

Assessing knowledge, attitudes and practices of  
KwaZulu-Natal health professionals towards  
men who have sex with men (MSM): exploring  
access to mainstream public healthcare services.

Precious S. Greehy

Student number: 212562435 / 211539713

Submitted to the Faculty of Humanities, School of Applied Human Sciences,  
University of KwaZulu-Natal in fulfilment of the requirements of a Master of  
Social Science Degree in The Centre for Communication, Media and Society

January 2016

## DECLARATION

I, Precious S Greehy declare that:

1. The research reported in this dissertation, except where otherwise indicated, is my original research.
2. This dissertation has not been submitted for any degree or examination at any other university.
3. This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
4. This dissertation does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
  - a. Their words have been re-written but the general information attributed to them has been referenced
  - b. Where their exact words have been used, then their writing has been placed inside quotation marks, and referenced.
5. This dissertation does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the dissertation and bibliography.



Signature: \_\_\_\_\_ Date: 23 March 2016 Place: Johannesburg

Supervisor: Dr Lauren Dyll-Myklebust Date: 23 March 2016 Place: Durban

## ACKNOWLEDGEMENTS

My sincere thanks and appreciation to the following individuals:

First and foremost, I thank God Almighty for the will, the strength and the wisdom he provided during this study. I acknowledge that without his guidance, I would not have made it this far.

Secondly, thank you to my supervisor, Dr Lauren Dyll-Myklebust, for your continuous push and encouragement throughout everything. There were times when I nearly gave up, especially during the ethical and gatekeeper approval stages. However, your active and unwavering support made me realise that I had a friend holding my hand all the way. Additionally, your constant encouragement, suggestions and feedback during the writing process were valuable to the development and progression of this dissertation.

This study would not have been possible without contributions from the Imbalenhle clinic and King Edward VIII healthcare workers. Thanks to Mrs Mtunzi from Imbalenhle clinic and Mrs Khuzwayo from King Edward VIII hospital for facilitating the recruitment process and for allowing me to conduct this research within their facilities

Thanks to Simone, Lesedi and Gabriel Greehy – my beautiful children for inspiring me to be better and do more for their sake. I pray that one day you grow up to achieve more than I have. Shine bright and be the brightest shining stars wherever you go!

Last but not least, I want to thank Stuart Matthew James Greehy for his unwavering support and encouragement. This also goes to anyone else who believed in me throughout my career or who meaningfully contributed to the realisation of this dissertation.

Thank you.

## ABSTRACT

**Background:**

Healthcare institutions tend to ignore the role healthcare workers (HCWs) play in shaping perceptions of and responses to service uptake. Lack of appropriate HCW skills and their perceived attitudes towards men who have sex with men (MSM) patients has been connected to “misdiagnosis, delayed diagnosis, and delayed treatment, leading to poor health prognosis and higher risk of transmitting HIV and other sexually transmitted infections to partners” (Smith, 2015).

**Research Aim:**

This study explores key factors at individual, group and societal levels which influence perceived HCWs attitudes towards MSM; and how this limits access to HIV prevention, treatment, and support and care services for the MSM population. A Knowledge, Attitudes and Practices (KAP) study is conducted to evaluate the KAPs of HCWs and the ways in which these may affect service provision to MSM patients. The study aims to provide evidence-informed solutions required to equip HCWs with necessary skills to provide HIV/AIDS and quality healthcare services that are sensitive to the needs of MSM.

**Methods:**

The study employs qualitative methods and data will be collected through face-to-face interviews. The social ecology model informs this study. Prospective participants include various health professionals, such as the head of the provincial health department, doctors, nurses, pharmacists, and technicians or medical students from two public healthcare facilities in Durban – King Edward VIII hospital and Imbalenhle clinic, in Pietermaritzburg. Methods used were structured interviews in the form of focus group discussions and self-administered questionnaires. These were conducted with various categories of HCWs in both healthcare facilities.

**Conclusions:**

HCWs play a huge role in influencing responses to HIV and AIDS interventions among key population groups, including the perpetuation of stereotyping and stigma. There is a need for a multi-faceted intervention that addresses perceived HCW attitudes towards MSM. Lessons learned from other studies about barriers to HIV prevention and management may have application in other populations.

**Keywords:** Healthcare worker attitudes; knowledge, attitudes and practices study; MSM health; MSM healthcare policies

## ACRONYMS

BCC:	Behaviour Change Communication
CDC:	Centres for Disease Control and Prevention
DoH:	Department of Health
HBM:	Health Belief Model
HCT:	HIV Counselling and Testing
HCW:	Healthcare worker
HIV:	Human Immunodeficiency Virus
HPCSA:	Health Professions Council of South Africa
ITMHC:	Ivan Tom Men's Health Clinic
KAP:	Knowledge, Attitudes and Practices
KZN:	KwaZulu-Natal
MSHP:	Mailman School of Public Health
MSM:	Men who have sex with men
MSMGF:	Global Forum on MSM and HIV
NGO:	Non-Governmental Organisation
NSP:	National Strategic Plan
PEPFAR:	President's Emergency Plan for AIDS Relief
SAfAIDS:	Southern Africa HIV and AIDS Information Dissemination Service
SANAC:	South African National AIDS Council
SANC:	South African Nursing Council
SCC:	Social Change Communication
SEM:	Social Ecological Model
SEMCHB:	Social ecology model for communication and health behaviour
STI:	Sexually transmitted infection

TB:	Tuberculosis
UoC:	University of Columbia
USAID:	U.S. Agency for International Development
WHO:	World Health Organisation
WMA:	World Medical Association

## **List of Appendices**

Appendix 1:	Information sheet and informed consent form
Appendix 2:	Interview questionnaire
Appendix 3:	Gatekeeper permission - Provincial health
Appendix 4:	Gatekeeper permission – District health
Appendix 5:	UKZN ethical committee letter

## **LIST OF FIGURES**

Figure 1.1: uMgungundlovu health district map

Figure 1.2: eThekweni health district map

Figure 3: The social ecological model (Sallis and Owen 1997)



## TABLE OF CONTENTS

• DECLARATION .....	i
• ACKNOWLEDGEMENTS .....	ii
• ABSTRACT .....	iii
<b>Background:</b> .....	iii
• ACRONYMS .....	iv
• List of Appendices .....	vi
• LIST OF FIGURES .....	vii
• Figure 1.1: uMgungundlovu health district map .....	vii
• Figure 1.2: eThekweni health district map .....	vii
• Figure 3: The social ecological model (Sallis and Owen 1997) .....	vii
• CHAPTER ONE: INTRODUCTION .....	1
Aims and objectives of the study .....	2
Study Setting .....	3
Figure 1.1: uMgungundlovu health district map .....	6
Organisation of the dissertation .....	9
• CHAPTER TWO: LITERATURE REVIEW .....	11
Introduction .....	11
Men who have sex with other men (MSM): What's in a concept? .....	11
MSM: a historical background .....	16
Marginalisation of same-sex relations: a historical overview .....	18
Religious influences on healthcare .....	19
Public vs private healthcare access .....	21
The rise of advocacy groups .....	25
Healthcare policies vs practice .....	26
Poor policy implementation .....	28
The National Strategic Plan on HIV/AIDS, STI and TB, 2011–2016 .....	29
Poor healthcare access for MSM .....	30
Perceived healthcare worker's attitudinal barriers .....	32
Conclusion .....	36
• CHAPTER THREE: THEORETICAL FRAMEWORK .....	38
The Social Ecological Model (SEM) .....	40

Figure 3: The Social Ecological Model.....	40
The SEM in practice.....	44
SEM at the individual level.....	45
SEM in relation to interpersonal level of influence .....	46
SEM at the societal level of influence.....	48
Conclusion.....	52
• CHAPTER FOUR: METHODOLOGY .....	53
Introduction .....	53
Research paradigm .....	53
Research design.....	54
Sampling strategy .....	56
Data collection.....	58
Data recording .....	60
Data analysis .....	61
Thematic analysis.....	61
Use of the SEM in data analysis.....	63
Individual.....	64
Interpersonal .....	64
Organisational and community.....	64
Validity, reliability and rigour.....	65
Ethical considerations .....	66
Limitations .....	68
• CHAPTER FIVE: RESULTS AND DISCUSSION.....	72
Introduction .....	72
Structural and healthcare environment.....	72
Healthcare workers' (HCWs') knowledge and practices about MSM health issues .....	74
HCWs' knowledge and practices: Understanding of MSM terminology vs gay identities .....	75
Cultural influences on HCWs' knowledge and practices.....	80
Disparities between knowledge and practice .....	81
HCWs' knowledge and practices: Understanding of MSM health related issues.....	84
HCW knowledge and practices: Awareness of stigma and discrimination at clinic level ...	85
HCW knowledge and practices: MSM health seeking behaviours and health risk behaviours .....	90
HCWs' knowledge and practices: Substance abuse.....	91

HCWs' knowledge and practices: Counselling and testing .....	96
HCWs' knowledge and practices: Receptive unprotected anal intercourse.....	99
HCWs' knowledge and practices: Commercial sex work.....	101
HCWs' knowledge and practices: Multiple concurrent sexual partnerships .....	104
HCWs' knowledge and practices: Views about tailored MSM health promotional materials .....	106
Summary: Knowledge and practices.....	112
Attitudinal responses of HCWs towards MSM.....	114
Perceptions of MSM sex .....	114
Beliefs and values about MSM .....	115
Exposure to MSM .....	117
Views on freedom of sexuality.....	117
HCWs as role models at interpersonal levels of the SEM .....	119
HCWs' tolerance towards MSM.....	120
Views on patient confidentiality .....	126
Overall perceptions of MSM.....	129
Summary: Attitudes.....	131
• CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS.....	133
Introduction .....	133
Invest in sensitisation and gender training .....	133
Challenge family, group and societal norms to effectively address prevailing HSWs' KAPs .....	135
Address structural factors in addressing HCWs' attitudes and practices.....	137
Address power dynamics at all levels of SEM.....	141
Improve internal systems .....	144
Invest in monitoring and evaluation activities .....	144
Final remarks.....	146
• BIBLIOGRAPHY .....	147
Primary sources .....	147
Secondary published sources .....	147
• Appendix 1: Information sheet and consent form.....	171
• Appendix 2: Interview questionnaire.....	174
• Appendix 3: Gatekeeper permission - Provincial health .....	177
• Appendix 4: Gatekeeper permission – District health .....	178

• Appendix 5: UKZN ethical committee letter .....	179
---	-----

## CHAPTER ONE: INTRODUCTION

This chapter provides background information about healthcare work and relevant policies, as well as the motivation and objectives of the study.

In its definition, the national Nursing Act (2005) explains that a professional healthcare worker (HCW) is a qualified individual who is competent to independently practice comprehensive healthcare work and is capable of assuming responsibilities and being held accountable for health related practices. According to the Act, HCWs are well trained and equipped with skills to render quality care to all, and they are required to provide positive, non-judgemental services to encourage responsible health-seeking behaviours in patients.

HCWs have a key role to play in the provision of non-discriminatory health provision due to their interaction with a wide range of population groups. However, the reality is that the majority of men who have sex with men (MSM) are unable to access public health services without being judged by HCWs due to their sexual behaviours. This may result in lack of correct diagnosis, wrong medication prescription and late treatment uptake which could serve as prevention of transmitting the Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STIs) to MSM partners (OUT 2013).

Implementation of targeted prevention interventions for MSM in South Africa's mainstream public health facilities is very limited. Appropriate MSM health service provision is mostly restricted to metropolitan cities or urban areas (Desmond Tutu HIV Foundation 2011). This is in spite of the growing recognition that MSM are disproportionately affected by HIV; that MSM have been severely under-served by the country's previous national HIV and tuberculosis (TB) response; and that MSM contribute considerably to sustaining high rates of new infections that are recorded every year (Imrie *et al.* 2008).

Regardless of policy recognition by the South African National AIDS Council (SANAC) of the need to establish widely accessible MSM appropriate healthcare interventions (Imrie *et al.*, 2008), implementation and access to the few available services is generally funded by external institutions such as the United States' President's Emergency Plan for AIDS Relief (PEPFAR); the Global Fund to Fight AIDS; Tuberculosis and Malaria and the Centres for Disease Control and Prevention (CDC). Due to limitations in accessing public healthcare, MSM may frequently choose not to seek medical healthcare, thus preventing appropriate risk factor identification and effective treatment and care. International studies investigating healthcare barriers for MSM populations have frequently cited homophobia among HCWs as an important determinant that restricts access (Rispel *et al.* 2011, Lane *et al.* 2010).

Meanwhile, South Africa already has enabling legal and policy frameworks in place that emphasise equity, social justice, and non-discrimination (Tim Lane *et al.* 2010). Lane states that these frameworks are essential prerequisites for meeting the healthcare needs of MSM individuals. Given this and South Africa's pre-eminence in the region, it "has the potential to provide a leadership role in sub-Saharan Africa by improving service provision for MSM, thus providing important lessons for other low- and middle-income countries" (De Swardt and Rebe 2010: 708-10). It was these factors that encouraged this study in order to contribute to the knowledge of the shortcomings of existing healthcare efforts with regard to MSM populations, and associated information or communication materials that may/may not support these efforts.

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

This study seeks to assess the Knowledge, Attitudes and Practices (KAP) of different groups of HCWs in the uMgungundlovu and eThekweni districts, in KwaZulu-Natal (KZN) towards

MSM, as well as the kinds of practices that are followed regarding the healthcare management of MSM patients.

This KAP survey gathers information about what HCWs know about MSM (knowledge), what they think about them or about the health system response to MSM (attitude), and what they actually do with regards to the health management of MSM (practice). This study thus, identifies knowledge gaps, cultural beliefs, or behavioural patterns that may facilitate understanding and action, as well as pose problems or create barriers for MSM healthcare efforts. The study also aims to identify information that is commonly known and attitudes that are commonly held by HCWs. This includes looking at aspects of cultural and socioeconomic backgrounds that are likely to have an impact on HCW KAPs.

Additionally, the study explores how HCWs feelings towards MSM, as well as any preconceived ideas they may have towards them, may influence healthcare service provision.

This will be achieved by expanding on this study's main questions as detailed below:

1. What is the level of knowledge held by health professionals of the relationship between MSM and HIV?
2. How do health professionals perceive the relationship between MSM, sexual practices and HIV?
3. What attitudinal responses may occur (e.g. sympathy, blame or judgement) in counselling/treating MSM?
4. In what ways, if any, do these attitudes impact on the practice of treating MSM patients?

### ***Study Setting***

The uMgungundlovu District (see Figure 1.1, page 6) is an area within South Africa's KZN province and houses the provincial capital of Pietermaritzburg (PMB) and the township of Imbalenhle, within which this study took place. The term township in the South African context refers to underdeveloped living settings that, from the late 19th century until the end

of apartheid in 1994, were reserved for non-white residents, namely black Africans, Coloureds and Indians. Townships were usually built on the periphery of towns and cities (Pettman 1913). According to Pettman, the term township also has a distinct legal meaning in South Africa's system of land title, which carries no racial connotations.

The DoH (2015), states that the uMgungundlovu district is the second largest district in KZN after the eThekweni Metro. The district comprises of seven local municipalities: Impendle, Mkhambathini, Umngeni, Richmond, Mooi Mpofana, uMsunduzi and uMshwathi. As demonstrated on the map below, the district is surrounded by other smaller districts: iLembe to the east; Harry Gwala to the southwest; Ugu to the south; UMzinyathi to the north; uThukela to the northwest and eThekweni to the south-east (DoH 2015).

The district is strategically situated and houses the provincial seat of government. The locality of this district therefore has implications for service delivery and health planning especially when it comes to migration patterns of MSM communities in the urban and rural parts of the district and to referral patterns for higher levels of care and specialised care. In the South African context, urban areas can include small towns or cities, while rural areas include villages. Unlike townships, urban areas are defined by their advanced civic amenities, opportunities for education, and facilities for transport, business and social interaction and overall, better standards of living (Statistics SA, 2015)

For this research, Imbalenhle clinic was selected because it is based in uMgungundlovu district which has the second and highest numbers of people living with HIV after the eThekweni district (HIV and AIDS in South Africa 2014). According to the information provided by the uMgungundlovu district health (2015), the district carries 10% of the provincial population, second to the eThekweni Metro, with a population of 1 052 730. The population distribution in the district is slanted toward the uMsunduzi sub-district which



houses the Imbalenhle clinic; with 60% of the population residing in this sub-district. This slant is because most formal employment opportunities are found here (DoH 2015). The other sub-districts have lower population with Impendle having a population of 34 212. This sub-district is also the poorest and has the highest unemployment rates.

The DoH (2015) states that the majority of the population within the uMgungundlovu district falls between the 5 to 24 years age group, showing that the district has a relatively young population. However, the 15 to 24 year old group carries the highest HIV burden, with the district reporting a 40.7% HIV sero-prevalence rate for the 2012 Sentinel HIV Survey (DoH 2012).

Moreover, the uMgungundlovu district struggles with socio-economic challenges like informal settlements in its urban core (uMsunduzi municipality) and high poverty and unemployment rates in the periphery of its largely rural local municipalities. Of the total population, 65% is economically active in the district and there is a 30% unemployment rate (DoH 2015). uMgungundlovu is a district of two distinct profiles with the uMsunduzi Municipality exhibiting a highly industrialized, highly mechanised employment sector wherein more than half the district population resides against the other six municipalities which are more rural and depend more on agricultural and forestry activities for economic purposes. This can be noted in the sub-districts such is Impendle with 45% unemployment rate and uMkhambathini with 66% household with access to portable water (uMgungundlovu district information 2015).

*Figure 1.1: uMgungundlovu health district map*



Source: uMgungundlovu district (2015)

On the other hand, the eThekweni metropolitan municipality (see Figure 1.2, page 7) is the most populous in KZN, with the eThekweni municipal area being the home to nearly four million people (eThekweni Municipality, 2012). The people who reside within the metropolitan area consist of individuals from different ethnic backgrounds. The majority of the population are comprised of the African community (71%) followed by the Indian community (19%), White community (8%) and the Coloured community (2%). Individuals within the 15 to 34 year age group comprise the majority of the population (eThekweni Municipality, 2012).

