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**A qualitative assessment of HIV risky behaviours among male students who have sex with other men: A case study of university students in Durban**

**Masters Dissertation by**

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## COLLEGE OF HUMANITIES

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## **ABSTRACT**

Although unprotected anal intercourse (UAI) has a higher chance of HIV transmission than unprotected vaginal intercourse, research suggests that risk taking behaviours are regarded as a key driver of the AIDS epidemic among men having sex with men. Risky behaviours include unprotected anal intercourse, transactional sex, forced sex, and use of alcohol before sex etc. The aim of this study was to explore HIV risky behaviours and risk perception among male students who have sex with other men. The qualitative data considered in this study came from 15 in-depth interviews with male students who self-reported to be having sex with other men. The findings of this study showed that MSM perceive themselves to be at risk for HIV contraction. Awareness of the main routes of HIV transmission is high among the men. Their perception of HIV risk also exists because HIV has affected them through the loss of close family members. While they use condoms with casual partners, MSM engage in unprotected anal intercourse with their regular or primary partners. The study also points to the existence of sexual violence among MSM whereby some individuals have been manipulated into having sex with someone despite their unwillingness to do so. The study also revealed that MSM are not open about their homosexuality with family, health care workers and most importantly with their female partners although they use condoms as the main form of protection in their sexual encounters with female partners. Due to perceived homophobic attitudes of health care workers, the majority of participants did not know their partners' HIV status as they tested separately. There also exist limitations to practising safe sex which included limited access to lubricants and condoms due to the cost. This study recommends that there is need for campus health care workers to build trust within the university campus society by arranging separate testing services for students so that they can also feel comfortable with accessing health care services.

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## ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARV	Anti-retrovirals
HAART	Highly Active Antiretroviral Therapy
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Questioning
MSM	Men who have sex with men
PEP	Post-exposure Prophylaxis
PrEP	Pre-exposure Prophylaxis
STI	Sexually Transmitted Infection
UAI	Unprotected Anal Intercourse
UKZN	University of KwaZulu-Natal
UNESCO	United Nations Educational, Scientific and Cultural Organisation
WHO	World Health Organisation

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## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background of the study

Men who have sex with men (MSM) are an internationally recognised key population at risk for HIV. HIV does not discriminate but it does disproportionately affect some populations such as MSM who are considered one of the main target groups for HIV intervention programs. Key populations are people who, due to “specific higher-risk behaviours are at increased risk of HIV irrespective of the epidemic type or local context” (WHO, 2014: xii). These key populations include men who have sex with men (MSM), sex workers (male and female), drug users, people in prisons or closed settings and transgender people (WHO, 2014).

The term MSM is used to describe all men who engage in male-to-male sexual contact and includes, gays, homosexuals, men who do not identify as homo or bi-sexual, male sex workers, as well as transgendered people (MSMGF, 2008). Boellstorff (2011) notes that, there is an increase in the number of men who have sexual intercourse with other men and yet do not identify as gay, homosexual or even bisexual. Therefore, he concludes that MSM is not a term that refers to an identity or sexual orientation but rather it points to a behaviour. This distinction between identity and behaviour is important because, behaviour is what places one at risk of contracting HIV not identity. As defined by Scheibe et al., (2015: xii), MSM is “a behavioural term that refers to sex between people who were born biologically male. The term does not make reference to sexual identity nor sexual orientation as many MSM sometimes do not identify with a specific sexual orientation”.

Despite the observed decrease in new infections, HIV prevalence remains high (Reddy and Frantz, 2011). Most of the HIV transmissions in sub-Saharan Africa occur through heterosexual intercourse (Baral et al., 2011). Since 2006 however, research has been suggesting that there is a neglected high HIV prevalence among men having sex with men in developing regions (Solomon et al., 2010; Baral 2007). Due to the rigid physiology of the anal canal, which is prone to tearing, people who engage in unprotected anal sex, are at a greater risk of contracting HIV in comparison to vaginal intercourse (Baral et al., 2007). The chances of an HIV negative MSM finding himself engaged in sexual contact with an HIV-

infected partner are higher than they were 15 years ago ( Mor and Dan, 2012). A meta-analysis found HIV prevalence to be 3.8 times higher than that of other male populations in Africa and 33.3 times higher than that of non-MSM populations in the Americas and 18.7 per cent in Asia (Beyrer et al., 2010; Kilmax, 2009).

The rate of prevalence among MSM remains high in many countries regardless of the country's economic status (Beyrer, 2010; Mor and Dan, 2012; Sohn and Cho, 2012). In South Korea, the government published that of the 771 cases of new HIV infections in 2009, 42 per cent were via the homosexual route while 58 per cent resulted from heterosexual intercourse. In the case of Africa, South Africa has an HIV prevalence rate of 15.3 per cent among MSM, which is low in comparison to other African countries such as Zambia that stands at 32.9 per cent (Burrell et al., 2009). This however is still a very high rate of infection considering the size of MSM communities (Sohn and Cho, 2012). While it is true that anal sexual intercourse carries a much higher risk of infection than vaginal intercourse, the continued increase in infection among MSM, cannot be attributed to the physical risks involved in anal intercourse (Beyrer, 2012). It is attributed to risky sexual behaviours such as unprotected anal intercourse (UAI) which increases the risk of contracting HIV.

A HIV risky behaviour is an activity that exposes the individual to a significant possibility of contracting the HIV virus (Molefe, 2013). While MSM are considered to be at a higher risk of acquiring HIV, there are certain sub-groups of MSM who have much higher prevalence than others due to the behaviours they engage in. These varied sub-groups include individuals who engage in risky sexual behaviours due to lack of knowledge of own and sexual partner's HIV status. They have multiple sexual partner relations, unprotected sexual intercourse/inconsistent condom use, commercial sexual intercourse, use substances before sexual intercourse, coerced/forced intercourse (Maluleke, 2010; HSRC, 2014). Although risky behaviour is not the only reason MSM are a high-risk group, studies show that there is an increase in the rates of high-risk sexual behaviour among MSM globally but particularly in low and middle-income countries (Baral, 2007).

The prevalence and impact of the HIV/AIDS pandemic is not uniform around the world. The drivers of the disease are contextual and differ between regions and countries. For example, in Eastern Europe and Central Asia the HIV epidemic is driven by injecting drug use (DeHovitz et al., 2014). In sub-Saharan Africa, these drivers occur concurrently and often overlap (McKinnon and Abdool-Karim, 2016). This is the most feasible reason why the

epidemic is explosive in the sub-Saharan Africa region. These drivers range from economic and political factors to psycho-sociocultural factors. Economic and political factors include the level of poverty that often results in commercial sex work, war and social conflict that promote a rape culture as well as sexual abuse and the state of the health care system, which is affected by the response of the state to the epidemic. According to UNAIDS (2016), the goal to ending the AIDS epidemic cannot be met unless the social and structural drivers of the disease are addressed. The UNAIDS (2016) identifies these social determinants of HIV to be factors that fall under broad categories of poverty, inequality and discrimination. Thus, social protection, which ranges from social insurance and social assistance, is worth investing in as it will reduce the risk of those living with HIV as well as those not yet infected. At the epicentre of these social and structural drivers are risky sexual behaviours resulting from these restrictions. In this way, risky sexual behaviours are drivers of the disease. A number of studies have linked the persistence of risky sexual behaviours to the persistent spreading of HIV in sub-Saharan Africa (Beyrer et al., 2010; Erinoshio et al., 2012; Alamrew et al., 2013). Evidence from studies that sought to explore the linkages between risky sexual behaviours and the spread of HIV shows that behaviours increase the risk of HIV contraction (Eaton et al., 2003; Grassi, 1999; Yao, 2009). Risky sexual behaviours do not emerge out of nowhere; they result from several factors that act as determinants of risky sexual behaviour as mentioned earlier (Beyrer et al., 2010; Maleke et al., 2017).

Sexual behaviour is recognised as the cornerstone for the sexual and reproductive health of not only the individual but also for all the people connected to that person via sexual networks. The major determinants of sexually transmitted infections (STIs), HIV transmission, and other sexual health outcomes are patterns of sexual health (Johnson et al., 2000). Studies have shown that risky behaviours together with low perceptions of risk and socio-cultural perceptions of risk render people of all ages vulnerable to STI/HIV (Sychareun et al., 2013; Kibombo et al., 2007; Adedemeji et al., 2007). According to Mhalu et al. (2013), the practise of risky sexual behaviours by both HIV-positive and HIV-negative individuals is the main driver of the pandemic in Southern Africa. Mhalu et al. (2013) state that despite several studies focusing on the general population in examining the extent of risky behaviours no study has specifically examined each of these behaviours within the general population let alone within MSM populations.

A number of studies have paid attention to young adults and adolescents without giving sufficient attention to young men who have sex with other men (Eaton et al., 2003; Kibombo et al., 2007, Sychareun et al., 2013). In academic contexts, behaviour change reduces HIV-transmission risk and increases access to healthcare services even among key populations (Vu et al, 2015). It is therefore important to understand the dynamics of sexual behaviour across all population groups because as HIV-seropositive persons are the source of transmission of HIV it is important to characterise the type and extent of their risky behaviours for HIV transmission particularly in key populations (McGowan, 2004). WHO (2017), states that as part of the international public health and human rights guidelines, people who test positive for HIV should receive post-test counselling services whereby they will be informed on how HIV is transmitted and how they can prevent the transmission of HIV. This is why HIV risky behaviours are a serious public health concern. In fact, according to the Canadian HIV/AIDS Legal Network (2014), any Public Health legislation and policy in HIV prevention should hold the power to report cases of HIV/AIDS, issue orders of how individuals suspected of having HIV should behave and suggest examination, testing and treatment. The problem however in the context of many countries is that public health measures regarding HIV fail in implementation as they are neither enforced nor monitored (Sane and Edelstein, 2015). As a result, it is often unknown to researchers how behaviours place certain individuals at risk of HIV acquisition.

A better understanding of sexual attitudes and lifestyles often leads to better prevention strategies for public health purposes (Regitz-Zagrosek, 2012). Behavioural intervention is an important aspect of HIV prevention programs. It is therefore important to ensure that these kind of intervention programs are effective among high-risk groups. The first and most important step in doing this is to understand the behavioural dynamics of HIV infection in key populations. By the year 2009, the World Health Organisation had already found that the global prevalence of HIV was declining but among the MSM populations, the prevalence continued to rise even in developed countries. It is important to monitor the sexual behaviours of people in different contexts because sexual networks of key and general populations are often interlinked (Cleland et al., 2004; Adimora et al., 2006; HELLERINGER and Kohler, 2007). Research suggests that the relationship between years of formal education and HIV prevalence is negative in the general population (Bunyasi and Cotzee, 2017). Gaps however exist in literature in terms of whether or not formal education has the same impact as in the general population although an assumption affirming the possibility of this needs to be

explored. The crossover between the MSM epidemic and the general epidemic is associated with MSM also engaging in intercourse with women (HEAIDS, 2014) who due to their biological make-up are easily infected. Thus, it is important to understand the sexual behaviour of people in different contexts.

## **1.2 Why focus on university students?**

University students are vulnerable to HIV infection due to a number of physical, psychological and socioeconomic attributes of adolescence. This makes them more likely to engage in risky sexual behaviours mainly because of their lifestyle, attitudes as well as the constraints occurring in their immediate environment (Oppong and Oti-Boadi, 2013). The HIV infection rate is highest among 30-34 year olds although it is also high among the 20-24 year olds (Reddy and Frantz 2011; Amornkul et al., 2009). These are the age groups likely to be enrolled in universities where they engage in explorative sexual behaviours at a time when many of them are experiencing freedom from parental guidance for the first time in their lives. The university environment on its own increases opportunities for sexual encounters which promotes risky behaviours (Chanakira et al., 2014). According to Emeka-Nwabunnia et al. (2014), many of the studies focusing on HIV sero-prevalence are mostly focused on men and women of the general population, while few studies have focused on youth in institutions of higher learning where they enjoy some degree of sexual freedom. University students are an important but often neglected public health population group (Stewart- Brown et al., 2000). The reasons for the lack of sexual behavioural research involving university students are not clear but this is likely due to poor response rates as a result of academic and social distractions (Stewart- Brown et al., 2000). There is an assumption that university students are educated and knowledgeable regarding sexual health matters (Stewart- Brown et al., 2000; Chanakira et al., 2014).

While some African studies found that HIV prevalence is higher among university students than the general population (Emeka-Nwabunnia et al., 2014), other African studies particularly in South Africa, show that the prevalence of HIV in universities is lower than the general population (HEAIDS, 2014). In a number of countries, little is known about the prevalence and impact of HIV among university students (de Beer et al., 2012). A 2010 study by HEAIDS (cited in HEAIDS, 2014) observed that the South African distribution of HIV in universities follows national patterns along the lines of age, sex and education level but

across all these, the higher educated people had the lowest prevalence. Within the institutions themselves, academic staff had the lowest prevalence (1.5 per cent) followed by students (3.4 per cent), administrative staff (4.4 per cent) whilst the highest prevalence was among service staff (12.2 per cent). MSM students had a prevalence of 4.1 per cent in comparison to the 1.7 per cent prevalence among other male students (HEAIDS, 2010, cited in, HEAIDS, 2014). However, female students were three times more likely than male students to be living with HIV despite great awareness of HIV amongst all students. Another study by Reddy and Frantz (2011) showed that while it was obvious that students have acquired basic knowledge of HIV, detailed knowledge about its transmission was still lacking as evidenced by the number of students who were well aware of the risks involved but still engaged in risky behaviours. Despite this, HIV prevalence remains substantially lower in the higher education sector than the general South African population and this is due to the lack of knowledge about the HIV epidemic in the general population (HEAIDS, 2014).

With regards to MSM in universities, some studies have shown that MSM who engage in risky behaviours are most likely to have lower levels of education (Sohn and Cho, 2012). This fact is not universal because people's sexual behaviours are affected by other factors apart from their level of education. Student MSM have been reported to engage in risky behaviours such as unprotected anal intercourse, commercial sex, multiple partnerships, and alcohol and drug use (HEAIDS 2014). Many of the studies on MSM risky behaviour do not contextualise MSM in universities, but rather focus on the general MSM population particularly those in urban areas (Frye et al., 2006; Baral, 2007).

Several risk factors have been identified among MSM in universities. These risk factors can be either direct or indirect. Direct factors include unprotected anal intercourse while indirect factors are behaviours such as forced/coerced sex, transactional sex and HIV testing practices. Among university students, there is likely to be no difference in the age of sexual debut although for MSM the first sexual encounter is more likely to be with a casual or commercial partner and they are more likely to experience unwilling or coerced sex without the use of a condom (Cong et al., 2008). A South African study revealed that more than 24.4 per cent of MSM students had their first sexual experience before the age of 16, whereas for non-MSM students the corresponding figure was 15.9 per cent (HEAIDS, 2014). In China, male students who have sex with other men are more likely to have more partners and are less likely to use condoms (Cong et al., 2008). MSM students at a South African university reported having multiple partners who happen to be either male or female (Semba, 2015). In



this same study by Semba (2015) at a university in South Africa, it was found that despite the high levels of HIV knowledge among MSM students, there are lower levels of knowledge regarding the associated risks of unprotected anal sex as well as prevention strategies when compared to similar information regarding vaginal or oral sex.

### **1.3 Rationale and significance of study**

South Africa has the largest HIV epidemic in the world. The South African National Strategic Plan for HIV, STIs identifies lesbians, gays, bisexual, transgender, intersex and questioning (LGBTIQ) as a key population. According to Scheibe et al. (2015), neither has there been a national estimation of the MSM population size nor a large-scale multisite epidemiological study conducted among MSM. However, despite having no accurate estimate of the size of this population, it is possible that up to 1 per cent of the adult population could be considered as engaging in same sex practises and as of 2012, this would have made the population to be approximately 1.4 million adults (Scheibe et al., 2015). Cross-sectional studies conducted in different locations in South Africa have indicated that MSM have an HIV prevalence ranging from 10 per cent to 50 per cent depending on the context (Scheibe et al., 2015). This marginalised population needs protection from HIV infection regardless of their sexual orientation.

Findings have shown young MSM at South African higher institutions are well informed about HIV/AIDS since many of them have tested for HIV or intended to do so yet they still frequently engage in intimate relationships that put them at increased risk of acquiring HIV (HEAIDS, 2014). It is important to study the sexual behaviours of this population because many MSM have sex with only men but others are also intimate with women. The fact that the risk of HIV transmission is highest among MSM and yet these relationships are often kept secret makes it even more important to ensure that this population have their health needs met. In order to achieve success in the fight against HIV/AIDS, there is a need to address the totality of the risk factors and behaviours that contribute to the HIV epidemic.

Behavioural studies are therefore a necessity in that they highlight young MSM's knowledge about HIV, their behaviours and attitudes. These are useful in shedding more light on the areas that HIV programmes need to focus their efforts. Reducing the vulnerability of high-risk groups will certainly have a huge impact on the number of new HIV infections and this

will help in the achievement of reaching zero infections. Wang (2015) found that high-risk behaviour is prevalent among MSM populations and therefore additional behavioural research such as this one are needed. Studies have shown that university students continue to engage in risky sexual activities despite full knowledge of how to prevent infection (Reddy and Frantz, 2011). This means that studies such as this one are important because many HIV related studies focus on levels of knowledge about HIV and related issues however, knowledge does not translate to protective behaviour.

There are numerous benefits to understanding the perspectives and experiences of MSM. In a paper titled *The HIV epidemic among men who have sex with men, behaviour beats science-* Mor and Dan (2012:1) emphasise the fact that “public health measures to reduce the prevalence of HIV among MSM (and subsequently general population) should focus on the behavioural and psychological factors that increase the risk of infection”. Studies of risky behaviours, therefore inform public health experts on the sexual practices of MSM student communities because evidence has shown that social changes can bring about changes in HIV transmission (Mor and Dan, 2012).

#### **1.4 Aims and objectives of the study**

The overall aim of the study was to shed insights into the HIV risk behaviours of men having sex with men. The specific objectives for this study were:

- To explore perception of HIV risk of men having sex with men
- To explore HIV risk behaviour of men having sex with men
- To explore the factors influencing their HIV risky behaviours
- To explore opportunities and constraints for changing the risk behaviours of men having sex with men

This study sought to address the following research questions:

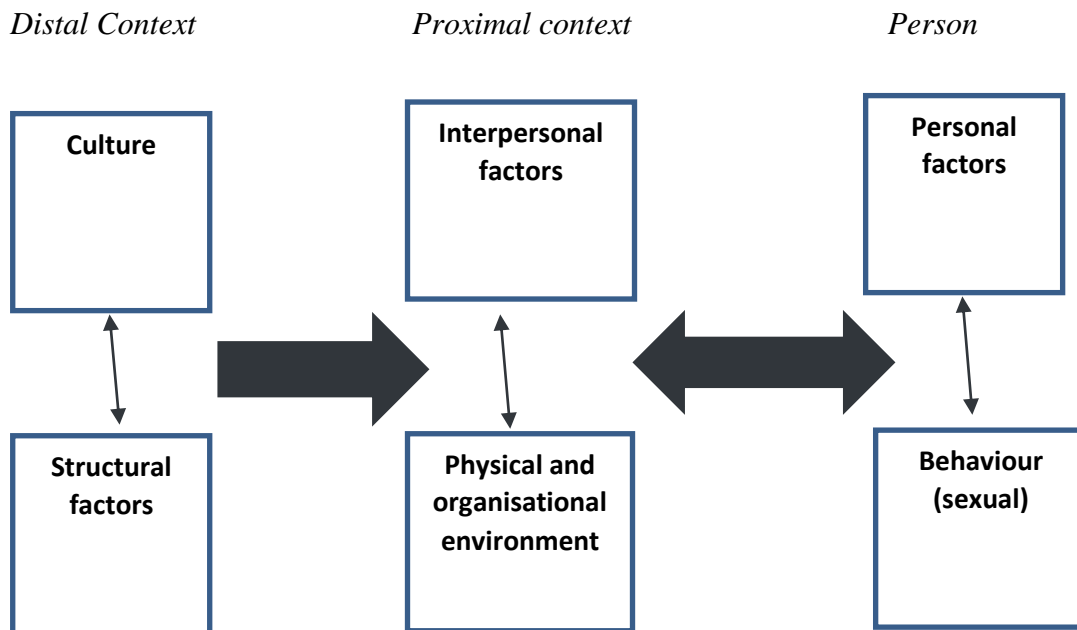
- Do MSM students perceive themselves to be at risk of HIV?
- Do MSM engage in HIV risky behaviours?
- What types of behaviours increase their risk of HIV infection?
- What are the factors promoting HIV risk behaviours?

