only a few identified as “feminine”. Eighteen (18) were openly gay while three were “discreet” or still in the closet. For those who were not in school, one was self-

employed (running a '*spaza*[3]' shop), two were formally and gainfully employed, though earning meagre salaries, while the rest were unemployed.

3.2.2 Data Collection

3.2.2.1 In-depth interviews

Dicicco-Bloom and Crabtree (2006), outline that individual in-depth interviews grant the researcher an opportunity to delve deeper into personal and societal phenomena. In order to have an insider perspective and to see social reality through the participants' lens, the researcher can use qualitative interview methods (Weiss, 1995). Semi-structured interviews are often the only data source for qualitative research that are usually scheduled in advance at a designated time and location outside of everyday events. They are generally organized around a set of predetermined open-ended questions, with other questions emerging from the dialogue between interviewer and interviewee (Dicicco-Bloom & Crabtree, 2006). Moreover, qualitative interviews provide in-depth, contextualized, open-ended responses from research participants about their views, opinions, feelings, knowledge, and experiences (Creswell, 2009; Patton, 2002, as cited in Mikene et al., 2013). This method was helpful in fully responding to the research question, which quantitative methods like surveys with closed-ended questions would be unlikely to answer in depth. For example, when asked about their community participation such as going to church, one participant outlined that 'they used to go to church but they don't anymore'. I probed further to request about their reason/s for not going to church. The participant then outlined that 'he felt the church stripped him of his manhood and identity, and he was demonised, judged and vilified for his sexuality' hence he stopped going to church, yet he still believed in God. He further outlined that 'the church only seemed to be interested in my money through tithes and offerings and the church leaders use the Bible to condemn my sexual orientation'. A quantitative research such as a survey for instance, would have not been able to delve deeper to get this rich narratives as the participant would have answered a simple closed ended question such as 'yes' or 'no', when asked whether they go to church or not.

[3] A spaza shop, also known as a tuck shop, is an informal convenience store usually run from home and commonly found in South African townships

Most of my interviews took place at MSM's homes and in community parks. All interviews were conducted on weekends when people (including myself) were off work. I conducted interviews in places most comfortable, safe, and convenient for participants. Usually, my interviews lasted between 45 mins and an hour each. I spent a great deal of time with the key contact who assisted me, ensuring I was safe and scheduled interviews with his network. This social network provided connections and provided access to the study participants which were his friends and acquaintances. Most participants were at ease and consented to the use of an audio-recorder, with the exception of one participant, who stipulated that he was still in the closet and as such, was not comfortable being audio-recorded. I therefore only took notes during this interview. The advantages of digitally-recorded interviews are that it is less likely that the files will get damaged as times goes by and it is easy to ensure the integrity of the data by having the data backed-up (Tessier, 2012). In addition, audio-recording interviews give the interviewer time to concentrate on the content of the interview by not only taking notes. I kept a note pad during the research process, where I would briefly write notes on significant issues or themes that emerged during the interview, immediately after the interview or when I got home.

I attempted to build a flexible approach with interviewees where I strived to make sure that interviews occurred in an organic and natural manner, and I provided participant the opportunity to do most of the talking. I had already built good rapport with my key contact, and this worked in my favour as it was easy for participants to be comfortable with me, due to the connection I had with their acquaintance as well. This flexibility and association led to an informal atmosphere which enabled a natural flow of the dialogue. In addition, having worked with stigmatized and sensitive populations like MSM before, I knew how to create a safe-space and a gay-friendly environment, through the use of non-judgmental language, by being supportive and understanding, which made gaining their trust and building rapport easier. Gaining their trust enabled us to operate in a calm environment, they were relaxed, and openly and freely shared their experiences. Flexibility was also needed in the language used for the interviews. Though the majority of the interviews were conducted in English, research participants were at liberty to respond and express themselves in Sesotho or isiZulu to make their point as clearly or accurately as they wanted to. During the interview

transcribing process, the interviews were transcribed in/to English. In a multi-lingual country like South Africa, it is important to acknowledge the existence of other languages which help in nurturing social cohesion, breaking communication barriers, and dismissing misconceptions regarding each language value. This multilingualism is imperative in facilitating intercultural communication (Ndimande-Hlongwa & Ndebele, 2017). Without this acknowledgement and recognition of other languages, the richness of individual experiences from participants of different cultural experiences and languages would have otherwise not been discovered. Therefore, transcribing interviews from either IsiZulu or Sesotho, provided in-depth and profound information which the participants would have otherwise not been able to provide if they did not express themselves in their home language, especially as several had difficulties in expressing themselves in English.

3.3 Data Analysis: Thematic Content Analysis.

Data analysis is the process of bringing order, structure, and meaning to the mass of collected data (Marshall & Rossman, 1995, as cited in Moyo, 2017). Therefore, the analysis is designed to capture narratives, opinions, and experiences that need to be structured, ordered, and examined to ascertain if they answer questions that the researcher sought responses to. Thematic content analysis was used to analyse the collected data. According to Anderson (2007) thematic content analysis is a descriptive presentation of qualitative data. Qualitative data may take the form of interview transcripts collected from research participants or other identified texts that reflect the topic of study. Data was analysed through a process of coding to ensure validity and reliability over a rigorous, consistent, and defined procedure. This process included open, axial, and selective coding (Williams & Moser, 2019). Open coding involves sorting and categorizing similar words and phrases into a thematic domain; axial coding is the second level of coding meant to sift, refine, and identify emerging themes and the relationship between open codes with the purpose of developing core codes. Finally, selective coding as the third level of coding enables the researcher to select and integrate categories of organised data from axial coding into cohesive meaning filled expressions which will in turn lead to theory building and the construction of meaning (Williams & Moser, 2019).

Audio-recorded interviews were first transcribed creating complete records of what the participants said, verbatim. I read each transcript line by line, taking notes of the categories that seemed apparent, this was done for a couple of rounds. This large, amassed data was then open coded in a multi-stage process where, as I began to see some commonalities across the data, I grouped similar categories or themes together. The second stage involved focused coding which entailed collapsing and reducing earlier identified themes and categories. Once collapsed these were merged and categorised under a broader theme which was renamed to represent the emerging theme. A brief description of each defining code was done to create the meaning of data and pave a way for discussing findings. Ultimately, these categories were classified into four main themes, which I present under the main research findings. These themes are sexual orientation and gender identity, awareness and knowledge of PrEP, gender performance, sexual identity and sex roles and PrEP and the healthcare context.

3.4 Ethical Considerations

Ethical considerations refer to the protection of participants' rights. Such as the right to self-determination, right to privacy, right to autonomy and confidentiality, right to fair treatment and right to protection from discomfort and harm, the need for the researcher to obtain and the participants to provide informed consent, and the use of an institutional review process (Sudheesh et al., 2016). It is important to protect participants, especially stigmatized groups such as MSM by maintaining their confidentiality and anonymity where possible (Surmiak, 2018).

Each potential participant received an invitation letter describing the study, and what participating in the study involved. Before commencing the interviews, I articulated that taking part in the study was voluntary and should they feel uncomfortable in responding to any of the questions, they are free to not do so, participants were also informed that they have a right to stop the interview at any given point during the process. Participants were asked to give their consent to participate in the study in writing (Appendix 1). Since most of the participants were associates and from the same network of acquaintances, they were further expected to sign a non-disclosure agreement (Appendix 2) which bound them not to

share any details of the interview with one another as friends. Also, this was signed to ensure that participants do not disclose their HIV status (to anyone), as this was not a prerequisite for participation in the study. This second layer of personal information protection was applied to ensure the confidentiality of discussions between the researcher and participants.

Though it was a challenge to maintain the anonymity of participants amongst each other because they belonged to the same network, I assured them that their identity would remain anonymous in my research report. The names presented in this report are pseudonyms and the real names of the participants are withheld to protect their identity and guarantee their anonymity. In addition, in order to protect the sexual orientation of the participants, the eligibility criteria form they signed (Appendix 3) stating their sexual orientation had no personal identification information on it and this was secretly and separately coded by the researcher without the writing of any explicit personal identifying information. As a continuation of disclosure management, the researcher mapped local clinics within the study location and informed their management about the study. This was done to ensure that no (emotional and psychological) harm was done to the participants. Should any participants require emotional and psychological support, they would get appropriate HIV counselling from surrounding clinics. The researcher was to refer participants to one specific facility where an agreement was made so that trained professionals could attend to the psychological needs of any referred participants. Upon the completion of the study, no participant needed or made use of the psychological support provided by the study.

3.5 Researcher's risks and vulnerability

I was cognisant of encountering possible risks and vulnerabilities while collecting data. First of all, the fact that I am female undertaking research within a highly masculine target group placed me in a vulnerable situation where potential participants could decline participation in the study and may find it difficult to discuss their sexuality with a woman. Nonetheless, due to the rapport that I built with the key contact; it was less risky to interact with participants since the key contact spoke on my behalf to first introduce the study to the participants. In addition, because of the experience that I have in working with marginalized populations,

such as MSM, once access was secured, I was also able to build trust with the participants who were comfortable and open enough to discuss their sexuality with me. Additionally, it could possibly have been easier for my study participants to open up and share their perceptions on sexuality and sexual health experiences with me, as a female who was also a stranger, without the fear of being discriminated or judged.

Regarding the risk of interviewing participants in their homes, the key contact was also very helpful in that regard as he accompanied me to all interview sessions and thus ensured my safety. No interview was done in any dangerous place such as a tavern or night club, and interviews were done during the day and not at night-time. Moreover, since the key contact was snowballing from his network of associates, this meant that he recruited people of integrity that he trusted and therefore ensured that I was not at risk. Lastly, I took into consideration my safety first (Lee-Treweek & Linkogle, 2000) by ensuring that my contact was always with me during interviews and provided me with some male security.

3.6 Research trustworthiness

Reliability and validity are methods of indicating and communicating the accuracy of the research process and research findings' trustworthiness (Roberts et al., 2006). In qualitative research, reliability implies dependability of the processes followed and data produced; while validity is determined by how well, the tools are capable of collecting logical, credible, and factual data (Roberts et al., 2006). According to Rose and Johnson (2020) trustworthiness in qualitative research denotes a methodical research design employed by the researcher, whether the researcher is credible and whether the research findings are accurate and believable. This further entails whether other researchers will attain similar results in different settings, using the same research methods and respondents if they were to undertake a similar study. Therefore, it is important that the study maximizes on trustworthiness to ensure that reliability and credibility are significant elements in qualitative research. Research quality is associated with generalizability of research results thus, assessing and increasing research validity (Bashir et al., 2008).

To assure reliability and credibility of this study, I kept detailed records of the decisions that were made during the entire research process which could easily be audited and contribute to the reliability of the study. To increase technical accuracy in recording, interviews were audio-recorded with the consent of the participants, and transcribed at a later stage, line by line, which could also assist in improving the reliability of the study. Qualitative content analysis was employed, as a particularly dependable and consistent approach in analysing data. The researcher created specific codes describing the data. These statements were generated from the interview transcripts and can be confirmed by re-evaluating the data that was coded to assess data stability and consistency over time. To maintain the integrity and validity of the data, I used verbatim quotes from participants for three main reasons: to deepen understanding, to give participants a voice, and to present these findings as evidence. Presenting findings in their original and raw nature as directly spoken by the participants provides an audit trail and justification of themes that emerged which could strengthen credibility (Corden et al., 2006).

3.7 Summary

In summary, this section of the research detailed the journey I took to understand how masculinity impacts MSM's utilization of PrEP. One of the strengths of my study was my personal experience and knowledge about working with marginalized groups such as MSM. This experience enabled me to access MSM, a hard-to-reach population and to invite them to participate in the study and to discuss their sexuality and experiences of accessing sexual health services openly and freely. Another strength that made this study successful was the rapport and relationship that I built with my key contact, his extensive network of young and diverse friends, his willingness and friendliness to take a lead in snowballing and recruiting participants for this study played a significant role in the success of this study.

The majority of participants highlighted that they appreciate the work that I was doing as I was the first researcher who seemed to have interest in MSM issues, and that my study was the first study of its kind to engage MSM and show an interest in them as people and their issues. This eagerness and willingness enabled me to have more participants to interview

towards the end of my research as more and more MSM showed interest in my study. The weakness of this study was that most of the participants form a convenient sample being part of a direct network of one of the contacts. Therefore, the generalizability of the study findings may be attributed to a large circle of MSM who are acquaintances and who live in the same semi-urban township in Gauteng. However, these experiences may not be the same in other settings such as rural or semi-rural area in a different province where MSM may have different experiences. Secondly, since MSM are generally a stigmatized group, some of their shared experiences may be context-specific and biased due to experiences of internalized stigma, that appeared common in the study. Finally, since the sample consisted of only millennials, the experiences of prior (older) generations are not accounted for by this study.

3.8 Conclusion

This chapter has provided a detailed account of how the research was undertaken, the nature of the research design as a phenomenological study that sought to understand the impact of masculinity on PrEP use by MSM. It also outlined the research methods and how 24 participants were recruited. A sample of twenty-one MSM were recruited to share their experiences and three experts were also used to provide their professional opinion on the challenges that MSM face in accessing healthcare through in-depth semi-structured interviews. The data analysis was also discussed as the study adopted Thematic Content Analysis and the overview the process undertaken. Ethical issues were taken into account as it is important to ensure, confidentiality and anonymity of study participants. The chapter concluded by discussing the study's strengths and weaknesses. The next chapter discusses the findings of the study and analyses these, comprehensively. It illuminates some of the challenges that MSM who participated in this study, experienced; how their sexual orientation and gender identity and its associated role impacted on them and their relationships; and coupled with healthcare barriers, the factors they experienced that hindered their access to health care.