The eThekweni metropolitan area includes small urban and township settlement areas. Unlike townships, urban areas are defined by their advanced civic amenities, opportunities for

education, and facilities for transport, business and social interaction and overall, better standards of living. However, urban areas still experience day to day problems such as roads/transport/taxis, poverty/cost of living/food, electricity, cleanliness, crime/safety/corruption, water and unemployment (DoH 2015).

**Figure 1.2: eThekweni health district map**



**Source:** eThekweni Municipality, 2015

The eThekweni Municipality has been recorded to have the highest HIV prevalence rates in the entire country and sitting at 45.7% (DoH, 2012). With this figure in mind, it makes King Edward VIII Hospital, which is based in the eThekweni municipality, a valuable location for comprehensive HIV research and programmes targeting MSM.

The disease burden in the KZN province, where both uMgungundlovu and eThekweni districts are located, is compounded by its unique socio-economic and cultural profile. It has a high population density, with more than half of the population of 10.6 million living in townships, rural areas or informal settlements. Although KZN is geographically relatively small compared with many other South African provinces, its topography renders many communities fairly isolated from formal and public health facilities, the main transportation routes, as well as other mechanisms that can be used for the delivery of health services (AIDS Foundation of South Africa 2013).

These infrastructural challenges have a direct impact on public health in the province. Primary healthcare in South Africa is delivered through local clinics (fixed and mobile), and to some extent, through individuals who are registered as traditional health practitioners and referring patients to public health facilities (Wilson and Fairall 2005). Both the primary and secondary facilities are over-burdened by service delivery demands, particularly due to HIV and AIDS, and concurrent TB infection. Health systems are not structured to respond in an appropriate and holistic way to the different needs of individual patients or to provide adequate outreach and screening, or follow-up on communities they serve (AIDS Foundation of South Africa 2013).

Apart from suffering chronic shortages of medical personnel, equipment and medication; most clinics operate in limited hours and restrict certain services to specific days. Stigma and lack of confidentiality may inhibit MSM individuals from seeking HCT, sexual and

reproductive health services. Other factors also include cultural and religious beliefs of service providers which result in exclusion of many sexual and gender minorities (De Swardt 2010).

Having briefly outlined the demographic setting of this study, I will now explain the research paradigm and explore methodological approach that guides the study.

### ***Organisation of the dissertation***

This dissertation consists of six chapters. Chapter one serves as an introduction and provides background information about healthcare work and relevant policies, as well as the motivation and objectives of the study. Chapter two draws on literature that contextualises this study's own area of enquiry. A broad overview of the historical roots of the marginalisation of same-sex relations will be discussed initially, followed thereafter, by a focus on MSM healthcare service delivery shortcomings and how this impacts on effective primary healthcare policy implementation.

The third chapter documents the theoretical framework upon which my study is based. The social ecological model (SEM) will be discussed and how the various constitutive levels influence societal attitudes and impact on behaviour.

The fourth chapter presents the research methodology that was used during the data collection process. It expands on the research paradigm employed as well as clarifies the research design, which led to the plan for collecting and analysing data in this study. Adding to this, the sampling technique and recruitment strategy utilised to select participants will be explained. In conclusion, research and data validity issues are explored, and the research ethical deliberations for this study are examined.

The fifth chapter presents the results and discusses and interprets the HCW KAP study results. It discusses emerging themes that are analysed in light of the previously presented literature and the SEM that served as the study's theoretical framework. The collected data is discussed in relation to the study objectives and main questions. The data is then linked to the three themes that are identified in the methodology chapter – which are knowledge, attitudes and practices. Each of these themes is discussed by identifying relationships between the SEM concepts as the study's theoretical framework, or between one variable and another. The analysis is also informed by relevant information presented in the literature review.

The sixth and concluding chapter summarises the main findings of my study, and synthesises these into a set of clearly defined implications. The concluding chapter also makes recommendations based on how much HCWs know, believe and practice regarding the subject of MSM. Recommendations will be based on the collected data and aim to help decision-makers to set programme priorities and make strategic decisions. The KAP findings from this research project may also assist healthcare facilities to evaluate their current interventions and make strategic decisions about future treatment practices for MSM. Discussions follow a format whereby each key finding identified by the KAP results is addressed in relation to the SEM and provide the conclusions deduced during data analysis. Recommendations and implications for MSM health are highlighted where relevant.

## CHAPTER TWO: LITERATURE REVIEW

### *Introduction*

This chapter will focus on recording the broad literature related to my research enquiry. Firstly, an extensive overview of the MSM terminology and concept as well as the barriers faced by the MSM population in accessing healthcare at public facilities is explored and discussed in detail. Both quantitative and qualitative evidence related to this is surveyed and discussed. Following this, focus is directed towards the historical background that characterises the marginalisation of same-sex relations. Having covered the background of MSM, the relevant healthcare policies in South Africa are discussed and how ineffective implementation of these policies may morph and take healthcare priorities and implementation down unintended paths. The role of advocacy groups in influencing healthcare provision for MSM in South Africa - including strong commitments from the government; but weak implementation and commitments at facility level - is then discussed.

Research assessing KAP of HCWs is not easily available in South Africa, with most research on this topic having been conducted in Western countries, if at all. Studies have mainly focused on the experiences of MSM in healthcare settings without seeking in-depth views from HCWs. I will therefore identify the contribution made by previous studies on MSM experiences of HCWs and the public health sector, as well as the gaps in HCW KAP literature so that they can be improved.

### *Men who have sex with other men (MSM): What's in a concept?*

The concept of MSM was first introduced in the 1990s (Glick *et al.* 1994). This was intended “to describe an epidemiological category of men with behaviours that potentially put them at higher risk of acquiring HIV and other STIs” (UNAIDS 2011). UNAIDS add to the

explanation and states that the MSM category was introduced to reflect the idea that individual behaviours, rather than sexual identities, are largely responsible for placing people at risk of HIV and other STI infections. The UNAIDS emphasises this as an important distinction considering the significant scientific and medical differences between MSM and gay identities. Some, experts had initially identified gay sexual identities as a risk in the contraction of HIV/AIDS, a classification that added to the stigmatisation and marginalisation of lesbian, gay, and bisexual (LGB) populations. This worked against the much needed efforts to prevent HIV infection within the MSM population. The definition on MSM therefore describes the population's sexual behaviours, notwithstanding personal identity, motivation for partaking in sex, or identification with any particular sexual orientation. Simply put and from the understanding of the UNAIDS's definition, gay is a chosen identity whereas MSM is a descriptive for a form of sexual behaviour. MSM thus relates to men who are non-heterosexual or questioning (UNAIDS 2011).

The term MSM additionally covers various settings and contexts in which sex between men takes place (UNAIDS 2011). For example, same-sex attraction might be situational, a singular event in a man's life or coerced, such as in the case of male-to-male rape which may happen in prisons, during childhood, and is reported "as a weapon of terror in warfare" (Storr 2011: 1). Male-to-male sex may also occur throughout sexual experimentation in puberty and during the life course. For instance, a man might marry early and later in life, he may decide to self-identify as gay.

Literature on the topic of MSM also provides insights into consensual male-to-male sexual activities which occur in all-male environments, particularly wherever access to females may be restricted, such as in boarding schools, the military or in sports and in prisons (Rosario *et al.* 2006). As an example, prisons are separated by gender (Prison sexuality 2015), so most sexual activities are conducted with a same-sex partner, typically in contradiction to one's



traditional or social sexual orientation. Holland (2007) states that in prison settings, relationships also occur between correctional staff and prisoners (Prison sexuality 2015). This is applicable to prison wardens, security guards, counsellors, medical workers, contractors and spiritual employees (Holland 2007).

A study done in Ghana among MSM, found that some of the men keep female partners as the simplest way of removing any suspicion that they are gay or to hide their true sexual orientation. This is often echoed in many other studies, where MSM in Africa are found to “engage in sexual activities with women or many are said to be married to or are in a long-term relationship with a woman” (Cáceres *et al.* 2009:84:49–56). This trend also corresponds with MSM behaviour elsewhere in the world. For example, evidence from a New York City survey (WebMD. 2006) found that nearly 1 in 10 men say they are straight and have occasional sex with men. In addition, 70% of these men are heterosexually married, with 10% of all married men in this survey reporting engaging in same-sex behaviour during the previous year. MSM are also likely not to disclose their same-sex activities to their female counterparts (Doll and Beeker 1996, Stokes *et al.* 1996, Wolitski *et al.* 1996). The female partners of these men are therefore likely to be unaware of their risk to HIV exposure and other STIs.

In his analysis of the description of MSM, Meyer (2010) suggests that the definition of a typical MSM is difficult since MSM come from all socio-economic backgrounds and professions, as well as engage in different same-sex behaviours. For instance, there seems to be a general application of sexual identity labels such as gay, straight, bisexual to identify or describe MSM. It is understood that communities tend to apply their own local understanding and meaning to describe sexuality, (Meyer *et al.* 2010), with emphasis placed on sexual elements in relation to other, non-sexual and personal factors. This understanding is

also documented in similar observations from non-Western contexts (Bereket and Adam 2006, Cantu 2002, Donham 1998, Ngo *et al.* 2009, Niang *et al.* 2003).

As already pointed out by the above authors, the term MSM does not seem to include single groups, especially those that are most visible, for example, transgender and gay. Diverse categories of MSM also persist in communities where such activities occur and these are fueled by cultural values. This diversity is in contrast with a popular notion that suggests the MSM term covers any male - either self-defined or biologically-determined - who engages in any same-sex erotic activity at any time in their lives (Buoyant 2013). While one can argue that there is a reasonable case for the MSM term to encompass a very broad range of males and their behaviours, it is counter-argued by some gay rights activists who assert that:

the term MSM strips gay communities of visibility and relevance, failing to acknowledge gay men's social relations through identity, culture and history, and reducing them to a mere behavioural category. It conceals the extent to which they have been affected by HIV and their contribution to the response against HIV, and risks distorting prevention efforts. It reduces the importance of gay communities and associated human rights agendas. The emphasis on the term 'MSM' implies that all homosexually active men are equally at risk, diminishing the importance of the risk to gay men (Prestage 2011: 3)

Supporting the growing evidence which shows that MSM are not necessarily gay or bisexual, the CDC (2015) points out that more than 3 million men who self-identify as straight secretly have sex with other men. From this understanding, MSM and gay are not the same. As alluded to earlier, the general suggestion is that "MSM refers to sexual activities between men, regardless of how they self-identify, whereas being gay refers to sexual or romantic attraction between members of the same sex" (Buoyant 2013, Online Library 2015). This is

consistent with Anova Health Institute's suggestion (2014), that MSM solely describes behaviour (MSM) and not an identity (gay).

This complicates the sexual landscape for anyone wishing to study MSM issues. In order to easily manoeuvre around such complexities, the term MSM was therefore adopted by public health researchers as a behavioural description.

However, "clean parallels among sexual behaviour, identity and desire cannot be assumed" (Young and Meyer 2005:7). Uniform and one-size-fits- all terms like MSM reduce identity to sexual behaviour and are often found to be offensive since they overlook different social factors, perceptions, meaning of gender and sexuality (Minichiello and Browne 1995, 1996).

According to literature, the term MSM, is overly simplified and is limited in its epidemiological description (Altman 2002) because it overlooks the complex nature of human behaviours, its diverse relationships and sexual identities in which individual men participate (Binnie 2004). Many thinkers such as Puri (2002), have stated that though the biological component is important to understand, a deeper knowledge of gender constructions and its impact on societies is also required. OUT (2012) also adds that understanding gender constructions includes knowledge of the diverse emotional, psychological and physical health risks that may emerge as a result of such diversity. OUT's assertion is largely supported by Ramello (2015), Niang *et al.* (2003) and Asthana and Oostvogels (2001).

However, as I have located my study to only focus on KAP of HCWs, I am conscious of the limitations of my research to explore this extensive subject, which alone, has a major influence on attitudinal behaviours towards MSM. If explored comprehensively, this research would spread well beyond the focus and scope of my masters dissertation. Therefore, the focus of my inquiry is to investigate perceived attitudes, knowledge and practices of HCWs towards MSM in public healthcare settings. Insights into the other terms will be to a certain

degree, established through research questions investigating basic social, community, and structural circumstances. However, as the core of this study is based around HCW attitudes towards MSM in general, and considering the diversity of MSM sexuality, relationships, identities and behaviours in which they participate, the researcher will use the terms homosexual or other terms such as sexual minorities, and same-sex behaviours, interchangeably to describe MSM.

### ***MSM: a historical background***

This section aims to explore and understand the root causes of perceived attitudes towards MSM. For instance, it is so called un-African for men to have sexual relations with other men. This remains an increasingly controversial topic in South Africa and in most African societies. As recently as 2007, the International Gay and Lesbian Association performed a world survey on the legal status of same-sex practices. The findings were remarkable in that 75% of the African nations, (40 of the 53), deemed same-sex practices to be illegal. This analysis provides additional evidence that of the world continents, Africa has the highest rates of intolerance towards same-sex practices.

However, same-sex practices, to the contrary, occurred in pre-colonial Africa, across all cultures and at all times and is well described in African oral histories, anthropological research, scholarly books, art, literature, film and scores of articles from all over the continent. For instance, cross-gender roles have been recorded in over 30 African societies (Aldrich 2006), with Meersman (2012) showing that Egypt has a rich MSM history, from transvestite khawalat dancers introduced when Muhammad Ali, the founding Pasha of Egypt, banned women from performing, to the famed oasis of Siwa on the Nile that practised boy marriages up until the 1930s. Meersman (2012) states that in the late 1930s, it was noted among the Nuba tribes and the Otoro from Sudan, a special transvestic role existed whereby

men dressed and lived as women. Transvestite homosexuality also existed amongst the Moru, Nyima, and Tira people, and in the Korongo and Mesakin tribes, while Siegfried Nadel reported a common reluctance among men to abandon the pleasure of all-male camp life for the fetters of permanent settlement (Nadel 1947).

This is in obvious contrast to the un-African myth provided as justification for homophobic views in most African societies, which claims that same-sex practices were brought by colonialists or have Western roots. Rather, and as described by one missionary in the 18<sup>th</sup> century, Father Richardtz, sodomy and bestiality were common. For instance, in the Zezuru around Salisbury (Harare). In fact, Richardtz and his fellow colonialists were generally disgusted by African same-sex relations and considered the acts to be perverse. (Louis, 2003)

In many of the early American colonies, male-to-male sex was understood as sodomy – “this is an umbrella term that encompassed a wide range of sexual acts that were non-procreative” (Louis, 2003:187). Such behaviours were often described in Latin, or with terms like wickedness not to be named (Boswell 1980). Strict criminal rules were enforced and in some places, same sex practices were punishable by death as currently witnessed in some of the modern day African countries (International Lesbian, gay, bisexual, Trans and Intersex association, 2013).

Having discussed a brief historical background and implications of male to male sex, and given the enormous importance of providing non-discriminatory healthcare services to all people, including to MSM, the next section will discuss the history of sexual marginalisation and how this potentially contributes to HCW attitudes towards MSM in general. Especially since this area is heavily under-researched.

***Marginalisation of same-sex relations: a historical overview***

According to Epprecht (2004), colonialists who arrived in Mashonaland and Matebeleland in 1890 and 1893 were not very attuned to African same sexual practices and relations. For instance, Adamo (2011) states that Christian missionaries had a negative attitude and antagonistic stance towards Nigerian cultures. Their goal was to convert as many individuals as possible since their practices were generally considered to be un-Christian. What followed was, and as many studies have pointed out, the change in the way people felt, thought, talked, or acted sexually. For instance, many other forms of religions, including the Eastern faiths and Abrahamic faiths, condemn same-sex practices. Evangelical Christianity (Litt *et al.* 2006), Catholicism (Ontario Consultants 2006), Mormonism (The Church of Jesus Christ of Latter Day Saints 2012), Orthodox Judaism (Shafran 2012) and Islam (Ontario Consultants 2005) all view homosexuality as a sin.

As discussed above, colonialism and religion strongly contributed towards the evolution of new sexual ideas that are dominant today among all sectors of society. This is also supported by Foucault (1978), who provides proof that the onset of colonialism transformed same-sex activities which were already in existence. This is consistent with religious ideas of sexual behaviours and gender which were developed in the West. Such ideas in turn formulated the idea of same-sex relationships as foreign to humanity and to the African continent in general.

Foucault (1978) influenced the identification of the social and cultural construction of sexuality. On the other hand, Weeks (1981) placed an emphasis on the ways in which sexual behaviours were increasingly being defined and viewed as a distinct characteristic of human practise in 19th-century European thought. Foucault, for instance, first illustrates the distinction between seventeenth century sexuality, where "codes regulating the coarse, the obscene, and the indecent were quite lax" (Foucault 1979: 3), and nineteenth century

sexuality, where "sexuality was carefully confined; it moved into the home". Foucault argues that this Victorian view on sexuality influences the modern day (Foucault 1979: 3).

Foucault's work identified the social and historical processes that constituted homosexuality as an identification of a particular type of individual, and "which have led to the on-going stigmatisation and marginalisation of those who came to be identified as homosexuals" (Foucault 1979:3).

Colonialism and religion both had a remarkable influence in shaping societal attitudes; politics and country laws; cultures and the everyday lives and accepted norms of present day society. Informed by Victorian and patriarchal Christian gender norms, colonialism also brought definitions of sex and sexuality, which colonial officials and Christian missionaries imparted on their subjects worldwide (Foucault, 1979).

### ***Religious influences on healthcare***

This section aims to discuss religious explanations which potentially contribute towards perceived HCW attitudes.

After the end of colonialism, the newly independent African states became responsible for developing and maintaining their own healthcare systems. This also became a matter of international priority because at this time, the majority of African governments were faced with a new challenge of managing the health sector that had largely been ignored by colonial governments (Obrist *et al.* 2007). Obrist *et al* state that in the absence of this much needed public service, Christian missionaries became the first, and for a very long period, the primary providers of healthcare services in most rural areas. However, these missionaries also brought with them Christian values which still fuel anti same sex sentiments in most public healthcare facilities. Though the missionaries made an important contribution in reaching out

and filling health provision gaps in rural and peri-urban areas (Yach and Tollman 1993), their religious values still played a major, even a dominant, role in every sphere of life. Adding to this, by the end of the 19th century, medicine and psychiatry were effectively competing with religion and the law for jurisdiction over sexual behaviours, (Boswell 1980). This expanded discourse about same-sex practices from the realms of sin and crime, to include that of pathology, thus making linkages between homosexuality and mental health (Homosexuality and Mental Health, 1973). The link between homosexuality and mental health was largely viewed as an innovative idea since a sick individual was considered less blameful than a sinner or a criminal (Chauncey 1982/1983, D'Emilio and Freedman 1988). Nowadays, most forms of sexual behaviours, other than heterosexuality, continue to be viewed as widely non-religious (AIDS Foundation of South Africa 2013).