This study used qualitative data from in-depth interviews with MSM students at the University of KwaZulu-Natal (UKZN) in Durban. The sample population consisted of 15 male students identified through snowball sampling. These students self-report to be sexually active and involved with other men. The findings of the study draw from individual interviews and seek to understand risky sexual behaviours and risk perception among MSM university students.

### **1.5 Theoretical Framework**

The theoretical framework for this study comes from the model of sexual behaviour developed by Eaton et al. (2003). After observing that previous major theories of behaviour were useful only within the contexts in which they were designed (particularly Western societies) and not necessarily in all other circumstances and problems, Eaton et al. (2003) developed a model that includes both subjective and objective influences on behaviour particularly in Southern Africa by also focusing on factors beyond the individual. This model illustrates a unilateral process where individuals and their primary environment are influenced by broader social conditions. This theory recognises that in order to understand sexual risk behaviour in Southern Africa there is a need to understand HIV risk behaviour at three levels. These levels are: 1) within the person, 2) within the proximal context i.e. interpersonal relationships and physical/organisational environment, 3) within the distal context, i.e. culture and structural factors (Eaton et al., 2003).

**Figure 1.1: Model of Sexual Behaviour**



Source: Eaton et al., (2003: 150)

**Personal factors**- These include an individual's thoughts, cognition and attitudes regarding sexual behaviour and HIV/AIDS. These factors include for example, one having the understanding that HIV is a deadly disease but lacks understanding of the disease itself and also on how to prevent transmission. Some personal factors are influenced by the misconceptions held by the larger group such as feeling invincible, low perception of risk, denial of the presence of HIV in the community, - for example, some individuals believe that when a partner has a low viral load then it is not necessarily a risk to engage in unprotected sex. Individual factors are determinants that are unique to each individual, such as demographic characteristics, mental health factors, and personal beliefs about sexual pleasure.

**Proximal context**- This considers the interpersonal relationships with the physical and organisational environment. Fields et al. (2012) states that social-environmental factors, precede and potentially influence both partner selection and the decision to have unprotected sex with that partner. Patterns of interpersonal behaviour are influenced by various other factors such as peer pressure or social anxiety-whereby sexual partners become preoccupied with being negatively evaluated by others, avoid embarrassing conversation, fail to negotiate sexual relationships and this is more common among MSM than exclusively heterosexual men (Hart et al., 2008).

*Distal context*- Cultural and structural influences such as traditions, society norms, beliefs and values, variations across sub-population groups, legal, political, economic elements of society all play a role in influencing the sexual behaviour of the members of that particular society.

## **1.6 Organisation of Dissertation**

The study is organised into five chapters. This first chapter introduces the study by giving background information on the topic and its importance. It also highlights the objectives of the study including the rationale and significance of the study. Chapter two reviews relevant studies focused on factors that influence and inhibit risky behaviours among MSM. Chapter three outlines the research methodology including the research design, sampling procedures, and data collection methods as well as data reduction strategies. Chapter four outlines the main findings of the in-depth interviews. Lastly, the final chapter includes the discussion, conclusion and recommendations based on the findings of this study

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

Research has established that risky sexual behaviour maintains the persistence of high HIV prevalence among MSM in both developed and developing countries (Beyrer et al., 2012). Risky sexual behaviours in this population group have emerged as the central focus of research for behavioural strategies implementation in terms of HIV prevention. The objectives of this study are to explore the HIV risk behaviours and HIV risk perceptions of men having sex with men as well as to explore the factors that influence and inhibit HIV risk among them. This chapter will review literature on risky behaviours among MSM as well as the factors facilitating and inhibiting the HIV risk of HIV among MSM.

##### 2.1.1. MSM in research

Despite bearing a high burden of HIV, MSM in sub-Saharan Africa have been neglected even in HIV research circles (Smith et al., 2009; Abara and Garba, 2017). Smith et al. (2009) state that research has indicated the existence of MSM groups in Africa, high rates of HIV risky behaviour and infection among African MSM as well as links between MSM and heterosexual networks in sub-Saharan Africa. In the 1980s during the beginning of the epidemic, reported case-fatality ratios (the number of fatalities from a specific illness divided by the number of reported cases for the illness) for *Pneumocystis carinii pneumonia* (PCP) cases were high among gay men (Jones and Salazar, 2016).

During the early stages of the epidemic, gay men constituted a large proportion of patients succumbing to HIV/AIDS compared to their heterosexual counterparts (Jones and Salazar, 2016: 23). However, as more people that are heterosexual began to show signs and were being diagnosed with the disease, the focus shifted from MSM to their heterosexual counterparts. Currently, a notable decline in new infections has been observed especially in high burden countries where declining trends of AIDS morbidity and mortality have “led to a new optimism that control of the HIV pandemic may be an achievable goal” (Havlir and Beyrer, 2012: 1). Surprisingly, research shows that the epidemics of MSM continue to expand in most countries including developed countries that are not counted as part of the

high-burden countries. According to Beyrer et al. (2012), the global understanding of MSM epidemiology is far from complete because as of 2011 only 93 out of 196 countries had managed to report on HIV prevalence in MSM populations.

In many developing regions of the world, data is only emerging. These data gaps are a result of the hidden and stigmatised nature of homosexuality in much of the world. Many countries in sub-Saharan Africa have failed to address the needs of MSM in their national HIV/AIDS programmes which further drives the epidemic in these regions. The reasons for this include; denial and criminalisation of homosexual activity, focusing on heterosexual transmission, failure to acknowledge MSM as a high-risk group, institutional neglect of MSM through the implementation of discriminatory laws and policies. Amongst all the high burden countries of East and Southern Africa, South Africa is more accepting of homosexuality as evidenced by the liberal laws and policies of the country. However, the fact remains that even in South Africa, MSM are disproportionately affected by HIV and underserved by the country's national response thus they contribute significantly to sustaining the high number of new infections recorded each year (Imrie et al., 2013).

This chapter reviews studies focused on factors that contribute to risky practises among MSM. This literature review intends to contextualise risky HIV behaviour among MSM within the broader context of risky behaviours and HIV infection in tertiary institutions and in sub-Saharan Africa. The review attempts as much as possible to include South African data. However, there are gaps in current knowledge particularly around behavioural studies targeting and limited to MSM populations especially in sub-Saharan Africa as many of the studies focused on heterosexual adolescents and young adults (Molefe, 2013; Maluleke, 2010; Mhalu, 2010). There are very few qualitative studies and therefore most of the data included came from cross sectional surveys, modelling studies and systematic reviews.

Of importance is also the fact that research has only focused on MSM in metropolitan areas whilst neglecting other MSM in important contexts such as rural areas (Frye et al., 2006; Imrie et al., 2013; Maleke, 2017). This literature review will highlight how these socio-economic and structural factors influence risky behaviours among MSM.

### **2.1.2 Risky behaviours among MSM**

Unprotected anal intercourse (UAI) increases the risk of HIV transmission through the anal canal by 18 times more than through the vagina because unlike the vagina, the anus has a thin mucosal surface and is not self-lubricating (Baggaley et al., 2010; Beyrer, 2012). Increased condom use leads to a reduction in new HIV infections however; the problem sometimes does not lie in the use or non-use of condoms but in the level of consistency (Rebe et al., 2011). Due to the concealed nature of MSM relationships, it is difficult to track condom use patterns (Deb et al., 2009). A study conducted at two Chinese universities showed that many MSM students are at high risk due to inconsistent use of condoms as only 32 per cent reported using condoms all the time (Cong et al., 2008). The percentage of UAI as observed in the National UAI study (cited in Scheibe et al., 2015) has decreased from over 40 per cent to just above 20 per cent between 2008 and 2013. Data from the HEAIDS (2014) study indicated that 63.4 per cent of MSM students who participated in the study reported using condoms in their last encounter. About 36.6 per cent who reported not using condoms implies that these individuals use condoms either inconsistently or not at all. Among those who used condoms, 50.6 per cent did not use lubricants, which increases the chances of the condom breaking (HEAIDS, 2014). In a study investigating condom use among MSM in Uganda, several reasons for the non-use of condoms by MSM were identified. Among others, the accessibility of condoms was not the only reason why some men did not use condoms because some of the reasons included lack of knowledge and misinformation regarding condom use, discomfort and pain when using condoms, concerns about condom quality and lubrication (Musinguzi et al., 2015). This means that beyond condom availability, there are many other factors that can still hinder a person from using condoms therefore the availability of condoms alone will not deter people from unprotected anal intercourse. A South African MSM triangulation study by Scheibe et al. (2015) however showed that risk factors such as unprotected anal intercourse that are directly associated with HIV infection appear to be decreasing while risk factors indirectly associated with HIV infection appear to be increasing.

It is suggested that when MSM engage in intergenerational sex or sex work, it is associated with a desire for upward social mobility especially in areas where resource inequalities are rampant and this predisposes them to HIV in different ways, including sexual violence (Fox, 2010, cited in Semba, 2015). The HSRC (2014) report on MSM stated that South African college and university students engage in commercial sex. Studies in Asia have associated sex for money with a higher risk for HIV infection among MSM (Guadamuz et al., 2011;



Pisani et al., 2004). For example, Dandona (2006) found that men who engage in transactional sex had a much higher risk of acquiring and transmitting HIV in comparison to women who participated in similar activities. In a study with 200 MSM in Chennai India, the results showed that many of the MSM who engaged in transactional sex were also at a much higher risk of experiencing harassment and forced sex with partners of unknown HIV status (Newman et al., 2008). While the prevalence of paid sex among MSM was 59.9 per cent, more than a third of the participants reported inconsistent condom use which increased their risk of exposure to the virus (Newman et al., 2008).

Forced sex together with transactional sex are correlates of HIV infections, its prevalence and their risks among MSM have not been fully explored. Participants enrolled in a Thailand study on forced sex among MSM showed that of the 2049 participants, at least 18.4 per cent had been forced to have sex either with someone they know more than once (Guadamuz et al., 2011). The chances of forced encounters occurring are increased when transactions are involved. In the South African sample of MSM students who participated in the HEAIDS (2014) study, 11.8 per cent reported having been forced to have sex against their will while 14.3 per cent admitted to having sex with someone who did not want to have intercourse with them. Regarding transactional sex, only 5.6 per cent of student MSM in this study reported having accepted material benefits in exchange for sex and 36.4 per cent accepted having met a sexual partner via the internet, the corresponding figure for non-MSM students was 8.5 per cent. The South African MSM triangulation project showed high levels of transactional sex among MSM ranging from 13 per cent in Mpumalanga to 53 per cent in Cape Town and is more prevalent among MSM who come from lower socio-economic backgrounds (Scheibe et al., 2015). At the same time, the level of reported sexual violence among MSM is also on the rise.

Intergenerational sex is often linked with transactional sexual intercourse. In the same way, sexual unions between young men and older men are a driver of HIV in the MSM context. Intergenerational sex increases the risk of HIV transmission because often it renders the financially dependent partner more vulnerable as they cannot negotiate safer sex as they have reduced power in their relationship (Semba, 2015). It is not only the younger MSM who are at risk but the older and more financially stable MSM also increase their risk of HIV acquisition by having access to many partners through their wealth (Morris and Kretzerman, 1997; Epstein, 2007, cited in Natrass, 2009). Once infected these men also become vectors spreading the diseases to their multiple and younger partners.

## **2.2 Factors influencing HIV risk**

### **2.2.1 Perception of HIV risk**

Risk perception is embedded in beliefs and attitudes. It is perception that determines how one ultimately behaves when confronted with a situation. According to Eluwa et al. (2015), perception of health risk is a key dimension of most health behaviour models that are used to construct health promotion campaigns particularly those targeting HIV related risk behaviours. Very few studies have focused on reasons why MSM may perceive whether they were or were not at risk of HIV infection (Ma et al., 2013). In one study, some students exhibit an “optimism bias” behaviour despite being classified as high risk of contracting HIV (Reddy and Frantz, 2011). This feeling of being invincible to the virus is the main reason for risky behaviours such as low condom use and multiple partners by some of these young people, thus some MSM do not see HIV/AIDS as a relevant topic of conversation to raise with their sexual partners (Ma et al., 2013).

Men who have sex with men and women sometimes do not perceive themselves to be part of the larger gay community and therefore they may not heed prevention strategies aimed at the community (Washington et al., 2009). MSM who have ever tested for HIV have a higher risk perception than those who have never tested thus risk perception influenced by HIV testing (Eluwa et al., 2015). Factors associated with risk perception are varied and especially hard to determine since many MSM sexual partnerships are hidden because in the African or any traditional context the goal of pro-creation supersedes that of sexual pleasure (Dandona, 2006). Therefore, a great number of MSM may not perceive themselves to be at high risk as this culture of secrecy makes it difficult even for individuals to determine where the distinction between heterosexuality and same-sex behaviour lies (HEAIDS, 2014).

### **2.2.2 Peer pressure**

Peer pressure is the influence of one’s peer group on the individual’s behaviour. Although the term peer pressure is commonly used in reference to teenagers, Carlos et al. (2010:431) note that the term in fact applies to individuals of all ages because peers have a strong influence on the health and social behaviours of individuals of all ages. Among young people in general, peer pressure is regarded as the prime driver of sexual behaviour (Cherie and Berhane, 2012). Peer pressure often leads to individuals avoiding social penalties by conforming to prevailing

norms (Bursztyn and Jensen, 2015). This is expected because young people become involved with groups that share similar values and identities and as a part of these groups they begin enacting the norms of these groups and turning them into behaviours (Crosnoe and McNeely, 2008, cited in Bauermeister, 2009). The role of peers becomes influential and assumes a greater importance in young people as they transition into adolescence (Fearon et al., 2015) and/or become independent of caregivers (Hartrup, 1993 cited in Bauermeister, 2009). Peers influence sexual behaviour in a number of ways which include; normative mechanisms (i.e. perceived peer approval among peers, social connections to other individuals). For example an individual might be introduced to an older sexual partner by friends and peers can also influence decisions about sexual behaviour (Fearon et al., 2015).

The influence of peers on the sexual activities of young people in sub-Saharan Africa has not been explored (Bingenheimer et al., 2015). Research from other parts of the world suggests that the sexual norms of peers influence youth's individual attitudes and behaviours because perceptions of peers are associated with higher frequencies in risky sexual behaviours (Cherie and Berhane, 2012; Potard et al., 2008). In a systematic review of sub-Saharan Africa studies that link peer pressure to risky sexual behaviours, Fearon et al. (2015) conclude that there is no evidence that peer pressure plays a role in adolescent sexual behaviour in sub-Saharan Africa.

Gender differences in sexual socialisation have also been identified as playing a role in influencing peer sexual behaviour as evidenced by the differences in associated risk between young boys and girls (Potard et al., 2008). Among MSM, the results of a socio-demographic/behavioural study, that explored variables associated with low peer support of condom use, showed that peer pressure played a role in increasing the risk of contracting HIV among the highly impacted black and Latino MSM populations in the United States (Carlos et al., 2010). Carlos et al. (2010:430) state that, "perceived low peer support of condom use is associated with increased odds of recent unprotected anal intercourse among Black and Latino MSM". However, many of the studies on the influence of peer pressure have been focused on adolescents (Potard et al., 2008; Bauermeister, 2009; Fearon et al., 2015) without particular focus on MSM or adult populations. This is mainly because peer pressure is only commonly associated with teenagers.

The influence of peers is not always negative because from a social influence perspective, peers within an individual's social network may reinforce positive attitudes and protective

sexual behaviours (Bauermeister, 2009). In a study whereby intervention programs measured the effect of peer norms on adolescent sexual behaviour, it was found that peer norms promoted protective behaviours such as abstinence and safer sex, delayed sexual initiation and consistent condom use. The majority of these interventions reported that safer sex peer norms increased from baseline to follow-up (Pedlow and Carey, 2004, cited in Bauermeister, 2009). A better understanding of peer issues could lead to effective interventions in promoting sexual and reproductive health as evidence has shown that peer based intervention programs promote safer sex practices (Bingenheimer, 2015).

### **2.2.3 Attitudes to condoms**

Condom use patterns are affected by differential attitudes, beliefs and self-efficacy about condom use (Sohn and Cho, 2012). The term attitude refers to an individual's settled way of (thinking i.e. their feelings and standpoint about something). Several studies have analysed people's attitudes towards condoms (Kaighobadi et al., 2013; Starosta et al., 2014). It is difficult to define and understand attitudes towards condoms because they are multidimensional in nature. According to Masoda and Govender (2013), attitudes to condoms include acceptability of condoms as contraceptives in heterosexual unions, individual readiness to use a condom, religious views on condoms.

Negative attitudes range from minor anxiety to excessive worries about sexual activities and these negative factors are often associated with partners' dissatisfaction about condom use requests (Artistico et al., 2014), religion or culture and even personal views (Masoda and Govender, 2013). Meanwhile positive attitudes such as higher levels of self-efficacy have been associated with individual ability to mitigate the effect of the potential partner's dissatisfaction with condom use thus positive attitudes such as self-efficacy are associated with better sexual health outcomes (Artistico et al., 2014). Perception factors also play a role in the decision a person makes regarding whether to use a condom or not. These perception factors include: positive attitudes towards using condoms, perceived condom acceptability by sexual partners, perceived ability to negotiate condom use in a relationship, self-efficacy in asserting condom use and perceived efficacy of condom use for HIV prevention (Yi et al., 2015). Some research has shown that MSM often make decisions on condom use based on the characteristics of their partners that they perceive to be associated with HIV risk (Newcomb et al., 2014). For example, in some American studies, MSM used condoms with

black partners due to a realisation that HIV prevalence is much higher among African American MSM (Eaton et al., 2010). Yi et al. (2015), goes on to state that although the findings on the relationship between self-perception of HIV risk and condom use among MSM are mixed, some studies have suggested that self-perception of higher risk of contracting HIV is associated with more positive attitudes towards condoms which leads to consistent condom use.

Concerning condom attitudes among MSM, a study by Wildman et al. (2012) showed that in comparison to heterosexual men, attitudes to condoms were unrelated to risky sexual behaviour although they were predictor for safer sexual behaviour among heterosexual men. This study went on to show that attitudes to condoms were not an independent predictor for condom use among MSM after self-efficacy and other sexual attitudes were controlled. This finding was associated with the type of sex that MSM engage in (i.e. insertive versus receptive anal sex) since condoms reduce the sexual pleasure of intercourse for exclusively or primarily the insertive sexual partner whereas MSM who are primarily or exclusively the receptive sexual partner are less influenced by their attitudes towards condoms (Wildman, 2012). In contrast, in another study that aimed to assess the relationship between age and sexual risk among MSM in South Africa, it was found that the older ages had less positive attitudes towards using condoms and were therefore more frequently engaging in unprotected insertive anal intercourse (Kaighobadi, 2014). This shows that attitudes to condom use are affected by a several factors and therefore to understand them in relation to risky sexual behaviour among MSM, studies need to be conducted in a range of contexts, i.e. different sub-groups of MSM populations (Kaighobadi, 2014).

#### **2.2.4 Notions of masculinity**

Societies are shaped by cultural beliefs as it is cultural and/or religious beliefs that place gendered expectations of how men and women are supposed to behave based on their biological differences. This may at times have a direct negative impact on the rate of HIV infection and ultimately the prevalence within a society. Masculinity refers to the set of behavioural roles that men are encouraged to adapt from a young age. A cross-cultural study by Gilmore 1990, cited in Brown et al., 2005: 586, showed that masculinity is an “achieved status which almost universally includes toughness, aggressiveness, stoicism and sexuality although now scholars define it not as a natural attribute but rather as a collective gender

identity that is fluid and socially constructed”. According to Beynon (2002), the term commonly referred to as masculinity is in fact composed of many masculinities (i.e. experienced, enacted and represented masculinities. The idea of hegemonic masculinity refers to a hierarchy of masculinities) that vary across time, culture and the individual. It “grew directly out of homosexual men’s experience with violence and prejudice from straight men” (Connell, 2005: 851).

In most societies, MSM are not considered real men because cultural perceptions equate male homosexuality with femininity; a construct that contradicts hyper-masculine gender role expectations (Fields et al., 2012). These socio-cultural conceptions of masculinity, sexual identity, and male gender role expectations influence the type of sexual partners that bisexual MSM select, their sexual roles (as insertive or receptive partner in anal intercourse) in sexual encounters as well as their perceptions of partners’ HIV risk. For example, being the receptive partner (referred to colloquially as the “*bottom*”) is seen as feminine and bisexual MSM have been found to have a preference for partners perceived as masculine (Fields et al, 2012).