CHAPTER 4 – FINDINGS AND ANALYSIS

4. Introduction

This chapter gives an account of the main research findings that emerged, and these are presented in four themes. The themes provide insights regarding how dynamic MSM are and a myriad of challenges that they have to overcome in order to successfully navigate the healthcare system and acquire health services that they need. Theme one, sexual orientation and gender identity unveils the diversity of MSM, the types of sexual relationships they engage in, their motivating factors, and how each MSM, as an individual, constructs their own identity, based on who they are, how they define themselves, how they perceive themselves and their chosen lifestyle according to these identities. As per the literature, the terminology and definitions of sexual orientation and gender identity (SOGI) differ depending on one's socioeconomic status, race, culture, and geographical location. Knowledge and understating of these concepts and identities is a fundamental aspect of the delivery of culturally sensitive and client-centric health care provision (Aleshire, 2016).

The second theme, awareness of and personal experiences with PrEP explores MSM's awareness of PrEP as an HIV prevention strategy, their extent of knowledge and whether this influences their willingness to use PrEP. In addition, this theme provides an account of MSM's personal journeys towards PrEP use, including what factors act as barriers to use and what factors enable PrEP utilization. The third theme, gender performance and sexual role demonstrates how gender roles in MSM's relationships can affect decision-making about who has to be on PrEP and it considers whether the sexual role one plays has any impact on who utilizes PrEP. The fourth and final theme, PrEP and the healthcare context explores how MSM navigate the healthcare system in order to access health services such as PrEP, in contexts and environments which are generally hostile towards their sexuality and being.

4.1 Theme discussion

4.1.1 Sexual orientation and gender identity

Majority of the men interviewed in this study, identify as openly gay, others as gay but straight-acting, discreet/in the closet, and bisexual while very few mentioned that they do not like to label themselves as they do not believe in labels. There is a lot of fluidity that exists between these men when looking at issues of sexual orientation and gender identity. For the majority, being homosexual means "being who they are", being true to their sexuality and how they were born. This encompasses having romantic and emotional feelings and being sexually attracted to men. These men make a clear distinction that, they are same-gender loving men, who are simply attracted to other men, and they are not men pretending to be women.

> "*when you are gay, they strip that away from you. Once they know you are gay, they strip that away from you, they start calling you a girl, I don't like that, I am still a man, I am a man who likes other men, so people would understand that people think when you are gay you are a woman and you are not, you are a man who loves other men, so I can be masculine*" (*Pule, 29)

Many MSM came across as very liberated and very accepting towards themselves, this was mainly seen in the younger generation of MSM who exude confidence, pride, and totality in owning their sexuality. These men felt more comfortable being part of the gay community than others. Sexual orientation and gender identity have diverse attributes of human identity that occur in every individual and separate one from another. Their components are not dichotomous instead, they are complex and multidimensional and have a greater variation and fluidity (Aleshire, 2016).

Some gay men clarify that being homosexual, and gay in this case does not equate to being metrosexual, where the expectation is that they are effeminate, concerned with grooming, and super clean.

"I am masculine, I am man enough, more than heterosexual men. You know some are soft, some are sissies, some are metrosexuals, I am not a metrosexual, I am not neat, I am not clean, I am just gay" *(Randy, 20)

Men who identify as bisexual stipulate that initially after discovering their sexuality during their adolescent years, they were confused by having romantic feelings for both boys and girls and they questioned their sexuality. They found themselves happy when dating both men and women which resulted in a period of confusion whilst trying to discover their true sexuality,

"I am gay but sometimes I find myself attracted to a female and I would ask myself, how come, why am I confused again or maybe it's the disappointments that I had before with men or what, it's a thing that you can't even explain" (*James, 32)

It was during this quest for self-discovery that some discovered that they had a stronger romantic connection with men or boys, than with women or girls, though some maintained open relationships with girls to maintain a social cover for their real self.

"People don't get it. It's more or less like with us, you don't know yourself, and you need to find yourself 'cos no one just wakes up and say I get attracted to men, it's something that you ask yourself, why do I feel like this for a guy. You grow up and you date a girl because of the surroundings and people, just to protect yourself" (*Sthembiso, 27)

Historically, tensions around bisexuality have always existed, where monosexism is glorified and bisexuality is shunned. The context of bisexuality discloses a fluidity in terms of sexual classification and meaning. Many scholars have come across challenges to locate bisexuality in relation to heterosexuality and homosexuality (Fahs, 2009). There are debates that there has to be a distinction "between homosexual behaviour, deemed universal, and homosexual identity, which is historically specific" (Weeks, 1990, p. 3). Although bisexuality has

persistently existed as a fact of human life, it represents a cultural creation that changes in meaning for heterosexuality and homosexuality as binary concepts (Fahs, 2009). As identified by Moore and Norris (2005) bisexuals were often more conflicted regarding their sexuality and Blumstein and Schwartz (1990) also noted that bisexuals identity is "more fluid and malleable" than heterosexuals.

The majority of men, in this study, who identified as bisexual seemed to have a myriad of identity concerns. The apparent oscillation between two genders in relationships exposed these men to a lot of challenges with their families and in society. For some, yearning for parental and family acceptance meant they continued dating girls as a way to protect themselves from family rejection. Others admitted to getting pressured by family to get married and having children so that they could continue to get the support and acceptance of family and to belonging in society. Some men wished they had a choice and could be straight because "being straight makes life easier" and being gay is hard and not a choice. Some of the issues these men faced included being called "a girl" despite being men. These men reiterated that they do identify as gay but that does not make them men who want to be women. In their quest to belong in society, some claimed they feel fortunate for not having feminine qualities so that society perceives and treats them as men.

> "*I was fortunate because I don't have any feminine qualities and stuff like that, so it's difficult for people to pick up I am like that and stuff like that, so many people just don't know because I am just who I am. Even though of course you are going to have those feminine qualities but once in a while, there's that one factor, and it's not like I am hiding myself or anything, it's who I am, I would say that I am fortunate to not have any feminine qualities*" (*Victor, 18)

This outcome supports a finding by Lynch and Clayton (2017) who found that MSM are generally vulnerable to social exclusion due to heteronormative and heterosexist perspectives and conforming to these dominant standards provides MSM access to a sense of belonging and social integrity. As a result, in order to align themselves with these societal

expectations of heteronormativity, some opt to display a heterosexual sexual identity as opposed to their true homosexual self.

For some men who identify as gay, societal expectations and family pressure affect their identity and definition of manhood in terms of how they see themselves as men. One mentioned how his mother had a sense of guilt and blamed herself for the way he turned out since when growing up, he was always in the kitchen playing roles traditionally associated with women such as cooking and cleaning the house. During his adolescent years when he started being sexually attracted to boys, his mother suggested performing traditional rituals so that he could be turned into a 'proper man'. This ritual involved going to a traditional healer who was to draw impure blood from his head as a way of cleansing him and ridding this blood which makes him attracted to men.

At some point, his mother took him to church so that he could be prayed for to cast away the satanic spirit that he was believed to have been possessed by. This man grew up wondering who he was, why he was created the way he was, he hated himself and questioned his identity and was angry at God for creating him that way. He was determined to go through a journey of self-discovery to understand his identity and he started going to church religiously to find the answers from God.

To his disappointment, the church was a place of condemnation and judgment about who he was to the point where he completely stopped attending because of the homophobia he experienced at church. The life-long journey of self-discovery still continues for him, in his late thirties as he still questions who he is and why he was created the way he was.

> "*I used to go to church more often because I wanted to find out who is God, who am I to God, where do I belong, why God has created me, why am I this guy who is attracted to this other guy. I don't know whether I read the Bible right, there is no male or female, there is no sexuality in heaven, it's just spirit beings, it's just one, I don't know whether one sex or must I say, because even others say God is a she, or he, so God, why am I*

straight but still having sexual attraction towards another male person who is similar to me?" (*Neville, 36)

Questioning one's sexuality in Biblical terms seems to be an expression rooted in deterministic understanding of gender. Participants essentialized gender identities to try to understand the different and assumed necessity of gender and role expectations, especially in the church. This quest for deeper understanding of gender and being male specifically as a 'natural', 'god – given' aspect brings gender confusion as one's own gender deviates from the natural expression of gender identity, of being male and accepted by the church in this case (Graham & Mphaphuli, 2018). Moreover, The Bible defines homosexuality as sin, a demonic act that people need to repent from and that should not be flaunted. At the core of Christian faith is the belief in self-righteousness, as a result, gay men often experience that gender and sexuality is used against them to question their identity.

The application of heteronormative gender identity takes place in numerous ways in societies more especially in churches. Gender essentialism troubles brew within this religious environment where the church is expected to be a place of refuge and safety for all, regardless of sexual orientation. Yet the church and other religious groups condemn sexual minorities and actively promote their condemnation. It endorses a patriarchal world view which supports and favours sexual dualism where men are in charge and argues that a male/female binary only exists in the Christian Bible and nothing else. This is accompanied by carefully selected scriptural references that push forward heteronormativity at the total exclusion and ignorance of homosexuality (Mitchem, 2018).

4.1.2 Self-acceptance

On the other hand, the majority of men in the study have embraced their homosexuality and perceive it as being "who they are, being born this way, and being who they have always been". This could also be partially attributed to family acceptance and support as some mentioned that their parents were very supportive when they came out, whilst others stated

that they felt lucky that they did not have any pressure of having a coming out meeting with their family to explain their sexuality and that everyone at home adjusted to who they are and never questioned their sexuality.

> "*I am one of the blessed individuals to an extent that I never had to sit down with anybody and explain my sexuality, they saw it and they adjusted to it and not even at once I was questioned about my sexuality*" (*Pule, 29)

The majority of men in this category believed that it is important for society to get used to and to be more tolerant towards homosexuality. Whilst they state they do not care much about societal approval; all emphasized the necessary and much needed support from family and friends. Gay men appreciate life more as gay identifying men, and they would not change who they are to get societal and even familial acceptance and approval. Men under this self-chosen label demonstrate the importance of self-acceptance, which appeared to make life easier for them, the moment they accepted themselves. One man mentioned that he never believed that homosexuality existed until he fell in love with a man, then he started to believe and accept that homosexuality is real, once he accepted it, he felt societal acceptance.

> "*I never believed the whole idea of being gay exists until I dated a man for four years and then I realized that I loved this person. The moment you accept, and maybe from time to time, you get accepted"* (*Max, 26)

This reiterates Camp et al. (2020a) finding that self-acceptance is an integral part of positive self- identity development for homosexual people, as Max found his self-perception was his greatest stumbling block. The majority of MSM have accepted and embrace their gender identity accordingly. The next section delves more into this acceptance in terms of femininity and masculinity.

4.1.3 Masculinity

MSM in this study, consider themselves very normal, they are openly gay/bisexual, and they are proud of who they are. Many are focused and confident, and they have truly accepted and acknowledged their sense of self, whilst some never questioned their sexuality. They do, however, acknowledge that initially, or at some point in their lives, their sexuality concerned them, and for some, it was not easy to accept who they were at first. Nonetheless, through the support of family, especially non-judgmental parents, they have fully accepted who they are, they are happy with their sexuality and are generally free in society and they do not care much about what others think of them because their families have accepted them. Others have accredited their success in life to their sexuality, they detailed that being gay motivated them to work hard and they have had access to opportunities such as speaking in LGBTQIA+ conferences on issues affecting gay community, had they not been gay, they would have not had access to such opportunities.

The experience of being a homosexual man is distinctively different according to individual men. However, they appear to fall into two main categories of: identifying as masculine or feminine. For those with masculine attributes, being a homosexual man does not make them different from heterosexual men, they are not inferior to straight men, and they possess the same physical strength as heterosexual men. They reported feeling equal to every other man and iterated that being homosexual does not make them feel like women.

> "*I don't see myself different from other men because I am a man, it's just that other people think that I am not man enough because I am gay. There is no man, even the heterosexual man, stronger than the gay man. We multi-task when we do things. It's always in our mind that one is gay because of the society because the society is still narrow minded towards those different from them*" (*Simon, 36)

These men differentiated that they are still male, and man enough even though they are gay, they clearly outlined that they are not girls, and they still have male friends. Some indicated that they have children, thus they are man enough, and one specifically articulated that he

operates the biggest truck in his workplace, that many heterosexual men cannot operate. As a result, he is not less of a man, he is in fact, stronger than those driving smaller vehicles.

Other men indicated that as gay men, they feel under pressure to out-perform heterosexual men to prove their masculinity, this involved striving to do better in everything that they do, being competitive and feeling the need to always prove themselves which leads to hypermasculinity. Some mentioned having to assert themselves in society through violence, so that they could earn the respect they deserve as men.

> "*In my teenage years, I was a bullfighter. I was fighting to assert myself as a gay man and one thing that I wanted to sink in on a lot of people was that I can do almost everything that every man can do*" (*Mpho, 36)

Constructing their own gay masculinity has been challenging and numerous gay men have opted to stick with the traditional standards of hegemonic masculinity. From this finding, it is evident that the creation of masculine identities different from hegemonic masculinity is a challenge for MSM because of homophobia and stereotyping (Halkitis et al., 2004). This further leads to MSM exhibiting feelings of shame or guilt about themselves. In addition, they link their gender performance to their sexuality, this in some cases, perpetuates negative masculine attributes such as the expression of anger and violence and feeling compelled to have children (Garcia et al., 2016). Lynch and Clayton (2017) also support this finding that MSM in South Africa, negotiate gender identity mainly in heteronormative contexts which entails a certain version of masculinity in which fathering a child is deemed as a significant embodiment of normative masculinity. Therefore, heterosexual sex and procreation become significant traits of a socially valued masculinity. In this study, such men's identity also seems to oscillate between their heteronormative social appearance and their homosexual behaviour.