In addition to religious factors, marginalisation of MSM in terms of equal access to healthcare services was further compounded by the apartheid system (Van Rensburg and Benatar 1993). According to Van Rensburg and Benatar (1993), the apartheid system sought to fully segregate all aspects of South African society. For instance, established as semi-autonomous administrative entities, each of the homelands allocated to African citizens was charged with the provision of healthcare and other public services. These healthcare services were usually poorly organised, inefficient or ineffectively maintained or managed. Though there were many committed healthcare professionals who endeavoured to provide effective and friendly services, a lot of the so called homeland healthcare services struggled to provide adequate medical and public health care. The apartheid system's influence is still evident in the unequal distribution of services in rural and urban areas (Van Rensburg and Benatar 1993). This continues to have a negative impact on healthcare provision for the MSM population. Coupled with unequal access to services and attitudinal factors such as stigma and discrimination, MSM have been shown to hide their sexual behaviour from healthcare



workers in order to protect themselves (Global Forum on MSM and HIV 2012). These perceived attitudes could either be influenced by religious or poor implementation of healthcare policies at the clinic level.

### ***Public vs private healthcare access***

In democratic South Africa, access to healthcare for all individuals, including the MSM population, varies from the most basic primary healthcare as offered free by government, to highly specialised services provided by both the private and public healthcare sectors (Health care in South Africa 2010). However, the public sector is stretched and still under-resourced in places. For instance, “the state contributes about 40% of all expenditure on health, while the public health sector is under pressure to deliver services to about 80% of the population (Health Care in South Africa 2010).

However, MSM remain invisible in health settings due to lack of HCWs knowledge on MSM health issues (McKirnan *et al.* 1995). As discussed in previous sections, MSM are generally under-served and ignored in the delivery of health information, treatment and care. This view is supported by work done by the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) which highlights the existence of high levels of marginalisation and discrimination in the public healthcare sector. This is often directed towards sexual minority groups, including MSM (SAfAIDS 2013).

Many studies also suggest that public HCWs are often not supported to fulfil their duties in the provision of services to MSM (De Swardt and Rebe 2010, SANAC 2011, Lane *et al.* 2009). Therefore, HCWs’ organisational environments, as well as their personal views tend to affect their ability to provide appropriate services in a non-discriminatory way. What follows from this is that many who practice same-sex practices avoid public healthcare services out of fear of being mocked or discriminated against (Laurino 2011).

In support of Laurino's finding, Anova Health Institute (2014) reports that MSM in most townships are less likely to seek healthcare in the public sector as a result of the alleged mistreatment they experience or endure at the hands of public HCWs. Stigma and discrimination at the hands of public HCWs has also been documented in many other international studies and public reports concerning sexual minorities (Nuwaha 2006, Shefer *et al.* 2002, Ndulo *et al.* 2000). Additionally, observations made by the Human Rights Council (2011) concluded that homophobic, sexist and transphobic practices and attitudes on the part of healthcare institutions and personnel may deter sexual minority groups from seeking services, which in turn has a negative impact on efforts to tackle HIV/AIDS and other health concerns (Human Rights Council 2011).

Laurino (2011) adds that it can be a very humiliating ordeal for MSM individuals to disclose their sexual practices to public HCWs. This is often met with unfriendliness, discrimination, isolation or ridicule. Laurino's observations are also supported by McIntyre (2011) who asserts that MSM are reluctant to present themselves at public healthcare facilities or reveal that they are MSM to HCWs. One of McIntyre's and Laurino's joint study participant affirmed that healthcare workers humiliate them at clinic facilities:

[S]ome of them don't treat us with respect. Sometimes, if you were having sex without a condom and maybe you get an STD, then you go to the clinic, the nurse will ask questions like "What was in here?"—she means in the anus. And that makes us afraid of going to the clinic to get treatment on time and that's why many gay men get sick. (Lane *et al.*, 2008:430)

However, in South Africa, the concerns highlighted by McIntyre and Laurino and the majority of MSM patients are being addressed by many privately funded institutions such as the Ivan Tom Men's Health Clinic (ITMHC), the Desmond Tutu HIV Foundation (DTHF),

OUT clinic and MOSAIC Men's clinic. Such private health institutions aim to create MSM friendly services - often incorrectly referred to as MSM-sensitised services (ITMHC 2012). These institutions provide a much needed competency concerning MSM specific sexual healthcare requirements. The interventions provided by these are also based on recommendations from various studies that suggest that services for MSM ought to take a more comprehensive approach in addressing their needs, as well as being sensitive and competent, especially if they intend to draw and retain MSM in public health care (De Swardt and Rebe 2010).

Though this may be the case, these services are not available at government funded healthcare facilities, which adds to the marginalisation of MSM, especially those in rural and informal areas who often avoid seeking public healthcare when having specific health concerns (DTHF 2013). This suggests that to some extent, public healthcare workers are not adequately trained and equipped to respond to the needs of MSM healthcare needs. This is demonstrated by attempts made by many communities, including HCWs, to 'cure' same-sex practices (OUT 2013). According to OUT, MSM patients are judged, harassed, or in extreme cases denied access to basic medical care.

The Mailman School of Public Health (MSPH, 2013) adds that HCW stigma towards MSM contributes to MSM hiding their sexuality and taking less care of their sexual health, thus fuelling the current HIV and AIDS rates. Some of these attitudinal factors result from HCWs' religious beliefs, personal values, societal norms and poor knowledge and skills on MSM health issues. The MSPH (2013) asserts that showing care and compassion to MSM patients can lead to them adopting a healthy and positive lifestyle and acting in their own and other people's interest. McIntyre (2011) supports this and adds that due to increased isolation and discriminatory attitudes towards MSM at public health facilities, most MSM become stressed

out and resort to seeking comfort in harmful substances. This places them at increased levels of risk and HIV infection and other STI or drug related infections.

Other complex obstacles have been shown to contribute towards MSM's vulnerability to HIV as well as to other physical and psychological health concerns. As McIntyre explains, MSM experience "multi-layered stigma and discrimination as a result of their perceived or real HIV status and their same-sex behaviour" (McIntyre 2011: 708-10). OUT (2013) adds that social and cultural non-acceptance of their sexuality and fear of being ridiculed, causes MSM to experience internalised stigma, which manifests as guilt, depression, lack of confidence and unwillingness to discuss their sexual lives. Not only does this experience negatively influence their health seeking behaviours, but when combined with continued or aggravated discrimination from healthcare workers, this can altogether affect their mental health and inform decisions to use or not use public facilities.

Similar studies conducted for HIV and AIDS patients have shown that stigma and discrimination is associated with negative health problems ranging from increased depressive symptoms to engaging in risky sexual behaviour (Semple *et al.* 2012, Kinsler *et al.* 2007, Sayles *et al.* 2007, Venable *et al.* 2006). Likewise, experiencing stigma or discrimination in any public environment, including at the organisational level of the SEM such as healthcare facilities, has been found to adversely affect the behaviours of affected individuals. This included health seeking behaviours such as seeking treatment, testing, and adhering to medical regimes (Butt 2008, Fortenberry *et al.* 2002, Pascoe and Richman 2009).

The private health sector is hugely operated on commercial lines and mainly caters for those who fall within the middle or high-income earning brackets. These individuals tend to be members of private medical schemes. The private health sector is also known for attracting the majority of the country's health professionals. This has resulted in public healthcare

institutions suffering poor management, underfunding and deteriorating infrastructure (Badimo *et al.* 2015). As a result, South Africa's dual healthcare system is both inequitable and inaccessible to ordinary South African citizens. While access has improved for general populations, the quality of healthcare and access for MSM remains poor in public health facilities. As already discussed previously, the exceptions are innovative, though "small-scale programs by lesbian, gay, bisexual, and transgender organisations that play important roles in responding to the HIV epidemic among MSM" (Rispel *et al.* 2011: 17:133-42; Nel 2009, Reddy *et al.* 2009).

### ***The rise of advocacy groups***

In response to the unequal provision of healthcare services for MSM in the public sector, an extraordinary number of Non-Governmental Organisations (NGOs) and community-based organisations mobilised themselves to support equal rights and healthcare access for all. For instance, while MSM and other sexual minority groups are quite different from each other in terms of sexual practices, class, ethnicity, culture, age and social position, they all came together to challenge the processes of marginalisation and stigma. Up until today, these and other local groups, notably the DTHF, have been able to shift many of the dominant ideas about same-sex practices and rights, and these are increasingly being accepted globally among governments and the scientific community. For example, South Africa, known as Africa's rainbow nation (Heywood 2002), is the only country in the African region which recognises laws that are accepting towards other sexual orientations or 'gay friendly' (Kovac 2002: 90). The country's constitution provides extensive protection against discrimination based on sexual orientation. This is in addition to the country's laws and legislation – the Civil Union Act, Act 17 of 2006 – that allows same-sex marriage for and jurisprudence.

Additionally, the Constitution of the Republic of South Africa (1996) clearly prohibits unfair discrimination on the grounds of sexual orientation under Section 9.

### ***Healthcare policies vs practice***

South Africa was a global leader in the conceptualisation and development of primary healthcare approaches throughout much of the twentieth century (Parle and Noble 2014). South Africa's contributions included the development of many health models and policies such as the Pholela Health Centre model; the development of the community-oriented primary care movement and experimentation with new models of health service delivery and primary care. However the implementation and success of these policies remained fragmented and of limited impact as a result of hostile state interventions and an egregious policy environment prior to and throughout apartheid (Kautzky and Tollman 2009).

Kautzky and Tollman (2009) acknowledge that despite structural reforms in the public health sector and genuine commitment to achieving health for all, a series of obstacles continue to limit the full implementation of primary healthcare today. Some of the obstacles listed by Kautzky and Tollman, include health worker shortages and inequities in the distribution of public health facilities, and issues of accessibility. These obstacles have to some extent, contributed to the exclusion of groups who are at increased vulnerabilities, such as MSM or those who are on the margins of society. According to the DTHF (2011), this undermines the ability of any policy response to be effective, while disregarding fundamental human rights, public health principles of health for all and freedom from discrimination and access to equal healthcare services.

Considering that increased HIV figures among MSM have always existed alongside the generalized HIV epidemic for quite some time now, current strategies and healthcare policies

and interventions still remain inadequate in addressing the needs and healthcare requirements of MSM (Reddy *et al.* 2009, Rispel and Metcalf 2009).

Some of the obstacles as highlighted previously have a negative impact on the health of MSM individuals (OUT 2013). Rispel and Metcalf (2009) state that HCWs' unpreparedness and even unwillingness to discuss same-sex relationships and behaviour, means that MSM often hide their status. Relatively few make their orientation known to healthcare workers, with those disclosing their sexual practices finding themselves being discriminated against or mocked by HCWs.

The South African progress report on the declaration of commitment on HIV/AIDS (2010) discovered that healthcare workers who have negative attitudes towards same-sex practices tend to provide inadequate care for MSM individuals. With the CDC (2013) adding that prejudices of HCW have demonstrable negative effects on patients and their wellness, making it crucial for them to be sensitised about patients who may practice different sexual orientations. The Desmond Tutu Foundation suggests that in order to successfully implement South Africa's National Strategic Plan (NSP) on HIV, STIs and TB, which contains HIV program targets for MSM and other vulnerable groups, and in keeping with the principle of Health for All (WHO 1980), healthcare workers need to be made aware of potential biases, which can either be unconscious or deliberate. Rispel and Metcalf (2009) support this statement since according to them, nothing much has been done in terms of implementing policies that relate to MSM healthcare. There is also little progress made on term of achieving the envisioned goals as stated or aspired in the NSP on HIV/AIDS, STIs and TB. (Rispel and Metcalf, 2009).

### ***Poor policy implementation***

Section 27(1)(a) of the South Africa's Constitution encourages HCWs to take appropriate steps to create an environment that makes it possible for all individuals to access health services. Other policy provisions that provide guidance to all HCWs include the DoH's eight Batho Pele principles (1995). These principles were developed to serve as the policy and legislative framework regarding service provision in the public service. The principles are aligned with the constitutional ideals of promoting and maintaining high standards of professional ethics; providing service impartially, fairly, equitably and without bias; utilising resources efficiently and effectively; responding to people's needs; encouraging citizens to participate in policy-making; and rendering an accountable, transparent, and development-oriented public administration.

However, despite the constitutional provisions made by the Government of National Unity at the time of South Africa's transition to democracy in 1994, including a range of other pro-equity policies and programmes, which were initiated throughout the public sector, stigma and discrimination based on sexual orientation continues to occur. For instance, work done by SFAIDS and other organisations in Africa, highlight the existence of high levels of homophobia and discrimination in the public healthcare sector. Stigma and discrimination at the hands of HCWs has been documented in many other international studies and public reports concerning sexual minorities. (Lane *et al* 2008, Baral *et al* 2009, Jewkes *et al*, 2006) Additional observations made by the Human Rights Council concluded that transphobic, sexist and homophobic behaviours and attitudes on the part of professional healthcare workers and their services might deter MSM and other sexual minority groups from seeking appropriate care. This has a negative impact on the healthcare ambitions of the state as well



as other efforts to mitigate HIV/AIDS and address other MSM health concerns (Human Rights Council 2011).

***The National Strategic Plan on HIV/AIDS, STI and TB, 2011–2016***

More specific to MSM is the South African five-year NSP on HIV/AIDS, STIs and TB, which was first introduced and approved in March 2007 by the South African cabinet (Wouters *et al.* 2009). It is widely praised for its dynamic and comprehensive policy content (UNAIDS 2007). The policy contains HIV program targets for MSM and other vulnerable groups and has two primary aims: firstly, to reduce new HIV infections by 50%; and secondly, to reduce the impact of the epidemic by extending access to appropriate treatment, care and support to 80% of people diagnosed with HIV (DoH 2012). To achieve these aims, the interventions contained in the NSP on HIV, STIs and TB are structured into a few priority areas, among them, and critical to this study, is the aim of ensuring human rights and access to justice by countering stigmatisation and discrimination (DoH 2011).

The priorities combined in the NSP on HIV/AIDS, STIs and TB are meant to contribute to the creation of a health-enabling community, which facilitates and supports health-enhancing behaviour (Tawil *et al.* 1995); Despite the potential for success, and since South Africa has one of the worst HIV epidemics in the world, consecutive iterations of the NSP on HIV/AIDS, STIs and TB have been repeatedly marked by failure over almost three decades (Van Rensburg *et al.* 2010). This is largely due to lack of appropriate healthcare interventions for MSM at all levels. Without these, the current NSP on HIV/AIDS, STIs and TB will probably be ineffective in bridging the gap between policy ideals and policy implementation. Evidence has shown that poor policy recognition or ineffective policy implementation around the needs of this population will result in poor health programming for MSM (Beyrer *et al.* 2011).

For instance, an online survey by the Global Forum on MSM and HIV, or MSMGF (2012) which included 5779 men from 165 countries and focus group discussions with 71 MSM across five cities in South Africa, Kenya, and Nigeria suggests that structural and social barriers like homophobia play a significant role in blocking access to MSM healthcare services. Therefore, without a strengthened or even transformed health system, the chance of a successful implementation of South Africa's NSP on HIV/AIDS, STIs and TB remains thin.

Failure to effectively implement policy ideals also contradicts the whole notion of primary healthcare, as defined by the World Health Organisation (WHO), which comprises: essential health care, based on practical, scientifically sound, and socially acceptable method and technology; universal access to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination (WHO 2011).

The previous and current HIV/AIDS policy for South Africa has been received with universal recognition and praise. This includes civil society organisations and most of the government's well known and most vocal critics (Wouters *et al.* 2010, Kaap 2007). However, despite this, the real benefits and success of this policy remain to be seen. This is considering the repeated shortcoming of previous HIV/AIDS policies.

### ***Poor healthcare access for MSM***

Though UNAIDS (2011) reports that access to HIV prevention programs and services for MSM and transgender people has increased somewhat in the past few years, access remains inadequate overall. A 2012 survey MSMGF in collaboration with African Men for Sexual Health and Rights, assessed the availability of, and access to testing and prevention services for sexually transmitted infections and HIV among MSM in eight regions. Of the 17 services assessed (including STI and HIV testing and counselling, HIV treatment, free condoms, mental health services, circumcision, and mass-media campaigns to reduce HIV and fight

homophobia), only in two areas (STI testing and circumcision) did a majority of respondents (51% in both cases) report that the services were easily accessible. Respondents also noted the many barriers to their access to services, including homophobia; stigma; criminalization of same-sex acts; policy barriers; and insensitivity or lack of awareness among healthcare workers (UNAIDS, 2011).

Research conducted by the DTHF (2011), found that there are currently no counsellors or healthcare provider training materials that address the specific healthcare needs of MSM, the risks of HIV infection or the anal acquisition of STIs in sub-Saharan Africa. Elicitation of anal sexual practices is also not included in standard HIV Counselling and Testing (HCT) procedures (CHANGE 2011). There is no national Behaviour Change Communication (BCC) nor Social Change Communication (SCC) campaigns for MSM that have been launched to date. Coverage of MSM healthcare services in South Africa is limited to major metropolitan areas and are mainly provided either by private institutions or by NGOs funded through external sources (Metcalf *et al.* 2009).

This is supported by a study conducted by Rispel *et al* (2011) who documents the scarcity of targeted HIV prevention and treatment services for MSM. In this study, key informants and focus groups participants could not identify any government health services for MSM, but only NGOs or private institutions that provide MSM-targeted services. The following comments are illustrative of Rispel's findings:

In Johannesburg I do not know where to go. I must go to many places in order to know where bisexuals or gays can get help. I must seek around until I get the direction where to go. What they [government] can do is to ensure that the [services] are known and near to the people (Rispel *et al*, 2011: 137).