#### **2.2.4.1 Impact on HIV prevalence and health status**

Normative cultural values play a huge role in influencing behaviour and communication. The misconceptions about HIV stemmed from culturally acceptable myths about HIV transmission such as HIV being transmitted by causal contact or HIV being cured by sleeping with a virgin (Leclerc-Madlala, 2002). There still remains a number of societies that continue to hold on and perpetuate harmful traditional views of masculinity and the influence of these notions on the population’s health status are observable even on national levels across societies of different races and socioeconomic statuses. For example, according to Gonzalez et al. (2009), within the MSM communities of the USA, socio-cultural and ethnic minorities in the United States of America are disproportionately affected by HIV/AIDS and these are African American and Latino MSM. Another study done in South Africa by Rebe et al. (2011) produced similar results. This study showed that in comparison to white MSM, African MSM are a vulnerable group that suffers from a much higher HIV prevalence. The ratio odds for an African MSM in South Africa testing HIV positive are 3.8 times higher than the odds for a heterosexual man. This study confirmed that HIV prevalence is high among African MSM ranging from 10.4 per cent to 33.9 per cent. (Rebe et al., 2011). Research

suggests that, the prevalence of HIV among MSM in developed countries has remained high due to a lack of tolerance for homosexuality because of the restrictive religious and cultural beliefs of the society (Vu et al., 2013).

Living in heteronormative, stigmatising societies creates a conducive environment for sexual behaviours that facilitate the transmission of HIV among MSM (Rebe et al., 2011). The reasons for this are mostly associated with living in communities that do not tolerate homosexuality. The consequence of culture being intolerant of male-to-male sexual behaviour with respect to HIV is that men who are legitimately in heterosexual relationships will have extra-marital sexual relations with other men. Therefore, due to the secretive nature of such relationships, these men will act as a bridge transmitting the virus from a high concentration population group to the general population (Friedman et al., 2014). In a society where masculinity and femininity are distinct and pre-determined by traditional norms, the risk for HIV among MSM is increased due to cultural beliefs. The health needs of these men who have sex with other men are not being met as evidence has shown that even in high income societies HIV prevalence remains high among MSM (Beyrer et al., 2012). Thus, masculinity as defined by a society's cultural and/or religious practises put men who have sex with men at increased risk of HIV by forcing them to engage in risky sexual behaviours such as having multiple sexual partners as some relationships have to be hidden. When by societal standards a man is expected to marry a woman, he will publicly have female partners while still engaging with men in private. When for cultural reasons men are not open about their sexuality, it becomes difficult even for health intervention programmes to reach out to men who have sex with men (Wirtz et al., 2014; Trapence, 2012).

Socio-cultural factors that influence notions of masculinity include knowledge, beliefs and health-care provider communication. Aspects of culture and acculturation, which include language barriers, norms for sexual behaviour, stigma and social oppression accompany these elements (Gonzalez et al., 2009). Notions of masculinity not only influence risky sexual behaviour in terms of how one acts but these socio-cultural factors also influence the degree to which individuals' access and utilize health care services, which according to Gonzalez et al. (2009) explains the racial and ethnic differences in health care. Studies have shown that there are cultural influences in the health seeking behaviour of individuals (Abubakar, 2013). According to Lynch et al. (2010), notions of masculinity have negative implications for the sexual health of men whilst a greater level of understanding of their realities (including social and sexual networks) can benefit the development of programmes aimed at reducing the

spread and impact of HIV (de Voux et al., 2016). In general, men have been shown to have weaker health outcomes in comparison to women as they either delay or fail to seek health care as often as required particularly in response to physical and mental health concerns (Galdas et al., 2005). A study by Galdas et al. (2005: 1) notes that delays in men seeking medical attention is “traditional masculine behaviour”.

According to Xu et al. (2017), there is very limited research that has sought to explore health-seeking behaviours in the context of MSM. In the case of MSM, the impact of negative health seeking behaviours is concerning because it places them at double risk for HIV. In addition to negative health seeking behaviours there is a general lack of sexual disclosure to health care practitioners, i.e. it is unknown who the MSM are and who they engage with (Wirtz et al., 2014). In a UNESCO (2012) study conducted across five provinces in Thailand, it was found that the health seeking behaviours of MSM and transgender women (male to female) was affected by the quality of services provided to men who sleep with men. This is mainly due to the pre-determined notions of homosexuality as an inadequate or unacceptable expression of masculinity. This hinders MSM from taking advantage of the health services where they are available and while others discontinue using the services, others do not disclose their full sexual history (UNESCO, 2012). This is identified by Lynch et al. (2010) as one of the main reasons why heterosexual intercourse is considered the main driver of HIV in Southern Africa. To explain this point further it means that the impact of male-to-male intercourses is unknown in areas where heterosexual intercourse is considered the norm. It is possible that male-to-male intercourse is also a driver of the epidemic but the impact is unknown because MSM relationships are often hidden as men have a gendered role to play in society (i.e. to be head of families and provide for their wives and children).

#### **2.2.4.2 Negative influence on attitudes to homosexuality**

Cultural notions of masculinity not only affect the attitudes of other people towards MSM but they also result in stigma and discrimination against oneself. Due to a lack of social and cultural acceptance of their sexuality, many MSM live in fear of being ridiculed this fear usually manifests as guilt, depression, lack of confidence as well as secrecy about their sexual lives and ultimately it all leads to MSM experiencing internal stigma (Vu et al., 2012). In a study exploring sexual risk behaviour among MSM, the results showed that while over half of the 414 participants in this study reported high-risk sexual behaviour, stigma related to the



respondents' low self-esteem and internalised homophobia increased their participation in risky behaviour (Preston et al., 2007). Baral et al. (2013) states that social and structural level risks not only facilitate HIV transmission but they can also reduce transmission on a population level which is why it is important for behavioural interventions to play a role in challenging harmful traditional practises.

Notions of masculinity also play a role on an individual level, when MSM do not feel men enough because they also believe that masculinity should be expressed in a certain way. When homosexuality is associated with femininity, it becomes something to be ashamed of for some MSM thus it results in internalised homophobia. Internalised homophobia is the “self-hatred and shame of homosexually oriented individuals that has been incorporated into their belief system” (Xu et al., 2017: 1). This construct includes negative attitudes toward homosexuality, discomfort with disclosure of homosexual orientation, connectedness with other LGBTIQ individuals as well as a discomfort with same sex sexual activity (Xu et al., 2017; Chen, 2005; Dandona, 2005). Therefore in many cases internalised homophobia has led many MSM to opt for marriage with the opposite sex (Xu et al., 2017; Chen, 2005; Dandona, 2005) because they still believe that their role as men is to become providers for women and children. Although social attitudes towards homosexuality have improved particularly in countries where same-sex marriages are accepted some individuals struggle with accepting their own homosexuality (Preston et al., 2005).

MSM who experience discrimination even if it is self-discrimination based on perceived orientation and gender identity are more likely to engage in unprotected anal intercourse with casual sex partners whilst binge alcohol drinking (Mizuno et al., 2012). In a study examining structural and environmental predictors of internalised homo-negativity among MSM, Berg et al. (2013) found that the presence of laws recognising same-sex relationships was associated with lower levels of internalised homophobia. Therefore, with that realisation it is important to understand the extent to which internalised homophobia influences risky sexual behaviour. This will promote social equity for self-acceptance around MSM identity as a prevention strategy (Berg et al., 2013).

### **2.2.5 Place of residence**

Geographical disparities also exist in the level of impact that cultural notions of gender identity have on the sexual behaviours of different people. Rural MSM are more bound to

abide by the traditional standards of gender norms and sexuality as defined by the society and the culture to which they ascribe. MSM in rural areas face constant threats of violence, ridicule and physical assault against them which further motivates them to engage in risky behaviours (Preston et al., 2004). As a result, secrecy becomes a risk factor as it predisposes them to limitations in carefully choosing sexual partners. Among rural MSM sampled in a South African study, almost none of them identified as gay or exclusively MSM as they concurrently engaged in sexual activities with females (Imrie et al., 2013). Research suggests that while sexual behaviour is more risky in rural areas as a result of harmful traditional beliefs (e.g. distinct gender roles), HIV interventions have focused on urban areas especially because the HIV epidemic had its roots in urban areas (Voeten et al., 2004; Imrie et al., 2013). The interaction between rural and urban epidemics remains important due to the high rates of urbanisation. In fact after HIV had spread in the urban areas of South and East Africa it spread through mobile core groups such as truck drivers and migrant workers into rural areas (Voeten et al., 2004). Among MSM, the majority of diagnoses are made in urban areas and that is because the true extent of the epidemic among rural MSM is unknown although research suggests that the prevalence of HIV/AIDS is increasing three or more times faster in rural than urban areas (Williams et al., 2005). Thus, the persistence of harmful cultural notions of masculinity in rural areas put rural MSM at increased risk of HIV than their counterparts in urban areas.

### **2.2.6 Alcohol use**

The use of alcohol before a sexual encounter among MSM is often an understudied HIV risk factor despite its importance (Deiss et al., 2013; Li et al., 2010). Clearly, alcohol affects a person's brain function by lowering inhibitions, increasing sexual aggression, impairing judgement and increasing the likelihood of memory lapses (Yoruk and Yoruk, 2013). Zablotska 2006 (cited in Gerbi et al., 2009) found that alcohol use increases the risk of transmission because individuals are more likely to have unprotected sex with multiple partners. According to Yoruk and Yoruk (2013), it is evident in literature that once young adults gain legal access to alcohol, their level of consumption significantly increases. Vagenas et al. (2013) and Gerbi et al. (2009) state that sexual disinhibition has been discovered to be one of the behavioural consequences of alcohol consumption. A study by (Galvez-Buccollini et al., 2009 cited in Vagenas et al., 2013), showed that heavy drinkers

were threefold more likely than occasional drinkers (including MSM) to engage in high risk sexual activities such as unprotected sex with sex workers, casual partners.

An internet based study involving 10 861 MSM in Asia (China, Singapore, Malaysia, Taiwan, Hong Kong and Thailand) showed that over one third of them reported that they use alcohol before or during sex. This risky act was positively associated with other risky behaviours such as having multiple partners (>11 in six months), partner-seeking venues (gay bars, gyms, parties etc.), commercial sex (Yang et al., 2016). The place of meeting partners was more closely linked to alcohol use before a sexual act. As the results showed, people who met their partners online were less likely to be intoxicated before sex than people who met their partners in social scenes such as parties and nightclubs and those who frequently visited alcohol use venues were more likely to engage in risky sexual activities than those who visited other social scenes. Therefore, in this study alcohol-use venues were identified as critical sites for high risk MSM (Yang et al., 2016). Other factors identified include the fact that the use of other drugs as poly-drug users were more likely to have sex under the influence of alcohol than MSM who only take alcohol (Yang et al., 2016). Participants who reported having sex for money also reported doing so under the influence of alcohol (Yang et al., 2016). While Peacock et al. (2015) agrees with Yang et al. (2016), about how the social scenes and place of meeting (clubs etc.) and purpose of meeting (commercial sex) promote alcohol use before a sexual act, they further state that some individuals among MSM use alcohol as a coping mechanism to deal with stigma and stress related issues.

For some, the stress of being at risk for HIV may also lead to increased sexual risk behaviour and alcohol abuse in order to escape their reality and participants who have not disclosed their sexual orientation to anyone are more likely to use alcohol before intercourse reality (Peacock et al., 2015). This becomes important in commercial sexual encounters and especially with older partners. In a study by Dirks et al., (2012), it was the amount of alcohol taken that was a risk factor. Dirks et al., (2012) also found that when HIV positive MSM engage in risky behaviour under the influence of alcohol they reported both insertive and receptive intercourse. There is a lack of understanding of the socio-cultural factors that link risky sexual behaviours to alcohol consumption (Yang et al., 2016). It therefore remains important for HIV behavioural studies to assess the extent to which alcohol consumption among young people is associated with increased participation in risky sexual behaviours that result in negative outcomes.

### **2.2.7 Relationship factors**

Relationship types and sexual partner choices have very important implications for sexual health outcomes. MSM are more likely to engage in sexual relationships with concurrent or multiple partners. The Marang Men's Project reported that MSM in South Africa's big cities had three or more sexual partners over a period of six months (HSRC, 2014). A study conducted in Vietnam observed that among the sampled individuals, 69.5 per cent of MSM reported having had sexual contact with multiple partners (Garcia, 2014). Approximately 41 per cent of MSM students in South African tertiary institutions have reported having one or more concurrent partners (HEAIDS, 2014). In this same study, the results showed that despite 45.4 per cent of MSM student report not having any female partners, the remaining 54.6 per cent report having one or more female partners (HEAIDS, 2014).

According to Newcomb et al. (2014), it is important to examine sexual risk behaviour in the context of sexual partnerships, which includes relationships type, characteristics of the sexual partnership as well as relationship dynamics. This is because despite sexual risk behaviour showing inconsistent trends among young MSM, the desire to be in a lasting partnership is considered protective against risk. Since the introduction of highly active antiretroviral therapy (HAART) in the mid-90s, risky sexual behaviours have increased among casual but not for steady partners (Dirks et al., 2012). In the USA it has been reported that HIV sero-discordant MSM couples do not use protection therefore low viral load is a motivation for HIV negative people not to use protection with their partners (Eaton et al., 2009; Mitchell, 2013; Starks et al., 2014). Great age gaps between partners often strip one partner of their power in the sexual negotiation process. This often results in the younger MSM having higher per sex contact with HIV risk. Therefore forced sex/ sexual manipulation and power imbalance often co-exist in relationships that have big age gaps between partners and also in relationships where sexual contact is in exchange for material benefit (European Centre for Disease Prevention and Control, 2013).

Among students who participated in the HEAIDS (2014) study, non-MSM students were more likely than MSM students to be in a relationship and engaging in intercourse with a primary partner. This means that due to a number of factors such as homophobia, stigma and discriminations a number of MSM do not have long-term partnerships which increases their chances of having more partners on average in comparison to heterosexual men (Glick, 2012). While not having a steady partner predisposes some individuals to multiple sexual partnerships, some individuals opt for monogamy as a way of protecting themselves from

STIs and HIV. However, research done by Corbin and Fromme (2002) shows that when serial monogamy is common among young adolescents, it increases their likelihood of having a high partner turnover and ultimately on average the individual will have more lifetime partners. Risky behaviours are not only limited to casual unions because emotional aspects of a relationship have been linked to higher rates of unprotected sex, higher incidence of HIV particularly among primary MSM partners (Davidovich et al., 2004). This becomes dangerous when an individual has more than one sexual partner. Mustanki et al., (2011) found that young MSM in serious partnerships were less likely to use condoms.

MSM who also have female partners (serious or casual) do not use protection with their females partners because as they are well aware that the prevalence among MSM is much higher they assume that females do not have HIV or they cannot contract HIV from a female even if she is infected (Dodge, 2008, cited in Newcomb et al., 2014). MSM who report having both male and female partners often cite social pressure and fear of discrimination as the main reasons. Due to smaller and more exclusive sexual networks, there are high chances of MSM exchanging sexual partners (Centre for Disease Control and Prevention, 2016).

#### **2.2.7.1 Relationship power dynamics**

Power imbalances can exist in any kind of relationships and in the context of intimate relationships; they increase one's exposure to HIV for example by challenging the individual's ability to negotiate for safer sex. Intimate partner violence (IPV) is predominantly viewed as a woman's health issue and existing within the context of a heterosexual relationship especially in South Africa where the levels are alarming (Jewkes et al., 2010). Studies have shown that, members of the LGBTIQ society are also impacted by IPV (Brown and Herman, 2015; Oliffe et al., 2014). Donovan et al. (2006) (cited in Oliffe et al., 2014) observed that gay men who suffered from IPV were more likely than women to be sexually victimised but they are less likely to report or seek help.

In a systematic review of studies from 1989 to 2014 by Brown and Herman (2015), the results showed that the prevalence of IPV among gay men was at least 2.6 times higher than the prevalence among men in the general population and this only includes reported cases. In another systematic review, Jefferies and Ball (2008) note that HIV positive men experienced psychological aggression from their male partners and were victims of physical assault and sexual coercion. Another study of gay and bisexual men recruited through domestic violence

programs found that 73 per cent had been sexually abused. On the other hand, men who use physical abuse and sexual coercion against their intimate partners end up having a high partner turnover, less frequent condom use and high levels of sexually transmitted infection (STIs) exposure relative to non-abusive men (Casey et al., 2016).

### **2.2.8 Lack of social and family support**

The relationship between social or family support and HIV risky behaviours has been explored in literature ( Qiao, 2015; Frye et al., 2006; Stevens et al., 2013) and more recently even among MSM (LaSala et al., 2016). Social support is important not only for the psychological well-being of an individual but also for their physical well-being.

Parental monitoring and parent-child communication are associated with low risk sexual behaviour. In their study, LaSala et al. (2016) found that among MSM youth who communicated with their parents, the level of sexual risk behaviour was very low as there was less conflict between the parents and their sons. According to Stevens et al. (2013), among many others some of the factors that promote risky sexual behaviours among gay, bisexual and transgender African American youth include familial disconnection due to families rejecting them, the absence of a father figure and the mental toll of homophobia within the black community. This means that a lack of tolerance for homosexuality in the family and community circles increases the risky behaviours of MSM as it promotes secret relationships and the like. Resultantly, “MSM with and without high-risk sexual behaviours have different social and psychological characteristics” (Chen et al., 2012: 1) and these should be considered when implementing behavioural and therapeutic prevention interventions.

### **2.2.9 Poverty**

Evidence suggests that poverty influences sexual behaviour (Rodrigo and Rajakpakse, 2010). Poverty is a major determinant of sexual behaviour as it often results in the commodification of sex. Due to the nature of sexual interactions between those who have the money and those who do not the fact still remains that poverty plays an important role in predisposing both the financially stable and the economically vulnerable to HIV risky behaviours such as transactional sex and substance abuse (Mojola, 2007; Rodrigo and Rajakpakse, 2010).

According to Scheibe (2014), previous studies have highlighted that limited range of suitable HIV prevention products (more especially condoms and condom-compatible lubricants) are contributing to the high prevalence of unprotected sex and the use of incompatible lubricants among MSM in most parts of the world. In some African countries, the cost of condoms is a major barrier to their use. In South Africa, despite the level of poverty amongst the majority of the population, condoms are widely accessible particularly in government institutions such as clinics and institutions of higher learning. Condoms are accessible but free lubricant access is restricted to distribution points of civil society organisations that implement MSM programmes (Scheibe, 2014).

#### **2.2.10 Attitudes of health care workers**

Discrimination of MSM in the public health care sector by health care workers (HCWs) negatively affects the health seeking behaviours of MSM before and after HIV infection (Scheibe et al., 2017). It also hinders them from fully disclosing their risky sexual practises as it has been identified as one of the major barriers to accessing care for sexual health problems among MSM (Scheibe et al., 2017). In a study that aimed to evaluate the outcomes of an MSM sensitisation-training programme for HCWs, it was found that before the sensitisation training only 42 percent of HCWs were comfortable with asking their clients about having sexual intercourse with other men (Scheibe et al., 2017). A study conducted in Malawi by Wirtz et al., (2014) showed that some of the HCWs were actually unaware of the level of HIV risk among MSM. In Thailand, a UNESCO study (2012) revealed that some MSM participants discontinued using their sexual health services for various reasons but the most common one amongst all was unfriendly staff who were reluctant to help them because of their sexuality or gender identity. In a study by Baral et al., (2013), some participants who had tested HIV positive reported that they heard healthcare workers gossiping about their sexual orientation. They assumed that their HIV positive status lead some healthcare workers to make assumptions about their sexual behaviour. This may lead to various individuals deciding not to go for testing for that particular reason. Studies done in Southern Africa showed that only the rate of disclosure of sexual practises to health care practitioners was very low among MSM. Between 9 to 17 per cent of MSM had ever disclosed to HCWs that they engage in sexual intercourse with other men (Baral et al., 2009; Fay et al., 2010).

### **2.2.11 Discriminatory Laws and Policies**

Aside from societal and cultural discrimination, legal discrimination also plays a role in influencing the HIV infection rate particularly among MSM. Homosexuality remains a criminal act in a number of countries particularly in sub-Saharan Africa where the burden of HIV is very high. A study in the United States showed that states that did not legally recognise same sex marriages had higher HIV infection and diagnoses rates (Francis and Mialon, 2009). Another study by Hatzenbuehler et al. (2012) looked at the impact of legalising same-sex marriages and the results showed that the recognition of same –sex marriages improves the health outcomes of gay and bisexual men, as there was a 13 per cent drop in medical visits as well as a 10 per cent drop in health care costs for MSM.