4.1.4 Femininity

On the other hand, there are men who are openly gay and identify as feminine. Some of these men acknowledge that they are males but with feminine attributes. Others advanced that they feel less manly, and they do not consider themselves man enough. They have feelings of not belonging since they exhibit so-called unmanly attributes, they do what men are thought not to do, they are more effeminate in mannerisms and dress code.

> "*I never shifted from the fact that I am a male, I used to make up, I used to dress flamboyantly so, in a way that has feminine touch*" (*Mpho, 36)

One participant outlined that he 'feels like a woman trapped in a man's body' because he feels like a woman though he is biologically male. Another stipulated that when growing up, he felt 'special', he felt like a girl and not a boy and he enjoyed playing with dolls with girls. He mentioned that he had a childhood friend, next door, who was a boy and that he used to visit him for play dates. However, he soon felt a stronger friendship connection with his friend's sister and ended up befriending her, thus his friendship with the boy ended there and then. Another effeminate male detailed that during his adolescent years, he started listening to music by female artists such as Beyonce and this was an indication that he felt and identified as more feminine than masculine. He also mentioned that listening to Beyonce's music helped him unwittingly disclose his sexual orientation to his parents because his mother learnt from his music preference that he was gay and identified him to be more feminine.

Social constructionism outlines that societal norms are governed by social constructs of reality which shape one's perception of reality through subjective meanings brought about by social interaction. Concepts such as gender and its constructions emanate from many sources such as family, school, peers, and society and are embraced through socialization (Lindsey, 2015). These cultural norms provide an outline of role behaviour. Thus, according to gender roles, males and females are stereotypically expected to negotiate and act according to their gender. As a result, MSM may either choose or feel an affiliation with typical identity which helps them blend in. The identities that MSM chose also revealed the interconnection

between gender and sexuality. Thus, instead of regarding them as contrasting identities, fixed or independent of each other, they are interlinked and fluid, and this fluidity and interconnectedness is evident in partnering strategies for MSM (Garcia et al., 2016).

4.1.5 Family Rejection

While some men enjoyed family support that helped them accept their identity and assert their position in society, some men faced major challenges such as family rejection upon coming out. Some outlined that it was rough at first, several even fought with their mothers who rejected their sexuality. One specified that his mother has not accepted him up to this point, he is not on speaking terms with her, and their relationship is estranged, he was kicked out of his home and the family has never spoken to him since he came out. He left his family home in Kwa Zulu Natal (KZN) and moved to Gauteng where his friends are more accepting and supportive of who he is.

Another man put forward that his relationship with his father is tainted as well. Owing to that, he also moved out of his family home since his happiness is a priority and it was very difficult for him to get along with his father because he expected him to get married to a woman and have children just like his elder brothers. Due to the fear of being rejected by his very traditional family, one discreet man specified that he does not intend on having a coming out meeting and he hopes his family will see his sexuality for themselves and he will take whatever consequences that will follow.

> "*I think it's just coming from a religious family, a traditional family also, it's not that easy to come out because I don't think they are going to accept me just like that, so I just prefer that they are just going to see for themselves and they accept me or not and life goes on*" (*Victor, 18)

Less than a handful of participants reported to have faced family rejection which led some to move out of their homes whilst others are still not on speaking terms with their parents. This is quite an interesting finding as it is in alignment with what Szymanski and Carr (2008)

illustrated that most traditional families exhibit a lot of heterosexism (the acceptable dominance that heterosexuals are superior than homosexuals), and as a result, they are entitled to more rights than homosexuals. Set and Altınok (2016) outlined that many children are exposed to anti-gay judgements from a tender age from their family and society. Heterosexism makes life difficult for sexual minority groups, who are denied their rights by majority cultures that are predicated on the assumption that everybody is heterosexual. Therefore, non-heterosexuals have an invisible status and when they become noticeable, they are termed abnormal and unnatural and are generally discriminated and stigmatized against (Set & Altınok, 2016). These negative experiences in relation to MSM's sexual orientation leads to homophobia, which will be discussed at length in the next section.

4.1.6 Homophobia

In terms of experiencing homophobia in society, the majority of the men, spelled out that they are treated poorly by what they termed 'narrow-minded' people in society. MSM alluded that in their township, homosexuality is viewed as sickness and homosexual people are treated as if they have a disability. They indicated that this treatment hurts, they are seen as demons, and are frequently referred to as "*istabane*", a derogatory Zulu term referring to homosexual men. Some parents are mostly judgmental and contribute to homophobia towards their own children as well, and society at large further perpetuates the discrimination of homosexuals. Many stated that the older generation is worse, they consider homosexuality 'weird' and immoral. One gentleman specified that growing up in rural KZN was especially difficult for him. He never felt safe as he was provoked and bullied to the point where he lost his self-esteem, isolated himself, and suffered from depression. He could not fully be himself and participate in community activities associated with men.

Others opted to stop going to church completely for example, because the pastors use specific Bible verses to judge and condemn them in church. One assumed that by taking a leadership position in the church through becoming a home-cell leader, would enable him to instill respect for homosexuals in the church. Nonetheless, the church continued to strip him of his manhood and sexuality.

> "*I wanted the church to respect me as human, they strip me off my manhood or masculinity, they strip me off my sexuality, they strip off everything that I am*" (*Neville, 36)

Lynch and Clayton (2017) assert that MSM are susceptible to social exclusion as a result of heteronormative and heterosexist ideals, whilst some aspire to conform to these dominant standards as these award them access to a sense of belonging and grant them social integrity. In addition, some gay men go an extra mile in participating in cultural practices such as traditional circumcision or attending church, in an attempt to fix their compromised gender identities in order to align with the idealized masculinity that grants them manhood and complete citizenship in their communities, unfortunately they are typically further condemned in such spaces.

Finally, in societies that require strict compliance to heteronomy, deviation from sexual norms is condoned as long as the person adapts to other normative gender characteristics such as portraying themselves as normatively male or female or undertaking socially and culturally appropriate gender roles (Lynch and Clayton, 2017). This was also seen in the actions and behaviour undertaken by some MSM, such as those with children. The next section discusses MSM's awareness of PrEP, their perception of HIV risk infection, and risky sexual practices.

4.2 Awareness of PrEP

4.2.1 Risky Sexual Practices

When asked whether they consider themselves at risk of being infected with HIV, majority of interviewed men admitted to being at risk of HIV infection, only a handful did not consider themselves at risk. For many, the number one contributing factor to HIV infection is risky sexual behaviours. Some revealed that MSM engage in condomless sex and for those using condoms, sometimes condoms break during sexual intercourse with the possibility of unintended infection. This is perpetuated by other risky behaviours such as alcohol and drug

abuse. In addition, many MSM indulge in condom-less sex with random sex partners that they meet in public bars, clubs, and shebeens.

This finding confirms research by Hugo et al. (2016) which revealed that rates of continuous condom use amongst MSM are low hence there is need for further biomedical interventions to prevent new infections. In addition, Stahlman et al. (2017) reiterate that many HIV prevention studies have discovered that in terms of individual determinants of HIV infection among MSM, condomless sex, high frequency of casual male partners, and other drug use presents an increased opportunity for HIV exposure. In the UK for instance, the phenomenon of "chemsex" refers to sex between men who are under the influence of disinhibiting drugs, particularly 'club drugs' such as ecstasy or cocaine. Others shared how they struggle to find and maintain stable relationship partners, as a result, they end up with multiple casual sex partners. Another contributing factor is sexual engagement with older MSM and "*after-9s*." These types of men are "known" to not like using condoms during sexual intercourse and by virtue of having sexual relationships with women, "*after-9s*" have multiple concurrent partnerships and their chances of infecting both their female partners and male partners are high. Some men articulated that anal sex is risky since there is no natural lubrication in the anus. Owing to that, any minor abrasions or cuts can easily lead to infection. This finding supports the point made by Stahlman et al. (2017) that beyond individual level risk factors, according to the social ecological model levels of HIV risk among MSM, are higher due to biology, physiology, and immunology.

As shown by Stahlman et al. (2017) the socioecological model has highlighted how MSM are more vulnerable because of their structural position in society as well as the networks they associate with and the cultural practices adopted. This was also shown by Halkitis et al. (2004) who demonstrated that MSM's risky sexual behaviours are related to masculinity. Furthermore, specific socio-economic groups, such as low income or unemployed and uneducated MSM are at more risk (Sivhabu & Visser, 2019). Love, intimacy, and trust were also other fundamental issues raised that often-deterred condom use. This study confirmed

this as one of the many reasons that bring about a complex degree of influence on risky sexual behaviours (Goldenberg et al., 2015).

For the few that do not consider themselves to be at risk of HIV infection, they explained that they do not always engage in sexual activities, they use condoms at all times when having sexual intercourse, and they are regular HIV testers to monitor their HIV status. These men put forward that they are more careful about who they interact with sexually. For some, they are currently not dating, and not sexually active. As a result, they consider themselves to be less at risk. Some believed that MSM's risk of HIV infection is not in any way different from heterosexual's risk. One stated that any person who has multiple concurrent sexual partners, who engages in unprotected sex, whether homosexual or heterosexual is equally at risk.

> "*they say that people who are at high risk with HIV are gay people, it doesn't work like that, because even a straight person has sex with a woman, and a gay person, so why should it be us who are at high risk? There are girls who have ten boyfriends, at work I know women who have many boyfriends, they date the security guy, they date an escort, they date an HR guy, what does she do with all these people? She has sex with them, so they are also at risk"* (*Max, 29)

Anyone can be affected by HIV irrespective of their sexual orientation, or their geographic location. Nonetheless, there are specific groups of people highly likely to be infected by HIV due to certain factors such as the communities they come from, subpopulations they are affiliated with, and their individual risk behaviours (HIV.gov, 2020). Although the majority of MSM who participated in this study seemed to have an in-depth understanding of the individual risk factors they face due to the subpopulation they belong to and the nature of sexual engagement they participate in, others held the belief that MSM are not the only subpopulation at risk of HIV. In South Africa, MSM are at high risk of being infected with HIV and the prevalence of HIV amongst MSM according to numerous studies, is estimated to be between 10.4% and 34.5% (Maleke et al., 2017). As a result, MSM remain a highly vulnerable group despite the high prevalence amongst the general population (Rispel et al., 2011).

4.2.2 Knowledge about PrEP {Pre-exposure prophylaxis}

Nearly all MSM interviewed had heard of PrEP and had some knowledge about it, except one who admitted to hearing about it for the first time from the researcher. This contradicts the finding by Jenani et al. (2016) that MSM had low knowledge about PrEP. Another study by Al-Tayyib et al. (2014) outlined that PrEP knowledge amongst MSM remained low, despite the fact that MSM may benefit from its potential preventative benefits. Most MSM in this study had heard about PrEP from friends, from social media, from Life Orientation lessons when in high school, while others learnt about it from workshops they participated in, that were hosted by NGOs.

Even though nearly all MSM have heard about PrEP, it was interesting to discover that most had limited knowledge about it, others confused PrEP with PEP (post exposure prophylaxis) and others admitted to not knowing fully how it works. There were very few who had basic comprehension and knowledge about what PrEP is and how it works.

> "*My knowledge, PrEP is a pill that, let's say your partner is HIV positive, you take that pill for two weeks or three weeks before having sex, then after that certain period they gave you, you go to the clinic and you check your vitals that now you can have sex without protection and then you won't get infected*" (*Kagisho, 25)

In terms of awareness and knowledge about PrEP, the experts interviewed in this study do support the assertion that although MSM have an awareness about PrEP, it is their professional experience and observation, that MSM's knowledge about PrEP is insufficient and limited. They indicated that the majority of MSM are not fully informed about the drug and where to access it because, currently, PrEP cannot be accessed in all local public facilities. A Project Coordinator for an MSM project outlined that their program uses social media, especially dating platforms where some of their target population members will declare their negative HIV status and being on PrEP, which seems to attract potential sex partners because everyone can see that they are HIV negative. He explained that working with different social media and dating sites where most MSM search for sexual partners is fascinating and

informative because for those who do not know about PrEP, these sites become platforms to learn about PrEP and its benefits. This was reiterated by one MSM who stated that he learnt about PrEP on social media from a guy whose social media username was 'Mr. PrEP,' Mr. PrEP urged everyone who was interested to know more about PrEP to get in touch with him.

> "*I think majority of MSM, based on my experience are aware of PrEP but not fully informed as to where to access it because you can't really access it everywhere right now, so I think they are aware, sometimes they are aware of the drug, or there is an injection, or whatever it is that will prevent you from getting infected with HIV but not really have all the information they need in terms of PrEP but they are aware of PrEP, rather have an idea about PrEP*" (MSM Project Manager)

According to Al-Tayyib et al. (2014) access to PrEP, knowledge about it, and adherence leads to an increased likelihood of PrEP use. In this study, the majority of MSM who had some education and knowledge about the effectiveness of PrEP showed a high interest in using PrEP. Believing that PrEP was effective in reducing the risk of transmission of HIV was an important factor of willingness to be on PrEP. In addition, acknowledgement and recognition that one might be at risk has a great influence on whether MSM will adhere to PrEP or not, and this awareness by MSM may improve the efficacy of PrEP (Jenani et al., 2016). Buchbinder (2018) also attests that PrEP effectiveness is related to adherence.