Rispel *et al* (2011) concludes that healthcare service are not friendly towards MSM and adds that this population group has difficulty accessing appropriate services and prevention materials. Materials produced by the public health sector for awareness, prevention, behaviour change and access to care are generally not appropriate for this population group.

The lack of targeted and friendly public health interventions for MSM and other high risk groups as illustrated by Rispel *et al*, have the potential of jeopardising the DoH's efforts to meet the NSP on HIV/AIDS, STIs and TB's objectives. As clearly articulated by the DTHF (2011), which corresponds with other national and international findings, the exclusion of populations who are at the margins of society and are at higher risk and vulnerable to acquiring HIV undermines any effort to effectively respond to the epidemic.

### ***Perceived healthcare worker's attitudinal barriers***

Although access to friendly healthcare services is generally a concern for all populations (Kigul *et al.* 2009), MSM patients are usually faced with unwelcoming HCWs because of their sexual practices. HCWs do very little to make MSM patients feel welcome usually due to homophobic attitudes (Smith *et al.* 2013). The term homophobia is commonly used to illustrate negative attitudes towards sexual minorities, including MSM. In particular, being homophobic usually refers to an unreasonable fear of same sex practices. With increased suggestions and calls from others that the term homophobia be replaced with what is known as homophobia. This implies a more active form of discrimination, which generally perpetuates hatred and anger towards an individual (Logan 1996).

As seen from the discussion in the previous sections of this study, stigma and judgement from public HCWs, remains one of the most important single factor driving the majority of African MSM to hide their sexual practices from HCWs (McKirnan *et al.* 1995, Anova Health 2014). Such behaviour from HCWs fuels levels of dissatisfaction with the public health system

among MSM. Studies have shown that patient satisfaction is crucial to healthcare as it influences whether a person will seek medical advice, comply with treatment and maintain a relationship with the health facility (Schoeps *et al.* 2011). The lack of approachable healthcare services or friendly health professionals in some cases, may contribute towards MSM's lack of knowledge on safe sex practices or lack of knowledge on appropriate risk reduction strategies (Adam *et al.* 2009).

This negates the fact that primary healthcare facilities are often a point of first point of entry for many individuals seeking healthcare in most developing communities. The WHO (2012) asserts that a key objective of any good health system is to deliver quality services to all people, when and where they need them. However, despite this idealism and all the other policy guidelines discussed above, attitudinal barriers around MSM health issues are widespread across the country. For example, a study conducted by Rispel *et al* (2011) to assess the utilisation of health services by MSM in South African cities, found that the majority of participants who depended on the public health sector experienced negative and judgemental attitudes from HCWs. According to the report, this made participants become reluctant to use public healthcare services and to disclose their sexual orientation to healthcare workers because of past negative experiences. These findings are similar to those from other African studies that reported low rates of disclosure of sexual practices to HCWs, driven by both fear and experience of stigmatization and discrimination (Lane *et al.* 2008, McIntyre 2010, Smith *et al.* 2013).

A Kenyan study found that MSM in Nairobi did not approach healthcare workers for advice, for fear of exposure, and discrimination (Geibel 2012), while other African studies report that homophobia limited MSM's utilisation of HIV and AIDS programs (Johnson 2007). These findings are similar to results which found that MSM avoided services where they were stigmatised by HCWs, with more reports that non-gay-identifying MSM avoid discussing

same-sex practices with HCWs (Lane *et al.* 2008). When HCWs do not consider the needs of MSM, or create barriers to care, it is difficult to ensure utilization of HIV prevention and treatment services (McIntyre 2010)

Though the South African DoH encourages all individuals across all population groups, regardless of sexual practices to access and utilise public health services, MSM remain excluded from sexual health services on the whole and usually find it hard to access condoms and lubricants to protect themselves from STIs including HIV (DTHF 2011). Rispel (2011), for instance, states that only 7% of survey participants indicated a government clinic as a preferred healthcare provider. According to the report, this was largely due to MSM's experiences of an unresponsive public healthcare system and other factors such as stigma and discrimination. Rispel continues that an even smaller percentage (4.3%) of participants indicated that a private healthcare provider was their preferred service provider, suggesting that public HCWs are generally not equipped with the necessary skills to provide appropriate care around the risk of unprotected anal sex.

Though not proven to be linked, the lack of skills on handling anal STIs may directly contribute towards the stigma and discrimination faced by MSM in public healthcare facilities (Kombo *et al.* 2015). This generally contravenes MSM human rights and contradicts South Africa's public health principles of freedom from discrimination and health access for all.

The University of Columbia, or UoC (2013) adds that the lack of appropriate skills to provide specific MSM healthcare services is fuelled by the inadequate distribution of HCWs in public health facilities. For instance, in its baseline assessment conducted in 2012 in the Eastern Cape, Free State, Northern Cape, Limpopo and KZN, it found that responding provinces demonstrated MSM-related public health and training needs in varying degrees:

1. The need for sufficient and skilled human resources was mentioned by all provincial respondents.
2. Poor infrastructure and overcrowding illustrated the need for effective and simple administrative measures.
3. Identified learning needs and gaps included training on both general and more specialized topics, including diagnosis and management of all forms of STIs and TB.
4. Existing monitoring and evaluation systems in many of the provinces remain fragmented and compounded by the challenges of capacity.(UoC, 2013)

As skills are not evenly spread across the different nursing categories, especially in rural settings, the UoC recommends the need to build MSM-related skills competency and adequacy to improve quality and efficiency of MSM health provision and programs.

Another qualitative study conducted by the Centre for AIDS Prevention Studies at the University of California and by the University of the Witwatersrand, described the public health clinics where MSM sought sexual health services as places where MSM were verbally harassed, especially those MSM who identified as gay (Lane *et al.* 2011). In addition to verbal harassment, HCWs compromised their patients' right to privacy and confidentiality by openly gossiping about the patients and their conditions. This ill treatment of MSM patients by HCWs and the breach of their confidentiality contravenes the South African Nursing Council's (SANC) pledge and commitment to ensuring patients' right to confidentiality and the provision of non-judgemental healthcare service in the fight against HIV/AIDS (SANC 2005).

SANC clearly condemns discrimination against patients and violation of their confidentiality. SANC is responsible for ensuring the protection of the public and has pledged to do

everything in its power to make sure that patients get the care they deserve. It believes that ethical problems with the nursing of patients arise mainly from ill-informed perceptions (SANC 2005). It also states that HCWs should: provide effective nursing according to personal needs of the patient; show empathy to patients' social dilemma; provide expert accompaniment to patients, their families and communities in order to continue a normal, responsible life; and protect life, in the case of the unborn child.

### ***Conclusion***

Despite the goodwill and good intentions of policy makers through the development of the Batho Pele principles and the NSP on HIV/AIDS, STIs and TB; delivering healthcare to MSM individuals is generally not simple due to multiple factors or barriers. In some cases, there is a possibility that such barriers could just be imagined by MSM patients or be a mere perception of challenges into receiving healthcare. However, these factors or barriers may also be real in communities, at a structural level, or at individual HCW levels. Examples of community barriers may include homophobia, discrimination and stigma, intimidation and blackmail. Structural barriers may include a lack of policy provisions around access to appropriate treatment tools and healthcare materials for MSM individuals. This also includes lack of appropriate skills training and knowledge in meeting the unique and comprehensive healthcare needs of MSM individuals. Personal barriers may comprise of HCW bias and unfair judgement towards MSM sex behaviours, lack of self-recognition as MSM; one's false perceptions of personal risk for HIV acquisition or a belief that one is immune to risk and therefore can engage in high risk behaviours. This also includes an individual's own stereotyped beliefs about who is at risk. For instance, a person may believe that he or she is not at risk because he/she does have sex with MSM or gay men, even though the individual may engage in behaviours that places him/her at high risk. Another individual factor could be



the illusion of vulnerability – this means the individual generally underestimates their personal risk in comparison to the risk faced by others who engage in the same behaviours. Individual misconceptions about HIV transmission and other STIs means there is misunderstandings on how such an illness is acquired. Therefore, any such mistaken beliefs may interfere with the individual's understanding of what is actually risky or not.

Lack of effective policy implementation and the lack of recognition of healthcare needs for MSM and other high risk groups will result in government's failure to realise its policy ambitions. The exclusion of key populations also contravenes human rights and public health principles of freedom from discrimination and access to health services. The UNAIDS (2010) stresses the importance of health services for MSM, stating that the lack of HIV-related services for MSM is a massive failure. Therefore, setting appropriate interventions has to be a high priority with the aim of achieving universal access to HIV prevention, treatment, care and support for all groups, including MSM and transgender people.

## CHAPTER THREE: THEORETICAL FRAMEWORK

### Introduction

This chapter intends to explain the theoretical framework that informs my study and the related data.

Carl Jung (1971) describes an attitude as a hypothetical construct that represents a person's like or dislike for anything. Jung adds that attitude is a judgement made on the object - a person, place, task, event, skill, etc. These judgements can range from positive, negative or ambivalent as attitudes arise from an inner framework of values and beliefs, developed over time. Similar to Jung's school of thought, most theories emphasise individual behaviour and usually disregard and ignore the influence of alternative factors such as environmental influence of social norms, structural problems and peer influences concerning certain behaviours (Bronfenbrenner 1999). In addition most of these theories are based on the decision-making of rational individuals who follow an established linear path from awareness/knowledge to attitude to behaviour change. For instance, the Health Belief Model (HBM) (Rosenstock 1966) emphasises that decisions concerning health behaviours are motivated by the individual's subjective perceptions about a potential health threat. According to this model, perceived threats motivate people to take action in order to address a perceived health problem.

Research related to health behaviours such as smoking, dieting and exercising, which applied the HBM, have shown that benefits of adopting positive health behaviours should outweigh any costs (Orji *et al.* 2012). However, other studies have reported conflicting findings (Janz and Becker 1984). Overall, evidence suggests that though the beliefs specified by the model are prerequisites for preventative health behaviours, social and economic variables and other

cognitive imperatives, which are likely to be involved or play a part in prompting such behaviours, lack acknowledgement within the model. Another social cognitive model, the theory of planned behaviour (Ajzen 1985,1988), has received less criticism than other models, yet researchers have pointed out that its significant weakness is that the model does not include a temporal element (Berry 2006, Rutter and Quine 2002). This means the model does not describe the order of the different beliefs or any direction of causality. Others argue that the model is too subjective and neglects important social variables and does not specify the relationship between the different health beliefs (Shwartz 1995). For example, Klein *et al* (1999) and other researchers such as Rousseau and House (1994) and Stokols (1996) emphasise that research that focuses on any one level underestimates the effects of other factors. Therefore, the approach of focusing on HCWs' attitudes alone will not be adequate without looking at other enabling or disabling factors that may be present. For instance, the SEM, which will be elaborated in the next discussion, considers the complex interplay between individual, relationship, community, and societal factors. It allows us to understand how the range of factors that act together at one level influence factors at another level. The model emphasises the necessity of acting across multiple levels of the model at the same time.

The “historical heterogeneity” of social ecology has meant that the perspective has garnered support from numerous academic fields (McLaren and Hawe 2005: 6). As a consequence, since the 1980s social ecology model has become increasingly popular, especially within the fields of social science, health promotion and public health (Hawe and McLaren 2005). The emerging popularity of social ecological perspectives has been recognized not only to the “qualitative shift” from individualistic to socially orientated health promotion strategies, but the important review of what characterises one's personal health (Stokols 1996: 282).

It is in light of this holistic approach that this study will adopt the SEM model (Sallis and Owen 2002), as its main theoretical framework. The US Department of Health Services (1996), states that programmes that are designed using the SEM model are likely to sustain prevention and treatment efforts over time than interventions which are based on single theoretical approaches. This is evidenced in interventions based on some theories which are formulated as guides to understanding behaviour, including those designed as frameworks for behavioural interventions. These theories' purposes are not consistent and their effectiveness in the African context are not widely researched and documented (U.S. Department of Health and Human Services 1996). Such criticism brings to light the strengths and weaknesses of previous models and theories, showing that there is room for more research into behavioural change theories, especially those that apply to unique African issues and contexts (Aribenhuwa and Obregon 2000).

### ***The Social Ecological Model (SEM)***

The SEM (Sallis and Owen 1997), is the theoretical approach I have adopted for this study. The SEM draws upon several sources in an attempt to acknowledge the complexities involved in the process of assessing behaviour.

***Figure 3: The Social Ecological Model***



Authors: Sallis and Owen (1997)

The use of these interrelated sources and levels is driven by the fact that no single factor explains why public HCWs are perceived to hold negative attitudes towards MSM and other sexual minority groups. Possible discrimination; acceptance and the perceived attitudes of public HCWs towards MSM is a complex phenomenon that has its roots in the interaction of many factors.

The SEM's approach is comprehensive in that it not only focuses on the individual; like the HBM and the other theories mentioned elsewhere (McLeroy *et al.* 1988, Green *et al.* 1996); but also consider the norms, beliefs, social systems and public policies that frequently fuel perceived negative attitudes towards MSM.

Described as having “tackled the problem of complexity by dividing the environment into four levels beyond the individual”, the SEM has accommodated the determinants of behaviour by adopting a multi-levelled approach (Green *et al.* 1996: 278). As illustrated in Figure 3 (see page 40) the SEM seeks to understand the multiple and interrelated factors that influences individuals to do what they do. These include intrapersonal or personal factors – such as past experiences and self-efficacy, social processes and primary groups, the institutional situations and factors, cultural norms and community factors. Finally, the SEM looks at the public and structural policy that affects people's behaviours and actions. The stratified approach of the SEM notably distinguishes itself from the other somewhat controversial individually orientated health behaviour change theories (McLeroy *et al.* 1988, Green *et al.* 1996). As demonstrated above, many of the threats to MSM healthcare access are directly linked and related to HCW behaviours. I will therefore briefly summarise the different aspects of the SEM variables respectively.

The intrapersonal level of the SEM looks at aspects of one's knowledge, attitude, behaviour, skills and one's perceived self-efficacy (McLeroy *et al.* 1988). These factors encompass the

internal thought processes that influence a particular behaviour, interest in adopting safer behaviours, belief in the value of those behaviours, and a sense of capacity to carry these out. Unlike other theoretical models of behaviour change, the SEM recognises that it “may also incorporate techniques to modify the nature and extent of social influences” (McLeroy *et al.* 1988: 356). Several strategic interventions that are supported at the interpersonal level of the SEM are the use of “mass media, support groups, organisational incentives, or peer counselling” (McLeroy *et al.* 1988: 356).

The individual’s interpersonal situation and their primary group such as family, religious groups, political groups, colleagues, peers or friends are very influential in an individual’s social life (McLeroy *et al.* 1988). At times, individuals find themselves pressured by their social groups to engage in behaviours which are deemed to be socially unacceptable in order to maintain their position or status in their social groups. Unequal power in the relationship and the stakes involved in not complying can make refusal difficult. The individual’s social group can also be used to bring together people who are dealing with behaviours that are difficult to change. Individuals within the same group can share experiences and learn from each other about how to handle particular situations that may be potentially challenging. Thus the social environment and relationships of an individual at the SEM acknowledges the social and relationships an individual may value or belongs to.

The institutional or organisational environmental factors of the SEM refer to characteristics or aspects of formal and informal organisational policies and procedures. When encouragement to change behaviours is offered in the context of a workplace or other established social groups, a change in group norms can take place that can increase the chances of an individual adopting a new or desirable behaviour. Organisational policies and rules might also provide more efficient access to a large group of people than individual interventions can. By assessing the organisational context of individuals the SEM suggests

that interventions can be instrumental in “creating healthier environments in addition to creating healthier employees” (McLeroy *et al.* 1988: 360).

The fourth level of the SEM relates to an individual’s community. There is a shared belief that people within a community can exert some control over what take place around them and are influenced, in turn, by the same community as a whole. One’s neighbourhood or community can, for example, decide to take a collective stance or responsibility to challenge unequal social norms or values. This is usually when people within a particular community have a sense of shared belonging and identification with their community.

The SEM also identifies three distinct elements at the community level. These are discussed by McLeroy *et al* (1988: 363) as follows:

First, community refers to mediating structures, or face-to-face primary groups to which individuals belong. This view of community embraces families, personal friendship networks, and neighbourhoods. Second, community can be thought of as the relationships among organisations and groups within a defined area. Third, community is defined in geographical and political terms, such that a community refers to a population which is coterminous with a political entity, and is characterized by one or more power structures.

There is thus a strong psychological investment in the community and a belief that the community can take care of many of an individuals’ needs. This means the community as proposed by the SEM should not be simply viewed as “aggregates of individuals sharing common demographic or geographic characteristics” (McLeroy *et al.* 1988: 363). Instead, the community ought to be viewed as part of the overall comprehensive structure which acts as an individual’s social support, and that has potential of encouraging or undermining the adoption and /or maintenance of certain behaviours or attitudes

Finally, the SEM considers structural factors and these refer to aspects of social policies and broader legislation issues. These are designed to guide issues such as social inequalities, community planning, healthcare and other aspects which affects individuals at all spheres of life and environments. Structural factors come together to form the context within which social and personal behaviours takes place. Larger social structures shape the everyday life of individuals and at the same time, the everyday practices of individuals help to shape those larger structural forces.

With this in mind, the SEM recommends that in order to change attitudes or behaviours, it is important to consider other environmental barriers and factors across the different levels simultaneously. This is because a person's environment at any given level can either help or impede the adoption of certain behaviours. For instance, the availability of transportation, neighbourhood safety, the presence of friendly healthcare services; are examples of aspects of the structural environment that can affect health related behaviours. (WHO 2002).

### ***The SEM in practice***

The SEM has been successfully applied, including programmes focusing on bullying and victimisation (Garbarino and deLara 2002, Olweus 2001, Swearer and Doll 2001, Swearer and Espelage 2004). The SEM has also been used to develop non-discriminatory healthcare interventions by Seattle's public health department in the United States. In the 1970s, for instance, the CDC used the SEM to address violence as a priority area for public health. Throughout the 1980s, the CDC established goals and programs for the prevention of violence through the Division of Violence Prevention. In order to fully understand violence as a public health issue and to inform its prevention efforts, the CDC used the SEM because of the understanding that violent behaviours are extremely complex in their root causes. The interplay and connectedness between individual, community and social level of influences on



the susceptibility to and protection from violent behaviour, were examined (Dahlberg *et al.* 2002). This resulted in the employment of prevention strategies which included a continuum of activities, such as community education and awareness efforts, identification of risks and protective factors and continuous monitoring of violent behaviours. These activities addressed all levels of the SEM in order to create a sustainable approach to violence prevention (Andersen *et al.* 2000).