High levels of human rights violations therefore increase the likelihood of members of key populations becoming infected. A study by Baral et al. (2013) observed that in Swaziland, a very high numbers of key populations including MSM faced legal discrimination and were reluctant to seek health care for fear of discrimination because of their sexual orientation. Approximately 30.2 per cent of MSM in Swaziland have experienced legal discrimination (Baral et al., 2013). In China, the illegal status of same-sex marriages has led to the association of homosexuality with HIV and the rejection of family members who are homosexual, thus sexual minorities experience stigma, prejudice and harsh treatment by society as well as by law (Xu et al., 2017). This has resulted in MSM choosing to conceal their same-sex orientation and settling for marriage with the opposite sex (Xu et al., 2017).

Lawful discrimination in institutions such as clinics, universities reduce the motivation for MSM students to seek HIV counselling, testing and treatment services. It is however not enough to influence laws if policies do not shift as well. A study by Wirtz et al. (2014) showed that weak public health policies resulted in HCWs lacking information about HIV risk among MSM. Therefore, without this information as well as political support, health care providers were reluctant in serving MSM as they are perceived as less threatened by HIV and thus it discouraged MSM from seeking health care attention.



## **2.3 Factors inhibiting HIV risk**

### **2.3.1 Level of HIV knowledge**

Negative beliefs regarding HIV/AIDS and a general lack of knowledge is dangerous because it often has negative consequences such as late diagnosis for those already infected (Solario et al., 2013). An individual's level of knowledge influences how they behave. A number of studies have shown that good knowledge of the basic facts surrounding HIV transmission is usually accompanied by behavioural change such as an increase in condom use and regular HIV testing (Lammers et al., 2013). A study by Pando et al. (2013) showed that among MSM in a Buenos Aires men who had previous HIV testing experience and those who were HIV positive had higher levels of HIV knowledge whilst those who practised risky behaviours answered most of the questions asked incorrectly indicating low level of HIV knowledge. A study conducted in Portugal by Nodin et al., (2014) identified the lack of HIV campaigns targeting MSM as the main factor affecting the levels of HIV knowledge.

Based on global estimates by Adam et al. (2009), approximately 56 per cent of MSM in middle and low-income countries do not have the correct knowledge about HIV, a staggering 70 per cent had never tested for HIV and nearly 46 per cent did not use condoms during anal intercourse. Studies from other parts of Africa such as Kenya and Sudan indicate that MSM in Africa have low knowledge of the routes of HIV transmission as well as the prevention strategies (Geibel et al., 2008; Elrashied, 2006, cited in Wagenaar et al., 2012). Of the individuals sampled in the above-mentioned studies 55 per cent of MSM in Sudan and 35 per cent MSM in Kenya did not understand the risks involved in anal sex. Another study done in Uganda showed that some MSM believed that anal sex is less risky (Musunguzi, 2015). Coming further south, research suggests that MSM in Southern African countries such as Namibia, Botswana and South Africa MSM have higher levels of HIV knowledge particularly in institutions of tertiary education (HEAIDS, 2014; Kharsany and Karim, 2016)

According to Wagenaar (2012) while data on levels and correlates of HIV/AIDS knowledge in Africa are important for the development of effective prevention strategies research has mainly been focused only on levels of knowledge without paying attention to the factors associated with the levels of knowledge. A UNAIDS (2009) report highlights that there has been global failure in terms of addressing the needs of MSM communities with regards to knowledge about research, prevention, transmission, treatment, and care.

### **2.3.2 Social cohesion**

Social cohesion is defined as the willingness of members of a society to freely choose to form partnerships with each other in order to survive and prosper in achieving a particular goal (Stanley, 2003). A cohesive society is one that works towards the wellbeing of all its members by fighting exclusion and marginalising, ensuring that all members have a sense of belonging and trust one another. “MSM communities are frequently linked through social and sexual networks, shared cultural and political affinities, and groups seeking rights and health or fighting discrimination, such as coalitions of LGBTIQ or people living with HIV” (Trapence et al., 2012: 3). Social capital (i.e. the resources that result from people cooperating towards common ends) is important to disadvantaged groups in society as it facilitates internal group-related mutual aid and support as well as access to social and material resources. Social cohesion and social participation are identified as factors that may help to reduce HIV risk and optimise health-seeking behaviours (Grover et al., 2016). In a cross-sectional study that sought to find associations between social factors and HIV testing, Grover et al. (2016:1) found that “building solidarity and trust within and between groups may be a strategy to improve the uptake of HIV testing”. This is because in this study the level of social participation was found to be associated with HIV testing in the previous 12 months. In this study, the majority of MSM (73.6 per cent) had strong social networks to confide in and find support (Grover et al., 2016). The support came in some forms that are likely to impact on HIV risky behaviours such as accompanying one another to hospitals, support in finding other MSM and support with the use of condoms.

Social capital can empower key populations to practise HIV preventive behaviours through the elimination of social and political barriers to behaviour change (Samuels et al, 2006). Social cohesion does not only refer to the cohesion of an individual into the LGBTIQ societies but also of the LGBTIQ people in the overall fight against HIV. According to Trapence et al., (2012), HIV leadership and participation should also be inclusive of MSM leaders to improve response to HIV by including engagement with networks of MSM i.e. cohesion for action against HIV. This is because without MSM community involvement, government run health programmes have little chance of effectively reaching communities or scaling up interventions end the HIV pandemic (Trapence et al., 2012).

### **2.3.3 HIV testing and counselling**

The knowledge of one's HIV status is a very important component of HIV prevention. When an individual does not know his HIV status, he risks passing on the infection to others as well as the possibility of reinfection. Data from HIV testing is also useful in informing us about the prevalence and incidence of the disease in the MSM community.

Despite being part of a recognised key population, very few MSM who are already infected know their HIV status (Sandfort et al., 2015) let alone their partners' HIV status. About 88 per cent to 94 per cent have been estimated to not know their status (Beyrer et al., 2011) in comparison to an estimated 34 per cent in developed countries such as the USA (Katz et al., 2013). Two studies of HIV prevalence among men having sex with men in Soweto, South Africa and Senegal showed that HIV prevalence was very high among MSM and yet the level of testing was very low which increased their risk of passing on the disease (Lane et al., 2011; Wade et al., 2007). In the Soweto Men's Study, while 37.9 per cent of the respondents had ever tested for HIV, 57.2 per cent and 0.8 per cent perceived themselves to be HIV negative and positive respectively while 41.1 per cent did not answer (Lane et al., 2011). In a similar multivariate study conducted in Peru, low perceived self-risk was reported as being the main reason for not testing among others such as to check health status, availability of testing, fear of a positive result and lack of access to testing services (Lee et al., 2015). The conclusion in this study was that low HIV testing was directly linked to high-risk behaviour because research suggests that knowledge of HIV-serostatus is often accompanied with a change in behaviour (Nagaraj, 2013).

In South Africa, the level of testing among MSM has increased on a national level. At least 90 per cent of MSM have ever tested. Moreover, in the MSM triangulation project- of the university students sampled in the Western Cape, at least 80 per cent had ever tested and 70 per cent had recently tested (Scheibe et al., 2015). In the HEAIDS (2014) study, more MSM students (73 per cent) had tested for HIV at least once in their lifetime than 65.1 per cent of non-MSM students.

A systematic review of 62 global studies by Evangeli et al. (2016), found that there are homosexuality related stigma factors that discourage people from testing. Based on this review, there is a negative association between internalised homophobia and previous testing and a negative relationship between sexuality based discrimination and testing. Wilkerson et al. (2014) measured the openness of homosexuality and found that openness about

homosexuality actually positively influences testing behaviour. Wilkerson et al. (2014) also found that a community's perceived acceptance of homosexuality is associated with a greater likelihood of knowledge of HIV status between partners engaging in unprotected anal intercourse. Therefore, greater openness about homosexuality such as universities actively showing acceptance of LGBTIQ students will encourage members of this key population to test for HIV (Wilkerson et al., 2014).

#### **2.3.4 Access to health care services and treatment**

According to the World Health Organisation (WHO), primary health care refers to health care that is based on “scientifically sound and socially acceptable methods and technology, which make universal health care accessible to all individuals and families in a community. It is through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO, 1978: iii). The primary goal of health care is to ensure better health for all. The key elements to achieving this goal as identified by the WHO are: reducing exclusion and social disparities in health (universal coverage reforms); organizing health services around people's needs and expectations (service delivery reforms); integrating health into all sectors (public policy reforms); pursuing collaborative models of policy dialogue (leadership reforms); and increasing stakeholder participation. One of the key elements of achieving the above-mentioned goals is ensuring the provision of appropriate HIV prevention treatment and care services to key populations. This undoubtedly challenges many health care systems as noted by Beyrer et al. (2011). However, the benefits of extending these services to key populations such as MSM is that it will reduce the prevalence of the disease by reducing the number of new infections.

This will not only benefit the affected individuals but health care systems will also benefit in that they will become efficient in addressing the primary and secondary prevention needs of those at risk of contracting diseases, such as HIV and the individuals who are most at risk should have the greatest access to health care services and treatment (Beyrer et al., 2011).

According to the World Health Organisation, the strategic use of antiretroviral HIV medications can significantly reduce the transmission of the virus by suppressing the load of the virus in their bodies. Ensuring that all infected individuals are on treatment is important because it reduces their chances of transmitting the disease to their sexual partners.

According to Cohen et al. (2016), some studies have shown that early initiation of anti-retroviral treatment (ART) reduced the chances of individuals infecting their sexual partners among sero-discordant couples. Higher levels of transmission were observed among sero-discordant couples whose partners were not virally suppressed or who delayed the initiation of ART (Cohen et al., 2016). According to Granich et al. (2010), lowering viral loads is essential to reducing the transmission of HIV. Research evidence has provided conclusive evidence that highly active antiretroviral therapy (HAART) is effective in reducing HIV transmission (Attia et al., 2009, cited in Granich et al., 2010).

Antiretroviral drugs are also effective as an HIV prevention tool. Pre-exposure prophylaxis (PrEP) and Post-exposure prophylaxis (PEP) are anti-retroviral treatments taken when individuals who are at very high risk of contracting HIV take HIV prevention medicines to lower their chances of being infected. They work by stopping HIV from spreading in an individual's body. According to Rebe et al. (2011), it is important for MSM to have access to ART after infection and early initiation of the treatment is essential. Rebe et al. (2011) also note that targeted programmes addressing HIV among MSM have also been successful in affecting the overall rates of HIV rates in countries with generalised epidemics. In a systematic review of literature Muessig et al. (2012) found that there are mixed results in studies that investigate whether or not ART prevents transmission among MSM.

## **2.4 Summary**

The literature suggests that risky behaviours remain at the epicentre of the HIV epidemic in MSM populations. There are various ways in which the risk among MSM can be reduced and these range from biomedical strategies such as the uptake of ART before and after infection to prevent those who are not infected from contracting the disease as well as suppress the viral load of those who are already infected. Other strategies require the challenging of structural systems that continually undermine the rights of some human beings based on their sexual or gender identity. This chapter also identified the importance of behavioural strategies as prevention tools. These behavioural strategies include behavioural interventions in various ways such as promoting the use of condoms and increased voluntary HIV counselling and testing (VCT).

## **CHAPTER THREE**

### **METHODOLOGY**

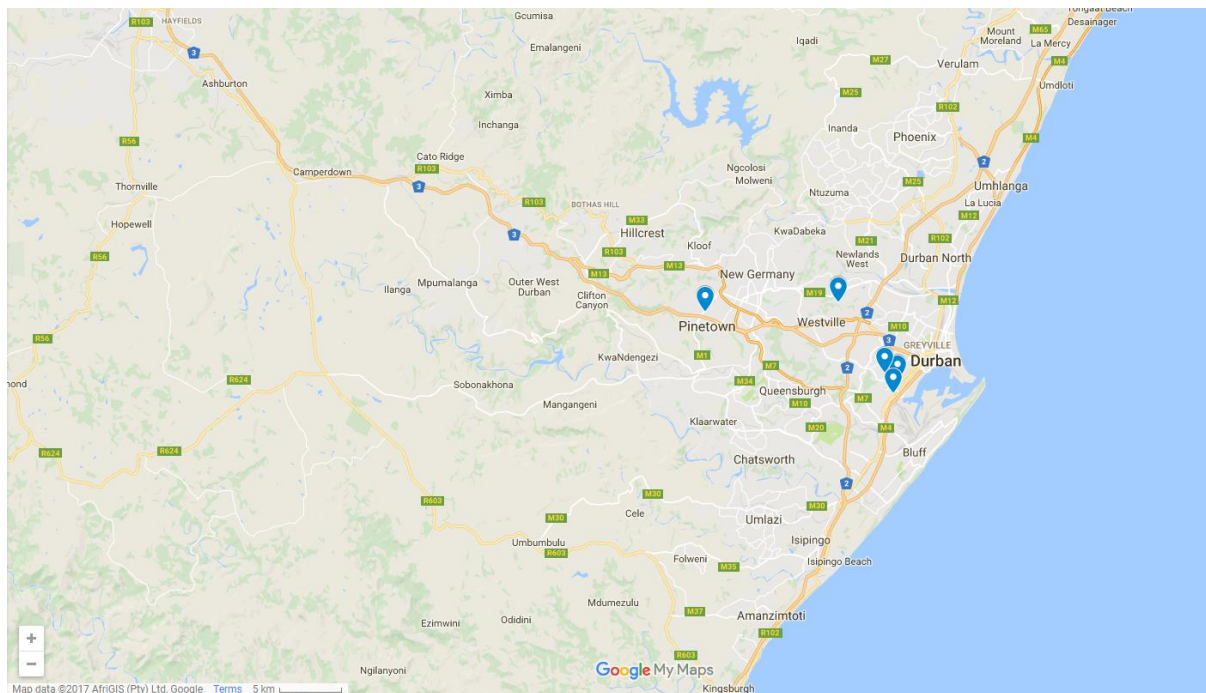
#### **3.1 Introduction**

The overall aim of this study as explained in the first chapter is to shed insights into the HIV risky behaviours of men having sex with men. The primary data considered in this study was obtained from in-depth interviews that consisted of open-ended questions, which sought to explore the types of risky behaviours MSM engage in as well as the factors that influence these behaviours. This chapter presents the methodology that was applied in conducting this study. It starts by providing an overview of the study area and the target population from which the sample of 15 participants was drawn. As presented in this chapter the methodology consisted of various steps that included; research design, sampling procedure, sample recruitment, data collection and data analysis. Ethical considerations as well as the limitations of this study are also explained in this chapter.

#### **3.2 Study site**

This study was conducted at one of South Africa's leading public universities- the University of KwaZulu-Natal. The institution is made up of five campuses situated within the province of KwaZulu-Natal (one Pietermaritzburg campus and four Durban Campuses). The respondents who took part in this study came from the four campuses situated in Durban. The province of KwaZulu-Natal has the highest HIV prevalence (39.5 per cent in comparison to the Western Cape Province where the prevalence rate is 16.9 per cent which is the lowest in the country (Reddy and Frantz, 2012). Durban has an unusually high HIV infection rate among MSM, which also happens to be the highest in the country at 48.2 per cent and 71.1 per cent among MSM in the age group 18-24 years age category (HSRC, 2014). According to the South African HIV Prevalence, Incidence and behaviour Survey of 2012, 12 per cent of youth living in KZN in the 15-24 age group are HIV positive. Across all age groups the infections rates are as high as 31 per cent for women and 16 per cent for men. According to the South Africa MSM Data Triangulation Project Report, 48.2 per cent of MSM living in the Durban area are HIV positive (Scheibe, 2015).

**Figure 3.1 Map of University of KwaZulu-Natal (Durban Campuses)**



*Source: Google Maps*

### **3.3 Research design**

The study relied on a qualitative approach to understanding risky sexual behaviours and risk perceptions amongst MSM students. Qualitative approaches to HIV behavioural studies are useful because they explore in a very personal and confidential way issues that relate to sexuality on a personal level (Razak, 2003). According to Lewin et al. (2005), qualitative research creates rich and detailed material that can be used in analysis. The qualitative data collection methods that were employed are individual in-depth interviews. This ensured that the responses given generated insights towards sexual behaviour and allow for clear understanding of not only the respondent's behaviours but also the factors associated with such behaviours.

The study used a case study approach. A case study research approach is one that refers to the in-depth analysis of a single or small quantity of units in the context of qualitative research. It may include a single person, a group or a phenomenon (Starman, 2013). Zainal (2017) notes that case study methods are a controversial approach to data collection as they are criticized for lacking rigour since it is assumed that the researcher produces biased interpretation of the

data but, the advantage of the case study method is that it enables the researcher to closely analyse the data within a specific context. Case studies explore and examine contemporary real-life phenomenon through in-depth contextual analysis of a limited number of events and their connections (Zainal, 2017).

### **3.4 Sampling procedure**

Sampling is the selection of some units to represent the entire set from which the units were drawn and should be representative of the entire population. This study employed purposive sampling to identify the initial sample after which snowball sampling was employed. According to Guest et al. (2011), Purposive sampling involves the choosing of participants who will provide rich answers to assist in meeting the objectives of the study. Purposive sampling involves the non-random selection of participants on purpose. In identifying the respondents, snowball sampling and criterion sampling were employed as sampling strategies. Snowball sampling is a type of purposive sampling that aims to recruit future subjects from acquaintances.

Criterion sampling is useful when selecting cases that already meet some predetermined significant criterion. In this study, the respondents were required to be a registered UKZN student between the ages of 18 and 30 years old and self-report to be sexually active and involved with other men. A snowball strategy was used to identify 15 respondents. Also known as chain sampling, chain-referral sampling, referral sampling; snowball sampling refers to a technique for finding research subjects whereby one subject gives the researcher the name of another subject who in turn provides the name of a third and so on (Atkinson and Flint, 2001). It is a non-probability technique where existing study subjects recruit future subjects from among their acquaintances. As the sample builds up, enough data are gathered to be useful for research. This sampling technique is often used in hidden populations that are difficult for researchers to access (Atkinson and Flint, 2001). The snowball sampling strategy is useful when there is a need for the researcher to identify cases using information from people who have that information and particularly when they are hard to reach populations (Shaghagi, 2011; Palinkas, 2015).

The sample size was set at 15 because according to Crouch and McKenzie (2006) in order for the researcher to penetrate social life beyond appearance there is a need to establish continuing and fruitful relationships with the respondents through theoretical contemplation.



A small number of participants (i.e. below 20 individuals) allows the researcher to address the research problem in depth (Crouch and McKenzie, 2006). In addition, while there are no guidelines used to establish non-probabilistic sample size, evidence suggests that when using data involving in-depth interviews saturation occurs within the first 12 interviews (Guest et al., 2011).

In recruiting respondents, two crucial considerations were upheld and these are: 1) Sexual orientation/gender identity is not defined or measured by observation and therefore cannot be assumed without the individuals confirming it themselves. 2) For various reasons such as fear of stigmatisation and discrimination and other personal reasons known to the individual, some men who have sex with men might be reluctant to identify themselves or be identified as MSM.

The researcher therefore ensured that the recruitment process did not invade potential respondents' private space. This was done by leaving the task of identifying a person as MSM to the respondent. The respondents were required to confirm that they fit within the definition of MSM for the purpose of this study, which is "men who engage in male-male sexual behaviour i.e. gay men, homosexual men, men who do not identify as homo or bisexual, male sex workers, transgendered people" (MSMGF, 2008). The researcher did not randomly approach individuals to enquire about their sexual orientation or sexual behaviour. Snowball sampling was useful in identifying MSM hidden populations who already are difficult for researchers to access. The starting point to the recruitment process was as follows: For months before the recruiting process, the researcher was informally communicating with members of the UKZN LGBTIQ society and the UKZN LGBTIQ community who passed the word round in their organisations and personal circles. This was done by means of social media where they posted about the study on society social media pages on Facebook, Twitter and WhatsApp and during society meetings. No one was forced or coerced to participate in this study. Individuals who were interested in taking part in the study took the initiative to get in touch with the researcher through the committee members or other individuals who would have made contact with the researcher already. They also encouraged other members to individually request their friends who were MSM students but not members of the campus LGBTIQ society to get involved if they are willing.

The advantages with this recruitment strategy was that- by the time the respondents made contact with the researcher their status as MSM was not questionable, therefore their human

rights were not infringed by asking whether they are MSM or not. Another advantage was that the research participants were actively involved in the research process, which increases the credibility of the research. However, on the downside, there are possible biases such as the selection of members from the same group (e.g. UKZN LGBTIQ campus society) who have similar practises although this was overcome by ensuring that non-members of the LGBTIQ campus society were also included in the study.

### **3.5 Data collection**

Data was collected by means of in-depth interviews whereby the participants were asked a series of open-ended questions over a period of one hour. In-depth interviews are open-ended interviews that acquire a participants' comprehensive perspective on the topic (Jamshed, 2014). Furthermore, according Gill et al. (2008) in depth interviews help shed light on the underlying attitudes and perceptions of the interviewee on the subject at hand. The in-depth interviews were initially supposed to be conducted in person but this was not the case for all the interviews as some participants were not comfortable with having face-to-face meetings. These participants reported that they were shy, uncomfortable talking about their personal lives to a complete stranger and they wanted to protect their identity completely. Some of the participants also withdrew their participation citing fear of talking about HIV as the reason.