4.2.3 MSM's attitudes toward PrEP

When asked about their thoughts about PrEP, MSM presented mixed views. Most MSM exhibited positive attitudes towards PrEP, while others revealed negative ones. Many thought that PrEP was a well thought initiative by the Government as an HIV prevention strategy. They remarked that PrEP is a good pill because it saves lives and gives MSM an opportunity to protect themselves. Others think PrEP is helpful because there is no sexual enjoyment when using condoms and sex with condoms is boring. Thus, MSM can freely engage in condom-less sex and use PrEP to protect themselves from being infected with HIV.

Contrary to these beliefs, there are some MSM who held negative attitudes towards PrEP and do not support PrEP use as they feel that it condones and promotes recklessness. They expressed that there are people who believe unprotected sex is more enjoyable than protected sex, and therefore, they see PrEP as their 'support structure' and 'savior.' One specified that people are too careless and reckless because they rely on PrEP as a form of safety and protection against HIV infection.

> "*they fail to get ownership and now they make PrEP their "**umsindisi**" that's why you will find a person intentionally engaging in unprotected sex with innocent people, knowing there's PrEP for them*" (*Mpho, 36)

This supports the findings by García and Harris (2017) who discovered that PrEP users such as MSM could falsely feel safe from being infected with HIV and this may as a result lead to increased risky sexual behaviours. Owing to that, MSM who use PrEP may change their lifestyle and engage in risky sexual behaviours due to the perceived reduced risk of HIV transmission, this is called PrEP optimism. On the contrary, a study by Dubov et al. (2018) discovered some underlying causes of stigma amongst MSM in relation to PrEP use. This included the assumption that the utilization of PrEP as a protective strategy is done by irresponsible and wild people, this pervasive example of stigma serves as a constraint, limiting the uptake PrEP by MSM.

4.2.4 PrEP information sharing amongst MSM

Regarding information sharing amongst MSM, many deemed that MSM are not open to talking about PrEP and sharing information with each other, with a very small number who believed that MSM are open to talk. The majority indicated that it is not easy for MSM to raise such conversations, and some are uncomfortable talking about sexual health issues. Sex is still considered a taboo in many communities, therefore, MSM are shy to talk about anything related to sex. Many explained that not all MSM are open to talk because men are not supposed to open up and share information, men are supposed to be strong and keep issues to themselves. In addition, men have pride and due to peer pressure and the need to fit in,

they will not share information that may imply they engage in unprotected sex because they do not want to appear careless in front of their peers. For the few that uttered that MSM are open to talk, they do interestingly admit that even though MSM are open to talk, they are not open enough, sometimes they talk, sometimes they do not, and even for those who choose to open up, they only do so amongst people they consider to be their peers and who are in the same social class as them.

> "*a lot of people, when I talk about MSM here in Ekurhuleni, the thing is we have pride, there is no communication, people don't share what they know with others, people just deal only with people at their level or standard*" (*Kagisho, 25)

Lin et al. (2021) showcased that peer education was positively linked with accessing HIV services amongst MSM. Peer education firstly, can create awareness of accessing HIV services and give information regarding where services are available and thus increase health seeking behaviour by MSM. Secondly, peers can offer social support, and service referrals. Finally, emotional support shared amongst peers can help MSM as the key population to overcome certain barriers to gain access to HIV services (Lin et al., 2021).

4.2.5 Personal experience with PrEP

Even though nearly all MSM reported having heard of PrEP and possess some knowledge about PrEP and its benefits, nearly all of them reported having never used PrEP, except one. For those who had no personal experience, they demonstrated a great willingness to use PrEP due to its benefits, and only a handful stated that they are not willing to utilize it. Those interested, cited wanting to protect themselves from HIV and having benefits of enjoying unprotected sex as the main reasons for their willingness. For those unwilling to be on PrEP, they expressed that it is pointless for them because PrEP does not prevent other sexually-transmitted infections except HIV. Moreover, they do not believe in PrEP, and they prefer condoms over it. There were those who specified that, at the moment, they are not willing to use PrEP since they are not sexually active. Nonetheless, some did acknowledge that in as much as they do not believe in PrEP and prefer condoms, if a condom broke during sexual

intercourse and they had an opportunity to use PrEP or PEP they will do so, because they fear being infected with HIV.

> "*I don't believe in PrEP; I believe in a condom. But I won't lie to you, if a condom would blast and there's PrEP, I will use it, I am scared of HIV*" (*Pule, 29)

The participant who had personal experience with PrEP mentioned that he stopped taking PrEP due to the fact that he had to take the pill while he was HIV negative. He decided to adopt a healthy lifestyle and safer sex practices because he reported to having a challenge with taking many pills daily and he saw no difference between a person who was HIV negative and HIV positive.

> "*You know my issue with it is that you are HIV positive, you taking anti-retrovirals, and you are HIV negative, you are taking PrEP, then, for me to say prevention is better than cure but you are still taking medication doesn't make sense. I decided to eat healthy, safe sex, gym and you will be ok, so you wouldn't have to take ARVs, you won't have to take PrEP. That's the argument that we always had, you are negative, why are you taking PrEP, 'cos we always have safe sex, and another person is HIV positive, and they are taking ARVs, so let me rather eat healthy and have safe sex so that I don't have to end up taking any of those two, I am good, but you understand my point?*" (*Qhawe, 29)

Findings from a study by Dubov et al. (2018) discovered a link between PrEP stigma and HIV stigma. HIV negative MSM were stigmatized for wanting to protect themselves from contracting HIV. Furthermore, PrEP stigma seems to trail a similar path as HIV stigma and lead to lack of motivation to use PrEP and social exclusion based on PrEP use. This speaks to the finding quoted above.

4.2.6 Enabling and disabling factors for PrEP utilization

MSM who are willing to be on PrEP stipulated specific barriers which hinder them from fully taking advantage of the prevention pill. Common reasons outlined are access and health seeking behaviour, knowledge and information-sharing, pharmacological effects, and treatment adherence. Issues pertaining to access were recurring, with the majority of MSM indicating that the unavailability of free PrEP in public facilities is a major barrier. Many MSM who are unemployed or do not have money for transport to travel to Johannesburg or Pretoria to access PrEP (since currently, no local clinics offer PrEP to MSM in Ekurhuleni) cannot obtain PrEP.

Furthermore, these men held the perception that accessing PrEP in private facilities is expensive and that only MSM who are financially stable and on medical aid can afford to do so. It is becoming increasingly evident that understanding sexual and gender identity is significant in healthcare provision. Sub-populations who are considered gender and sexual minorities (such as MSM) encounter health disparities at rates higher than their heterosexual counterparts. Often health care providers disregard the relevance of sexual and gender identity to patient care and try to maintain professional neutrality, and this usually gives rise to suboptimal treatment or negative health outcomes (Aleshire, 2016).

A couple of MSM stated that health seeking behaviour is also a challenge for MSM in accessing health care services such as PrEP. They expressed that men are stubborn and afraid of taking medication, are ignorant, and generally do not want to seek help.

> "*it's just that people are stubborn, that's what I have noticed, people are afraid of taking medication. Sometimes you will see that someone is sick and when you tell them to go see the doctor, they refuse, they don't even like to ask for help when they are sick, they suffer in silence*" (*Linda, 24)

Fleming et al. (2016) attest that there's evidence in sub-Saharan Africa that hegemonic masculinity characteristics such as stubbornness and fear of being on medication hinders men enacting them from accessing HIV Testing services. In addition, health seeking behaviour is deemed unmanly (Graaff & Heinecken., 2017). South African men generally access treatment less and normally later on, thus their rates of HIV testing are lower in comparison to women, because masculinity norms make it more difficult for them to get essential care as this is regarded as feminine and deemed a sign of weakness (Gittings, 2016).

4.2.7 Pharmacological effects and adherence

Several MSM detailed that other barriers to using PrEP are efficacy, side-effects, and adherence. They stipulated that they are skeptical, do not trust PrEP, and wonder if it is efficacious. Moreover, they are worried about side-effects, such as weight gain and contra-indications for those with pre-existing chronic conditions. Others articulated that they have a phobia of needles, and as these are a requirement for blood samples they are deterred, whilst others are afraid of testing for HIV. Therefore, these issues make it challenging for them to be on PrEP.

When examining adherence, many advanced that they would have a problem of taking a pill at the same time every day. They stated that men do not like relying on something continuously as this makes them feel like they are being controlled. Many expressed that taking PrEP daily feels like they are on ART medication, yet they are not sick.

> "*I feel like it's us thinking that we cannot be taking pills every day because it's like we are taking ARVs, so we feel like we cannot be on a pill every day and feel like we are taking ARVs, yet we are not infected with HIV, we are not sick, why take the pills if we are not sick?"* (*Linda, 24)

Healthcare experts in a study by Krakower et al. (2014) also held reservations regarding adherence and logistical threats as challenges to implementing PrEP successfully. This was based on knowledge of HIV positive patients not adhering to antiretroviral treatment. In

addition, findings from research by Marra and Hankins (2015) revealed reluctance of Dutch MSM to utilize PrEP as they disliked the idea of taking the pill on a daily basis. García and Harris (2017) further outlined that generally, MSM are cautious of PrEP's long term health effects. Latino MSM who were not on PrEP stated that they were unlikely to be on PrEP due to potential side effects.

Several other participants alluded to culture as a contributing factor against PrEP use. Some men have strong traditional and cultural beliefs, especially in connection with blood. While others fear blood samples being drawn simply because of their phobia of needles, others are uncomfortable leaving their blood samples in health facilities where they do not know what is going to happen to their blood. Issues related to institutional mistrust and of medical providers amongst MSM generate extra barriers for governmental initiatives that support PrEP as an HIV prevention strategy for at risk populations such as MSM. Mistrust in the medical profession and pessimism about PrEP may influence its use or non-use by MSM (García & Harris, 2017). Eaton et al. (2015) further support this finding, noting that medical mistrust has been recognized as a barrier in MSM participating in regular health care, resulting in poor adherence to ART and mental health.

The experts who participated in this study seem to share similar sentiments with majority of MSM in respect to factors that may hinder PrEP utilization. From their point of view, adherence is a challenge, the responsibility of taking a pill daily depends on whether someone feels like it and will not forget to take it as well. These reasons may lead them to being disinterested. Interviewed experts in the field of MSM service provision further cited perceived risk as a factor. Sometimes people do not see themselves at risk, if MSM are properly counselled and understand that their sexual practices put them at risk, if they perceive the activities they engage in as risky, that then may drive them into participating and being interested in PrEP.

The other issue experts bring up is that of testing and initiation procedures, when nurses have to draw blood, a lot of MSM exhibit 'crazy' fears of needles. Owing to that, blood draws become an obstacle. Another hindrance is related to traditional reasons, people do not want to draw blood because of their beliefs, they wonder what would happen to their blood. Fascinatingly, this is in alignment with what some of the MSM have described as an impediment to PrEP initiation. The PrEP nurse iterated;

> *"One of the things that they don't like is that we need to take bloods, they don't like that. Some are very traditional, I guess that's how they were socialized, they will ask what are you going to do with their blood and where are you going to store it*" (PrEP Nurse)

4.2.8 Lack of information, stigma, and discrimination

Another aspect that stood out as a barrier to PrEP use that was commonly reported was the lack of information, coupled with stigma and discrimination. MSM declared that there is a general challenge of lack of information about PrEP. Information should be widely disseminated to reach all MSM as lack of knowledge is generally pervasive amongst MSM. This pervasiveness propagates a stereotype that MSM are ignorant, which is not necessarily true.

Stigma and discrimination also play a role in discouraging MSM and making it difficult for them to utilize PrEP. This is experienced both at the familial level and societal level, such as accessing healthcare services in discriminatory facilities. Many MSM worry about their parents' or partner's reaction should they find out that they are on PrEP. They are concerned that their parents or partners may assume that by being on PrEP and, they are involved in risky sexual practices and that they are reckless. Owing to that, their fear of family stigma discourages them from using PrEP.

> *"It's masculinity and also the stigma of the people who take pills every day. If you take pills every day obviously people are going to be thinking like, why is he taking pills every day, is he sick or something, so I feel like it's masculinity and also stigma involved in taking pills*" (*Livhu, 30)

This finding is supported by findings from Stahlman et al. (2017) whereby they discovered that another potential social driver of HIV transmission is related to several kinds of stigma MSM experience which limit healthcare service utilization. Repeated stigma experiences drive MSM to avoid HIV prevention services leading to limited opportunities for diagnosis. The reduction in the use of health and HIV services, by MSM, as a result of perceived discrimination, inhibits health information dissemination, and lack of support and knowledge may lead to mental health stressors related to stigma (Stahlman et al., 2017).

4.2.9 Enabling factors for PrEP utilization

With reference to enabling factors, it was commonly outlined by MSM that information-sharing and PrEP awareness would contribute positively to making it easier for MSM to be well informed about PrEP and it's health benefits, which may lead to an increased PrEP uptake. Many MSM highlighted that the use of media in all its entirety to disseminate information about PrEP could be helpful. Some suggested the use of print media such as billboards, posters, pamphlets, and brochures would have a wider reach to MSM in rural areas. These printed materials can also be distributed in public and private facilities so that those going for healthcare services can access the information. Further, others spelt out that the use of radio and television adverts and commercials can also be adopted.