From these and other findings, it is clear that HCW perceived attitudes towards MSM may be a phenomenon which can, similarly, be influenced by the individual, family, school, peer group, community or society.

### ***SEM at the individual level***

Individual aspects of the SEM are biological and personal history factors that increase the likelihood of an individual becoming a victim or a perpetrator (CDC 2013). Interventions at the individual-level factors can be designed to address issues of social, cognitive skills and behaviour. This may include appropriate educational training strategies to address each aspect (Powell *et al.* 1999). However, training alone is not a sufficient approach for behaviour change to occur. This study will show later on that high levels of knowledge do not necessarily result in corresponding changes in attitudes or behaviour. HCW perceived attitudes and behaviours are linked to the marginalisation of MSM individuals within the healthcare context. Consequently, these perceived attitudes are often complex and difficult to change thus not a simple linear process. Therefore, the SEM recognises that in order to change individual's attitudes and effectively change their behaviour, it "may also incorporate techniques to modify the nature and extent of social influences" (McLeroy *et al.* 1988: 356). Other interventions which are strategic in effectively addressing the SEM's intrapersonal

issues include the use of peer groups, role models and communication interventions and appropriate guidelines (McLeroy 1988 ).

***SEM in relation to interpersonal level of influence***

The CDC (2013) suggests that frequent negative attitudes can be fostered at the interpersonal relationship level of the SEM due to influences from peers, intimate partners, and family members. Since much of the victimisation reported by MSM and other sexual minorities occur in public healthcare settings, researchers have recently begun to examine the early developmental processes, such as family socialisation, that may contribute to an individual's victimisation of others. The role of parenting methods and relationships with one's siblings contributes to the understanding of the family connection to maltreatment of other individuals. According to Lickel, Schmader, and Hamilton (2003), research of the Columbine shootings in Littleton Colorado, revealed that parents were largely viewed to be responsible for the shooting disaster. All three researchers argued that parents are usually held responsible by the public when crisis strikes. This is because one's parents are expected to be the close source of nurture, authority and education provider to their children.

Generally speaking, children who are found to demonstrate bullying behaviours relatively have parents who are authoritarian (Baldry and Farrington 1998). Therefore, peers in the HCW context are a powerful force or authority figures who are capable of contributing to negative attitudes within their work environment. At the interpersonal and family level of the SEM, a person's closest social relationships can shape an individual's attitudes and range of experience. For example, the family environment is where social norms and values are learnt from a young age. HCWs' families may have a great deal of influence over their perceptions around MSM issues.

Several theories in the literature such as the dominance theory (Pellegrini *et al.* 2001), attraction theory (Bukowski *et al.* 2000) and the homophily hypothesis (Cairns and Cairns. 1994), and other research also emphasise that peer group members play an important role in motivating what is called the bully-victim phenomena (Craig and Pepler. 1995, Salmivalli 2004).

From a social dominance point of view and in the context of perceived HCW attitudes towards MSM patients, individuals are usually expected to follow a vertical chain of importance. This means that their position may occupy a particular order in society and this may influence their access to resources or services (Pellegrini and Long, 2004). Both authors discovered there was a very strong relation between aggression and dominance and concluded that aggression is used to establish dominance within a particular context, social environment or peer group. However, the initial aggression decreases overtime because the group now understands who occupies the highest rank (Varjas *et al.* 2009). In addition, the homophily hypothesis (Berndt 1989, Kandel 1978) suggests that peers affiliate with those with similar attributes, including behavioural characteristics, such as attitudes, academic achievements and tendency toward misbehaviour (Flannery *et al.* 2007).

Other studies which examine peer networks and aggression have found support for the homophily hypothesis (Cairns and Cairns 1994), and state that peers tend to influence each other over time. For example, in a short-term research conducted by Swearer *et al* (2003) of verbal aggression among middle school students, levels of peer aggression were prevalent and expected from individual youths over a school year. This finding was found to be true in both females and males, even after controlling for baseline levels (Espelage *et al.* 2004)

Therefore, strategies to address HCWs' perceived attitudes towards MSM at organisational level may include communication skills to address potential verbal aggression. This may

include the provision of peer programs which are designed to promote positive reinforcements based on mutual respect for all, patient equality, and trust between HCW and patient (CDC 2015). According to the CDC, patient trust is the key to a successful relationship with HCWs in which the rights and responsibilities of both the patient and the HCW are upheld. The CDC adds that trust implies a firm reliance by the patient on the integrity, ability and character of the HCW. For instance, if a patient trusts or has confidence in his or her HCW, he or she is more likely to be willing and able to adhere to treatment and follow the HCW's instructions and advice. HCWs should therefore strive to be worthy of this confidence by earning the patient's trust; which the CDC enlists can be earned through three key steps: respecting the patient's autonomy, and a patient's right to determine what will be done with his or her body, belongings, and personal information i) freely providing complete and accurate information, ii) rigorously maintaining confidentiality. (CDC 2015).

### ***SEM at the societal level of influence***

The community level of influence of the SEM model may include factors such as gender norms, religious or cultural beliefs, societal norms, and social policies (Murray 2000). Community level influences can also be factors that influence one's attitude based on individual experiences and relationships with community, and social environments such as health facilities, workplaces, neighbourhoods and schools.

HCWs play a key role in creating a positive or negative healthcare environment. This may be influenced by one's own cultural values regarding appropriate or inappropriate sexuality, which may disapprove of same-sex activities. Therefore, it is likely that serving an MSM patient may conflict with a particular physician, nurse, and other HCW's own moral or religious principles (Gerbert *et al.* 1991). However, HCWs who continuously resist or object to the provision of care to MSM as a result of their moral beliefs against homosexuality can

subsequently do more harm to their patients' health. The World Medical Association, or WMA (2013) states that refusal of HCWs to provide non-partisan healthcare provision is in direct opposition with a healthcare principles and obligations to provide non-discriminatory healthcare services. The WMA also emphasises that the patient's interests takes precedence over those of the healthcare provider. There is also a broad consensus that public healthcare workers who are unable to provide appropriate services in the context of public healthcare; should by law refer such a patient where he or she will access quality clinical care and appropriate services (Savulescu 2006, Dickens 2006).

However, refusal to provide healthcare services to an MSM patient could be viewed as a manifestation of bullying behaviours towards the individual. Research by Murray (2007) points out that HCWs are prone to exercise or adopt negative attitudes or bullying tactics for various motives. The major reason that was provided is that the majority of perpetrators of bullying; in any given context crave for complete control over their environment. This form of control is not about the HCW empowering their patient in any way; empowering being the belief that change is necessary and possible, but rather a negative attitude which reflects unequal power relations between the HCW and the patient. Once that sense of power is established between the parties, effective healthcare provision cannot take place since part of the empowering process includes being sensitive to the healthcare needs of the patient, being respectful and extremely cautious and sensitive towards their private information. Therefore, HCWs who "lack the ability to be remorseful or feel guilt over the harm inflicted upon others" in the healthcare setting, make it impossible for the MSM population to access appropriate healthcare interventions (Anderson and Whiston 2005:378).

Though such attitudes may be prevalent and visible at a clinic level, fellow HCWs may lack the skills to effectively address this. This corroborates research on other negative attitudes and practices such as bullying in schools. For instance, in the teaching environment, teachers

have been found to lack adequate skills for addressing or establishing the extent of victimisation that occurs at school level (Holt and Keyes 2004).

Taking this example into the healthcare setting and context, HCWs may lack the necessary skills on how to effectively handle or address situations of HCW-patient victimisation at clinic level (Espelage and Swearer 2003). HCWs' inability to respond to issues of ill-treatment has implications related to MSM patient's perceptions of public healthcare interventions. When MSM individuals witness the lack of responsiveness from the concerned HCWs' peers, or on the part of the healthcare facility management, or the higher level authorities within DoH, they may feel hopeless and believe that recognition of their rights to healthcare is impossible (Dupper and Meyer-Adams 2002, Houndoumadi and Pateraki 2001).

Typical examples of discrimination at healthcare facilities were reported at nearly 30 different public and private healthcare facilities throughout King County in the United States (Plough 2000). Such behaviour included acts of racial slurs and as well as differential treatment of patients. As a result of these HCW attitudes, interviewees reportedly changed their health seeking behaviours, including delays in seeking treatment and care. A call to action was made to enforce non-discrimination policies in the region's major public healthcare facilities.

From this, it is easy to see the interaction and interplay between the individual, the institutional environment and community variables that inform one's victimisation of another individual. Such multiple and interrelated systems are critical to understanding the social-ecological origin of HCWs' attitudes towards MSM (Swearer and Doll 2001). For instance, during the transition from elementary school to middle school, according to Swearer and Doll (2001:7):

individuals enter a new environment where the nature of peer groups are changing, the family may also be an influential force in the life of the individual, the community that surrounds the home becomes more important as individuals walk to and from work and become more involved in community activities.

As ordinary individuals who are part of a larger community and likely to be influenced by their environments, HCWs may use aggressive behaviours to create some sort of hierarchy or authoritarian environment within their own family, peer group as well as the healthcare setting. Rodkin suggests that such individuals are likely to be considered “attractive by their peers” and “could potentially have a socializing effect on others, either positive or negative” (Rodkin 2003: 384.)

Thus in order to effectively tackle negative social dominance issues within a given community, strategies should be designed to positively impact the individual’s environment, processes and policies within a given context or community. According to the CDC, this includes the use of social norm campaigns which are aimed to nurture community environments that promote positive relationships between individuals. These must also be based on mutual respect, equality, and trust between the parties involved. Strategies at the society level include collaboration and linkages at multiple levels. These partnerships should work together to promote gender equity, promote positive social norms, facilitate policies and laws that promote trust and encourage patient relationships based on equality. (Powell *et al.* 1999).

This study will also look at other SEM variations such as the SEM of Communication and Health Behaviour (SEMCHB), (Kincaid *et al.* 2007). This will be briefly discussed at the theoretical framework and analysis stages of this study. Overall, the major objective of this

study is to assess how the SEM's different spheres of influence work reciprocally to influence HCWs' knowledge, attitudes and practices towards MSM

### ***Conclusion***

Due to its complex nature, the SEM has been criticised for the difficulty of applying its principles when designing programs and public health interventions. However, over time, the model is being increasingly used to design comprehensive public health programs (CDC, 2014) and other social related interventions. As discussed in previous sections, perceived HCWs attitudes towards MSM are driven by multiple factors and these contribute to most challenges faced by this population. Therefore, efforts to address perceived HCW attitudinal barriers will be maximised by assessing and finding solutions at multiple levels. This study thus aims to produce enough theoretical rationalisation to justify this study's objectives as well as outline the theoretical concepts that support the analysis of the data gathering.



## **CHAPTER FOUR: METHODOLOGY**

### ***Introduction***

This chapter presents the research methodology that was used during the data collection process. It expands on the research paradigm employed and clarifies the research design of this research, thus leading to the plan for collecting and analysing data within this study (Guba 1990: 17, Ragin 1994: 191). The sampling technique and recruitment strategy utilised to select participants for this study will be explained. Lastly, issues of research and data validity are examined, and the ethical considerations for this research explained.

### ***Research paradigm***

This study employed qualitative approaches. Qualitative research is a method of inquiry which aims to gather an in-depth understanding of human behaviour and the reasons that govern such behaviour (Denzin and Lincoln 2005). Qualitative research explores the richness, depth and complexity of a phenomenon (Strauss and Corbin 1990).

Generally, little has been written on the subject of exploring and examining knowledge, attitudes and practices of HCWs towards MSM in uMgungundlovu and eThekweni districts in KZN. Research has mostly been limited to major international fora and metropolitan areas. However, there is growing recognition in South Africa that MSM are disproportionately affected by HIV; that they have been severely under-served by the country's previous national HIV and TB response; and that they contribute considerably to sustaining the high rates of new infections recorded every year (Imrie *et al.* 2008). Another reason for little research, especially in rural settings, is that, generally, MSM is a taboo subject in many cultures and most societies are generally in denial or unaware that sex between men happens or that MSM exist in their homes, families and communities (UNAIDS 2010). Therefore, the

choice of a qualitative research approach is pertinent to this study as it is well documented that where there is little evidence on a particular research topic, qualitative strategies and approaches are a very useful method to adopt. The added benefits of recruiting qualitative research approaches in this research is also due to their exploratory nature (Denzin and Lincoln 1994). In addition, the researcher was able to make use of open ended questions and this made room for participant probing where necessary, thus allowing all study respondents to express views in their own words. The use of qualitative research methods in this study was an effective opportunity to identify factors which are not easily identifiable or seen. These SEM variants include individual and interpersonal values and beliefs, organisational practices, structural processes and other interrelated aspects of the social ecological model (Bernard 1995).

### ***Research design***

This study is designed as a Knowledge, Attitudes and Practices (KAP) study. KAP studies explore the knowledge, attitude and practices of a community (Kaliyaperumal 2004). The main purpose of this KAP study is to explore knowledge, attitude and practices of the HCW community towards MSM, and the kinds of practices that are followed regarding management of MSM treatment. Kaliyaperumal (2004) states that before beginning the process of creating awareness in any given community, it is first necessary to assess the environment in which awareness creation will take place. KAP studies tell us what people know about certain things, how they feel and also how they behave.

The knowledge possessed by healthcare workers refers to their understanding of the subject of MSM in relation to healthcare. Attitudes refer to healthcare workers' feelings towards the subject of MSM, as well as any preconceived ideas they may have towards this topic.

Practices refer to the ways in which HCWs demonstrate their knowledge and attitude through actions (practice).

KAP studies can also identify knowledge gaps, cultural beliefs, or behavioural patterns that may facilitate understanding and action, as well as those that pose problems or create barriers to health related efforts (WHO 2008). They can identify information that is commonly known and attitudes that are commonly held. To some degree, they can distinguish variables affecting one's behavioural conduct that is not known to other people, the purpose behind these practices, and how and why individuals adapt certain practices or attitudes. KAP studies can likewise evaluate communication methods and processes that are vital to define effective programmes and communication strategies in HIV prevention. In this study, these KAP principles are interpreted by assessing and understanding the knowledge of healthcare workers regarding the relationship between MSM and HIV, as well as assessing their attitudes towards MSM, and the ways in which these attitudes may affect their practices of treatment or general service provision to MSM patients. It is proposed that understanding the levels of knowledge, attitude and practice of HCWs will enable a more efficient process of awareness creation as it will allow health programmes to be tailored more appropriately to the needs of the MSM community.

Additionally and in relation to the features described broadly as KAP, the objectives of the study are to establish:

1. The **knowledge** held by health workers of the relationship between MSM and HIV.
2. **Perceptions** of health workers on the relationship between MSM, sexual practices and HIV.

3. **Attitudinal** responses which may occur (e.g. sympathy, blame, judgement) in counselling and treating MSM.
4. What ways, if any, do these attitudes impact on the **practice** of treating MSM patients?

As illustrated above, the questions were designed with the objectives of the study in mind. In addressing the above it aims to assess: how comfortable HCWs are in communicating with a patient about their sexual history, their level of comfort in taking care of a family member who is an MSM and whether HCWs witness cases of discrimination towards MSM patients during consultation or treatment by fellow HCWs.

### ***Sampling strategy***

HCWs who participated in this study were selected through convenience sampling, which refers to a sample that is “restricted to a part of the population that is readily accessible” (Singh and Mangat 1996: 7). This strategy was selected because it is practical in terms of producing an estimated number of people to interview without the cost or time required to select a random sample. Being a nonprobability technique, the findings cannot be generalised to the population at large, but still reveal insights into the area of question.

The sample size was a total of sixteen healthcare workers, from the original sample of twenty due to shortages of HCWs on site. The criterion for the sample size included interviewees being familiar with the topic under scrutiny. Selection for the discussion group was also based on the use or knowledge of public healthcare. The most important criterion for inclusion in this research was that participants should be registered and practicing professional HCWs. This included a variety of HCWs such as the heads of department,

doctors, nurses, pharmacists, technicians or medical students from each of the identified public health facilities in eThekweni and uMgungundlovu districts.

Homogeneity among the participants was extremely important since in focus groups, researchers are interested in the attitudes and behaviours of a specific demographic, rather than in a widespread generalisability (Greenbaum 1998, Krueger 1988). Moreover, some researchers recommend that women and men should be interviewed separately, and that the age difference within a single group should not be more than 15 years (Berger 1998, Greenbaum 1998, Krueger 1988). In relation to this and the homogeneity of participants, a conscious effort was made to interview 50% male and 50% female HCWs. However, due to the shortage of on-site professional health staff, 70% (11) of the interviewees were female and 30% (5) were male. Additionally, the group comprised of six professional nurses and one doctor from Imbalenhle community health centre, herein referred to as Imbalenhle clinic, and five pharmacists and four professional nurses from King Edward VIII hospital. These research participants were all aged between 20 and 50 years of age. The research was conscious of staff and time limitations posed by the healthcare environment, thus a pilot study was not conducted.

Though the original sample size was twenty HCWs, 10 from each facility, the final sample size was characteristic of an “information-rich” sample style arrangement; that is to say, smaller in size but yielding thorough and informative findings (Bertrand and Hughes 2005: 65).

For ethical purposes, HCWs requested that their names not be mentioned in the study; hence respondents were allocated numbers and referred to as “respondent 1” all the way to the sixteenth respondent, followed by their location and date of interview (see Appendix 1).

### ***Data collection***

The researcher compiled the guiding questionnaire and framework for the interview process (see Appendix 2), designing the interview template for the purposes of gathering relevant data in line with KAP study methods. This was a necessary step to commence with the research, and demonstrated the ethical integrity and relevance of the proposed interview questioning.

The data collection was based on two gathering techniques. The first was focus group discussions with a sample of sixteen HCWs, with one group from eThekweni, comprising nine HCWs, and the second group from uMgungundlovu with seven HCWs. Focus groups are usually interested in delving into people’s attitudes, interests and opinions concerning specific phenomena, situations, products or artefacts. “Focus groups create a setting in which diverse perceptions, judgements and experiences concerning particular topics can surface. Persons in focus groups are stimulated by the experiences of other members of the group to articulate their own perspectives” (Lindlof 1995: 174).