According to Farber (2006), interviews should be conducted in a place where the person being interviewed will be as comfortable as possible as they will be sharing information about their experiences in life. Faber (2006) further notes that it is important for the respondent to decide where the interview will be conducted. In this study therefore, the respondents chose the location where the interviews were conducted although the researcher ensured that when meeting face to face, the sites were private rooms with no outsiders present. In cases where the participant was unavailable to meet in person, they were given the chance to decide how they would like to participate. All of the respondents who did not want in person meetings decided to "meet online" (i.e. the researcher carried out conversations with them via instant messaging on WhatsApp) and they would immediately respond as if it is an in-person meeting. This allowed the researcher to concentrate on the interview whilst analysing the transcripts (Fontes and O'Mahony, 2008) before losing contact with the respondent and therefore the researcher was able to do follow-up questions immediately. According to Fontes and O'Mahony (2008), using text messaging as an interviewing strategy

is cost and time effective and therefore it allowed the researcher to interview the respondents in their own time. It however required the researcher to quickly grasp and understand their communication etiquette.

The researcher also managed to ask the same questions differently through engaging in informal conversations with the participants. According to Berry (1999), this is very effective in that by mixing both informal conversational and interview guide approaches, the researcher is able to elicit information and explore specific topics for further investigation without the respondent being cautious about their responses. This increased the level of honesty on the part of the respondents.

The field notes in the form of message responses as well as audio recordings from in-person meetings were transcribed within 24 hours of each interview to ensure that no aspect of the data was lost. This was very important because according to Stuckey (2014), transcription plays a role in determining the level of accuracy and dependability of the results. Transcribing soon after the interview allowed the researcher to initiate data analysis much earlier in the data collection process. This allowed the researcher to recognise the strengths and weaknesses of the interview guideline as such, the researcher was able to find better ways of asking the questions in order to get the right answers.

The interview guide that consisted of nine in-depth questions explored the participants' perceptions about HIV risk, their sexual behaviours such as condom use habits, commercial sex, alcohol use, multiple partners, forced sex, and HIV testing. These aspects under investigation were asked in different ways under different questions, as some of the questions were not direct. This was to ensure that the participants were consistent in their responses. For example, when asked about measures of protection a respondent might highlight condom use but when responding to another question that enquires about reasons for using or not using condoms, their response might reveal that they do not use condoms all the time as previously stated.

### **3.6 Data analysis**

Qualitative data analysis is a range of processes that involve the collation of textual qualitative data collected in the form of interview transcripts; field notes, videos etc. into some form of explanation, understanding and interpretations (Lewin et al., 2005). For the

purpose of this study, field notes were expanded and interviews transcribed within 24 hours of each interview to ensure accuracy. Manual thematic analysis was applied in the analysis of the data obtained from the in-depth interviews. With its main advantage being flexibility, thematic analysis is seen as the foundational method for qualitative analysis (Braun and Clarke, 2006). A thematic analysis was useful because it provided a rich interpretation of the study. Data from each participant was analysed separately to allow for easy comparison of the respondent's responses under each theme. The themes were not pre-determined but rather they developed from the codes that were generated in the course of the study, as there was no code list produced prior to data collection.

The six phases of thematic analysis as outlined below were applied (Braun and Clarke, 2006). The researcher first developed familiarity with the data through transcribing data within 24 hours of each interview, reading the transcripts multiple times whilst noting down initial ideas. Thereafter, the researcher separately developed initial codes in a systematic fashion across for all the interviews. These codes were then categorised into potential themes depending on how they relate to one another. This type of coding system is known as "open and relational coding" as it is used to create relationships between different categories. Emerging themes were reviewed by checking if the potential themes worked in relation to the codes and the entire data set. This process led to the generation of a thematic map of the analysis. The specifics of each theme were refined which led to the generation of definitions and names for each theme. The final report was a selection of vivid and compelling extract examples. Final analysis involved the analysis of selected extracts by relating the extracts to the search questions and literature.

### **3.7 Validity, reliability and rigour**

Validity refers to the exactness in which the findings accurately reflect the data. According to (Joppe, 2000, cited in Golafshani, 2003), validity determines whether the research truly measures that which it was intended to measure (i.e. the truthfulness of the research results are). Reliability is the extent to which results are consistent over time as an accurate representation of the study population. That is to say, if the results of a study can be reproduced under a similar methodology, the study results are reliable (Joppe, 2000, cited in Golafshani, 2003). Lastly, rigour is the quality of being thorough and careful. The results of this study are reliable in that qualitative methodology uses a representational approach that

seeks to understand phenomena in context-specific settings whereby the researcher does not manipulate the phenomenon of interest (Golafshani, 2003).

Regarding the extent to which the results are consistent over time, this was evidenced when the in-depth interview responses reached a point of saturation, which according to Guest et al. (2011) is after 12 interviews. In this study, the point of saturation was reached after seven interviews. This is due to the study sample having similar levels of HIV knowledge and therefore their practises are similar. This point of saturation is proof that the results of this study are a possible accurate representation of the total population under study. To ensure that high level of rigour is demonstrated, all interviews were recorded and transcription was done carefully. The criteria for demonstrating rigour developed by Guba and Lincoln's (1994) were applied and these are truth-value, consistency and neutrality during the data collection process. To ensure credibility of the methodology applied in this study, the researcher maintained neutrality throughout the interview sessions with participants, meticulously recorded all data through taking notes and audiotaping the interviews, ensured that data interpretation was consistent and transparent and established a comparison across different accounts, which ensured that different perspectives were represented.

### **3.8 Ethical considerations**

This study complied with the ethical requirements of the University of Kwa-Zulu Natal's Humanities and Social Science Research Ethics Committee. This included ensuring that an informed consent form in a language that the participants understood protected the autonomy of all participants. All participants willingly signed the consent form under a pseudonym to protect their identity. The pseudonym also served the purpose of preventing stigmatisation. Before signing the consent form, the participants were given assurance that should they choose to withdraw from the study at any given time they would not suffer negative consequences on their part. Some of the participants withdrew from the study because they felt the study did not encompass them as human beings but most were generally afraid of talking about HIV.

All the participants who carried on with their participation agreed to and signed the informed consent prior to the interviews. The participants who were not comfortable with in-person interviews also signed the informed consent except they sent the signed informed consent form via email or WhatsApp. The respondents' real names are not recorded anywhere on

research material (consent form and field notes). The results published in the dissertation do not reveal the identity of any of the participants. Any similarity in the pseudonyms to an actual person is purely coincidental. The data collected will be stored privately with the researcher and in the Supervisor's office for at least five years.

### **3.9 Limitations of the study**

The data collection process was long as it took a period of five months to do all 15 interviews. In these five months, the researcher was introduced to over 25 potential participants but some of them withdrew from the study. It was not easy to find willing participants who were comfortable talking about their private lives as sex is considered a private issue. Some individuals who self-report to be MSM did not consider participation citing fear of discussing HIV although they were more than willing to introduce their friends and even encourage them to participate. To overcome this challenge, the researcher ensured that all participants did not feel coerced and were indeed willing to participate. Education level might have played a role in influencing the results as university students are more exposed to awareness campaigns and therefore they are knowledgeable regarding HIV issues so they are not a very high-risk group in comparison to their counterparts who are not as educated.

There is the possibility that the respondents censored their responses to only give answers they consider appropriate in order to not reveal some of their behaviours that they may already understand to be risky. Some of the participants declined to respond to certain questions because they were concerned about their identity being exposed if someone from the university recognised their stories. Despite the sample coming from different campuses of the university the study focused on a small number of individuals and therefore it is not a true representation of all young student MSM at the university. Conducting interviews via text message also had the disadvantage of participants being unwilling to type very long answers and therefore they did not fully explain some of their answers.

### **3.10 Summary**

This study draws on in-depth interviews with 15 MSM students to shed insights on HIV risky behaviours among MSM. The students who participated in this study came from the

University of KwaZulu-Natal's Durban campuses. Using an interview guide of nine open-ended questions, the study explores risk perception as well as the risky behaviours that MSM engage in. The interviews were conducted both in person and via instant messaging, as some participants were not comfortable with in-person meeting. This allowed the participants to fully share their experiences without feeling coerced. This study complied with the UKZN Ethics Committee, as it was important for the participants to feel as comfortable as possible thus; no participants were coerced into taking part. Thematic analysis was used to identify emerging themes and the final stage of data analysis involved the analysis of selected extracts by relating the extracts to their search question and literature.

## CHAPTER FOUR

### ANALYSIS AND FINDINGS

#### 4.1 Introduction

The overall aim of the study was to shed insights into the HIV risk behaviours of men having sex with men by assessing their perception of HIV risk, the type of risky behaviours they engage in as well as the factors influencing these behaviours and to explore opportunities and constraints for behaviour change. The findings of this study are drawn from in-depth interviews with male students who identify themselves as MSM. This chapter describes their perceptions of risk of HIV infection. It also outlines the risky behaviours of men who have sex as well as the reasons for engaging in such risky behaviours. Lastly, the chapter outlines the factors that reduce HIV risk.

In total, interviews were conducted with 15 men. Table 4.1 presents the socio-economic and demographic characteristics. The ages of the participants ranged from 19 to 29, with an average age of 24 years. All the participants confirmed that they have been sexually active in the past. The participants defined their sexual orientation based on whom they were attracted to and not necessarily, who they engaged with sexually. The majority of participants commented that: “sexuality is not defined by who you sleep with”. The levels of study of the participants ranged from first year to postgraduate level. The ages of the participants did not correspond with their level of study. Some of the participants have also been in the university environment for longer but due to various circumstances, they are in lower levels of study. With the exception of one participant from an undisclosed African country, all the participants were South African nationals. Four of the participants came from other provinces namely Limpopo, Mpumalanga and Free State. The majority of the participants were not originally from Durban but came from the surrounding townships and rural areas in KwaZulu-Natal. Three participants mentioned that they came from the rural areas, One participant was born and raised in the city and came from an affluent neighbourhood, whilst the majority grew up in typical South African townships.



**Table 4.1: Distribution of participants according to their demographic profile**

<b>Participant</b>	<b>Pseudonym</b>	<b>Age</b>	<b>Sexual orientation</b>	<b>Relationship status</b>	<b>Year of study</b>
1	Emjay	25	Bisexual	Relationship	Undergraduate
2	Handsome	21	Gay	Relationship	Undergraduate
3	Kabelo	25	Bisexual	Single	Postgraduate
4	Kay Bee	21	Gay	Open	Undergraduate
5	Kwena	28	Heterosexual	Engaged	Postgraduate
6	Kritik	27	Gay	Engaged	Undergraduate
7	Leezy	23	Gay	Relationship	Undergraduate
8	Lekko Motion	26	Gay	Relationship	Undergraduate
9	Panda	29	Bisexual	Serious Relationship	Postgraduate
10	Mtho	23	Bisexual	Single	Undergraduate
11	Njabulo	23	Gay	Relationship	Postgraduate
12	Sinazo	19	Gay	Single	Undergraduate
13	Star Mor	24	Gay	Engaged	Postgraduate
14	Thando B	24	Gay	Relationship	Postgraduate
15	The Queen	25	Gay	Complicated	Postgraduate

## 4.2 Perception of HIV risk

All the participants in this study indicated that they did perceive themselves at risk of HIV infection. They mentioned that they always consider their HIV risk before engaging in every sexual act with any other person in particular male partners. Further to that, they were aware of the high risk associated with anal sex and as a result, they felt at great risk of HIV infection. The main source of HIV information was the media. In addition, their personal childhood losses to HIV through living with infected family members or having lost close relatives to AIDS increased their awareness of the disease. One participant mentioned that the initial reaction is fear of the disease but as one grows up there is greater acceptance of the reality, which makes them one keen to protect himself.

*“Yes I think about HIV all the time because I know that anal sex is a high risk for HIV transmission” (Lekko Motion, 26 years).*

*“I have lost close relatives to it [HIV] and I’m aware of the threats it poses” (Panda, 29 years).*

*“They say gay people came with this thing of HIV. I have to think before I engage with a guy” (The Queen, 25 years).*

*“Growing up I was so afraid of this thing. So I am no longer afraid, it’s just a matter of protecting yourself when you can” (Emjay, 25 years).*

The participants demonstrated that their awareness of HIV has helped them develop a positive perception, as they believe that having HIV is not the end of the world. As such, the majority of the participants said that they did not have a problem with having sexual relations with infected partners because they are able to protect themselves from HIV infections. One participant stated that after testing with one of his former partners, he was ready to carry on with the relationship although this partner ended the relationship abruptly because he could not understand why anyone would be willing to be with him. In addition, the participants also mentioned that their social groups also provide them with support. The statements below best illustrate this:

*“HIV is not the worst thing that can happen to you, all these lifestyle diseases like diabetes are much more scary. This is not the first time I am dating someone who is HIV positive....I don’t want people to kind of take my mentality. HIV is not a monster okay, trust me there are ways to protect yourself with the person you love” (Star Mor, 24 years)*

*“To us [MSM] it’s not shocking; not exciting it’s just a situation [HIV positive status]. We see HIV as “a tenant that lives in your body that you need to control”...I have been fortunate to be around people who have knowledge and understand. I have supportive friends, we pressure each other to test, gym and eat healthy etc. Some people don’t like those things but why would such a person even be my friend?” (Lekko Motion, 26)*

#### **4.2.1 Factors influencing risk perception**

##### **4.2.1.1 Role assumed during penetrative intercourse**

The study found that the participants believed that MSM who assume an insertive role “*top*” were at a much lower risk of contracting HIV than their receptive partners “*bottom*”. These roles were neither exclusive nor related to sexual orientation for some participants who described themselves as “*versatile/verse*” since they assume both roles at different times. One participant mentioned that the fact that he is exclusively insertive and circumcised meant that his risk of acquiring HIV was lower. Some of the participants said that they have never adopted the insertive role as a protective measure although they feel safer when they assume this role during intercourse. This is verified in the statement below:

*“I have also ensured that I don’t allow any penetration on me.....I read that being penetrated is more dangerous than being on top” (Kwena, 28 years).*

*“I think you are exposed either way. Some people think that if you are top then you are safer which is kinda true but I have never thought of it as a way to protect myself.” (Star Mor, 24 years).*

The exclusively receptive participants believed that their insertive partners feel safe and protected by their sexual role hence they do not usually suggest protective measures which then increases the risk of the receptive partners. For example, one participant stated that:

*“I expect to be protected by the top guy. Being bottom doesn’t make me responsible for lube [lubricants and condoms. For tops unprotected sex is fine if they are circumcised but for us bottoms it’s riskier. I’m sick of tops not bringing lubes and condoms.” (Thando B, 24 years).*

The study also found that depending on sexual role there exists a difference in opinions regarding the responsibility to provide condoms and lubes. Some insertive partners argued

that it was the responsibility of the receptive partner while in another cases; the receptive partner said it is the responsibility of the insertive partner.

*“Being top gives me more power because the top controls the relationship and they are usually the decision maker even about condoms. But, when you have sex with a bottom, they always bring condoms with them” (Kabelo, 25 years).*

*“I expect to be protected by the one who comes to propose. Being bottom doesn’t make me responsible for lubes and condoms” (Kay Bee, 21 years).*

#### **4.2.1.2 Socio-economic status of partner**

The participants’ perception of risk was evidently influenced by type of sexual partner. Many of the participants expressed reservations about engaging in sexual relations with men from a lower socio-economic status because they are assumed to likely be HIV positive, as they are supposedly less educated and subsequently less aware about HIV. This was expressed in the following statements:

*“To be safe [from HIV] I start by getting to know them, particularly where they are going in life, their aspirations. For me, positive, inspirational people are the best” (Lekko Motion, 26 years).*

*“When you converse what you actually do is measure their wellbeing and sometimes you go home with the one whose well-being is okay with you and sometimes you don’t if his well-being doesn’t sit well with you...By wellbeing I mean the way he presents himself for example his accent, the way he talks or dresses tell you about his lifestyle. That’s perhaps a way of measuring their economic status” (Njabulo, 23 years).*

#### **4.2.1.3 Perceived promiscuity and discriminatory dating patterns**

The participants made reference to perceived high levels of promiscuity in the MSM community with the belief that it placed them at increased risk of HIV. Some participants believed that promiscuity was high in male-to-male relationships because hormonally men are more sexually active.

*“Because most of them they just do sex anyhow. As you know we are males so we are very sexually active” (Leezy, 23 years).*

*“You must know the gay community is small, maybe out of 10 gay people 4 of them have slept with each other without knowing” (Njabulo, 23 years).*

In addition to this, considering that the MSM community is small, they believe that the risk is further increased when particular members show preference for MSM who possess certain characteristics such as those who are non-effeminate and financially stable. The majority of the participants believed that this kind of behaviour was discriminatory and wrong as it has a negative impact in the sense that it promoted the promiscuity of those individuals who possess these desirable characteristics.

*“Most gays select partners based on looks, socio-economic status, accent and all that leads to people narrowing their dating circle because everyone desires partners with the same characteristics. If everyone says no blacks/whites, no feminine, no you know those kind of characteristics then it reduces the number of your potential sexual partners and as you know already we are a minority. So this thing leads to people sleeping with the same people.” (Star Mor, 24 years)*

*“The gay community is small and people want straight acting partners. People shouldn’t be discriminated or forced to fit into heteronormativity” (Thando B, 24 years).*

*“Everyone wants a piece of me. Bottoms like me because I am focused, I have published articles, I am from a particular class, and my family is rich. They don’t like girly boys and I am like a real man” (Handsome, 21 years).*

#### **4.2.1.4 Preventive measured used**

This study also revealed that risk perception is affected by the use of protective methods. The participants who used PrEP or PEP expressed that they felt much more protected than when using a condom. One participant, whose partner is HIV-positive, also stated that he perceived his risk of HIV to be lower because his partner is on anti-retroviral drugs and he is on Truvada (PrEP). Further to this, all participants felt safer when they combined condoms and lubricants.

*“I don’t feel safe with just a condom; I have even abandoned the mission before because of lack of lubes [lubricants]” (Panda, 29 years).*

*“I am on Truvada since 2016 second semester; trust me PEP, Prep and Truvada it works wonders. If I tell you that I started having unprotected sex with him last year after 1.5 years in a relationship, that’s when he also started his ARV treatment but I knew his viral load and CD4 count so I knew he couldn’t possibly infect me but I still used Truvada on top of that” (Star Mor, 24 years).*

### **4.3. Factors causing inconsistent use of condoms**

#### **4.3.1 Attitudes towards condoms**

All participants expressed negative attitudes towards the use of condoms mainly because for them sexual encounters are less pleasurable when using a condom. For one participant however, HIV risk is not a cause for concern. This participant stated that he hated condoms “with a passion” to an extent that even when he feels that he is at risk, he still prefers unprotected intercourse.

*“I tried to use condoms but it never worked out because the condoms burst. Even with lube. In most of my relationships I don’t use them”. (The Queen, 25 years).*

He adds,

*“Even though I am bottom I don’t like using a condom. I use a condom when a guy insists on using a condom. ....It [risk exposure] really doesn’t bother me...but condoms really bother me, I don’t like them at all”. (The Queen, 25 years).*

The participants also explained that the negative attitudes to condoms among MSM had put them in compromised positions with their partners in the past. One participant reminisced how he nearly had unprotected sex with a partner of an unknown status. This particular partner was however hiding his sero-positive HIV status in an attempt to continue having unprotected sex with his partners, as he disliked having sex with a condom.

*“Apparently he was HIV positive. He didn’t request a condom and as we were about to have sex it just clicked to me that I want a condom and I told him that “I think we should use a condom” and he said “thank you for asking that [condom]”. I only found out the next day*

*from somebody that the guy is infected. So he kept quiet and if I didn't ask for a condom, he would have infected me. He knew his status, I didn't know but still he wasn't going to use a condom at all". (Leezy, 23 years).*

#### **4.3.2 Negotiation for safer sex**

The study revealed that condom use is closely linked to communication within a relationship. As shown in the above, one of the participants uses a condom only when his partners insists on using one. All the participants claimed that they were not afraid of demanding condom use but some of them mentioned that there are times when they did not use condoms because their partners were not in favour of the idea. Amongst the participants who had already stopped using condoms in their current relationships, the decision was a mutual one and with some of them stating that they had relationships end when the partners were not willing to use condoms.