The majority of MSM urged the government to do more, to invest in PrEP education to make sure that most MSM get educated about PrEP. Numerous MSM mentioned that the government should ensure that there are dedicated personnel educating MSM about PrEP and that more emphasis should be on adherence. This can be done through collaboration with NGOs in hosting events and campaigns on PrEP education. Concerning other enabling factors, many stated that perceived risk, high HIV prevalence, and improved access will further enable MSM to use PrEP. With respect to perceived risk, numerous MSM expressed that being sexually active, sexual addiction, and risky sexual behaviours will actually propel MSM towards PrEP use because of their fear of HIV infection. Additionally, increasing HIV infection rates will also motivate some to use PrEP. Finally, having PrEP in all local public clinics will also make it easier for MSM to access PrEP.

"*the level of HIV&AIDS is very high and that could be a factor that could scare or be a stigma to them that if I don't use PrEP for as long as I don't use a condom and for as long as I don't use PrEP, I am gonna be infected*" (*Zakes, 36)

Enabling factors for PrEP use can be better understood through the socio-ecological framework. At an intrapersonal level, enablers or facilitators include attitudes, beliefs, knowledge, and behaviours, (Ma et al., 2017). In addition, at the interpersonal level, MSM's family, social network, and their friends supported and encouraged them to seek health services. At the institutional level, enablers were highly distinguished. The presence of these factors would highly encourage MSM to access health services including PrEP. MSM preferred to be "treated with respect, privacy, and empathy by health care providers who were non-judgmental and had a positive attitude" (Ma et al., 2017, p. 2433). Finally, at the community level, MSM acknowledged that non-governmental organizations play an important role in enabling their health seeking behaviour. In order to promote culturally sensitive service provision, care should be provided in a welcoming and supportive environment, which will facilitate sexual orientation and gender identity disclosure by MSM, through advanced and effective communication and advocacy in the community and within the healthcare system for sexual and gender minorities (Aleshire, 2016).

4.3.0 Factors contributing to non-use

Factors contributing to non-use of PrEP were cited as power dynamics, culture, and positive HIV status. Several MSM specified that even though they may consider being on PrEP, if one tests positive for HIV then that would contribute to their non-use due to the fact that the person will now need to be on ART instead of PrEP.

4.3.1 Power dynamics

Power dynamics play a significant role in influencing PrEP use or non-use. The majority of MSM interviewed agree that those with power in relationships influence those without power to use or to not use PrEP. More powerful MSM are likely to be dominant, financially stable,

and generally older, and since they have the upper-hand, they usually have the last word in the relationship. Several men specified that in gay communities, those with money are the bosses, and may control who has to take PrEP or when to stop taking PrEP. Dominant and bossy MSM are more likely to be difficult and abusive, and if intimate partner violence (IPV) is present in a relationship, this may contribute to non-use if the dominant partner does not approve of the use of PrEP.

> "*Let's say you and I are dating, and I am this traditional person, I have paid lobola and say you should never mention anything about condom use, at home. You should never mention anything about prevention, you should never mention anything about PrEP and ARVs, that's what makes it difficult. And then sometimes if they see these pills and let's say it's an abusive relationship, the partner is going to beat you*" (*Max. 26)

This cultural and traditional association with heteronormativity, was also discussed by Maleke et al. (2017) especially in rural areas where there is a high social value placed on traditional value systems and heteronormativity was found to be predominant in the structuring of MSM intimate relations. Power dynamics in MSM relationships are also linked to the partner's employment status, with those employed having the ability to support their partners financially and this was associated with an unequal power distribution. Ricks et al. (2018) further alluded that socio economic factors such as, economic and financial dependency, and age puts some MSM in vulnerable situations leading to disparities in the perceived relationship power which could also affect one's agency to negotiate PrEP use with their sexual partner, for example.

4.3.2 Gender performance and sex role

In recognition of the impact of gender role and sex role on MSM's decision to use PrEP, most MSM held beliefs that sex role and gender performance should not have an impact on their decision-making, with the exception of two men who fervently believed that PrEP is for bottoms or for feminine partners. For those who do not hold these beliefs, they declared that sex roles are just labels, and that both partners should use PrEP since one can never know if

their sexual partner is unfaithful, or if one is disloyal, one never knows what sexual disease the next sexual partner has.

The majority of MSM perceived PrEP to not be intended for tops or bottoms because it is for the safety and protection of both partners, as both could be at risk. Men in this category do not believe in the dominance by one partner in the relationship. They stipulate that both are men, and both partners are equal by virtue of both being men. They believe in a 50-50 partnership and reiterate that it is better for both to be on PrEP because HIV does not discriminate and does not see labels.

This line of thinking (that PrEP use is for specific partners) appears to come from the men who are dominant and controlling, and yet they do not want to take responsibility and control of their health.

> "*There's nothing that irritates me as much as those, more especially with a guy who will approach you and then tell you that they are a top. Top or not, disease is a disease, it doesn't matter whether you are a top, a bottom or versatile, so, if both of you want to be on PrEP, be on PrEP, both of you are at a higher risk of getting infected so I don't think one should say, I think since you are the feminine one then you are the one who should be on PrEP 'cos I am the top. I think both of them, we must be treated 50-50, whatever happens on the right must happen on the left*" (*Qhawe, 29)

In order to understand the social reality regarding HIV prevention methods, it was imperative to explore the implication of gender performance and sexual practice as operational principles of social life which create social divisions and differentiate MSM. It is imperative to look at how gender is enacted and carried out as opposed to reducing it only to stereotypical MSM roles (Garcia et al., 2016) and to see how younger MSM enact hybrid masculinities. This leads to MSM's preference of the elimination of the gender hierarchy in their relationships and opting for more egalitarian unions (Shechory & Ziv, 2007) resulting in

a more equitable division of labour within same-sex couples who also hold more liberal attitudes regarding gender roles.

"PrEP is for bottoms"

From the point of view of those who believe that PrEP is for those playing a 'female' role, they remark that usually feminine partners like to take care of themselves, therefore, they should be the ones on PrEP. In addition, they express that "tops" are likely to be on PrEP if they are metrosexual. According to them, metrosexuals are "too clean", they like things to be 'on point,' they are soft, and some are 'sissies'. Hence, they are likely to utilize PrEP because they want to take good care of themselves and be in control of their lives. Additionally, as these men are perceived to play a feminine role in relationships, they are deemed likely to compromise, since women in general are believed to compromise a lot in relationships.

These specific MSM subsequently do not believe in equal relationships, they assert that there is no such thing as an equal relationship, and that equality in relationships does not exist.

> "*I feel like in normality, the one that plays the role of the woman is the one who is supposed to get PrEP and stuff like that because the one who plays the role of a man in the relationship, is just like any other man, even straight guys in the society depending on certain individuals, some will know that both of us will have to be exposed to such, it's not you because you are playing this certain role in the relationship, it's not just me because I am playing a certain role in the relationship, so I feel like those who play a woman, I just wanna put it that way, in the relationship, normally it's just them who have to go an extra mile. I don't really think it's a man-to-man relationship, it's never equal and I don't think it will ever be*" (*Victor, 18)

The alignment by some MSM to hegemonic masculinity as a way of evading homophobia and stigma leads to masculine MSM adopting gender norms considered culturally appropriate by mainstream society (Johns et al., 2012; Lynch & Clayton, 2017). The existence of heterogeneity in terms of sexual behaviours within MSM has an implication for traditional

gender roles which then guide MSM's understanding of their relationships, their sexual practices, and decision making which may lead to unequal power distribution (Moskowitz & Hart, 2011). As a result, it is imperative to understand that due to power and dominance that masculine MSM possess, receptive or feminine MSM's sexual decision agency maybe adversely affected as a result of adherence to subordinate gender roles that their dominant masculine partner may expect them to enact.

Experts interviewed in this study hold the views that sexual role and gender performance should subsequently not affect who should be on PrEP. They highlight that when PrEP was first introduced, it was aimed at sex workers and as time went by, it was given to more broadly groups regarded as key population including MSM. It was first taken by bottoms, but it does not have gender identity nor a sexual role-specificity, everyone eligible for it should take it, irrespective of the sex role they play or their gender performance in the relationship. They also outlined that the majority of MSM who get tested for HIV to determine their eligibility for PrEP, are in actuality - a range of masculine and feminine bottoms and tops; and that as it protects all from getting infected with HIV, whoever needs it, should take it. The common perception amongst some MSM that PrEP is for bottoms is problematic in that it deters MSM not identifying as bottoms from using PrEP as PrEP prescription is not related to gender performance nor sex role (Krakower et al., 2014).

The key informants articulated that quality counseling for nurses is very important, education in general is equally important because healthcare providers also need education about how PrEP protects a person from being infected with HIV, regardless of their gender performance or sex role. They emphasized the significance of quality education about PrEP and its advantages and disadvantages to dispel the myths and misconceptions about who should be on PrEP. When marketing PrEP, they articulated that they do not attach feminine or masculine values, or top or bottom roles, and even though they focus on PrEP as a prevention pill, they do not liken it to contraceptives.

"*We sell it as a vitamin pill, and now in the context of corona, everyone is taking a vitamin a day, so I don't think there is any femininity or masculinity associated with PrEP*" (MSM Project Coordinator)

Several MSM suggested that the government and non-governmental organizations should continue branding PrEP because 'prevention is better than cure'. These organizations should continue with education and the momentum created to ensure that everyone who tests negative should take PrEP. Use of social media was highly encouraged as the majority of MSM use social media, especially for meet ups. Therefore, disseminating information on social media is very important, as that is where the MSM community will know about services such as PrEP.

The majority of participants believed that there is a need to be very smart in marketing MSM services, they suggested that services should not be targeted as MSM-only services because once people know that a particular organization only services MSM, or gays, some men may not access those services because they do not want to be associated with or labelled as gay. Labelling a service as a men's health service approach will enable accommodation of men who are still in the closet. As a result, services need to accommodate and be friendly to all men, then service providers can stipulate within service departments, the categories of men they are targeting while welcoming all men regardless. There was, however, a prevailing belief in this group that knowing the target population is important for service providers. However, services should not just be gay services, as this will prevent reaching the objective or goal because some men may not want to be associated with such services.

4.3.3 Independent decision making

In relation to most men who believe in equal relationships regardless of one's gender performance and sex role, these men had strongly held views about the importance of independent decision making in relationships. They solidly oppose stereotypical macho men, usually masculine tops who want to control the other partner. They on the other hand,

suggest that being on PrEP is an individual person's decision, they put forward that each partner should use PrEP if they so wish and that this should be a personal choice, no partner should influence or force the other to be on PrEP if they do not want and vice versa. They expressed that everyone should be in control of their lives, think for themselves, put oneself first, be responsible and wise enough, and put their health first irrespective of their partner's views.

> *"I think we should all use it, all should use it, whether you play any role, you are top, you are bottom, you have to take it, at the end of the day you are a man. You can even wear your make up, but you are a man you need to think about yourself first, not about the other person but yourself first, it all starts with you. I think it needs to start with you, be safe, if that other person is not safe, be safe, be the safer one, be the responsible one, my health number one*" (*Floyd, 23)

These MSM have strongly held beliefs that their sexual health is in their hands and refuse to embed their behaviour within the idea of individual vulnerability as sexual behaviour has a direct link to being vulnerable to HIV. They prefer to adopt safe sex practices such as use of condoms to avoid HIV infection (Da Fonte et al., 2017). On the other hand, this looking out for oneself attitude may be a uniquely MSM attitude as they may feel the need to exert their manhood and masculinity in their relationships by making personal decisions regardless of opposing opinions of their partner.

However a study by Ewing and Bryan (2015) found that both pragmatic and emotional worries affect condom use in adolescent relationships. Adolescents who frequently engage in sexual activities found difficulties in consistently having condoms to hand when needed and always considering using one, before sexual engagement. This challenge may be worsened by social constructions that link the use of condoms to unfaithfulness, promiscuousness, and absence of trust and love in a relationship. Young people may transition into beliefs that using condoms is not necessary as they start to love and trust their partners, in addition, they may consider this as a barrier to the strong emotional and physical connection that they yearn for, in a relationship (Ewing & Bryan, 2015). The following section looks at PrEP and the healthcare

context, healthcare providers' attitudes towards MSM, sexual orientation disclosure, MSM specific services, and public care and private healthcare.

4.4 PrEP and healthcare context

4.4.1 Self-care

When asked about their views and thoughts about MSM who go to healthcare facilities to access PrEP, nearly all men considered this as a self-care act which they deemed good. This was a very interesting discovery as generally men are known to have low health seeking behaviour. Very few men held negative views. However, those that did, term men who do go to clinics careless and reckless as a part of the 'slut-shaming' that sees health seeking as a result of 'wild' or 'irresponsible' behaviour. The majority asserted that they approve of men going for healthcare services because they are taking care of themselves and are not afraid of healthcare providers. These men are considered very brave, smart enough, open, and understanding that they want to be safe rather than sorry because 'prevention is better than cure'. Many saw nothing wrong and were happy with them because this signaled that these men care about their health.

On the contrary, those with opposing views expressed that 'busy' MSM who know what they are doing and know that they might be at risk are the ones who go to health facilities. This act, according to them does not signify taking control and owning one's life, it implies being reckless.