The focus group interview format, which incorporated a structured questionnaire focusing on knowledge and practices, allowed for open-ended discussions thereby limiting interviewer bias and giving voice to the participant. This is because “the aim of the focus group discussion is not to build consensus, but just the opposite – to find out what each member of

the group thinks about the topic under discussion, and to elicit from each person his or her opinions and descriptions of the behaviour of interest” (Berger 1998: 89).

Additionally, focus group methods arose as a reaction to the confinements of traditional interviewing techniques which had undesired impact from the interviewer and limited the respondents' reactions and the advancement of new thoughts. These constraints of conventional interviewing strategies prompted the improvement of non-traditional methodologies, of which focus groups approaches, became “the exemplary format” (Krueger 1988: 19). The focus group questions were open ended and were the same for both focus groups as this was an effective way to understand the personal experiences of others (Fontana and Frey 1994), and ensure a level of consistency in the content of the data collected. The value of asking the same questions in both focus groups' discussions was to provide comparable responses, however the interview was developed by the conversation between the interviewer and interviewees (Wisker 2001). Open ended questions were deemed relevant in this study as they afforded participants the flexibility and time to delve deeper into aspects that might pertain directly to their roles as HCWs (Berger 2011) and explore key messages of the SEM variables.

The second data gathering aspect involved the same sample of HCWs collecting data through individual self-administered questionnaires. Seven carefully designed questions comprised the ‘attitudes’ template which assessed personal attitudes of HCWs towards MSM. Using a combination of both focus group discussions and self-administered questionnaires aimed to improve this study by ensuring that the limitations of one type of data was balanced by the strengths of another. It was important to combine both questioning strategies to all

participants in this study. All sixteen people participated, with a few participants opting not to answer all questions. The response rate was therefore  $16/16 = 100\%$ .

The questionnaires were organised and designed around the KAP study themes. Each of these themes was discussed by identifying relationships between the SEM concepts or between one variable and another. For example: Is the individual knowledge around MSM related to MSM acceptance or stigma? Is the social environment or background related to positive or negative attitudes towards MSM? At the organisational level, what are the norms related to caring for a patient with an anal STI? The results were then used to make inferences about the emerging findings from the data. The broader research questions also served as a comprehensive research guide for uncovering the necessary data.

In terms of the recruitment strategy, the researcher made contacts with both health facilities and the individual heads of departments were briefed on the purpose of the study and the desired sample. A verbal notice was sent out by each head of facility to the various departments and units, inviting participation in the research. This took place after a gatekeeper permission letter from the Provincial Health Department was issued as proof to proceed with data collection (see Appendix 3)

### ***Data recording***

Printed in both English and isiZulu, the informed consent document requested individuals to formally declare whether they were comfortable with the conditions of this study. Once individuals had consented to participate in the study and signed the informed consent form (see Appendix 1), the data gathering process commenced. The interviews were recorded with the use of a mobile phone recording device and questions were read out to participants in



English as the language of preference. Focus group discussions were approximately one hour long, and were conducted in a private and comfortable room that had been allocated during preplanning discussions with both the Imbalenhle and King Edward VIII heads of facility. Interviews at Imbalenhle clinic were audio-recorded on a recording device after securing both verbal and signed permission from participants to do so. However, participants from eThekwini opted not to be recorded and the researcher used the written form in order to record emerging themes. This was also an excellent way for the researcher to start familiarising herself with the data (Riessman 1993). When the day's data collection was complete, all audio recordings were manually transcribed by the researcher.

### ***Data analysis***

This section describes the form of data analysis employed in this study. The procedure of analysing qualitative data is said to be a “process of resolving data into its constituent components, to reveal its characteristic elements and structure” (Dey 1993: 31). Various methods can be utilised in the endeavor to achieve such an outcome; for the purposes of this study, an approach known as thematic data analysis was employed.

### ***Thematic analysis***

Thematic analysis “is a search for themes that emerge as being important to the description of phenomenon” (Fereday and Muir-Cochrane 2006: 3). Thematic analysis identifies analyses and reports patterns or themes within data. It minimally organizes and describes data sets in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic (Boyatzis 1998). Through the meticulous reading of the data, emerging themes can “become categories for analysis” (Fereday and Muir-Cochrane 2006: 3). A ‘theme’ can be described as a subject that “captures something important about the data in

relation to the research question, and represents some level of patterned response or meaning within the data” (Braun and Clarke 2006: 82).

According to Braun and Clarke, there are two ways to develop study themes. These can either be done inductively or deductively. While the latter, the deductive approach, can be determined by “the researcher’s theoretical or analytic interest in the area”, the researcher can predefine the study themes (Braun and Clarke 2006: 84). Inductive themes, on the other hand, are generated by thoroughly re-reading the data. This method is thus data-driven and not derived from pre-existing frameworks or by the researchers’ preconceived themes. In this study, deductive methodology to theme development was employed and guided by the KAP methodology. However, emerging sub themes were partly developed through the inductive approach and as guided by the social ecological model which informed this study.

The audio recordings were transcribed and the data generated resulted in a large volume of information. Transcribing and translating the data gave the researcher an opportunity to acquaint herself with the data and get a basic impression of the data. The data was then organised into the most important themes which emerged. In this sense, theoretical thematic analysis was used as the method of analysis. The formation of the different themes was made easier by the familiarisation of the data. The inductive themes that emerged from the data were compared with the deductive themes and guiding research questions that were used to collect data to examine whether there were any similarities.

The three deductive themes that were used to collect the data for this study were knowledge, attitude and practice. Themes which emerged from the data and belonged together but had clear and identifiable distinctions between them or with the main themes, were broken down into separate themes, (Patton 1990) for dual criteria judging. These form part of the inductive themes.

The knowledge explored HCWs' understanding of health issues concerning MSM, while the attitude component was interested in their feelings towards MSM as well as preconceived ideas that they may have towards the subject of MSM. The practice section sought to understand the ways in which HCWs demonstrate their knowledge and attitude through their actions or practice. Emerging themes from the data were compared with the initial study themes to assess whether both the initial themes and the new ones were relevant or not. Newly emerging themes were added to the pre-existing ones, at the same time, keeping in mind the study questionnaire and study framework.

Research comments or responses which were similar or commonly stated were grouped together and summarized. This also allowed the researcher to identify key emerging themes as well as finding the rationale behind respondents' various views and perceptions about MSM. Each response was interpreted with the aim of analyzing and understanding the true meaning of certain views which were expressed during both the focus group discussions and the self-administered questionnaire.

Additionally, the themes were discussed by identifying relationships between the SEM concepts, as the study's theoretical framework, which helped in making sense of the findings. For example, is one's social environment related to positive or negative attitudes towards MSM? What are the relations between the organisational culture and HCWs' attitudes towards caring for a patient with an anal STI? What SEM level factors contribute towards the difference in MSM healthcare knowledge between respondents? The results will then be used to make inferences about the findings from the data.

### ***Use of the SEM in data analysis***

As discussed in the theoretical framework chapter, it is clear that behavioural phenomena and challenges faced in society are equally influenced by the individual, family, public

institutions, peer group and the community (McLeroy *et al.* 1988, Green 1996). This study will identify factors at each level using the KAP study to determine the perceived HCWs' attitudes towards MSM.

### Individual

Data collected for this study aims to understand and identify personal factors that influence HCWs' perceptions of MSM. At this level, attitudes and beliefs that ultimately prevent or promote change in perceptions will be identified. Strategies which bring change at the individual level or focus on changing an individual's knowledge, attitudes, behaviour and skills are explored, and will be analysed in the next chapter.

### Interpersonal

In the SEM, Sallis and Owen (1997) propose that it is not only the environment that directly affects or influences the person, but that there are layers in between, which all have resulting impacts on the next level. The study will examine relationships that may inhibit or promote HCWs' attitude to change. According to the SEM a person's closest social-circle, peers, partners and family members influence their behaviour and contribute to their range of experiences.

### Organisational and community

As noted in previous sections, international and local research highlights that HCWs play a significant role in influencing health seeking behaviours of MSM. This study considers HCWs' social settings, such as workplaces and neighbourhoods or communities, in which social relationships occur; and seeks to identify the characteristics of these settings that influence HCW behaviours and attitudes towards MSM. Organisational and community factors constitute the social context that facilitates certain behaviours and negative attitudes towards MSM patients. For instance, one's perceptions are almost always influenced by one's

environment which may involve co-workers or one's community norms and values. Relationships with patients are played out within a larger context of organisational and social influences, including group norms and cultural expectations. Organisations, such as healthcare facilities, can be the source of social inequalities or can promote a sense of belonging as far as MSM health seeking behaviours are concerned. Additionally, the organisational environment of individuals at the SEM level of influence can be instrumental in "creating healthier environments in addition to creating healthier employees" (McLeroy *et al.* 1988: 360). For instance, lack of resources at clinic level can affect the quality of available healthcare to MSM as much as it will affect staff morale of HCWs in as far as their ability to provide these services is concerned.

The next section delineates the validity of the data gathering and the subsequent research findings.

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

Stemming from a positivist discourse, the concept of validity refers to "whether the research truly assesses that which it was intended to discover or how truthful the research results are" (Joppe 2000: 1). Validity has been a problematic concept to articulate within qualitative research practices, and as a result "many researchers have developed their own concepts of validity such as, quality, rigor, and trustworthiness" (Golafshani 2003: 602). However, traditionally within qualitative inquiry, validity has consisted of two contributory components, namely internal and external validity. Keeping in mind the interpretative perspective adopted in this study, this section discusses measures taken to ensure the internal and external validity of this study.

In general, internal validity refers to “the degree to which the results can be attributed to treatment”, which essentially addresses the credibility of a researcher’s given approach to drawing conclusions from gathered data (Ali and Yusof 2011: 30). Golafshani (2003) adds that there are no specific rules to evaluate internal validity or reliability of a given qualitative study. The exception is when exploring the researcher’s efforts at ensure academic rigour and credibility during research and the discussion of data.

This requires consideration of whether the right research questions were asked or not. In the context of this study, the reliability of research was promoted due to the confidentiality of research participants (see Appendix 1). In conjunction with this, the research methods chosen are well established and documented, drawing on long-standing theory to underpin the interview questions and data analysis. Central to this study is the KAP study design and the SEM which are both well documented methods, thereby providing a large measure of rigour.

### ***Ethical considerations***

Ethical considerations were very important for this study as they are to all research studies, so as to protect the individuals’ physical and mental integrity, to respect the moral and cultural values, religious and philosophical convictions and other fundamental rights including respect for privacy (Bastien *et al.* 2011)

Gatekeeper permission (see Appendix 3) to conduct interviews was first obtained from the provincial health district and subsequently, from district health authorities and heads of both healthcare facilities (see Appendix 4). Before the gatekeeper letters were obtained from both the provincial health department, UKZN ethics committee ethical approval letter (see Appendix 5) was first sought and obtained from the university.

Permission from the head of facilities was instrumental in terms of determining suitable times for the researcher to conduct the interviews. Emphasis was placed on ensuring interviews took place at a convenient time that would not disrupt provision of public health services. As part of the ethical deliberations, all participants were handed out with written informed consent form (see Appendix 1). This was written in a simple and clear language and clearly articulated the purpose and objectives of the study. In addition to this, the consent form made provisions for full participation or opting out from the study, as well as explaining issues of participant confidentiality. For example, individuals were handed informed consent forms and the researcher explained that individuals do not have to participate in this study if they are uncomfortable with the subject. It was also explained that if individuals opted to participate, they also had an option to discontinue participating at any given time during the discussions. Participants were also made aware that they did not have to disclose any confidential information or answer any question with which they felt uncomfortable to engage.

The informed consent forms were well thought through and designed to reiterate the voluntary nature of this study. Likewise, the individuals' perceptions would not be used against them whether they chose to participate or not. For example, if a HCW wished to participate, their identity would remain hidden by means of a pseudonym or a number identification followed by the location of the respondent and the date of interview; for example: respondent 4, Imbali, 8 May 2015. Imbali is a township or location, defined as an "area that is designated under apartheid legislation for exclusive occupation by people classified as Africans, Coloureds and Indians" (Lester *et al.* 2009: 6). In the event of the findings being published, this measure will ensure the protection of participant's identities. Participants were also made aware that no manner of compensation will be dispensed for

their participation in this study; however, their contribution could be of value to improving healthcare service provision for MSM.

The interview process commenced after individuals formally consented, in writing, to participate. During this time, the interviewer was conscious of the respondent's emotional wellbeing, allowing individual respondents to guide the discussion and discussing whatever information each person felt comfortable to disclose within boundaries. The researcher relayed back the respondent's answers after each question. This was to ensure each position was accurately understood by the researcher and the subsequent guiding questions. This technique provided for more ethical and valid findings.

### ***Limitations***

The limitations of this study that are worth mentioning relate broadly to three areas of this dissertation which are knowledge, attitudes and practices. A person's knowledge, attitudes and practices are overarching categories that encompass more complex and subtle psychological and social dynamics, such as their self-confidence and their susceptibility to peer pressure (WHO 2013). Understanding these dynamics may require more time which will allow the researcher to gather useful information for decision-making. However, this is beyond the scope of this particular study. This study intends to illuminate some of the socio-cultural and economic aspects of the context in which public health programmes for MSM are implemented. Such information has typically been gathered through various types of cross-sectional surveys, the most popular and widely used being the KAP survey (Green 2001, Hausmann-Muela *et al.* 2003, Manderson and Aaby 1992, Nichter 2008: 6-7). Due to the small sample in this research, I consider whether findings apply to the majority of the HCW population or whether there might be important differences between respondents.



Respondents may have been reluctant to talk about sexual matters, which required the researcher to explain, with respect, and help them understand why their honest responses were important.

It is documented that the facilitation of focus groups requires that the moderator be well prepared and fully aware of the research questions under discussion (Greenbaum 1998, Krueger 1988). He or she needs to balance a lively discussion since “interaction among participants is a vital part of the focus group process and must be encouraged to maximize the quality of the output from the session” (Greenbaum 1998: 66), while at the same time, exerting the moderator’s role as an “authority figure in the room who is in control of the group discussion” (Greenbaum 1998: 67). Throughout the focus group discussions, the researcher observed that some respondents sought to dominate the dialogue. To solve this, the researcher was well prepared for sensitivity to group dynamics and ensured that the more quiet participants got a chance to speak, while the more vocal participants observed the process. The researcher also tried to create a more relaxed environment due to the sensitive subject of MSM.

The method of a focus group discussion may have been limiting for some respondents due to the need to trust each other with sensitive or personal opinions. In order to combat this possible limitation somewhat, the same group of respondents filled in the self-administered questionnaire. Additionally, the health facilities were not able to provide the requested sample of 10 diverse HCWs as originally requested due to critical shortages of professional HCWs and the demands placed on their time. Therefore, the views of the 16 HCWs are not intended to be a complete reflection of the general healthcare workers necessarily, but it provides in-depth insight into the concerns motivating this research question. In terms of

mitigating time constraints issues, participants were interviewed an hour before commencing their duties.

The final limitation of this study relates to the sensitive and personal nature of the MSM topic, and the manner in which this may have influenced the long process in attaining ethical approval from the research committee or influenced delays in obtaining gatekeeper permission from both health facilities for data collection purposes.

Taking into consideration that discussing MSM behaviours can be a sensitive issue, the discussions on this topic generated emotional responses from a few participants, thus revealing true or hidden beliefs about the subject. In addition to this, the subject of MSM is of a politically sensitive nature thus the ethics committee felt the need to act as gatekeepers during the research approval process to protect participants from potential harm. Various reviews and documentation from literature points out that HCWs, as research subjects, may be hugely impacted by the research and its findings. Other individuals who may be affected by the research include the researchers, transcribers, supervisors and readers of publications may also be placed at risk. Potential risk could include physical and/or psychological (Walker 1979, 1984; Mccosker 1995). Therefore, in order to protect everyone who participated in this research from any form of physical and psychological risk, confidential protocols were developed and explained at the beginning of the research process to minimise risk through the confidentiality clause (see Appendix 1).

Finally, the findings depicted in this research are based on HCWs' KAPs. The findings do not claim to represent direct causal relationships between KAPs and subsequent HCWs' service provision to MSM individuals; more accurately, these findings depict KAPs that would ultimately influence, rather than dictate, MSM service provision.

While the above limitations will not hinder the adequate analysis of this research, future studies could potentially address these limitations by incorporating more participants through a probability sampling method. Since the main purpose of this KAP study is to explore knowledge, attitudes and practices of HCWs towards MSM, it will be valuable to evaluate, over time increases in knowledge, changes in attitudes towards MSM, as well as changes in the kinds of practices that are followed regarding health management of MSM.

The next chapter will outline and discuss results emerging from the research data collection. This includes detailing the significance of the emerging data while keeping in mind the objectives of the study, the study questionnaire and the pre-identified KAP themes.

## **CHAPTER FIVE: RESULTS AND DISCUSSION**

### ***Introduction***

This chapter presents and summarises results from the data collected from both focus groups and self-administered questionnaires. Interviews took place between May and July 2015.

The collected data will be discussed in relation to the study objectives and main questions and linked to the three themes that were identified in the methodology chapter, these being knowledge, attitudes and practices. Each of these themes is discussed by identifying relationships between the SEM concepts, as the study's theoretical framework, or between one variable and another. The analysis is also informed by relevant information presented in the literature review.

The findings will explain how HCWs' KAPs may influence their service, and how these attitudinal barriers can be addressed in order to positively influence MSM health-seeking behaviours, treatment decisions and access to comprehensive prevention services that are tailored to the needs of MSM in KZN. Results from the research will help understand the levels of KAPs which need to be dealt with in order to enable a more efficient process of awareness creation as it will allow MSM health interventions to be improved.

### ***Structural and healthcare environment***

The purpose of discussing the structural and healthcare-related environments of participants in this section rather than at the introduction stage of the thesis is to briefly draw attention to the structural and policy level of the SEM. To show how one's environment affects behaviour or influences certain processes at all the levels of the SEM. By taking this into consideration, the study aims to shed some light on the broader structural context within which HCWs

operate. The study utilises the SEM characteristics as points of reference when discussing patterns that emerge in subsequent KAP themes.