*"I wanted to use a condom but he said we already know each other so what's the use of it". (Mtho, 23 years).*

*"If there is no good communication about condoms with your partner, you might not use because your partner at that time may not like them". (Kritik, 27 years)*

#### **4.3.3 Partner related factors**

The use of condoms is dependent on the type of partner and the time of the sexual encounter. The vast majority of the participants stated that while they do not use condoms with their primary partners they always used condoms with new and casual partners. The position of "primary partner" was not linked to the length of the relationship but it had to do with mutual agreement, the level of respect and trust between the partners. The most common reason for not using condoms with the primary partner was that it is more pleasurable and more intimate and proved the level of trust between regular partners while for others it was a sign of progression from one stage in the relationship to the next.

*"I always use condoms but with my regular partner like my boyfriend we don't. The reason I don't use condoms with my boyfriend is that it's nicer and I trust him, we trust each other. I*

*use condoms with the other people I cheat with because I don't trust them" (Handsome, 21 years).*

*"I use condoms with new partners or my side people then as time goes on you stop using condoms, it's almost like nature that at some point in a committed relationship you have to stop using condoms either because you want to experience the real pleasure or you want to show how committed you are to the person" (Kwena, 28 years).*

One participant mentioned that he had recently started using condoms with his primary partner due to unfaithfulness in their relationship after his boyfriend had called to tell him that he had an STI. The participants who identify as bisexual also added that the reasons for using condoms differed for male and female partners. They always use condoms with their female partners, but in this case, the condom is used as contraception and not as an HIV preventive measure.

*"When I am with a woman, I use a condom to protect the girl against pregnancy. But when it comes to males, it's basically about me and nothing else but when it comes to females I am considerate towards the other person." (Mtho, 23 years).*

#### **4.3.4 Circumstance related factors**

According to the participants, the most common circumstantial reason for the non-use of condoms was intoxication. Other participants also reminisced of instances when they had unprotected intercourse due to the lack of condoms. However, by "lack of condoms" they did not refer to inaccessibility but rather to those moments when an opportunity presented itself and fetching or purchasing a condom appears to be an inconvenience. Inconveniences also occur when a condom bursts during sex and they continue without. The main purpose of testing for HIV was to decide if condoms are to be used in the relationship. Two of the participants have completely avoided using condoms and look to other strategies such as PrEP, PEP and ARV treatment for protection.

*"For me to not use a condom with my partner it definitely has to mean that me and my partner have discussed HIV and I know his status" (Njabulo, 23 years).*

*"I don't always use condoms, sometimes I don't and usually that is when condoms are not available at the moment and going to purchase them might take a while.....but most*



*importantly both of us should test and know our status so we can decide about condoms”.* (Kabelo, 25 years).

*“Sometimes the condom bursts then you just continue without it”* (Kritik, 27 years).

*“Because sometimes maybe after a party and you are all tipsy and getting a condom will kill the fire so in such circumstances, I wouldn’t have to worry because I know I have it covered [by PrEP]”* (Star Mor, 24 years).

#### **4.4 Lack of knowledge of partner’s HIV status**

With the exception of one, all the participants in this study confirmed that they were aware of their HIV status. Despite the majority of participants stating that they only engaged in unprotected intercourse after confirming the HIV status of their partner, only four participants knew their partner’s HIV status, while the rest were not sure of their partners’ HIV status. The most common reason for the lack of certainty is that they did not test together as couples. Most of the communication regarding HIV status was either done verbally or by provision of evidence such as a letter from the testing centre.

*“We never tested together, he says that he is negative but people can tell you lies”.* (Emjay, 25 years).

There were two main reasons why the participants did not test for HIV with their partners. The main reason for all the participants was that there are not many health care facilities that are LGBTIQ couple friendly. The other reason being that they were unsure how they would handle the situation in the event that one of them tested positive. .

*“I feel like it’s important to go with our partners which is not an easy thing because we don’t have so many clinics that support the LGBT community. Unless we are at the seminar where it’s only gays and lesbians. It easy to test there. But I am afraid of testing at the clinic because I am afraid of the things they [clinic staff] would say. I’m not saying they should have LGBT facilities, they shouldn’t discriminate against us by having clinics written “For LGBT” but the nurses need to be taught about us”.* (Leezy, 23 years).

*“I prefer to test separately because I feel that it’s the best way to handle the situation in case one is positive and one is negative so the best way is each person for himself”.* (Mtho, 23 years).

#### **4.5 Sexual relations with multiple partners**

At least half of the participants admitted to having multiple partners at the time of the interviews or having had multiple partners in the past. The definition of multiple partners was however different amongst the participants. One of the participants believed that the word partner should only apply to a person to whom one is emotionally attracted. Thus, whether or not the person engages with other people they should not be considered intimate partners. This participant was emotionally involved with one person and he stated that they had an open relationship where they could be sexually involved with other people and that way despite having sexual relations with other people it was not cheating, as his primary partner was aware of his escapades. By so doing, the participant believed that it lowered his and his partner's chances of acquiring the HIV.

*“I think the moment you have to do it in secret; your chances of contracting HIV and passing on to your partner are increased. If your partner is doing it with someone else, it's much better to know who the other person is. That's why my partner and I agreed that we do these things together so that no one is cheating on the other.... I cannot say I have multiple partners because my commitment remains with one person”. (Kay Bee, 21 years).*

The rest of the participants considered anyone they sexually engaged with to be a partner regardless of emotional attachment. One participant described how having numerous sexual partners, made him seek professional counselling services. The main identified cause of multiple partnerships was a lack of sexual satisfaction within a primary relationship. The unsatisfied partner normally leaves the relationship to find satisfaction elsewhere although often times they deeply care about the other person thus they remain in the relationship. The participants stated that sexual dissatisfaction occurred mainly due to a lack of effective communication in the relationship such as when partners cannot agree on sexual roles whereby one person is not comfortable with either being receptive or insertive. It also happens if one partner is not willing to have sex as often or he is not ready to become sexually active. Some of the participants also stated that they cheat to get revenge if they discover that their main partner was not faithful. Other reasons included difficulty in resisting temptations and perceived male hyper-sexuality.

*“He shouldn't restrict me because as we know in this gay love there are verse, bottoms and tops so I need a partner that if I want to go verse he wouldn't say no. I'm comfortable with someone who is just top. Some lie and say they are top when they are not and that leads to*

*cheating because you won't be getting exactly the thing that you want from him". (Leezy, 23 years).*

*"...they take time before getting sexual with you. So while you wait for them to get ready you start having sex with another person because your partner is not ready to have sex with you but because you respect him you won't push too hard." (Kabelo, 25 years).*

*"If I find out he is cheating, I also cheat. When I see you and I am attracted it is fine even if I am with someone" (The Queen, 25 years).*

*"I am human. It's a natural process of life maybe pervasive with us humans. I would say it's very hard to be loyal. Look at Facebook, Twitter. We are exposed to all these attractive things". (Thando B, 24 years).*

The majority of the participants felt that multiple partnerships were not risk factors for HIV as they felt it did not increase the risk exposure if protection was used. For the majority, their reasons for not having multiple partners were more to do with the physical demands of it as well as the moral aspect of the behaviour rather than the level of exposure to HIV.

*"..it [having multiple partners] shouldn't be a big deal. What's important is that you protect yourself in those situations. What I am trying to say is that it is not about having many partners, but if you find yourself in a situation make sure you protect yourself and your partner. On my part however, I cannot date many people at once I don't have the energy". (Thando B, 24 years).*

*"If I had not been a masters student or an academic per se I wouldn't have the self-value I have so I always tell myself that I cannot sleep with whomever because I have a reputation I am an academic I produce knowledge at this. The principles I hold guide me in life and in my sexual experiences". (Njabulo, 23 years).*

*"I was taught pure love at home maybe it makes me vulnerable but I believe in loving and respecting the other person. If you can cheat, you don't love. I am a Christian and saved, I put Him above and over all I do. I cannot hurt another person like that and then claim to love them". (Sinazo, 19 years).*

#### **4.6 Having a high partner turnover**

The participants of this study including those who stated that they did not engage in multiple sexual relations said that they move on too soon after a relationship has ended.

*“I have always been in a relationship. I have a partner for every year I have been at the university”. (Star Mor, 24 years).*

*“With my boyfriend, when we break up I need consolation from someone. I think its immaturity that we always break up and maybe also hormonal because I am 21 and he is 23. Like now, we broke up on the 2nd of September, by the 6th of September I entered a new relationship and by the 26th September we had reconciled.” (Handsome, 21 years).*

This however did not apply to everyone as three of the participants stated that they take time before entering a new relationship. The reasons for this included fear of contracting HIV by having more lifetime partners and taking time to nurse broken hearts. For one participant however, fatherhood has restricted him in that he does not feel comfortable with having to constantly introduce his daughter to different men.

*“In my life I have had four relationships. First one lasted one and half years, the second one lasted eight months and I was in first year, the third one lasted two years and the fourth one lasted one year. I am a father and my daughter will need to know who is in and out of my life. It might take years for me to introduce someone to my daughter”. (Lekko Motion, 26 years).*

#### **4.7 Sexual relations with women**

This study revealed that for the majority of the participants, their first sexual encounter was with a female. Many of them in fact started having sexual relations with men once they entered the university environment. The majority of the participants intentionally delayed having sexual relations with men mainly because they did not know what to expect in male-to-male sexual relations. According to the participants being in high school, forced them to be in relationships with women. According to one participant, this is a very critical stage in a gay person's life because some of the young boys remain stuck at that stage and they continue identifying as heterosexual despite harbouring sexual attraction towards men. For one participant, such a relationship with a woman resulted in the birth of his child. Although it is unlikely for some, the participants noted that there is a slight chance that they might

engage with women in future as they consider sexuality to be fluid and desire to become fathers.

*“I delayed having sex [with men] because I wasn’t ready. I wanted to wait until I was 21. I have had relationships with people 7- 8 years older than me and I have always told them that I’m not ready. I was fortunate also that I have good friends. I took heed of the advice I got” (Sinazo, 19 years).*

*“Previously, I engaged with a woman but it’s the setting that takes you out of the closet. University is a place to be free; I believe that true colours come out at university...should I feel at a later stage in life that I am attracted to women, nothing should stop me from going for what I want. Women do pursue me saying things like, you smell so great, oh you are so cute, if only you were not gay what if we could have one night. And sometimes I do have feelings for some of them because I tell you some women are attractive but I am not bisexual so I don’t date them.” (Njabulo, 23 years).*

*“One can be gay and accidentally straight. “Ubumnandi [fun] for that time”. Sleeping with a man won’t make a straight man gay and vice versa. I had a child when I was in a relationship with a woman and in denial about being gay. I will never consider being with a woman but I want more kids in the future”. (Lekko Motion, 26 years).*

One participant in this study, stated that he was heterosexual because he cannot stand emotional relationships with men because they are not “soft”. However, when it came to sexual involvement he did not mind having sexual relations with men occasionally.

*“I am heterosexual and don’t consider the males that I have been involved with to be my lovers, they are just for good sex. It was just fun. Currently I am involved with one woman for so many years and she knows that I used to get down with guys before”. (Kwena, 28 years).*

#### **4.8 Lack of openness about homosexuality**

The bisexual participants preferred to have women as casual partners stating that they encountered difficulties with explaining their sexual orientation to their female partners.

*“...The women I engage with don’t know my sexual orientation because for me it won’t be a relationship but rather a fling so they don’t need to know.” (Kabelo, 25 years).*

*“But with females it’s very difficult to be open. It’s never easy to tell females that you are bisexual; they just break up with you. Some try and understand but in the long run they feel uncomfortable and they leave you...I hide my bisexuality from girls but currently I am most likely to have sexual encounters with males because of my sexuality because guys whether bisexual or gay they will be more open to it whereas females are not as open as they can be if the guy is not heterosexual.” (Mtho, 23 years).*

*“I once cheated on my boyfriend with a girl when I went home for the holidays. When I confessed out of guilt he just laughed and said cool but if the opposite was the case, that would be the death of me so to avoid drama I just don’t tell them” (Emjay, 25 years)*

The majority of participants also stated that they were not comfortable with opening up about homosexuality with health care workers. This is because of perceived judgement by the nurses whilst for some they had bad experiences. One participant whose parents are in the medical field said that he is not comfortable revealing his sexual history to health care workers because of negative comments his parents have made after treating homosexual patients.

*“I am afraid of the things they [clinic staff] would say. They go like, you have a STI and they ask where you got it from? And they remind you that it’s because you are sleeping with men that’s why you have a STI. Whenever I go to the clinic I lie that I sleep with women because I was uncomfortable telling them that I sleep with men”. (Leezy, 23 years).*

For some of the participants non-disclosure is not related to their sexuality but rather they consider it a “male thing” to be uncomfortable with opening up about their private lives especially when the questions are seemingly very personal.

*“Men are never open discussing health issues, worse sex related, maybe because of ego” (Panda, 29 years).*

*“..I don’t mind having the nurses know that I sleep with men. I do tell them and the nurses by my house do encounter different people. My problem is the questionnaires that they use when they know about you. The questionnaires are too personal. Like they ask, “what position do you take”, “does it hurts and all those other things”. If it’s man-to-man, they usually ask what position you take during penetration and if any part hurts during sex. But if I’m with a woman they ask if I have weak ejaculations.” (Mtho, 23 years).*

The majority of the participants stated that they were not open about their homosexuality with their families despite living as openly gay or bisexual. Within the family, there were levels of openness. They are some family members who are aware of their preferences while they hide sexuality from the members whom they perceive to be unaccepting of homosexuality. Some of the participants said that while attending university in the city they were free to have open relationships with men. One participant from Durban city narrated how his partner's family knew about their relationship, whilst his parents knew his partner as a friend because he is aware that his family is firmly steeped in community norms. This is best illustrated by the following examples

*“Culturally black people in rural areas, they think you need to be indoda [a man] and marry a woman. Back home I have a boyfriend. He works there and when he is coming to see me he comes very late and my family thinks I am outside in the toilet because our toilet at home is outside. I have introduced him to my aunt as a friend”. (The Queen, 25 years).*

*“I live in a city so I don't have to act in a certain way. But back home, I would rather have a main relationship with a girl”. (Kabelo, 25 years).*

*“I live in a strict and culture bound house and they believe in tradition. A man is supposed to be the head of the house. A man is supposed to act in a certain way, a man is supposed to be with a female. That has made my uncle and my aunts to be very homophobic but because I was raised in the city, I am not ghetto so they have relaxed in their thinking. I believe they do know about me but then they are scared to talk about it...But with us the third generation as in my cousins, we are more open-minded because we grew up in the city. My father has asked about my sex life, I confirmed having sex with girls but not guys and I know that he doubts me. He investigated and asked me about protection. I will confirm to him later about having sex with men.” (Mtho, 23 years).*

These participants who were not open with their families, shared similar experiences of how their parents and in particular their mothers had in the past insinuated knowing about their sexuality but they never directly confronted them because they did not know how to start the conversations.

*“My family is not aware that I am gay. I haven't talked to them about it but my mother “knows” although we have never discussed it. She once said to me “stay where you are I*

*know you are with boys". She said in such a way that she knows I date boys they are not just my friends. I think every parent knows" (Sinazo, 19 years).*

*"...certain topics such as sex are not brought up at home, let alone homosexuality". (Kritik, 27 years).*

This participant quoted above, further lamented on the fact that not opening up with his family negatively affected him in that his first relationships with men were wrong relationships in which he ended up being hurt. He felt that had he received support and more especially psychological support from his family he would have been wiser and safer.

*"I think I would have been wiser and safer if my family knew about me. I needed emotional, financial and psychological support. The psychological support is probably the most important because it would have been easy to avoid such relationships. You can't tell the right people to date at a young age, in your teens...hearing something from a parent makes something stick better than reading in a textbook." (Kritik, 27 years).*

Other reasons for the lack of openness have to do with community attitudes towards homosexuality. Many of the participants in this study said that they have distanced themselves from religion because it promoted homophobia, which increased the numbers of secret MSM relationship. The participants referred to these MSM who live under the covers of heterosexuality as "*closet gays or after 9s*", meaning that they are only comfortable with meeting their male partners secretly. According to the participants these *after 9s* are often homophobic in the community and inspire the lack of sensitivity towards homosexuality in religious institutions

*"...you are just there [church] to pray but someone gives you a sign like a wink or when people are hugging and greeting in church they tickle inside your hand or wink to show interest in you- its gay code and they know it. Sometimes they want to have sex in the church bathroom. Meanwhile, everyone in the church is very homophobic and they are very outspoken about their hate for homosexuals. In areas like Kwa-Mashu those kinds of places, all hell breaks loose. They will embarrass you and they lack sensitivity when they speak". (Kritik, 27 years).*

*".....a person who has sex with men but is not out in the open about it they are at a greater risk because they sleep around. But they are the homophobic ones because they are dealing with a lot you know. They actually bottle things up, they are the ones who create heat*



*actually, because straight guys don't care and they are fine but you find that the one who hates you is the one who is in the closest- we call them the after 9s because at night they do guys". (Leezy, 23 years)*

#### **4.9 Having sex for financial gain**

The majority of the participants admitted to receiving offers to enter sexual relationships for financial gain. The participants who had never entered these relationships believed that it is students from poor backgrounds who enter transactional relationships. This is illustrated by the statements below:

*"They aren't in relationships for love but for sex and money. They date older men but you can't blame them because maybe they are poor and it's a way of getting money. It's hard to get an older woman to give money. Some aren't even gay, they just want money" (Sinazo, 19 years)*

*"I have had someone trying to do it. He kept on saying hey I wanna have sex with you. Every month he would say that. He offered me stuff. But he drives a Cleo and my parents drive BMWs". (Handsome, 21 years).*

Amongst those who have been in transactional relationships referred to as *blesser-blessee relationships*, they had their first male-to-male sexual experience in a transactional relationship because the first encounter is unanticipated. Often young MSM are naïve and unaware of the possibility of someone wanting to give money in return for sex. However, according to one participant, the first exposure is enough to alert any individual to the possibilities of benefiting financially from a sexual relationship. The benefits come in different forms such as money, vacations, material assets although it depends on the age of the recipient as well as the economic status of the *blesser*.

*"When I got into a relationship with the first guy, I discovered that he was rich and he was in it for the sex. At that point, I was 16 or 17 and that was the first contact. But I was never sexually active with him- it was an online relationship. He was between 20 and 30 years older than me. We met on Facebook; I just logged on one day and found an inbox. They take chances and just inbox anyone. I didn't know him before then. I became sexually active at 19 and the guy was also around 20-30 years older than me. At this point when I went into these relationships it wasn't for the money, I was naïve I believed in love but these men just wanted*

*sex. But when I turned 22, I started dating a man 30 years older than me and at that point I had enough experience so going into the relationship I had an intention but still I was looking for love except this time around it was finance plus love”. (Kritik, 27 years).*

The participants shared different experiences of being in a transactional relationship. The majority of them considered these relationships oppressive and would not consider entering them in future. Few narratives offer positive experiences as some did not think there is anything wrong with transactional relationships.

*“After that relationship I started dating within my age group and I found that there was a difference in that guys my age are not controlling. My experiences in the relationships is that there are benefits such as money, but I was a teenager then I got excited by small things but I think if you date them in your 20s the benefits are more like they buy you cars and go on vacations” (Kritik, 27 years).*

For one participant however, he has never received a transactional offer but states that he is the one who looks for potential partners by approaching strangers and offering them sex regardless of whether or not he knows their sexual preferences. He is more concerned about the benefits he gets from the relationship and he is not afraid to make his intentions clear.

*“I have never been offered money for sex. But, I have been the one saying if you give me this and that I will do this with you. I do this especially with guys from Nigeria and other African countries. They give me lots of money and I need it to buy alcohol, go out, do Instagram and all. I meet them ezindaweni zobumnandi [Places of fun] like clubs. Even if I am not sure they are into men, I am not scared of rejection. I take chances because for me it’s a financial thing. You give me material things and I give you pleasure”. (The Queen, 25 years)*

#### **4.10 Characteristics of transactional relationships**

Participants revealed that the majority of their transactional partners were in relationships with women. In terms of the age range between partners it varied because for some participants the lowest age gap reported was five whilst the highest age gap was 30, thus age was not an important factor in transactional relationships rather it was the economic differences that determined the nature of the relationship. In terms of the relationship dynamics, the most common theme was that transactional partners are very secretive about their personal lives and prefer to have everything done in private. In addition, they are willing

to have unprotected sex with their male partners. The participants description of transactional partners were less than pleasant as illustrated below:

*“It never sat well with me. I was very unhappy with the nature of the relationship because the fact that they have an economic upper hand makes you do all they want. We used to meet in restaurants but there was no touching, touching was reserved for the hotel rooms. They pick you in cars with dark windows and never ever talk about their relationships with their wives or children. Even on their social media pages it’s just them, I mean pictures. Not even family pictures. When you chat to them on WhatsApp, they even warn you saying “don’t screenshot this conversation”. (Kritik, 27 years).*

*“Men who go for young boys are usually men who are married, they are old and they have low self-esteem. They are ugly- ugly personalities. They probably hate themselves or they are obese but they are rich. They have money but most are from a strict traditional background so they are an older generation that grew up when men were not allowed to sleep with men. They can kill to keep their secret and they are very evil people sometimes. They are really powerful and influential people. They use you for that moment and then the next day they use another young person because they know that they can’t continue using the same person otherwise, they will be caught. They probably also have HIV because they think younger people do not have HIV so they engage in risky activities with them without using condoms.” (Star Mor, 24 years).*

Some of the participants claimed that they could not enter transactional relationships because they assumed an insertive role during sexual intercourse. They felt that receptive MSM were more likely to enter such relationships.