> "*You go to the clinic for PrEP and to me it means you are careless. You only go when you want PrEP because you know you are careless, because if you were not careless, you wouldn't go and be queuing for PrEP the whole day, you are queuing the whole day because you know that you are careless. How do you take control and owning your sexual life if you play recklessly?"* (*Mpho, 36)

A study by Krakower et al. (2014) on HIV providers' perceived PrEP barriers and facilitators found some health care providers had some reservations prescribing PrEP because of the belief that some people would engage in increased risky behaviours whilst utilizing PrEP, which may potentially increase their general risk for being infected with HIV.

In addition, some of these men further believed that it is metrosexuals who go to the clinic because they care, and 'they like taking care of little things.' This finding demonstrates the existence of diversity within MSM community. Some MSM seem to hold negative attitudes and stereotypes regarding particularly, metrosexuals. Metrosexuals are known to challenge the existing norms of masculinity through maintaining high grooming standards (Sin & Omar, 2020). In addition, metrosexuals may face discrimination and stigma exhibited by other MSM who consider themselves masculine and judge metrosexuals as being too effeminate for accessing health services. This supports the assertion by Garcia et al. (2016) that some MSM switch interchangeably between sexes (gender roles) when accessing services as frequent health routines are deemed feminine and a sign of weakness.

4.4.2 Nurses' influence on PrEP utilization by MSM

4.4.2.1 Nurses' judgmental attitude

Regarding the role nurses play in influencing PrEP use by MSM, many expressed negatively held feelings towards the majority of nurses. In general, nurses were believed to have negative attitudes towards MSM. The majority of MSM outlined that some nurses are homophobic, judgmental, and unprofessional. Most revealed that older Christian nurses, who are usually women, use Christianity to condemn MSM. They apply their stringent lifestyle values to their job which MSM felt was in contradiction to their professional code of conduct and ethics, which demands them to be non-judgmental and open minded. Moreover, nurses with religious principles were often experienced as wanting to instill their beliefs on MSM. Additionally, some religious nurses and doctors shy away from consulting MSM.

> "*You may come across one that's affiliated to a certain religion, and they may also want to come with teachings they learn in church. It depends on the individual that*

serves you. You may find those with attitudes and their teachings from "shembe" and they may want to implement "shembe" principles and forget that they are at work" (*Eddie, 20)

MSM reported the majority of nurses to be unprofessional as well. They say nurses cannot maintain patient confidentiality. They discuss private patients' issues with their colleagues, and in some instances, they gossip about patients' sexuality and HIV status. A couple of nurses are considered to be rude and insulting, ask inappropriate questions, and get angry when asked questions by MSM, and sometimes they make derogatory comments about MSM. Black township nurses are further considered the most unprofessional as they sometimes invite their colleagues into the consultation room when examining MSM. Some MSM reported that they prefer white nurses over black nurses because 'white nurses are nice', whilst others prefer male nurses over female nurses.

"It's not easy. Those comments that nurses make about gays do not make it easy. Black nurses from the township, they are rude, always tired and they are judgmental" (*Tim, 31)

The issue of judgmental attitudes by healthcare providers was further iterated by the interviewed experts. An MSM Project Coordinator for an NGO in Ekurhuleni reiterated that judgment, stigma, and unprofessionalism are the barriers to accessing health services for MSM. He articulated that as an MSM himself, an Activist for equal and equitable service provision for LGBTQIA+ population, he has personally experienced similar challenges as the rest of the MSM population.

"*They are mostly judged, in that judgement, the healthcare professional uses their beliefs, their culture and religion to judge other people. In our programs and activities, we encourage MSM through our empowerment programs to speak out, stand firm and to never leave the health facility without getting help or service because the nursing sister discriminated you because you are gay, or transgender*" (MSM Project Coordinator)

Another expert interviewed, an MSM Project Manager outlined the importance of the role that healthcare providers play in PrEP dispensation. She thought that nurses play a vital role because they have to determine PrEP eligibility, provide counseling, and provide real education about PrEP. In addition, they are the ones responsible for performing the actual PrEP initiation. She does, however, condemn nurses who discriminate against MSM and considers this conduct 'unacceptable'. She urged nurses, as healthcare providers, to be more tolerant of the diverse populations they serve and to observe South Africa's health provision policies. She called for tougher disciplinary measures to be employed by the government against this unprofessionalism and further calls for sensitization of healthcare workers to MSM.

> "*I think nurses also could work on how they are supposed to provide services, and not to discriminate and I think it's also against South African policies, discriminating based on sexuality or gender or discrimination of any kind or not providing appropriate services based on a person's gender, or sexual orientation for that matter, or sexual activities that they engage in. It's unacceptable and people should be more tolerant especially healthcare workers. I think even the government should really be tough, not only in terms of disciplining but sometimes when you are not well informed you don't do good you know, so sensitizing 'cos I know a lot of sensitizations are from NGOs*" (MSM Project Manager)

There are MSM who on the other hand, acknowledge that there are nurses who are friendly, positive, warm, and nice and this has a positive influence on PrEP use by MSM. These nurses are described as being professional, they maintain patient confidentiality, and provide MSM-friendly services. Several men stated that these nurses demonstrate in their work that they are well trained, qualified, and have taken the nursing pledge seriously, and perform their duties with excellence. As a result, these are the types of nurses who make it easy for MSM to access health services.

> "*Nurses, we are talking about qualified people, we talking about a person who went to school, uhm, we talking about someone who did the pledge, nurses again they did*

Psychology as well, they did Counseling as well, so, I think it would be much easier to consult to a nurse because now we are talking about someone whom it's their profession, they are a nurse. Remember even nurses, we have what we call confidentiality, they are still going to keep your information confidential, right? So, it should be easy for another person to go and consult, as much as it is easy to go consult for flu, even for PrEP it should be easy to and consult or enquire more about PrEP" (*Zondi, 30)

Several MSM hold beliefs that nurses do not treat people the same way. They scale people up and if one seems more intelligent or well educated, they award them more respect. If one seems to have nothing and not be well educated, they show little to no respect towards that person. Most MSM seem to push back towards this behaviour. They state that no nurse will overtly discriminate against them and get away with it. They would follow the necessary procedures to make sure that such a person is held accountable and disciplined.

"*Personally, I don't think there will be a nurse who can stigmatize me. Technically, they can't, otherwise hell will break lose that day. Nurses have Managers, Matrons or Nurses-in-Charge, so maybe let's say I am the one who is going to fetch PrEP or ask about PrEP and then I get such discrimination, honestly, I would report that person immediately. I would put that person on Twitter immediately*" (*Dan, 27)

Interestingly, there are MSM who are of the view that nurses are over-worked and generally suffer from burn-out. As a result, they feel people should be a little more understanding towards their conduct and unwelcome attitude, at times. Men in this group express that sometimes, feminine gays are dramatic. They explained that one nurse might have seen many patients in a day and might have not even taken a lunch break hence suffer from exhaustion, but these men like to act up. They stated that feminine gays sometimes act like they are special and when they get to facilities, they want special treatment simply because they are gay. They requested gay people to be more tolerant and understanding that nurses might be exhausted, and they need to be more patient with them because most of them are working under pressure and are over-worked.

"*I love my gay people but sometimes they irritate me because they forever think they are special and make things special about themselves. Being bi, being gay, it doesn't make me special, it doesn't mean when I get to the clinic, I should get special attention or treatment*" (*Thomas, 31)

It was refreshing to hear the expert's perspective in connection with the general beliefs that nurses have a negative attitude towards MSM which becomes an obstacle to accessing services such as PrEP. The PrEP nurse articulated that she believes HCPs play a crucial role as nurses, besides the clinical processes of initiating MSM on PrEP, nurses support MSM, and are there as an empathetic shoulder to cry on. She expressed that MSM bring their deepest issues to them, whether sexually, physically, or emotionally and nurses provide needed support and counselling.

Remarkably, she did not refute the criticisms made about some nurses' misconduct towards MSM. She admitted that stigma is rife, especially in public facilities. She fascinatingly brought up a challenge raised by several MSM that some nurses use their religion and culture to condemn MSM. She expressed that "it's bad, especially with our traditional and religious beliefs, so there is still stigma targeted towards MSM," so, there is still a long way to go until the goal of non-judgmental health service provision is actualized. She further highlighted that younger healthcare providers are more understanding. She concluded by urging healthcare providers to stop stigmatizing MSM.

"*It's the manner of approach I can say, with the healthcare providers, so that MSM can be more comfortable to express themselves freely without us judging them, I think our healthcare department needs to work on that, it's not fair for our society to go through that because there's still a big gap, even in our communities*" (PrEP Nurse)

Ma et al. (2017) unearthed that underlying social and internalized stigma is a huge deterrent preventing access to health services by MSM, hence the need for sensitivity training for healthcare providers. One such training in Kenya, produced positive results as healthcare

providers' knowledge of MSM increased and their deeply held homophobic attitudes were reduced significantly after the training (Ma et al., 2017). Owing to that, it should be a requirement for health personnel and health related students to undergo sensitivity training as this may reduce their bias and result in the delivery of quality, friendly, and non-judgmental services. In addition, participants from a study in Uganda acknowledged experiencing negativity from health providers. Another study by Kushwaha et al. (2017) in Ghana also confirmed this challenge where MSM reported lack of understanding and care from health providers, and this experienced stigma delayed health seeking resulting in missed opportunities for necessary HIV care for MSM Matovu et al. (2019). Thus, the training reported on in Kenya could be of use across the continent, not only in South Africa.

4.4.2.2 MSM specific services

Several MSM articulated that they would like to have MSM-specific services which they think would encourage more use of health services. They indicated that, there are currently no MSM specific clinics, and at the current clinics they access services, there is no section reserved specifically for MSM. They suggested that in the already existing facilities, there should be a separate consultation room for MSM. While others acknowledged that some clinics have limited space, they suggested that a separate examination room could even be in a container or a mobile clinic with services solely dedicated to MSM. Others suggested building new clinics altogether.

> "*We need MSM clinics here around because you cannot go to Johannesburg or Pretoria for a clinic, so that's what's tempering us at the moment, so if they can bring clinics closer, mobile trucks, mobile clinics, that can even do better, so there is no need for them to actually build a clinic for us, just a small thing with one room would make a big change*" (*Zweli, 19)

The experts also support this idea of specific services for men. Nevertheless, they suggest that to combat further stigmatization, these services should not only be MSM services but services for all men. Once people know that a particular organization or clinic only services MSM, some

men may not want to access that service because they do not want to be associated with 'gays', for instance, the '*after-9s.* So, services should accommodate all men, then the different types of men the services cater for can be stipulated. By so doing, the objective and goal of provision of health services friendly to all men may be reached.

There are opposing views regarding the provision of MSM specific services: whether these should be stand-alone or integrated within general men's health services. However, the underlying agreement is that having health care workers who are friendly and who exhibit non-judgmental attitudes towards MSM, with enough knowledge about the sexual health needs of MSM, and assurance of MSM confidentiality, and enhanced trust, would ensure that services are acceptable (Ma et al., 2017). On the other hand, a study by Rispel et al. (2011) confirmed that there is a need for targeted HIV prevention and treatment services for MSM. While their study suggested that MSM preferred attending facilities dedicated to their specific needs, they outlined that this was not likely presently achievable (Rispel et al., 2011). Therefore, the best option is to better train the existing professionals.

4.4.2.3 Public vs. Private care

Several MSM voiced that they do not experience stigma and discrimination when accessing healthcare services because they have medical insurance and can go to private facilities. One exclaimed that he feels very lucky that he now has Medical Aid, and he does not have to deal with public doctors and nurses anymore. Another expressed that he has not personally experienced discrimination in facilities because he goes to private doctors where the service, he gets is friendly and of superior quality. Meanwhile, other participants advocated the importance of having male nurses. They outlined that government should specifically employ male nurses, in public facilities. Some preferred gay nurses and white nurses because white nurses are perceived to be patient, polite and professional. In general, it is understood that government facilities are short-staffed, which perpetuates negative attitudes by nurses who are under pressure and overworked. Therefore, it is important to increase nurse capacity and include more male nurses who will serve MSM. It is also important for nurses to be able to speak to MSM in the township language they understand. Male nurses are often preferred

because of the positive attitude they exhibit compared to some female nurses who were reported to be moody, and not have deeper understanding of men's issues.

> "*Female nurses, sorry no offence intended, they get angry and have an attitude so if the government can do something, hire more male nurses, I think things will be ok, way much better. Others come to work moody, they come moody from home, I have never heard of a male nurse being labelled to have attitude, no they are always there to do their work and go back home*" (*Dan, 27)

This finding affirms the study by Rispel et al. (2011) where participants stated their unwillingness to use the public sector and to disclose their sexual orientation to healthcare providers because of previous unpleasant experiences. This resulted in only a small amount of MSM demonstrating willingness to access public health services. Contrary to this, the findings in this study, revealed only a smaller number of MSM who preferred private health care. This discouragement coupled with preference for male nurses implies that MSM who cannot access private care and cannot be attended by male nurses may fail to utilize health care services due to negative beliefs about public health sector and female nurses.

4.4.3 Sexual orientation disclosure to healthcare providers

'Good nurses and bad nurses'

Nearly all MSM stipulated that it is good to disclose their sexual orientation to healthcare providers. The issue of a 'good nurse' and a 'bad nurse' was frequently raised. Most MSM felt that they can only disclose to a 'good nurse' and not a 'bad nurse.' A good nurse was described as warm, friendly, and non-judgmental, while a bad nurse was described as homophobic, judgmental, and unprofessional. The majority of MSM acknowledged that disclosing is helpful as MSM feel they would be properly diagnosed and treated well. When they do not fully disclose, they feel the health provider may not give them quality appropriate client-centered care they deserve.