King Edward VIII hospital is based in Congella in the eThekweni municipality. According to the DoH (2014); Congella is a thriving industrial area with great potential for increased development. Congella is used for factory purposes and enjoys adequate road and railway traffic and access to a water frontage. The number of students and working class residents who live in Congella is on the rise and, the majority of these residents earn a low income or have none. As such, though no direct evidence of linkages, the assumption is that most of these residents are reliant on the public healthcare system as provided by the hospital. The rise in low income and student residents is partly attributed to the industrial activities in Congella and that King Edward VIII Hospital attracts job seekers since it is the second largest hospital in the southern hemisphere. It also provides regional and tertiary services to the whole of KZN and Eastern Cape provinces. It also attracts young people since it is a teaching hospital for UKZN's Nelson R Mandela School of Medicine, including a nursing college which is attached to it.

King Edward VIII Hospital can accommodate approximately 930 stay-in patients and nearly 360 000 outpatients. Though these are high numbers the hospital is stretched and, perhaps, under-resourced.

Though the eThekweni municipality has seen a growing number of private healthcare facilities, these are run on commercial lines and cater for middle to high-income earners who tend to be members of private medical schemes, or to individuals looking for top-quality medical care.

In contrast to King Edward VIII Hospital, Imbalenhle clinic is based in Imbali township, in the uMgungundlovu district. This district is known not only for its role as an industrial hub,

but also hosts the second largest metropolitan city, Pietermaritzburg, which lies approximately 80 kilometres outside of the eThekweni municipality. Research shows that 40% of the South African population resides in townships. Living conditions within these settings is reported to be largely underdeveloped despite the end of apartheid in 1994 and its 22 years of democracy (Bond 2008: 406).

Despite the said thriving industrial businesses, levels of poverty and unemployment remain high in both the eThekweni and uMgungundlovu districts. This means healthcare provision is largely the burden of the state through facilities like Imbalenhle clinic and King Edward VIII Hospital. Though the public healthcare system is well on its way to being reformed with the increase in funding for public facilities; infrastructural conditions within many townships like Imbali visibly remain inadequate.

It is within this context that both health facilities operate, with Imbalenhe serving an estimated population of 1 066 148 from 11 municipal wards. The clinic has 6 feeder municipal clinics that refer patients, with severe cases being referred to Edendale hospital which is located in the Pietermaritzburg. The clinic is one of the few in KZN which operates twenty-four hours, and currently has a headcount of approximately 25 000 patients per month (DoH 2014).

### ***Healthcare workers' (HCWs') knowledge and practices about MSM health issues***

Discussions under this theme aim to explore and identify knowledge and practices of HCWs around MSM issues in general and how these are related to health. This section only assesses HCWs' knowledge and practices and related sub-themes which emerged from data collection under both knowledge and practices. Emerging themes from this section, and as described in the methodology chapter, will be largely linked with the various levels of the SEM which takes into account: the intrapersonal factors, interpersonal processes and primary groups, the

institutional factors, community factors, and finally, public policy, associated with MSM. Informed by personal experiences and information, factors in these levels relate to how individuals perceive a certain practice or issue, as well as how it relates to them (Sallis and Owen 1997).

The degree of knowledge and practices assessed in this section helps to locate areas where awareness-raising or sensitisation efforts need attention. Knowledge refers to the awareness and understanding people have about a particular issue (Etter *et al.* 2000). From this, it can be deduced that knowledge may not be directly visible. However, practices or behaviours are. In this study, practices can be seen in the form of HCW actions in response to healthcare needs of MSM individuals. Therefore, for the purposes of this study section, practices deal with the concrete, with actions.

Both knowledge and practice themes and emerging or related sub-themes will be assessed together to show their connections, as described in the methodology section. I therefore hope to contextualise my study into the SEM theoretical framework and highlight some of the non-mediated channels shaping HCWs' perceived attitudes and perceptions towards MSM.

The attitudes findings will be discussed separately.

### ***HCWs' knowledge and practices: Understanding of MSM terminology vs gay identities***

To ensure general understanding of the study subject, HCWs were asked about the definition of MSM and how this differed from gay identities. Attempting to assess the level of knowledge among those interviewed, the researcher did not give a unified definition of the term MSM<sup>1</sup> (the definition to which this study subscribes is provided in Chapter one).

---

<sup>1</sup> The definition describes MSM's sexual behaviours, notwithstanding personal identity, motivation for partaking in sex, or identification with any particular sexual orientation. Simply put, gay is a chosen identity whereas MSM is just a descriptive for sexual behaviour.

In response to the question assessing knowledge and understanding of the term MSM, the overwhelming majority of respondents from both study settings said that though they have heard of the term MSM in various fora such as health reports, television programmes and other health related meetings; they found it difficult to understand or define it. This finding corresponds with Meyer *et al* (2011) in their analysis of the description of MSM. The authors suggest that the definition of a typical MSM was difficult since MSM come from all forms of backgrounds, socio-political, socio-cultural as well as professional attributes. This also includes being engaged in different same-sex behaviours. Despite this understanding, as evidenced from this study, there seems to be a general failure by the majority of respondents to recognise and uniformly agree what the term MSM entails or means in its various contexts or as per the UNAIDS definition.

However, in response to the question of whether it was possible to judge if a person is gay or MSM by looking at them, most of the respondents agreed that “90% of the time we can if they are gay, but no, if they are MSM” (respondent 2, Imbali focus group, 8 May 2015). Linked to the SEM, Bronfenbrenner (1999) acknowledges here the relevance of biological and genetic aspects of the person and how this influences other people’s behaviour towards them. Bronfenbrenner dedicated a lot of his attention towards the individual’s characteristics and how this may impact their social environment. Bronfenbrenner divided these characteristics into three types: demand, resource, and force characteristics. “Demand characteristics are those that act as an immediate stimulus to another person, such as age, gender, skin colour, and physical appearance” (Bronfenbrenner 1994). These types of individual characteristics have the potential of influencing one’s initial interactions and how they are perceived by others in a social setting since expectations of how they should respond will have been formed already. This explains why most respondents from both Imbali and eThekweni were very attentive and keen to understand the differences between MSM and



gays, while some considered it unethical to judge people's physical characteristics before providing services or that it was irrelevant to obtain such information, expressing that MSM "look like everyone else" (respondent 4, Imbali focus group, 8 May 2015). Differences which emerged the most were based on sexual behaviour and preference, dress code and physical characteristics, with most respondents stating that gay men were different to MSM because they tended to have an effeminate walk and manner of speech, while others said the majority of gay people have a tendency of using "too much" (respondent 6, Imbali focus group, 8 May 2015) - hand gestures when they spoke, described as 'enhanced physical gestures'. Others associated gay men with males who wear short skirts and applied female make-up, whilst MSM were seen as ordinary men who "act and dress like men" (respondent 1, Imbali focus group, 8 May 2015). For these reasons, a few of the respondents believed MSM were "confused individuals" (respondent 4, Imbali focus group, 8 May 2015) or "abnormal" (respondent 9, eThekwini focus group, 3 July 2015). This finding is also echoed in the Attitudes discussion section of this chapter.

Respondents from both health facilities were given an opportunity to discuss what the term MSM means in relation to public health. This gave respondent 10 (eThekwini focus group, 3 July 2015) an opportunity to express discomfort and challenged the term MSM as being overly complicated to define due to its variations. Respondent 10 cited the following examples to illustrate the complexities of understanding the MSM term: i) drag queens – described as men who dress up in female clothing, wear make-up and wear their hair as females, ii) queens – described as males who are very feminine and dress up in tight pants, love fashion and are "very proud" (eThekwini focus group, 3 July 2015) but do not wear female clothes or make-up, iii) straight-gays – described as those who have sexual relationships with men.

However, a few of the respondents, particularly those from Imbali where more likely to disagree that the term MSM is difficult to define or understand, than respondents from eThekweni. With one respondent making an attempt to explain MSM as simply “men who enjoy having sex with other men but identify themselves as straight men” (respondent 5, Imbali, focus group, 8 May 2015). However, the majority of respondents from both Imbali and eThekweni acknowledge the term is not easy to explain in the sense that it overlooks the complexities of human sexual behaviours. The descriptions mentioned by respondent 10 (eThekweni focus group, 3 July 2015) were used as good examples of the many variants used to describe the MSM population, alongside other terms which are frequently cited in various communities. Participants from Imbali discussed other terms which they described as largely used in local townships and many other communities but less used in professional settings - acknowledging their homophobic connotations. These terms include i) “double adapters” (for bisexuals), ii) “izitabane” (male homosexuals), iii) “ngqingili” (Zulu slang for non-gender conforming), iv) “isitshatsha” (derogatory township term for gay), v) “isiqenge” (Zulu word for transgender), vi) morphies (male homosexual), vii) “izinja” (dogs), viii) isikhawundane” (Zulu term for a promiscuous individual).

Respondents from both Imbali and eThekweni believe these terms are largely used in township communities and less mentioned in urban settings. This is because urban areas are believed to be more tolerant towards the MSM population and their behaviour. Linked to the societal level of influence of the SEM, and given that participants from Imbali mostly live in surrounding townships, while respondents from eThekweni largely live in surrounding suburbs, participants had diverse MSM descriptions and terminology. It is therefore evident that each meaning and description given was shaped by participants’ communities. For instance, while most respondents from both study areas were unclear about the official definition as prescribed by the UNAIDS, the majority identified MSM and gay as the same

population and in accordance to their communities' understanding of MSM. Therefore it is understandable that participants had different sets of terminologies used to describe the MSM population due to established understanding at community level. Additionally, community behaviour towards MSM generally reflects participants' life experiences which if repeated over the years, become established norms and values from the early years of childhood (Bronfenbrenner 1979). This may also influence other levels of the SEM such as family, organisational, personal and interpersonal on how MSM individuals 'should' be defined and treated.

Having said this, a few of the participants from Imbali were able to articulate the epidemiological meaning and differences between MSM and gay: "Simply put, men in this group are attracted to women, marry them, have babies with them and are generally described as heterosexuals. Difference is, they just like to enjoy sex with other men but they are not gay or bisexual and they also don't see themselves as gay or bisexual" (respondent 6, Imbali focus group, 8 May 2015). This statement corresponds with the growing evidence which shows that MSM are not necessarily gay or bisexual. The CDC (2012) points out that it is estimated that more than three million men who self-identify as straight secretly have sex with other men.

In a similar vein, respondent 8 (eThekweni focus group, 3 July 2015) remained unclear about the differences and wanted to know "I still don't get it, if they are not gay or bisexual, then what are they?"

Knowledge and common understanding of the differences between MSM and gay was therefore found to be lacking among the majority of the interviewed HCWs. For instance, the apparent contradiction in respondent 5 and 6's understanding with respondent 8's statement suggests there are deeper disparities in the level of knowledge, practice and understanding of

the differences between MSM and gay among individual HCWs, with MSM and gay terminologies most likely to be used interchangeably, while others see MSM as a distinct, homogenous group.

The lack of coherent understanding and lack of clarity between the two concepts usually implies that one size fits all approaches to MSM healthcare are likely to be adopted in public facilities. This has implications for risk reduction messaging, as non-gay-identifying MSM remain untargted in either mainstream heterosexual or gay media; and interventions (Rebe *et al.* 2011).

### ***Cultural influences on HCWs' knowledge and practices***

With regards to the SEM societal influences, respondent 8's comment could have been said in the context of not knowing the difference between gay and MSM, or having cultural stigma against MSM, religious beliefs opposed to MSM, family influences over perceptions around MSM, or personal attitudes towards male-on-male sexual relationships. For instance, the majority of the HCWs included in this study's focus groups are Zulu and the rest are either Xhosa or English, with their own cultural background or values which may place emphasis on appropriate or inappropriate sexual behaviors. This was evidenced by moments of uncomfortable silence from a few of the respondents who the researcher assumed may have been disapproving of the subject of MSM. This was also a possible manifestation of the dominant view of the un-Africaness of same-sex relations (AIDS Foundation of South Africa 2013), which remains an increasingly controversial topic in most South African communities.

This view is evident in the systematic vilification of homosexuality by leaders like the Zulu King Goodwill Zwelithini (*Reporter* 2012) who once stated that traditionally, there were no people who engaged in same-sex relationships and that same sex is not acceptable. In contrast to this notion, however, and when exploring the cross-cultural variability in sexuality,

extensive research reveals that same-sex practices took a number of forms and had very different meanings during the pre-colonial days. For example, as various studies suggest, same-sex acts were acceptable in the sense that the community agreed not to witness them. This was apparently common throughout Africa and was highlighted by Epprecht in his reflections on sexuality in Southern Africa. Moreover and according to Epprecht (2013), these same-sex bonds were seen as perfectly acceptable, as documented by experts in the field of Shona customary law (Epprecht 2013). There was no word to describe male-to-male sex because it was never seen as a defining or integral part of a person's identity but rather, a natural way of life (Hinsch 1992). Murray and Roscoe (2012) reported that the Yan Daudu societies of the Hausa described same sex practices in terms which describe such acts as not being irresponsible. This includes using terms like the *wasa* (to play), which literally allowed same-sex behaviours to be made invisible or totally ignored by the community.

However, from the focus group discussions it appears that condemnation of same-sex practices remains and is still dominant in communities like Imbali township, or they are dismissed as virtually unknown; or it is understood that "African tradition is rigidly heterosexual" (Lamb 1982: 37). As a result, UNAIDS (2000) records that MSM activities, its extent, and public acknowledgement varies from place to place, and some MSM choose not to accept sexual identities of homosexuality or bisexuality.

### ***Disparities between knowledge and practice***

Contrasting respondent 5's excerpt against the earlier comment by respondent 6 on the differences between MSM and gays, some interesting inferences could be deduced. Both respondents were from the same healthcare facility (Imbalenhle clinic) and were fairly knowledgeable about MSM. This highlights that such an institution has had its staff trained on MSM health issues and aims to create a friendly service - often incorrectly referred to as

an MSM-sensitised service (ITMHC 2012). However, and though knowledge and understanding levels of MSM health issues were quite high in Imbali compared to respondents from eThekweni, there was a discrepancy in terms of putting the knowledge into practice. For instance, HCWs at Imbalenhle were more aware and knowledgeable of the risks MSM face and to some extent, knew how to respond to MSM healthcare needs. However and despite this, it was also evident that some of the HCW respondents were most likely to put their own moral values or religious principles first during consultation, compared to prioritizing the needs of the MSM patient. More details from this finding is discussed in the Attitudes section of this research. In light of this evidence, MSM patients often experience practices of prejudice, and this may serve as potential barriers to MSM risk reduction and behavior change efforts.

Nevertheless, the use of sensitisation training as a tool to develop HCWs' awareness on MSM health related issues was widely discussed by all participants. There was a particular enthusiasm from Imbali and eThekweni respondents around the use of such training as a resource to develop HCWs' capacities to respond to MSM patients, receive information about MSM health programmes and, most recently, as a mode of interacting with public HCWs on sensitive healthcare issues. However, as evidenced in this study, knowledge alone is not a cure-all solution to address negative HCWs' attitudes and practices. Evidence from this research shows that though Imbalenhle clinic respondents are sensitised to respond to the needs of MSM patients, and had knowledge or skills acquired from the training by the MSPH to address MSM health issues, practical competency remains inadequate. Imbali respondents explained that prior to the sensitization training, brief assessments were done by the trainers to determine the level of attitudes and practices of HCWs. Different professional HCWs were invited to participate, including non-health practitioners such as security and cleaning staff. The training covered personal perceptions, attitudes and beliefs related to MSM, knowledge

of gender issues and human rights, and understanding of legal frameworks, national policies and protocols. This was later followed up by technical skills training tailored for professional medical staff in addressing biological components of MSM health. However, practical experience was not adequately enforced at the clinic level, post training. (Imbali focus group discussions, 8 May 2015). This is largely due to inadequate medical equipment tailored for MSM patients.

Such gaps and inadequacies neglect the recommendation that services to address MSM ought to follow a more comprehensive approach, especially if they require drawing in and retaining MSM in care (De Swardt 2010). In addition to being comprehensive, they must be of quality. Hulton *et al.* define quality as comprising of two components: the quality of the provision of care in relation to the service and the system, and the quality of care as experienced by users (Hulton *et al.* 2000).

Graham *et al.* (2012) adds that quality of care encompasses clinical effectiveness, safety, and a good experience for the patient, with Bruce (1990) adding that quality of care comprises six elements described as: choice of methods, information given to patients, technical competence, follow-up and continuity mechanisms, interpersonal relations and an appropriate constellation of services. On the other hand, Mannava *et al.* (2015) assert that positive attitudes, practices and behaviours - described as friendliness, caring, respectful, informative and sympathetic; can produce more desired impact in the health seeking behaviours of patients (Mannava *et al.* 2015). Therefore, when healthcare is deemed to be poor and unfriendly by the user, seeking of such services is likely to be neglected or negatively impacted (Sprague *et al.*, 2011).

***HCWs' knowledge and practices: Understanding of MSM health related issues***

Given that participants generally struggled to articulate the differences between MSM and gay, it was not surprising that only a few HCWs had knowledge of the relationship between MSM and HIV or that they were a high HIV prevalent group when compared to the overall population. This is because most of the respondents were not aware of the HIV figures specific to MSM, but were aware of the general national HIV statistics. The discrepancy in HCW knowledge around the extent of HIV infection among MSM is a particularly important concern given that HIV prevalence is high within the MSM population (CDC 2010). This evidence points out to potential under-reporting of the real prevalence rate among MSM. This could be linked to MSM not reporting or disclosing their sexual practices, owing to perceived discrimination from HCWs or lack of appropriate services to monitor MSM prevalence rates at clinic level.

Information and statistics on MSM HIV prevalence is freely available for HCWs' engagement purposes. This includes a variety of independent research reports, materials provided by organisations such as the Columbia University and the DTHF. Despite this, respondents from both study areas agree that MSM health statistics which are 'sometimes' presented in the various information materials or reports, are not disaggregated to reflect the extent of need at local or clinic levels. Accordingly, such information does not assist HCWs with the required awareness of HIV prevalence and related impact for MSM population within the local setting.