*“They have tried but it is difficult with me because I am top. If you are top, you must be the one with those resources to provide. Once you do they will do anything for you, anything” (Handsome, 21 years).*

*“I think bottom guys are at risk of having men offering them money in return for sex. I am more top than bottom”. (Kabelo, 25 years).*

This study revealed that transactional relationships are linked with forced sexual intercourse because one individual often assumes a dominant role in the relationship due to several factors such as having more money. This link between transactional and forced sex is best

illustrated by the experiences of one participant. Although not the victim, he was a close friend to the victim

*“One day he told me about this new guy that he had just met on social media. The guy was going to come and fetch him and they would go to his place. The man was very discreet, when I went out with my friend to meet him he only wanted to see my friend and not me so he just drove away. Then he called my friend to tell him that he only wanted to see him and not his friends. That night my friend’s drink was spiked and he got raped by that man”. (Star Mor, 24 years)*

#### **4.11 Violation of sexual rights**

The study further reveals that the majority of participants did not consider men to be victims of sexual violence. This is because they believed that only women can be sexually violated thus they did not consider themselves to have been victims despite having had their sexual rights violated in the past.

*“That [forced sex] has never happened to me. I hear most of those stories coming from girls not guys. How do you even force a guy” (Kwena, 28 years)*

Upon further probing, the participants revealed that they had found themselves in uncomfortable situations where they had to have sex against their will. They were more comfortable with referring to these situations as “manipulation” rather than “force” or “abuse”. A typical scenario of sexual manipulation involves one individual creating a situation in which the other person is forced to consent to sexual intercourse. Although the participants did not link sexual manipulation to the role assumed during sexual intercourse, some of the participants commented that forced sex applied to receptive MSM because their sexual role increases their vulnerability to manipulation. Below are extracts as told from both the victim and the culprit’s perspective.

*“I have been manipulated when I was young and naïve. People are very creative out there. They create situations that make you go like okay, we are here now, I’m horny you might as well give me some D [sex]”. (Thando B, 24 years).*

*“I have never been forced to have sex but I have been manipulated. I gave in as a means to an end where I was like okay let’s just get this over and done with this” (Lekko Motion, 26 years).*

*“I think it applies to bottom guys because they are at risk. I have manipulated people before, maybe once or twice. It happens say while we are talking or chatting as friends. I invite you to my place; we chill and say I promise to drive you home. I ask for sex and you say no then I will say leave my house I’m not going to take you home meanwhile I know it’s late or there’s no way you can go home. So the person just ends up doing it with me” (Kabelo, 25 years).*

Some of the participants admitted to having manipulated men their ages. One of the participant stated that the biggest manipulators are people that one has been in a relationship with because they feel that by virtue of having been sexually intimate with them they are entitled to be sexual with their past partners anytime they feel like.

*“I have been sort of manipulated or tricked. We had ended our relationship so we weren’t dating anymore then the guy said “let’s go out for old time’s sake meanwhile it was a plan to get me. Later that day we did it” (Kritik, 27 years).*

*“It happens a lot that you have sex without planning or consenting especially with guys who act straight”. (The Queen, 25 years).*

In addition, sexual manipulation was not limited to non-regular partners as some of the participants mentioned that the people who manipulated them were their primary sexual partners. Despite these not being transactional relationships, the relationships often assumed a manipulative nature when one partner has an economic upper hand. Two examples are illustrated below

*“Right now I am in a relationship even though I am not happy but still I do submit to him. I cannot say its money but he does have money and he is working but he has so much power over me. It has come to a point whereby I don’t want his money and I don’t receive anything from him because I feel small sometimes he is manipulative. He uses the money” (Leezy, 23 years)*

*“...it was a horrifying experience. Because when you are in those relationships, you don’t feel like you belong to yourself but to that person because they determine all your*

*experiences. I was 23 and the bastard was 35. He wasn't abusive in "that" sense but definitely manipulative" (Lekko Motion, 26 years).*

An extreme example of "sexual manipulation" is narrated below. In this instance, the participant describes his experience as manipulation despite admitting that the sexual encounter was non-consensual. He believes that as a man, he simply has to deal with the experience and move on with life, as it cannot be sexual abuse.

*"It happened to me last month. I was with my roommate who is also gay. We went out to a club and these two guys approached us. They bought alcohol for us and we drank together. They had already shared us between the two of them, like this one goes with me and the other one with my friend. They said they will drive us back to our residence but on the way, they drove to their flat. We slept with them without a condom. My friend was a virgin but I was not. The next morning he went to the hospital and they gave him PEP. It was not agreed or in any way consensual sex." (The Queen, 25 years).*

According to one participant, sexual manipulation is not considered a violation of someone's rights as it is another way of gaining consent when the conventional way is not working out. He states the following

*"There is always an element of manipulation when one has sex with someone they are not supposed to, like I mean if you ask nicely and the person is saying no, you become strategic so I wouldn't say I took advantage of the next person" (Panda, 29 years).*

#### **4.12 The influence of alcohol**

The participants said that sex is often used and expected as payment for alcohol if one goes out and someone buys a drink for them. They all agreed that alcohol does not entirely cloud an individual's judgement but it only serves to facilitate certain behaviours by giving them confidence to do something that they would not usually do as most of their drunken encounters are more likely to be with people they know, including friends who identify as heterosexual. The participants said they made conscious decisions not to use condoms when they are under the influence of alcohol therefore they do not blame alcohol for the inability to use condoms under influence of alcohol as it is a conscious decision.

*“...if you mix with the wrong crowd. You will have your drinks spiked. And usually it happens to people who go out knowing they don't have money expecting others to buy alcohol for them. Then after you drink their alcohol, the people demand or expect sex”. (Lekko Motion, 26 years).*

*“It's normally when two people have a thing for each other, but neither has the guts to kick-start the interaction, and alcohol then breaks the ice. I am usually aware of what's going on even after drinking”. (Panda, 29 years).*

*“I wouldn't fully blame alcohol but it contributes about 30 per cent to what you actually want to do already that night. It's not a matter of being weak or forced but it's a matter of unleashing what you actually wanted to do. It starts by being dizzy and actually drawing near to that person and when you start conversing. This usually happens at parties or clubs. You get men in a club, sometimes five men approach you and at that moment you are tipsy. Then they offer you drinks or offer to take you home”. (Njabulo, 23 years).*

*“...when it [UAI] happens you will be aware of what is going on. I say that because for us as men having sex with men, you can't have sex without lube so if you can think of lube then you know what you are doing and you can think of a condom as well but we just choose not to get it [condom]” (Kabelo, 25 years).*

Use of alcohol increases the risk of sexual intercourse. Of all the risky behaviours identified in this study, the influence of alcohol had an obvious link to peer pressure. The participants also commented by saying that most people consume alcohol because of their friends and that when they go out with friends they end up having sexual intercourse. What was common from the experiences of the participants is that consuming alcohol was not related to the intention to have sex as most of them said they consumed alcohol when invited by friends or as a way of dealing with academic stress.

*“It doesn't happen every day but now and then when you are stressed with books or after the exam you just go out with friends and drink”. (Star Mor, 24 years).*

*“Peer pressure plays a big role most of the times. Friend call and says lets club. We go, no money, get guys to buy us- friends make you drink. You see now peer pressure has gotten me out of my home. But it also depends on whether as a person you are easily persuaded or you can stand your ground”. (Lekko Motion, 26 years).*

#### **4.13 Attitudes to long term relationships**

In relation to HIV, some participants believed that having a long-term partner reduced the number of lifetime partners. Some of them believed that having one partner for a long time could increase HIV risk if that partner is not faithful.

*“It [long-term relationships] can protect me from HIV because it reduces the number of sexual encounters with different people that you are most likely to have. So like in a year, if you are going to have sex with one person then it would be that person only, whereas if you are not in a long term relationship you are most likely to have 25 plus sexual partners in a year and those are just encounters not relationships.” (Mtho, 23 years).*

*“I don’t think a long term relationship would protect me. People married for thousands of years die of HIV. It’s even riskier being married because married people you know they shun condoms and start infecting their partners when they get infected. I do want a long-term relationship but ‘since you being with the person suggests you are faithful you relax and it comes back to you” (Thando B, 24 years).*

Most bisexual participants said that they were not under pressure to settle with women. However, one participant stated that his decision on whether his future long-term partner will be male or female is uncertain because he is greatly affected by his cultural beliefs.

*“....they encourage female to male relationships and relationships with other men have to be behind closed doors. So you can’t have something long term with a man because your long-term partner has to be a woman. Tradition does affect me and I think it will for as long as I live” (Kabelo, 25 years).*

#### **4.14 Campus environment and community acceptance**

The participants said that they felt safe to be open about their sexuality without judgement from heterosexual students on campus. All the participants said that they were glad that the university allowed them their independence and they felt they could express themselves sexually. Students who had been in the university environment for longer said that in the time they had been in the university they had observed transformation in terms of how with the help of the government, universities had administratively accepted LGBTIQ students. They believe that this promotes openness and freedom of expression within the university



premises. One participant stated that he was satisfied with the services he got from the university clinic because they always had lubricants available for MSM students.

*“At the moment I think the campus is safer environment compared to the rural areas back at home where we come from, even outside in town. Many MSM feel safe to express ourselves on campus like even holding hands. Anywhere in the university premises but outside it is not safe. The environment can put someone at risk of being raped, assaulted, discriminated against then it forces them to be in relationships with women. When I left home I knew I was coming to a better and more accepting environment because at home being gay is not accepted. But when you come into the university I felt free to express myself because it’s a safe environment compared to home”. (Star Mor, 24 years).*

In comparison to the campus environment, the majority of the participants said that once outside the gates of campus they did not feel the same. Despite stating that the campus environment is safe, the participants in this study also mentioned that there is more that needs to be done in terms of ensuring that homosexual people are accepted in the communities around the university. In their experience, some heterosexual students changed attitudes once outside the university premises. According to one participant having transferred from a different university, the university environment promoted risky behaviours such as “*after 9*” relationships because there is no visibility of LGBTIQ support and protection from the heterosexual students. For one participant this is because there is lack of funding for the LGBTI societies in the university to actively create awareness around critical issues so that even the closet MSM students felt comfortable with expressing themselves.

*“The university needs to do more to make the environment more accommodating to men who have sex with men. Because our university didn’t even have a forum. We have been asking so that they can fund us but they don’t do as much as they need to. There isn’t enough funding for the gays and around the campus; there is stigma so people still need to be educated like a lot. I moved from an off-campus residence I stayed in because of being discriminated against like it was really bad because they beat up another gay student in front of me and that is why now I stay on campus. It’s dangerous in off-campus residences. People from the neighbourhood are uneducated. That means a person who has sex with men but is not out in the open about it they are at a greater risk because they sleep around”. (Leezy, 23 years).*

#### **4.15 Limitations in practising safe sex**

The participants said that they could not practise safe sex because condoms do not come with lubricants, which compromises their decision-making. The participants noted that although condoms are freely available on campus, they did not always have access to lubricants. With regards to purchasing these preventive commodities the participants said that it was costly to buy both thus sometimes, they had to make a decision to buy either condoms and risk having the condom burst or to buy lubricants and have unprotected intercourse. One participant however said that there are other ways to make up for lack of lubricants by using any water-based products.

*“The market should be responsive to the needs of MSM. For example, when they sell lube it’s in a bottle but condoms should come with lube. It becomes expensive to buy both condoms and lube separately and we are young people not all of us can afford both. That’s why I think all these HIV programs are not specific to MSM. It’s also important to find ways to change the way in which people think”. (Kabelo, 25 years)*

*“I know that lube has to be only water based or egg white or plain yoghurt. Things like lotion and Vaseline damage the anus and it won’t go back to its original state”. (Lekko Motion, 26)*

#### **4.16 Summary**

It is evident from the interviews that MSM perceive themselves to be at risk for contracting HIV. However, perception of HIV risk is not always constant as it is influenced by various factors. The study also showed that the participants engage in risky sexual behaviours such as unprotected anal intercourse, sex with multiple partners, high partner turnover, transactional, forced and intercourse. The participants also expressed concern over their lack of confidence with their partners’ HIV status. The participants also demonstrated a lack of understanding of sexual abuse in male-to-male relationships. The chapter has also attempted to highlight some set of circumstances that have made it possible for MSM to adopt safer sex practices. The last section of this chapter identified that the lack of sensitivity to the needs of MSM acts as major hindrance for practising safer sex.

## CHAPTER FIVE

### DISCUSSION AND CONCLUSION

#### 5.1 Introduction

There is widespread agreement that risky behaviours perpetuate the spread of HIV among MSM populations in both the high and low burden countries burden regions of the world (McQuaid, 2010; Imrie et al., 2013; Wang et al., 2015). Thus as some researchers have advocated, behavioural change is a necessity for the reduction in the number of new infections among MSM (Mor and Dan, 2012). In some sub-Saharan African countries, the decline in new HIV infections has been attributed to behaviour change programs that involved extensive promotion of condom use, faithfulness and partner reduction (Green et al., 2006; Halperin et al., 2011). Thus, behaviour change must be at the centre of HIV campaigns (Halperin et al., 2011). The central focus of this study was HIV risky behaviours among men who have sexual relations with men.

Most studies have generalised MSM populations, however this study was contextualised to only shed insights into the HIV risky behaviours of MSM under the age of 30 in institutions of higher learning because this is a critical and often overlooked population group. The under 30 age groups are very important in HIV studies because they have a high infection rate and are likely to be enrolled in universities at a time when most of them are enjoying their freedom from parental guidance for the first time in their lives (Reddy and Frantz 2011; Amornkul et al., 2009). The university environment increases opportunities for sexual encounters (Chanakira et al., 2014) and research suggests that MSM in universities are faced with a double threat of HIV since the university environment is conducive for risky behaviours and this is in addition to the high prevalence of HIV in young and MSM populations (Chanakira et al., 2014; Stewart-Brown et al., 2000). This study relied on qualitative data from 15 in-depth interviews with self-identified MSM students.

Qualitative research methods are often criticised for lacking representativeness. The findings of this study will not be generalised to apply to all MSM due to the relatively small size of the sample. The sample is also not representative in the sense that the participants in this study are highly educated. However, the in-depth interviews were used to gather detailed information on the perspectives and experiences of MSM. The study draws on the framework

developed by Eaton et al. (2003) for understanding HIV risk behaviour. This framework explains sexual risky behaviour in Southern Africa by considering the interactive factors at three levels i.e. within the person, within his proximal context and distal context.

## **5.2 Discussion**

The findings of this study reveal that participants perceived themselves to be at risk of HIV. This is mainly because AIDS is generalised in the country and has affected most individuals either directly or indirectly. As shown by findings of this study, the participants perceived themselves to be at increased risk for contracting HIV when they assumed a receptive role during anal intercourse. The participants who exclusively assumed an insertive role during intercourse did not consider themselves to be comparable to that of the receptive MSM thus these participants believed that medical male circumcision was an effective protective measure for them whilst, some of the participants who exclusively assumed a receptive role did not consider circumcision to be protective. Another factor that influenced the participants' perception of risk was the socio-economic status of potential partners. The participants believed that MSM who do not have high levels of education are more likely to be HIV positive. This is because the participants are aware of the socio-economic disparities of the HIV pandemic. In addition to the small size of the MSM community, discriminatory criteria set for potential partners created complicated sexual networks that resulted in MSM sharing partners over time. These discriminatory criteria included a preference for non-effeminate and financially well-off partners. However, it is possible that, if indeed promiscuity exists in MSM communities, it is not any different from promiscuity in heterosexual relationships. However because the LGBTIQ are a minority the chances of sexual networks connecting are much higher.

The participants engaged in risky behaviours such as UAI when their perceived risk is lower because they are on PrEP or know that they will have access to PEP the following day. This is consistent with the findings by Ma et al. (2013) where MSM reported not being concerned with their HIV risk if they knew that there are effective measures and treatments available. Thus due to increased awareness and knowledge of HIV, it was not something they were afraid of. Therefore, due to this perception of HIV, despite desiring to protect themselves participants were also aware of the fact that it is possible to live normal lives after one has contracted HIV thus they were not afraid to have unprotected anal intercourse with HIV

positive partners if their perceived risk of contracting the disease is lower. For some of the participants, contracting HIV was inevitable as MSM. In their view, prevention serves to only delay the acquisition of the disease. They felt that it is something that would happen eventually.

Despite perceiving themselves to be at risk of HIV, the study revealed that MSM engage in risky sexual behaviours. The question as to why people continue practising unsafe sex despite the concerted efforts of educational and HIV prevention campaigns to influence their behaviour was central to the development of the theoretical framework for understanding sexual behaviour by Eaton et al. (2003). The findings of this study confirm that there are various factors that exist at three levels which are; personal, proximal (interpersonal) and distal (structural) levels. Eaton et al. (2003), identify risky behaviours as “being sexually active (as opposed to abstaining from or postponing sexual activity); having many sexual partners (either serially or concurrently); and practicing unprotected sex (which includes the irregular or incorrect use of condoms).”

All the participants in this study displayed negative attitudes toward condoms, as the majority of them did not use condoms consistently. The main reason for not using condoms regularly had to do with having a main regular partner. The decision of whether or not to use condoms depended on whether or not the partner is a primary partner or a casual partner. The participants stated that they felt safer when engaging with their regular partners thus, they did not use condoms but meanwhile they always used condoms with casual partners. This finding is consistent with findings by Mitchell (2014), who found that many MSM acquire HIV from their primary male partners while in a relationship, as they do not use condoms with their primary partners. The reasons for not using condoms with regular partners are linked to the level of trust between the two, the need to connect with the other person but most importantly, it was a means of experiencing enhanced pleasure. This finding is also consistent with previous research by (Mitchell et al., 2012) where MSM self-reported to be having UAI with their main partner.

Condom use was also influenced by HIV testing such that for the majority of the participants- the results of an HIV test informed the condom decision-making process. In the event that one partner tested positive condoms would still be abandoned in the relationship once the infected partner has had his viral load suppressed by ARVs. A similar finding was obtained by Beougher et al. (2015: 9) who found that “testing at the beginning of the relationship

informed many couples' safer sex efforts, such as their decision to stop using condoms, which also speaks to relationship dynamics such as trust in, and the value of the relationship". For HIV-negative partners in HIV-discordant relationships, testing a way to maintain physical and mental health by monitoring their serostatus and reducing feelings of anxiety caused by the potentially risky sexual behaviours in which they engage (Beougher et al., 2015).

While research suggests that partner counselling services are a possible effective strategy to reach MSM with unrecognised infections (MacKellar et al., 2005), the participants in this study were not sure of their partners' HIV status even though they knew their own status. The findings of this study suggest that the main hindrance to couples testing is perceived homophobia from the health care workers. This is inconsistent with previous research that placed emphasis on relationship dynamics as the main hindrance to couples' voluntary counselling and testing (Mitchell et al., 2014). The reason for this inconsistency may have to do with the location of the study. It is possible that as MSM in a heteronormative sub-Saharan Africa context, the participants of this study encounter different challenges to couples testing in comparison to those in developed countries where the Mitchell (2014) study was conducted. In one study, Tao et al. (2014) concludes that home-based HIV testing is an alternative approach for increasing the coverage of HIV testing among MSM thus it will also create opportunities for MSM couples to test together.

The majority of participants said that they had either in the present or past been in multiple relationships at one time which confirms past findings that MSM do engage in multiple sexual partnerships (Garcia et al., 2016). Multiple sexual relations were identified to be mainly a result of lack of sexual satisfaction in the main relationship. The majority of participants however did not consider multiple relationships as increasing their risk because they felt that what matters is whether one uses protection.