Nonetheless, some mentioned that they fear disclosing because of possible condemnation by healthcare providers, and this leads many to shy away from disclosing. While the majority have not actually disclosed, some indicate that they first present themselves as heterosexual but if the nurse is a good one, they ultimately disclose. Others stated that they feel comfortable disclosing if they are convinced that the health provider is a professional and will not judge them. Interestingly though, several MSM claim that more feminine MSM disclose because they see themselves as women. On the other hand, there are those who have unintentionally self-disclosed through their dress code and how they speak. Reluctance to disclose sexual orientation has been reported in other countries such as Uganda where MSM reported not feeling respected by health providers (Matovu et al., 2019). Watson et al. (2020) stipulated that sexual orientation disclosure is linked with positive health outcomes for MSM and improved wellbeing, hence, the importance of improving the healthcare context for MSM.

The sustainability of HIV prevention efforts depend on the realization of the significance of improving MSM's perceptions and experience of the existing healthcare system. MSM still come across female healthcare providers who subversively exercise their power and impose their religious and moral beliefs on MSM. As nursing in South Africa still continues to be a highly female dominated profession (Budu et al., 2019), this power imbalance creates an unequal and unsupportive healthcare environment for MSM restricting their health seeking behaviour. This supports findings from other studies that male patients prefer male nurses over female nurses (Ahmad & Alasad, 2007).

The Self-determination theory (SDT) provides a credible framework that seeks to understand the health care provider – MSM relationship context. SDT theorizes that when patients have a greater experience of autonomy and support from their healthcare providers, they are more intrinsically motivated to take action and work towards attaining goals that improve their health (Ryan & Deci, 2000). As outlined in the SDT, three key components (autonomy, competence and relatedness) are needed to enhance health promotion.

If MSM feel that health care providers do not offer them autonomy over their health, (for example, due to excessive authoritative preaching, lack of assured confidentiality, or being unapproachable or fear-inducing consultations) they feel less motivated to disclose important health information such as their sexual orientation (Kushwaha et al., 2017b). In addition, healthcare providers who offer rigid advice, especially when the advice is intended to counteract normal habits or values of patients, this weakens patients' sense of control over how to live their lives. A lack of competence and support makes MSM feel that healthcare providers do not understand their unique needs, diminish their capacity to equip patients with knowledge and the skills they need to remain healthy. The existence of these knowledge gaps manifests in health care providers possessing limited understanding of health issues and the disease processes common amongst MSM and healthcare providers falling short in providing services that are patient-centred owing to the limitation in understanding individual motivations for same-gender activities and challenges related to this (Kushwaha et al., 2017b). Somewhat, as findings from this study have demonstrated, MSM feel they are judged and provided with advice that reflects a moral evaluation of health and risk as opposed to an evaluation based on their specific health needs. This was demonstrated in the complicated and unequal power relationship and role that female healthcare workers play in shaping MSM's use of PrEP.

4.4.4 Strategies to improve PrEP knowledge and PrEP distribution

When asked what strategies the government should employ to improve PrEP knowledge and distribution, many MSM indicated that the government should intensify education programs, information dissemination, and PrEP awareness. The government was urged to introduce PrEP in schools, and to host community programs in collaboration with NGOs. The government can use media (including social media, print media, and broadcasting media) to disseminate information and ensure that information about PrEP reaches everyone. Government can host campaigns and events about PrEP. In terms of awareness raising, nurses should be sensitized about MSM and how to provide MSM appropriate and friendly services and PrEP should also be locally available in all public clinics.

4.5 Conclusion

This chapter outlined the most significant research findings that illustrate how masculinity impacts on the use of PrEP amongst MSM. The findings were presented in summary format categorized into four key themes. The first theme explored the participants understanding of sexual orientation and gender identity in connection with self-acceptance, masculinity, femininity, family rejection and homophobia. With regards to sexual orientation, homophobia emerged with self-acceptance by MSM towards themselves, family, and society playing a huge role in enabling MSM's ownership of their sexuality and enabling their freedom to be who they are without fear of judgment. In defining their identity, a blend of self-labelled femininity and masculinity was discussed and observed. Most men emphasized that they felt equal to heterosexual men and not less than other men, regardless of being sexually attracted to men, while others felt distinctly more feminine.

The second theme explored MSM's awareness of and personal experiences of PrEP. Perceived risk influenced whether MSM are willing to be on PrEP as well as whether they are aware of the pill and its protective benefits against HIV. The sub-themes that emerged were risky sexual practices that placed a lot of MSM at risk; knowledge about PrEP which was discovered to exist although limited; attitudes towards PrEP were mixed, some participants advocated for PrEP use whilst others rejected it. Information sharing amongst MSM was prevalent, though insufficient because men are generally uncomfortable sharing sexual health matters amongst themselves, and this is still considered a taboo amongst some MSM. The findings have captivatingly demonstrated that though most MSM are willing and have an interest in PrEP, yet they have not used it, except one participant.

The third theme highlighted the high likelihood of future use of PrEP. Factors such as adherence, power dynamics in relationships, and sex role may impact PrEP. An observation was made that most MSM perceived that both partners should be on PrEP, whilst only a few deemed PrEP only for effeminate MSM. This discovery acts as an illustration that MSM are deconstructing and redefining masculinity for themselves since most believe in equality within relationships and that no partner should be dominant.

Finally, the fourth and final theme looked at PrEP in the healthcare context. Nurses' judgmental attitude towards MSM was flagged as the main deterrent to accessing health services for MSM, and their subsequent PrEP use. An aspect that stood out was the dire need for and interest by MSM to have specific men's health services, revealing the need for specialized MSM mobile clinics and dedicated male nurses which could be a solution to addressing challenges brought about by homophobia MSM experience in public health facilities. The next chapter will outline the recap of the main discussions of the report and will further put forward recommendations from the study.

Chapter 5 – Conclusion

5.1 Introduction

This section of the report seeks to conclude the study by restating the central research question, the aims and objectives that the study aimed to achieve, and the significance of the study. This study sought to explore the impact of masculinity on the utilization of PrEP by MSM. As a way of addressing this, the research firstly delved into the main layers of gender identity and sexual orientation, and their fluidity in order to appreciate how MSM define and understand their identity in terms of masculinity. This set the tone for MSM's experiences and how the enactment of masculine norms inform MSM's decision making in terms of access to HIV prevention services such as PrEP. This provided key insights and guidance that informed the study conclusions.

Another objective of the study was to discover whether MSM perceived sexual orientation disclosure as a barrier to access healthcare and whether they were willing to disclose their sexual orientation to their healthcare providers. This objective is linked to the third objective, that examined MSM's awareness, knowledge of, and willingness to utilize PrEP. Therefore, after bringing all the parts of the report together, I argue that although masculinity is a complex and fluid concept, the enactment of masculine norms most certainly does impact the utilization of PrEP amongst MSM. Based on this, I argue against the tendency of HIV programs grouping MSM into one epidemiological group based on their behaviour – that is of men having sex with other men – but I advocate for incorporating gender back into HIV prevention. Firstly, by rejecting hegemonic masculinity in its current form and secondly, by addressing masculine norms according to MSM's specific meaning and enactment of masculinity.

This study revealed a more complex depiction of MSM's experiences in terms of access to PrEP which was dominated by the intersectionality between individual factors, social, and structural factors. Individual risk factors such as sexual positioning, multiple concurrent

sexual partners, decisions about condom use, use of drugs, attitudes towards HIV testing, perceptions towards sexual orientation disclosure to healthcare providers, and adherence to treatment affected MSM's willingness to be on PrEP. These factors demonstrate enacting masculinity norms which make it harder for MSM to seek care and treatment services as these are seen as a sign of weakness or recklessness. This may delay health seeking and creates potential for HIV transmission. Therefore, focusing on these masculine norms can help create a MSM masculinity model for HIV prevention and reduce the delayed access to treatment. This has an implication for opportunities for counselling interventions that should recognise and incorporate how masculinity informs MSM's perceptions, emotions, and behaviours, together with the adoption of gender-transformative interventions to assist in forming new conceptualizations of masculinity for MSM (Zeglin, 2015). Such an approach and methodology has a potential to lower HIV infection amongst MSM by encouraging them to use PrEP. Finally, at structural or institutional level, it is imperative to design interventions that address factors related to improved access to health services, MSM empowerment and better education.

5.2 Overview of Key Findings

This chapter outlines the most significant research findings which illustrate how masculinity impacts on the use of PrEP amongst MSM. Findings were presented in summary format categorized into four key themes. From a social-epidemiological viewpoint, masculinity appears to have fundamental role in utilization of PrEP. Healthcare professionals should delve into masculinity with MSM to emphasize prosocial and positive aspects of masculinity. This study has clearly demonstrated the necessity to develop programs targeting masculinity in the MSM community through creation of socially accepted and friendly conceptualizations of masculinity. This approach can lead to empowerment of MSM by enacting masculinity in non-self-destructive ways that help reduce transmission of HIV through adoption of preventative biomedical treatment such as PrEP. Effective results from those interventions can have advantages for MSM as individuals and the MSM community at large (Zeglin, 2015).

There is a strong corelation between how the study participants constructed their masculinity and the theoretical and conceptual framing of masculinity discussed in the literature review

(Connell, 1995; Connell & Messerschmidt, 2016; Halkitis et al., 2004; Lynch & Clayton, 2017). A handful of the MSM in the study, self-identified in heteronormative and heterosexist terms.. This finding is connected to the conceptual framing of masculinity outlined by (Lynch & Clayton, 2017) literature that stipulates that MSM in South Africa in particular, negotiate their gender mainly in heteronormative contexts that is centred on assertive heterosexuality. In addition, this aligns to what (Szymanski & Carr, 2008) articulated that since most traditional families exhibit heterosexism, many MSM are subjected to anti-gay sentiments from their families and society at large. As a result, they enact their masculinity according to the traditional stereotypes of masculinity, especially those who were socialized according to traditional norms and belief systems to be accepted. Some MSMs still associate their masculinity with traditional gender roles as outlined by those who felt they were equal to heterosexual men and performed traditional masculine roles such as fathering children and working in male dominated environments just like heterosexual men. Another corelation of research findings and the theoretical aspect was that some MSM constructed their masculinity in terms of their physical strength, which led to violence at times, as a way of asserting themselves and securing their place in society as men. This construction is related to hegemonic masculinity which sees some of these men enacting toxic and hypermasculine traits as a way of demonstrating their manhood as outlined by (Connell & Messerschmidt, 2016).

It is interesting to further note a mental shift demonstrated by some MSM in terms of how they construct masculinity. Many MSM in the study, especially younger MSM portrayed an openness and flexibility to how they self-identified. This is in contradiction to traditional constructions of masculinity. Some men cared less about labels and preferred egalitarian same sex relations as opposed to having one's gender role aligned with traditional roles. These men saw themselves as equals to their partners and advocated for a hybrid masculinity in which same-gender relationships are not affiliated to traditional norms. These MSM stated that they are same gender loving which does not make them lesser men, nor does it mean they aspire to be women. Lastly, it is imperative to also acknowledge those MSM who defined their identity in feminine terms, such as feeling like a woman trapped in a man's body. The paradoxical nature of this self-identity is that it places these MSM on the traditional gender

role spectrum whereby they feel that their role in their relationship is a feminine one. These differences in gender identity demonstrates the diversity that exists in MSM community and how each individual expresses their gender. Therefore, it is imperative to take into account this diversity and not define gender in binary terms and acknowledge the blending of feminine and masculine gender norms and beliefs, independent of sexuality or biological sex (Garcia et al., 2016). Thus, these gender nuances help in theorizing masculinity according to MSM, not as dictated by society through simply reducing gender to male or female. Lastly, this demonstrates the complexities and fluid nature of identities (Holle et al., 2021).

The first theme (see 4.1.1 and 4.1.3 respectively) explored MSM participants' understanding of sexual orientation and gender identity in relation with self-acceptance, masculinity, femininity, family rejection, and homophobia. In defining their identity, a blend of self-labelled femininity and masculinity was discussed and observed. Nearly all MSM who identified as bisexual reported feelings or stages of confusion, at some point in their lives, and this struggle for self-identity is a common experience amongst bisexuals. During the study, it became evident that there are MSM, especially gay and bi-sexual MSM, who still align themselves to the societal heteronormative norms. This was because of fear of exclusion from society, and by defining themselves as masculine, these men are generally dominant and in control of their relationships and usually prefer partners who ascribe to the heteronormative femininity, usually associated with women. This finding supports Halkitis et al. (2004) who uncovered that some MSM prefer the adoption of hegemonic masculinity in defining their identity. Other participants, on the other hand, were very clear that they are feminine. Most interestingly, most MSM, emphasized that they felt equal to heterosexual men and not less than them, regardless of being attracted to men. Due to their sexual orientation, the majority of MSM had experienced homophobia in their life, which resulted in family rejection for some, whilst for others, their community participation and religious and moral obligations were affected when they experienced homophobia from church or members of the congregation. For others, self-acceptance both by oneself and family, played a huge role in enabling ownership of their sexuality in society, and this awarded them freedom to be themselves without fear of judgment.

The second theme (see 4.2 and 4.2.3 respectively) explored MSM's awareness, knowledge of, and willingness to be on PrEP. Majority of MSM in this study were aware of PrEP and this finding rejected findings from previous studies, such as Al-Tayyib et al. (2014) who stipulated that MSM were not aware of PrEP. This could be related to the fact that their study in particular was conducted when PrEP was just being introduced and indeed, MSM were not aware of PrEP at that time, and over the years, awareness of PrEP increased. Perceived risk influenced whether MSM were willing to be on PrEP as well as whether they were aware of the pill and its protective benefits against HIV. MSM who perceived themselves to not be at risk of HIV infection reported not being interested in PrEP, while those who perceived themselves to be at risk, showed willingness to be on PrEP as per research findings by Jenani et al. (2016). This could be attributed to masculinity in the sense that men who deemed themselves in control of their lives, and not vulnerable to HIV infection rejected the idea of being on PrEP, whilst for those who know that they are at risk, masculinity could be at play as they want to take control of their lives and be on PrEP and this finding represents dualism that exists in how masculinity affects PrEP use or non-use.

Masculinity also plays a huge role in men's sexual health, whereby it emerged that majority of MSM partake in risky sexual practices such as unprotected anal intercourse, multiple concurrent sexual partners, drug and alcohol abuse, poor adherence to treatment, and these place MSM at risk. Knowledge about PrEP, which was discovered to exist though often limited, and attitudes towards PrEP were mixed, some advocated for PrEP use because of its benefits whilst others rejected it because of their belief that it promoted reckless behaviour. Information sharing amongst MSM was prevalent, though not sufficient because men are uncomfortable sharing sexual health matters amongst themselves and some MSM still consider discussions of sexual matters a taboo. These findings have intriguingly demonstrated that though most MSM are willing and have interest in PrEP, underlying behaviours influenced by masculinity prevent many from using it yet, with an exception of only one study participant who reported having been on PrEP before. This participant ended up discontinuing the treatment because they deemed condomising and living a healthy lifestyle better and safer than being on PrEP.

The third theme (see 4.3.2) highlighted issues pertaining to gender performance, dimensions of sexual identity and sex role. Although the majority of MSM reported a high likelihood of consideration and future use of PrEP, factors such as adherence, power dynamics in relationships, and sex role may impact on the actual use of PrEP. Masculinity is enacted and acted out in many different ways on a daily basis which may adversely affected MSM's PrEP use.

In terms of adherence, for example, the majority of MSM outlined that they have a challenge with taking a daily pill, and some reported that men in general hate relying on something like a pill because it makes them feel like they are not in control of their lives. When looking at power dynamics, it was also extensively reported that MSM who identify as masculine, and who may be dominant in the relationship, may coerce the 'feminine' MSM partner to be on PrEP. This is especially likely if the more dominant partner is economically stable and 'provides' in the relationship. Thus, masculinity in this case, may have a role to play in determining which partner uses PrEP. A very small sample of MSM were of the belief that PrEP should be for MSM who play a feminine role in the relationship as women are generally known to take control of their health, thus, they should be on PrEP. This finding is a classic masculinity at play as this stereotype perpetuates the subjugation of those with effeminate identities. This outcome supports the finding by Garcia et al. (2016) that some MSM believe that PrEP is for 'bottoms'.

An observation was made that there was a greater number of MSM too, who held strong views that PrEP is for both partners. These are the MSM who seemed to emulate egalitarianism in their relationships. This group of men were clear that all partners in a relationship for example, are men, and therefore are equal, regardless of the sex role that one plays, as a result, both should be on PrEP. In addition, they claimed that they are both equally at risk, and they did not believe that receptive partners are more at risk than insertive partners. This finding supports discoveries by Shechory and Ziv (2007) that some people in same-sex unions prefer egalitarian relations where no partner dominates and influences the actions of the other. Additionally, these men strongly outlined that it is their individual

responsibility to take care of themselves and they cannot leave their healthcare needs in the hands of their partners. This discovery acts as an illustration that MSM are redefining and deconstructing masculinity since some strongly believe in equality in relationships and that no partner should be dominant. This in a way, is also an enactment of masculinity which could on the other hand, affect PrEP use in a positive manner with this group of men taking positive and proactive charge of their health and do not depend on their partner's guidance or preference.

Finally, the fourth and final theme (see 4.4. and 4.4.2 respectively) looked at PrEP in the healthcare context. Nurses' judgmental attitude towards MSM was flagged as the main deterrent, preventing access to health services for MSM, and their subsequent PrEP use. This was mainly because of the stigma and discrimination that MSM experience from healthcare workers when accessing health services. The majority of MSM illustrated that nurses, especially the older generation of nurses, seem to have lack of understanding of MSM and their issues. As a result, sometimes they use their own beliefs and religious principles to condemn MSM. This leads to the majority of MSM not disclosing their sexual orientation to healthcare providers, and this may result in MSM not receiving quality and MSM specific services that they need, which would improve their health outcomes. Arreola et al. (2014) support this finding and stipulate that inhibition by MSM to disclose their sexual orientation to healthcare providers is linked to misdiagnosis, delays in diagnosis, and delays regarding treatment which results in poor health diagnosis for MSM. Some MSM in this study have on the other hand, stipulated that there are bad nurses and good nurses. Good nurses are considered professional, gay-friendly, and possessing a non-judgmental attitude. These MSM specified that such nurses make it easy for them to disclose their sexual orientation because of their warmth and their welcoming approach.

Issues of private and public health care came up whereby some MSM preferred getting services from private health facilities as opposed to public, for example, because healthcare workers in public facilities do not adhere to confidentiality and gossip about MSM with their colleagues. Others have reported institutional and medical mistrust as a major barrier to

access to healthcare, whereby some MSM are skeptical about blood draws, for example, and as a result refuse PrEP initiation because they do not know where the specimens are going to be taken and do not trust the health sector to take care and store their samples safely. The next section concludes this chapter by providing recommendations from the study which would address individual, social, and structural barriers to PrEP use amongst MSM.

5.3 Recommendations

5.3.1 Addressing individual level factors

5.3.1.1 Gender-transformative interventions - Interventions that transform negative elements of masculinity through an emphasis of positive elements may perhaps alleviate the catalytic impact of masculinity on PrEP use amongst MSM. MSM who are provided with information that demonstrates how and why traditional conceptualizations of masculinity are harmful and who are given support to safely explore alternative conceptualizations of masculinity may potentially reassess and change their beliefs and harmful actions relating to masculinity (Zeglin, 2015). These gender-transformative interventions have been proven to facilitate healthier lifestyles and produce positive health outcomes through reducing risky sexual behaviours such as multiple sexual partners and engaging in unprotected sex (Zeglin, 2015).

5.3.1.2 Rejection of hegemonic masculinity - MSM should be encouraged to enact pro-social forms of self-esteem and selfcare as qualities of masculinity. In addition, if MSM can create a model of masculinity that is positive, and perceive themselves as active and responsible contributors to their healthcare, they are highly likely to improve their health-seeking behaviour through rejecting dominant and harmful traditional masculine norms (Zeglin, 2015). This process will enable MSM to understand masculinity from their own perspective in order to come up with a more nuanced theorization of masculinity specific to them.

5.3.2 Addressing barriers at institutional level

5.3.2.1 Sexual orientation disclosure

5.3.2.1.a Sensitivity training for healthcare professionals – sensitization trainings should be held for healthcare workers so that they are informed about MSM, their health needs, and how to provide MSM-friendly services that meet their needs. In addition, the integration of MSM specific awareness and communication skills into the curriculum for medical students is important to ensure that future healthcare providers are equipped with the necessary tools and skills to enable their future clients to disclose their sexual orientation and thus, render appropriate care and advice. This medical education responsibility should begin at undergraduate and extend into the postgraduate curriculum as well (Brooks et al., 2018). Moreover, at institutional level, policies enabling sexual orientation are suggested. Policy makers, researchers and the MSM community are encouraged to collaborate and create a supportive environment that facilitates sexual orientation disclosure. Furthermore, this should be integrated into comprehensive HIV programs tailored to address the health needs of MSM (Tang et al., 2017).

5.3.2.1.b Rejection of gender binary and adoption on gender-neutrality - Healthcare providers should be aware of the diversity, both similar and dissimilar physical and psychosocial needs of the MSM community. They should be open-minded in terms of their clients' sexual orientation. All healthcare professionals should be encouraged to reflect on how they use language, such as referring to clients as "he" or "she" without asking how clients prefer to be addressed, and whether they are in romantic unions with men or women or both. HCPs should be on the lookout for unintentional use of heteronormative phrases and assumptions, since these may inhibit MSM to disclose their sexual orientation (Brooks et al., 2018).

5.3.2.1.c MSM specific services – MSM specific services are necessary so that MSM can feel comfortable and go to clinics that cater for their specific needs. This could be done through men's health corners in fixed facilities or through MSM mobile clinics. Healthcare settings

should be considerate of the needs of MSM patients at the institutional level and create safe spaces for MSM to access stigma-free, competent and comprehensive health services. Simple and cheap changes can be implemented for instance, such as signs and symbols showing a friendly and accommodating atmosphere that appeals to MSM or including a rainbow symbol or Human Rights Campaign Logo (Brooks et al., 2018). In addition, it is imperative that healthcare workers' beliefs are compatible with the beliefs and needs of MSM. A key intervention may include producing information leaflets that accept the MSM community and that take into consideration the different needs of MSM, through the provision of MSM specific information at all times and integrating MSM services within the healthcare sector.

5.3.2.1.d Provision of culturally sensitive services for MSM - Qualities traditionally linked to masculinity could be incorporated in HIV interventions for MSM. Counselling professionals should assess how MSM conceptualise masculinity based on their culture and how this conceptualization informs their decision making when it comes to accessing healthcare services. Interventions sensitive to how a client defines masculinity according to their culture should be prioritized and implemented as these approaches will lead to a culturally competent and beneficial treatment (Zeglin, 2015).

5.3.2.1.e Male nurses - dedicated male nurses could also be a critical strategy that could be a solution to address the challenges MSM face in getting services from female nurses, who may be judgmental and not understand men's health needs in-depth. Owing to that, having more male nurses who may have capacity to approach men, from a men's point of view, may begin to improve access to health services.

5.3.3 Strategies to improve PrEP knowledge and PrEP distribution

5.3.3.1 Improve access to PrEP – PrEP is still not easily accessible to a lot of MSM, this is because it is currently available only in a few clinics around Gauteng province and it is not yet available in all public facilities in all provinces. As a result, it is recommended that government

should have plans to expand the coverage of facilities that offer PrEP so that even MSM in other townships and in rural areas can gain access.

5.3.3.2 Intensify education programs for youth - The government should introduce PrEP in schools, to educate young people about the importance and benefits of prevention strategies such as PrEP. This will give people an opportunity to make informed decisions about their sexual health from a young age, as opposed to waiting for them to have knowledge later and when they are older, since in some cases, sexual activity and HIV exposure might have already occurred.

5.3.3.3 Information dissemination and PrEP awareness - use of media (social media, print media, and broadcasting media) to disseminate information is a good strategy to ensure that information about PrEP is widely disseminated and people are aware of it. The Department of Health can cohost community programs in collaboration with NGOs because NGOs have a wider-reach into the community than the government and they already have programs that specifically target men.

5.3.3.4 Implications for future research – Future research should review the deconstruction of hegemonic masculinity and the importance of hybrid masculinities amongst MSM and how these impact MSM behaviour in relation to access to healthcare services. In addition, more studies are needed to assess the integration of MSM in healthcare curricula for medical students as future healthcare providers. Finally, further investigations can be done on how the government is intending to integrate MSM specific services through addressing individual, social and structural, and institutional needs through policy level interventions as recommended by social-ecological model.

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APPENDICES

Appendix 1 – Consent Form

I……. agree to participate in this research project. The research has been explained to me and I understand what my participation will involve.

Please circle the relevant response below.

I agree that my participation will remain anonymous YES NO

I agree that the interview may be audio recorded YES NO

…….. Name of participant

…….. Signature of participant

…….. Date

Appendix 2 Participant non-disclosure and confidential agreement

- I understand that the interview space is considered a private, confidential and safe space.

- I understand that I am participating in this research to enhance further understanding of same-sex behaviour (men who have sex with men) and HIV prevention.

- However, I do understand that I should not disclose or otherwise release **anyone's personal identifying information,** either directly or indirectly, when discussing sexual behaviour and/or HIV status.

- I acknowledge that the researcher, Lindiwe Seotsanyana, has also explained that she will ensure the privacy of any information that I share with her in verbal communication or otherwise. I understand that no personal identifying information will be associated with any information that I have shared or recommendations that I make.

• By my signature, I acknowledge that I have read, understand, and agree to comply with the terms and conditions of this non-disclosure and confidentiality agreement.

Participant's name _____

Participant's signature _____

Date _____

Researcher's name _____

Researcher's signature _____

Date _____

Appendix 3 Participants' eligibility screening form

No	Questions	Answers
Participant: Please answer the following questions		
1	How old are you?	_____ years
2	Were you born biologically male?	1. Yes 2. No
3	I am sexually attracted to	1. Men 2. Women 3. Men and Women
4	Have you had oral or anal sex with a man?	1. Yes 2. No
5	Are you currently on PrEP?	1. Yes 2. No
6	Do you currently live in Vosloorus?	1. Yes 2. No
7	I am willing to answer study questions and voluntarily participate in the research	1. Yes 2. No