A vast majority of people in this study were openly living as either gay or bisexual but this openness was only limited to individuals and situations where they knew they would not receive negative judgement or rather where they did not care about the opinions of people in that environment. Thus, most of the participants were not open to their close family members due to the fact they could anticipate negative reactions to disclosing their homosexuality. They were open with their siblings and cousins who were more understanding and more than willing to help them hide their sexuality from other family members. The participants who

also had sexual relations with women kept their bisexual behaviour from their female partners a secret because women were not accepting of MSM partners. This finding may have significant implications for the level of HIV transmission risk to women who have sexual relations with HIV-infected bisexually active men (Montgomery et al., 2003). In a comparison of black and white US communities, community practises play a role in promoting bisexual behaviour by influencing MSM to not disclose homosexual behaviour even to their female partners. This finding is consistent with the findings of this study which suggested that bisexual MSM experienced difficulties with disclosing their homosexual behaviour due to the fact that their community and family norms still had a hold over them (Montgomery et al., 2003; Millet et al., 2005).

The lack of openness about homosexuality also extends to health care workers. Perceived fear of judgement by the healthcare practitioners deterred the participants from disclosing homosexual behaviours. Not all the participants had experienced negative attitudes from the nurses but they felt that nurses were not educated about MSM relationships. Lane et al. (2008) found that MSM often employ specific sexual health seeking strategies such as concealment of homosexuality and gender identity to avoid encountering homophobia. Lane et al. (2008), note that these strategies are not conducive to sexual health promotion among MSM. They undermine the uptake of prevention measures such as condoms, accurate HIV education and testing for HIV (Kushwaha et al., 2017).

As mentioned earlier negative attitudes towards homosexuality often lead to homophobic attitudes within communities (Montgomery et al., 2003). Based on their knowledge and experiences the majority of the participants believe that homophobic attitudes promoted secret relationships. Secret relationships often assumed a transactional nature as one individual in such relationships often does not want to be identified as homosexual out of fear of being judged in the community. One might assume that it is people from poor backgrounds who enter relationships where sex is given in exchange for money, however according to the participants, they did not lack financially before entering these relationships because although not rich, their families could provide for them. The financial benefits were not for helping them meet basic needs but rather their desire for luxury.

Transactional offers also came in the form of someone offering or actually buying alcohol as a sign to show interest. The participants in this study said that accepting alcohol from another man was considered a way of agreeing to have sex with them. This finding is consistent with

findings by Masvawure et al. (2015) who found that alcohol-for-sex exchanges among MSM were common in local South African shebeens, pubs and taverns. The findings suggest that MSM enter their first transactional relationship without full comprehension of the nature of the relationship. Transactional relationships increase the risk of exposure to HIV due to the fact that one partner is often stripped of their ability to negotiate safer sex as observed in a study conducted in Nigeria (Bangboye et al., 2017). As shown in this study, there is a very thin line between transactional and commercial intercourse as research has shown that South African students engaged in commercial sex (HEAIDS, 2014; Brink, 2017).

This study also reveals the thin line between rape and sexual manipulation. The findings suggest that sexual manipulation is very common in MSM interactions. This kind of manipulation occurs when one individual is put in a position that forces them to consent sexual intercourse. While research has shown that LGBTIQ people are at elevated risk for lifetime sexual violence victimisation (Rothman et al., 2011), the majority of sexual abuse cases against male university students are not reported mainly because reporting is perceived to jeopardize their masculine self-identity (Sable et al., 2006). Thus for the participants in this study who were forced to consent or had non-consensual sex; perceived shame, guilt, embarrassment and fear of not being understood which deterred them from reporting these cases of sexual assault. Manipulation has the same detrimental effect on the well-being of an individual in the same way that direct abuse affects them. According to Sunstein (2015), manipulation does not respect people's autonomy and affronts their dignity. Another problem is that if people's choices are products of manipulation they might fail to promote their own welfare, and promote the welfare of the manipulator (Sunstein, 2015). In that way, manipulation compromises the sexual health of individuals by increasing the risk of exposure to HIV if the manipulated individual fails to negotiate safer sex. This begs for two questions to be answered:- To what extent is the sexual abuse of men by other men considered a serious violation of sexual rights? What facilities are there to support MSM who have been violated sexually?

As shown by the findings of this study, alcohol plays a big role in facilitating risky behaviours by boosting self-confidence, loosening inhibitions and clouding judgements. This leads an individual to engaging risky behaviours that they normally would not engage in (Yoruk and Yoruk, 2013). In such cases, intercourse often occurs without the use of condoms the risk of contracting and transmitting HIV is heightened. The chances of forced sex were much higher when under the influence of alcohol and in fact as shown by the findings of this



study as MSM often use alcohol influence to gain sexual favours from others- a claim confirmed by the Masvawure et al. (2015) study.

Long-term relationships have the potential to reduce the risk of exposure to HIV by reducing the number of lifetime sexual partners. However, according to the majority of participants in this study long-term relationships cannot reduce their risk of exposure to HIV due to the perceived levels of promiscuity among MSM. This finding is supported by other research such as Mitchell et al. (2012) who found that the main risk factor for HIV transmission in male-to-male encounters is UAI. Thus the level of risk exposure is the same regardless of whether the partner is long term, short-term or non-regular casual (Mitchell et al., 2012).

Few participants were taking a daily dose of PrEP while the other participants despite their knowledge of PrEP they did not take it as they were concerned about the long term side effects and also did not consider it protective enough. Their negative attitudes towards PrEP stemmed from a point of knowledge and awareness that this method was not protective against other sexually transmitted diseases. This finding is consistent with other research done which showed that the willingness to use PrEP was associated with indicators of sexual risk, self-perceived risk of HIV acquisition, and concern regarding side effects and long-term use of PrEP (Draper et al., 2017). As a result, of these factors another study showed that MSM report relatively low levels of willingness to use PrEP which is similar to the findings of this study (Lim et al., 2017).

In terms of the limitations to practising safe sex, which is understood as sex with a condom and sufficient lubricants, the majority of the participants felt that it was difficult as student MSM to always engage in safe sex in comparison to heterosexual couples. This is because they do not always have access to lubricants despite condoms being freely available on campus. Out of fear of perceived judgement from the health care workers, not many of the participants had access to lubricants from the campus clinic. Some of them thus resort to using any water-based products such as egg white and plain yoghurt in place of lubricants. This finding is consistent with findings by Scheibe (2014) who found that limited access to suitable prevention products such as condoms and condom-compatible lubricants was a contributing factor to the high prevalence of UAI among MSM.

### **5.3 Recommendations**

As shown in this study MSM engage in UAI which increases their risk of HIV. It is therefore important for future studies to focus on behavioural practises and relationship factors that influence some MSM to engage in UAI with their primary partners. While the process of measuring and determining attitudes to condoms cannot be certain, there are expected benefits to intervention programs emphasising on elements of communication to promote more open approaches to intimacy between partners which leads to safer sex practices such as increased condom use (Artistico et al., 2014). It is possible particularly in the context of bisexual MSM living in traditional Southern African societies that they have two primary partners and do not consider either their female or male partners to be secondary. Thus, future research needs to address the cultural barriers to MSM being in open relationships with their male partners as there is a need to address these social norms in research. HIV intervention programs aimed at reducing individual-level risk should also assess the influence of environmental characteristics on sexual behaviours particularly among MSM in urban environments as new infections are sustained by risky behaviours in both urban and rural areas despite the urban environment being more accepting of same-sex relationships (Frye et al., 2006; Imrie et al., 2013)

MSM in this study did not test with their partners because testing centres were not MSM friendly. This study recommends that the testing centres and the campus clinic staff could work in conjunction with the university LGBTIQ societies to arrange frequent VCT counselling and testing services throughout the year. This would encourage many of the MSM students to bring their partners for couples HIV testing. It will also allow the nurses to build trust with the MSM students, which would encourage them to go to the clinic for further counselling and assistance. There is a need for future research to investigate societal perceptions of sexual violence in different contexts e.g. legal and health context to increase awareness of the existence of sexual violence in MSM relationships. A possible area for further research could include assessments of the prevalence of sexual manipulation in MSM relationships. There is also a need to reach out to MSM through creating opportunities and services for them to feel comfortable with reporting sexual harassment and similar cases. Research focusing on barriers to reporting sexual violence in male-to-male interactions will strengthen rape theory as a crime of power rather than as an expression of unmet sexual needs (Sable et al., 2006).

## 5.4 Conclusion

This study showed that MSM perceive themselves to be at risk for HIV but still engage in risky sexual behaviours. The study identified several factors that promote these risky behaviours as well as the barriers to practising safe sex. In research, reported sexual risky behaviours do not match the level of HIV knowledge (Simbayi et al., 2005). According to Wagenaar et al. (2012), knowledge about key aspects of HIV is not adequate to promote sustainable behaviour change in MSM communities; however, accurate knowledge of HIV transmission and prevention is necessary if MSM are to adopt behavioural change as a prevention strategy.

Behavioural change is credited with the reversal of concentrated epidemics in Thailand and Uganda (Shelton et al., 2004). Due to national campaigns promoting consistent condom use the Uganda adult HIV prevalence fell from 15 per cent to 5 per cent in a decade and Thailand increased condom use by female sex workers which was followed by a decline in the number of men engaging with casual commercial sexual partners (Shelton et al., 2004). According to Bekker et al. (2012), behavioural intervention studies in a variety of settings and target groups have not objectively altered HIV transmission mainly because behavioural change is hard to maintain. Behavioural interventions, which remain a priority for HIV prevention are health promotion programs that seek to influence knowledge and attitudes, perceived risk of acquiring HIV and provide individuals with the motivation, skills and opportunities to alter their behaviours (Coates et al., 2008). Thus whilst behavioural intervention strategies are not sufficient to reduce the number of new infections they are a very essential part of a comprehensive prevention strategy (Bekker et al., 2012).

According to Scheibe et al. (2014:1), “despite consistent evidence, effective intervention and political declarations to reduce HIV infections among MSM, coverage of MSM programmes in sub-Saharan Africa remains low”. Sullivan et al. (2012) state that, the current content and coverage of HIV prevention programs is insufficient in addressing the HIV epidemic among MSM. Current intervention programmes that emphasise HIV prevention reach only less than 10 per cent of MSM globally with far lower coverage in low and middle-income countries (Baral et al., 2007). Interestingly these are the countries with the highest epidemics among MSM (Baral et al., 2007). With an improved understanding in multiple levels of HIV risk, there is a growing recognition for the need to implement multi-level prevention strategies (Baral et al., 2013). This means that research on HIV prevention should collect data on multiple levels of risk to inform combination HIV packages (Baral et al., 2013). An effective

combination package will therefore focus on biomedical, behavioural and structural components, as there is a need to characterise the drivers of HIV risk at each of these levels (Baral et al., 2013; Wirtz et al., 2014).

## APPENDICES

### APPENDIX 1: APPROVAL LETTER FROM THE UKZN ETHICS COMMITTEE



09 May 2017

**Ms Geogina C Gumindega 216072682**  
School of Built Environment and Development Studies  
Howard College Campus

Dear Ms Gumindega

**Protocol reference number: HSS/0205/017M**

**Project title:** A qualitative assessment of HIV risk behaviours among male students who have sex with other men: A case study of university students in Durban.

**Full Approval – Committee Reviewed Protocol**

With regards to your response to queries received 19 April 2017 to our letter of 06 April 2017, the Humanities & Social Sciences Research Ethics Committee has considered the above mentioned application and the protocol has been granted **Full Approval**.

**Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.**

**The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.**

Best wishes for the successful completion of your research protocol.

Yours faithfully



.....  
Dr Shenuka Singh (Chair)

/px

cc Supervisor: Prof Pranitha Maharaj  
cc Academic Leader Research: Prof Oliver Mtapuri  
cc School Administrator: Ms Nolundi Mzolo

## APPENDIX 2: INFORMED CONSENT FORM

### UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

#### APPLICATION FOR ETHICS APPROVAL

##### For research with human participants

#### INFORMED CONSENT FORM

##### Information Sheet and Consent to Participate in Research

**Date:**

I want to thank you for taking the time to meet with me today. My name is Geogina Gumindega. I am a Masters in Population Studies student from the School of Built Environment and Development studies (Cell: 0610806242; email address: [216072682@stu.ukzn.ac.za](mailto:216072682@stu.ukzn.ac.za)).

My Supervisor is Prof P. Maharaj ([maharajp7@ukzn.ac.za](mailto:maharajp7@ukzn.ac.za))

You are being invited to consider participating in a study that involves researching sexual behaviours that put male students who have sex with other men at risk of contracting the HIV virus. The abbreviation MSM as used throughout this document stands for “Men who have sex with men”. For the purpose of this research the term MSM includes “those who self-identify to be gay men, homosexual men, men who do not identify as homo or bi-sexual (but still engage in male-male sexual behaviour), male sex workers and transgendered people. The findings of this study will contribute towards the researcher’s Master’s level short dissertation as part of a requirement for the completion of the MA Population Studies programme. You were selected because you are registered at UKZN and report to be sexually active with other men and are under the age of 30.

The aim and purpose of this research is to shed insights into the HIV risky behaviours of men having sex with men that put them at increased risk of contracting the HIV virus. The

study is expected to enroll 15 students registered at UKZN, who self-report to be sexually active and involved with other men, and between the ages of 18 to 30. It will involve the following procedures: You will answer questions that require you to give details about your experiences, knowledge and perceptions regarding HIV risky behaviours as a student MSM. The duration of your participation if you choose to enroll and remain in the study is expected to be one hour.

The study may involve discomforts such as giving details about your private life and past painful experiences despite not having any foreseeable risks. In the event that you experience such discomforts and you become distressed, you may stop your participation at any given time. There is no compensation of any kind involved for this risk but if it happens that you become emotionally distressed during or after the course of the interview please contact student counselling services at Howard College; Physical address: HIV/AIDS Unit behind Island residences office, Contact person: Thandazile Mthembu (0833942932/0312603563 email: [mthembut2@ukzn.ac.za](mailto:mthembut2@ukzn.ac.za)). Should you be willing, I am able contact them on your behalf, but if you would like to contact them yourself (even for further counselling) I will give you a letter granting you permission to contact the counselling offices or Ms T. Mthembu directly yourself.

I also understand that you may feel that participating in this study will put you in a vulnerable position in terms of stigmatization or discrimination. However, I would like to assure you that all your responses should you decide to participate will be treated with a high level of professionalism, competence and sensitivity to your privacy in order to avoid stigmatization of any kind. For the purpose of protecting your identity to avoid potential stigmatization, your real name will not be used or required at all throughout the research process.

We hope that the study will highlight some of the needs of student MSM with regard to information about HIV risks and will also help other young and ignorant MSM to know how to protect themselves from contracting the HIV virus.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number **HSS/0205/017M**).

In the event of any problems or concerns/questions you may contact the researcher at (email: [216072682@stu.ukzn.ac.za](mailto:216072682@stu.ukzn.ac.za) or cell 0610806242) or the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as follows:

## **HUMANITIES and SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION**

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

Remember that your participation in this study is voluntary, you do not have to talk about anything you do not want to and you may end your participation at any point. In the event that you withdraw from the study please remember that you will still be treated with respect as you will not incur penalty or loss of treatment. There will be no negative consequences on your part should you choose to withdraw.

Except for your time, you will not incur any other costs by your participation in this study. Unfortunately, there will be no compensation of any kind neither will you be paid financially should you choose to participate in this study.

During the interview, I will be taking some notes because I cannot get it all down that fast but, I will be tapping the session just so that none of your comments will be missed. Because we're on tape, please be sure to speak up so that we don't miss your comments.

All responses will be kept confidential. This means that your interview responses will only be available to the researcher and her supervisor for purely academic purposes only. The data and stored samples (notes and audio recordings) including this consent form will be kept in the researcher's supervisor's office for five years after which they will be permanently destroyed and will not be made available to anyone else. I ensure you that any information to be included in the final report will not identify you as the respondent. Protecting your identity is a priority which is why you are required to sign this consent form with a pseudonym (false name/nickname) of your choice that will not point to you as the respondent. The reason you are required to sign this form with a pseudonym is to ensure you that no identifying information exists even in the research files.



Are there any questions concerning what has been explained above?

**Pseudonym** \_\_\_\_\_

-----

## **INFORMED CONSENT FORM**

I \_\_\_\_\_ have been informed about the study entitled *A qualitative assessment of HIV risk behaviours among male students who have sex with other men; A case study of university students in Durban* by Geogina Gumindega (student number: 216072682)

I understand the purpose and procedures of the study which include answering in-depth questions that give details about my personal life.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed that there is no available compensation or medical treatment if I become distressed as a result of study-related procedures however, I have been informed that I can contact Ms T. Mthembu to access free counseling services at UKZN Howard College Campus.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at [216072682@stu.ukzn.ac.za](mailto:216072682@stu.ukzn.ac.za) or Cell: +27610806242

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researcher then I may contact:

**HUMANITIES and SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION**  
Research Office, Westville Campus

Govan Mbeki Building  
Private Bag X 54001  
Durban  
4000  
KwaZulu-Natal, SOUTH AFRICA  
Tel: 27 31 2604557 - Fax: 27 31 2604609  
Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

**Additional consent**

I hereby provide consent to:

Audio-record my interview    YES / NO

\_\_\_\_\_  
**Signature of Interviewee**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

**APPENDIX 3: IN-DEPTH INTERVIEW GUIDE**

RESPONDENT PROFILE: Pseudonym (\_\_\_\_\_)

Age	
Year of study	
Relationship status	
Are you currently or have been sexually active?	
How would you describe your sexual orientation?	

1. Have you ever thought of your risk of HIV? What are some of the measures you have taken to protect yourself against the risk of HIV infection?
2. Let us talk about condom use. How do you normally determine when to or when to not use condoms with someone?
3. Sometimes for one reason or another people find themselves either involved with more than one sexual partner or involved with a new person immediately after a break up. What is your experience with such situations?
4. There are so many stories about people getting drunk on one crazy night only to find out in the morning that they had sex in their drunken state. How does that happen if it has ever ever happened to you? Explain.
5. Young people at times find themselves in situations where a person who is wealthy and sometimes a significantly older person offers them money or some form of material thing in return for a sexual relationship. Has that ever happened to you? What was your experience like?
6. Another situation that people have been in is being forced to have sex when they did not want to. What has been your experience with that?
7. One of the most difficult topics to bring up in a relationship is HIV status because it is related to issues of trust etc. How do you handle it? What experiences do you have regarding bringing up the HIV status issue with your partner?
8. What do you expect from a sexual relationship? What are your attitudes towards long-term relationships?

9. How do you think you could be safer when you meet someone you are likely to be sexually involved with? What measures will you take? Explain

#### APPENDIX 4: GATEKEEPER'S LETTER



3 March 2017

Miss Geogina Charity Gumindoga (SN 216072682)  
School of Built Environment and Development Studies  
College of Humanities  
Howard College Campus  
UKZN  
Email: [216072682@ukzn.ac.za](mailto:216072682@ukzn.ac.za)

Dear Miss Gumindoga

**RE: PERMISSION TO CONDUCT RESEARCH**

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN), towards your postgraduate studies, provided Ethical clearance has been obtained. We note the title of your research project is:

*"A qualitative assessment of HIV risk behaviours among male students who have sex with other men: A case study of university students in Durban".*

It is noted that you will be constituting your sample by conducting interviews with registered students on the Howard College campus.

Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book.

Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

  
**MR SS MOKOENA**  
REGISTRAR

Office of the Registrar

Postal Address: Private Bag X54001, Durban, South Africa

Telephone: +27 (0) 31 260 8055/2206 Facsimile: +27 (0) 31 260 7824/2204 Email: [registrar@ukzn.ac.za](mailto:registrar@ukzn.ac.za)

Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)

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## APPENDIX 5: COUNSELLING SERVICES PERMISSION



April 2017

UKZN Counselling Services  
HIV/AIDS Unit (behind Island Residence offices)  
Howard College Campus

To whom it may concern

### Request for permission to access counselling services for students taking part in a research

My name is Geogina Gumindaga (contact details- cell: 0610806242 email: 216072682@stu.ukzn.ac.za). I am a Population Studies Masters student from the School of Built Environment and Development Studies. As part of my studies (under the supervision of Prof Pranitha Maharaj) I will be conducting research for my dissertation. The title of my project is "A qualitative assessment of HIV risk behaviours among male students who have sex with other men: A case study of university students in Durban".

The study will be carried out in the form of in-depth interviews and some of the issues to be raised might raise feeling of discomfort and distress for the participants as they will discuss private matters concerning their sexual experiences in life.

My requests are as follows:

- 1) Permission to contact you on behalf of the respondents should they need your counselling services and
- 2) Permission to give any of the respondents your contact details should they need to access you privately or at any given time.

Thank you for your assistance

Kind regards

Miss Gumindaga (student 216072682)

Permission granted

YES  NO

Contact Person(s)

Thandazile Mthembu  
083 39 47 932  
031 260 3563

Contact details

Tel/ Cell:

Email:

Mthembu2@ukzn.ac.za



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