In light of this revelation from the HCW respondents, making sure that HCWs are aware of MSM health statistics at local levels can be linked to the policy level of the SEM and that of SEM of Communication and Health behaviour (SEMCHB) (Kincaid *et al.* 2007). This level is where healthcare policy makers should determine the processes of collecting and



dissemination of MSM health related data at local levels. This includes availing appropriate tools and capacity to collect such data and deliver the needed services in response to emerging evidence. Therefore, concerns highlighted here about lack of MSM data at local levels should be considered for additional research as they raise more questions about the accuracy of the available data at national levels, and whether HCWs have control over the data that is being produced at a national level, both in terms of its collection and responding through service provision at local levels. This is considering that, as this study shows, public HCWs do not have access to the necessary data collection tools and know-how necessary for analysis.

***HCW knowledge and practices: Awareness of stigma and discrimination at clinic level***

At the organisation level of the SEM, nearly all the respondents acknowledge lack of tailored healthcare services for MSM at public facilities. None, including those who were knowledgeable about MSM health issues, made any linkages with the lack of availability of, and access to appropriate risk reduction materials tailored for MSM, with the perceived discrimination of MSM at public health facilities. They just simply dismissed it while most expressed shock or stated they were not aware MSM opt not to visit public health facilities due to ‘perceptions’ of discrimination; or are reluctant to reveal their sexual practices due to fears of being ridiculed by HCWs.

At the individual level of the SEM, the lack of awareness of their own attitudes and practices towards MSM patients may indicate some level of internalised stigma or normalization of negative behaviours due to societal or organisational norms. Everyone at the individual level of the SEM has some level of internalised values or a set of beliefs and practices that they have adopted over the years or during the course of their upbringing. Such internalised set of beliefs may have originated from one’s religious beliefs or may have developed

independently from the same religion. Therefore, the likelihood of stigma or discrimination towards MSM may be greater than this study can reveal. Thus, the problem may be more severe for those men who choose to disclose their sexuality at clinic level.

In contrast to internalised attitudes, normalisation of a particular behaviour refers to social processes through which ideas and actions come to be seen as normal and taken for granted as natural in everyday life (Foucault 1999). In sociological theory, normalization of a particular behaviour involves the construction of an idealized norm of conduct – for example, the way HCWs ideally should behave in a clinical setting, walk, and present themselves, and so on. Maintaining the ideal will result in the individual being rewarded or punished for giving in, or from opposing the alleged ideal (Foucault 1999). Foucault adds that in the 19<sup>th</sup> century, the normalization process was one of many other psychological strategies that were used to impose supreme social control with as little force as possible. This was called by Foucault: the disciplinary power and was largely used to its maximum effect in healthcare settings, warfare institutions such as military barracks, prison settings, educational facilities, mass worker places such as factories and other work environments. Hence the disciplinary power became a very important tool in the normalization of many social aspects of the modern day society (Foucault 1999). However, it remains unknown how much of this type of influence is still used today in any given context.

Though the majority of the respondents used structural level policies, such as the South African Constitution (1996) as their basis for arguing that public healthcare facilities are mandated with providing equal health provision for everyone and therefore, all patients are and should be treated equally. This must be irrespective of gender or sexual behaviours.

Some respondents from both Imbalenhle and eThekweni pointed to policy provisions, which advocate for the patient's rights. For example, the DoH's Batho Pele principles (1995),

which, according to the respondents, are displayed within all public establishments in order to inform the public, including patients, of the level and quality of public services they should receive. The Batho Pele principles are a good example of a social policy designed by the state; at the structural and policy level of the SEM; with the aim of having a positive impact on healthcare service provision for all; at the organisational level. These principles exist as recognition by public policy makers that acceptable policy and legislative framework is needed to guide all aspects of public service delivery.

These legal provisions can facilitate the process of behaviour change since they are aligned with the country's constitutional ideals of promoting and maintaining high standards of professional ethics. Working with local health facilities to enable the behaviours envisioned in Batho Pele principles, such as the provision of impartial services which is equal, fair and without bias; can help to promote MSM health uptake and increase the health seeking behaviours of this population and beyond. The same principles also promote that available resources must be used effectively and efficiently, and that public service providers must respond to people's healthcare needs. More importantly, the principles promote a process by which citizens can identify their own critical needs and have increased engagements in policy-making processes in order for the state to provide transparent, accountable and progressive public services (DoH 2015).

Asked whether in reality, all public HCWs uphold these principles, most of the respondents expressed that in general, applying these principles in the context of social acceptance for MSM sexual practices was generally lacking in most public facilities. However, mainstream communities were said to be the least tolerant towards MSM and other sexual minorities. Reports of intolerance at community level were viewed by the majority of respondents, in both eThekweni and Imbali, as being “contrary to South Africa being a free and democratic country” (respondent 9, eThekweni focus group, 3 July 2015).

The Imbali participants, more than the eThekwini respondents, were more inclined to identify and discuss personal experiences of homophobia within their community. The main reason attributed to this is that most of the respondents from Imbali lived and worked in a township environment where violence against sexual minorities is said to be more prevalent than in urban settings like eThekwini, where tolerance of diverse sexual practices is more prevalent. In the respondents' views, what fueled homophobia at community level facilities was lack of education regarding diverse sexual behaviours, and "as a result, most MSM resorted to lead double lives in terms of their sexual practices" (respondent 4, Imbali focus group, 8 May 2015).

Though respondents were willing to discuss and identify acts of MSM-related stigma and discrimination at community level in general, they were reluctant to acknowledge any form of harassment, discrimination, patient ridiculing, stigmatization or prejudice because of one's sexual orientation or gender identity. They also denied displaying attitudes that potentially demoralizes MSM individuals into seeking public health, or behaviors that are seen to undermine patient's integrity and dignity within public healthcare settings. The following statement from respondent 6 (Imbali focus group, 8 May 2015) echoed the perceptions of most Imbali and eThekwini respondents:

Yes, not all public HCWs are sensitized to deal with MSM issues or uphold the Batho Pele principles, but I believe that HCWs are trained to provide equal and professional services to all populations. I have never known my fellow colleagues to make a mockery out of an MSM. For example, if one of them came with an anal infection, I wouldn't turn them away or ask personal questions as to how they got the anal infection. I will just focus on providing them with the intervention the patient came to seek.

However, the above comment contradicts personal accounts of many MSM individuals and other international studies and public reports concerning sexual minorities, which assert the opposite. For instance, observations made by the Human Rights Council (2011) concluded that homophobic, sexist and transphobic practices and attitudes on the part of healthcare institutions and personnel deter sexual minority groups from seeking services, which in turn has a negative impact on efforts to tackle HIV/AIDS and other health concerns.

Nevertheless, respondents pointed out that there are relevant bodies, such as the HPCSA, which health patients and individuals can approach to complain about healthcare services that either violate the rights to good health or breach ethical standards. Some respondents explained that each complaint is investigated before receiving an appropriate response by the relevant authority. Some of the respondents felt that the choice to disclose cases of MSM abuse to relevant authorities was a confidential and personal decision, and that the relevant channels to express feelings of stigmatisation and discrimination were available and open to all concerned individuals.

The policy level of the SEMCHB (Kincaid et. al, 2007) approach recognises the interdependence between individuals and their political environment and seeks to make interventions work by intervening at all the relevant levels. The establishment of the HPCSA and the Batho Pele principles highlights the existence of willing leadership and commitments at structural or policy levels. However, the gaps in implementation of these principles at community and institutional levels of the SEM highlight the need to confront the contradictions between policy provisions on equal provision of services and dignity for all.

***HCW knowledge and practices: MSM health seeking behaviours and health risk behaviours***

To determine knowledge of health seeking behaviours of MSM individuals and associated risks, participants were asked if they have ever asked a patient to disclose the sex of their partners, or the type of sex they have. In this study, risk is the quantification of a likely outcome occurring (Fielding 2014). In response to the question above, the majority of the respondents said they have never done so “because what MSM do in private is confidential and they are not required to disclose their sexuality during consultation” (respondent 14, eThekwini focus group, 3 July 2015). Others said even if they were required to ask, MSM may be reluctant to tell an outsider that they engage in same-sex activities as a result of being shy or not being ready to disclose.

Once again and as previously discovered in this study, none of the respondents were able to make any linkages with lack of self-disclosure of one’s sexuality with the fear of discrimination and stigma at clinic level. Though, some of HCWs echoed sentiments that non-disclosure of sexual practices has potential implications on the provision of accurate diagnosis which increase delays to access appropriate treatment “leading to higher risk of transmitting HIV and other STIs to their partners” (respondent 11, eThekwini focus group, 3 July 2015).

For this reason, the majority of respondents from both study areas felt that the national DoH needs to develop clear guidelines and testing and counselling protocols for implementation at every public health institution. This was recognised as a need which will enable HCWs to ask the correct questions when dealing with MSM patients.

### ***HCWs' knowledge and practices: Substance abuse***

The high rates of HIV among MSM has been attributed to many factors including high risk behaviours (UNAIDS 2012, CDC 2012, Global Men's Health Forum 2015). In South Africa, anonymous surveys conducted in Cape Town with 92 MSM found that high risk-taking behaviour; limited knowledge about HIV; high levels of alcohol use and human rights abuses were the main individual risk factors for HIV infection among MSM (Cloete *et al.* 2008). In line with these findings, participants were asked to identify other prevailing risk factors in their communities, especially those witnessed at clinic level. However, the risk factors identified and discussed in this section are not direct experiences of HCWs at clinic level, but more general.

A few respondents identified alcohol and substance abuse as a potential health risk to MSM, with one respondent stating that “[J]ust like everyone, MSM are also at risk because drugs and alcohol are a major problem in this community” (respondent 3, Imbali focus group, 8 May 2015.) This finding corresponds with the wider literature which links substance abuse and risky sexual behaviour among MSM (Benotsch *et al.* 1999, Halkitis *et al.* 2002, Mattison *et al.* 2001). MSM substance abuse is also linked to the lack of availability of appropriate services at public healthcare institutions, with McIntyre (2011) stating that many MSM remain depressed and seek comfort in substance abuse, which heightens their risk of HIV acquisition and other infections.

To some extent, substance abuse among the South African MSM population has received a lot of attention. This attention is far more than in other African countries (Bourne 2012: 152). For instance, a study conducted in Cape Town, Pretoria and Durban reports that 11% of men described themselves as “having sex while under the influence of a significant variation of drugs within the previous 12 months” (Metcalf and Rispel 2009: 4-5). Evidence from other

studies suggests that due to intoxication, drug users, particularly those who use club drugs such as ecstasy, “admit to not using condoms when having either anal or vaginal sex due to loss of control over decisions about condom use” (Vu *et al.* 2011: 178). These findings are consistent with several other studies that have found a statistical relationship between substance use and the likelihood of engaging in unprotected sex (Mansergh *et al.* 2006, Stall and Purcell 2000).

In spite of the fact that it might be conceivable to say that there is a reasonable relationship between certain substance utilisation and sex that leaves MSM more vulnerable against HIV transmission and the acquisition of certain STIs, it is not clear whether this is causal or basically co-relational. Other studies have challenged this “causal pathway” (Groß *et al.* 2008: 42–55). Nonetheless there is evidence to suggest that “the use of a range of drugs, particularly methamphetamines, and ecstasy, might have a detrimental impact on adherence to anti-retroviral therapy” (Halkitis *et al.* 2005: 545–58).

When asked how MSM can be helped to prevent themselves and their sex partner from acquiring HIV when under the influence of alcohol and other substances, the majority of respondents agreed that condom promotion was key but this was an ineffective strategy as long as drugs and alcohol were involved. One participant added that some MSM engage in unprotected sex for a “couple of beers” (respondent 3, Imbali, 8 May 2015). This has also been echoed in numerous other studies which suggest that drugs cause high-risk sexual behaviour among MSM (Nakamura *et al.* 2009, Fisher *et al.* 2009, Forrest *et al.* 2010), perhaps due to the removal of sexual inhibitions.

These findings are consistent with several studies that have found a statistical relationship between substance use during sex and the likelihood of participating in unprotected sex (Mansergh *et al.* 2006, Stall and Purcell 2000). The main cause of substance abuse among



MSM are not well-known. However, research suggests that MSM may use drugs for social purposes or as a strategy for coping with social marginalisation or family rejection or “to mitigate social unease and to gain confidence in seeking sexual partners” (Fazio *et al.* 2011: 625 - 41). Fazio *et al* also suggest that:

Harm reduction practitioners should seek to understand variations in drug use among MSM in their local area and tailor interventions accordingly. They should attend to changes in such use over time, and be accepting of the social and sexual environments in which drug use often occurs. Harm reduction practitioners should also attend to ethnic or sexuality variation within MSM communities, acknowledging that marginalised sections of the population are more likely to use drugs and for such use to be problematic (Fazio *et al.* 2011: 625).

Bourne (2012) agrees and adds that as long as sexual practices between men is ridiculed or disapproved by society, and as long as MSM face stigma and marginalisation, it will be extremely important to develop and implement interventions which are effective in meeting the diverse and complex healthcare requirements of the MSM population.

This is the obvious case in KZN, where it remains a challenge to establish the extent of drug use since the use of these illegal substances is outlawed in the country. Indeed, even where research about MSM and drug use has been conducted, it is difficult to analyse in light of conflicting research strategies. (Bourne 2012). This includes the different recruitment strategies, “the focus on various or different drugs or use in different settings or across varying time frames, for example within the last month, the last three months, within the past 12 months or drug use ever in life” (Bourne 2012: 148).

Delving deeper into aspects of McIntyre’s (2011) findings and respondent 3’s comments helps reveal that a proportion of MSM are susceptible to alcohol and drug abuse in their

communities. Respondent 3's response indicates that drugs and alcohol abuse is a general problem within the larger community, while McIntyre views the problem among MSM as a healthcare issue:

We find a high rate of alcohol and drug abuse. Those are the issues that intersect with risk for HIV infection and with treatment. That can affect adherence issues; that can affect the risk of being infected, in the first place. And we are also finding in our clinical services a number of other mental health issues – depression, things that are not really easily diagnosed in fleeting interactions with a health care worker unless they are looking out for them a bit more (McIntyre *et al* 2011: 23).

McIntyre's findings were partially opposed by many of the respondents who stated that being an MSM in most communities stigmatizes the individual twofold compared to the general population. At the group and community level of the SEM, this means they are likely to be marginalised in their own cultural group and the society in general because of their sexual behaviour. Furthermore, this study reveals that at the individual and community level of the SEM families of sexual minority groups tend to take a passive stance in most cases for fear of being mocked by members of the community. This points to the many vulnerabilities of MSM at multiple levels of the SEM, which could also lead most to turn to drugs and alcohol, thus not just an isolated healthcare issue. To illustrate this, one respondent from Imbali used a personal example where a friend was a victim of rape because of their sexual practices. The perpetrator, even though he was well known by the victim, still 'walked free' due to police inadequacies: "I have a friend who is gay and was raped, we went to open up a case and they never arrested the man even though we took them to him. He is still roaming the streets" (respondent 3, Imbali focus group, 8 May 2015).

Other respondents from this study argued against the notion that alcoholism and drug abuse is more prevalent among the MSM community, stating that all individuals, regardless of sexual behaviours, had unique ways of coping with stress, peer pressure or depression, with one respondent in particular expressing that “We all get stressed out by the situations we find ourselves in, such as abuse at home and in the community, and we are often pressured by our peers and while we have fun we tend to be irresponsible” (respondent 7, Imbali 8 May 2015).

However, behavioural and epidemiological data indicates that MSM in South Africa have high levels of HIV risk behaviour and high HIV prevalence, due to the high levels of stigma, discrimination, and violence faced in communities in which they live (Sandfort *et al.* 2011, Burrell *et al.* 2010). This is also echoed by other studies, including Beyrer *et al.* (2011). Beyrer *et al.* suggest that in developing or middle-income countries like South Africa, HIV prevalence rates within the MSM population is to some extent driven by HCWs’ unfair judgments; general violations of their rights; cultural, community and religious influences as well as the unavailability of suitable healthcare policy provisions and prevention materials.

In addition to these study findings, only a few respondents from both focus group discussions entirely supported Beyrer’s findings and McIntyre’s (2011) views. More specifically, respondents from Imbali expressed that at the individual level of the SEM, being an MSM can be challenging enough to lead one to abuse alcohol and drugs, especially when surrounded by a judgemental community and family members. However, both focus groups agreed that drug abuse as a coping mechanism should be discouraged despite one’s personal circumstances, by all population groups. Some stated that there is adequate public information in popular media such as radio, television and in newspapers to avert the risks associated with substance abuse. Participants felt that MSM and the general populace should therefore adhere to these education and awareness materials to reduce the risks of HIV and STIs for themselves and their sexual partners.

However, the majority of respondents from both study areas did not take into account that the success of behaviour change interventions is not only determined by the availability of information at community level, but also determined by altering behaviour at an individual level first (Parker 2006). Communication experts unanimously agree that “behaviour communication is notoriously difficult to initiate and sustain” (Panter-Brick *et al.* 2006: 2810). This difficulty is encountered in almost all health interventions (Panter-Brick *et al.* 2006). Whether it attempts to persuade the public to adopt an active lifestyle or practice safer sex, behaviour change remains a challenge. The reasons behind difficulties in behaviour change are largely unknown and are still under investigation (Panter-Brick *et al.* 2006). In relation to the SEMCHB, there is a need to establish a “compelling and comprehensive element inherent in every behaviour change campaign to mobilise communities, rather than affecting behaviour change in piece-meal fashion with the hope of trickle-down or trickle-up effects” (Panter-Brick *et al.* 2006: 2811).

### ***HCWs’ knowledge and practices: Counselling and testing***

In order to provide appropriate and comprehensive health services to patients, including MSM, the majority of respondents recognised that HIV counselling and testing is indeed the first key step to accessing services and treatment. However, the number of MSM who report for HCT at both facilities was said to be very low, unknown or “at least they seem invisible when visiting health facilities” (respondent 1, Imbali focus group, 8 May 2015). When asked to share what they think would motivate MSM to be more visible in counselling interventions, some of the respondents from both study settings expressed that the same awareness interventions or incentives intended for the general public are equally relevant or as effective for the MSM population.

Once again, the notion that interventions that are applicable to the general population will also work for MSM patients is strongly emerging. This negates the fact that every health intervention needs to contain a key element that is powerful enough to motivate the intended audience to adopt appropriate behaviour change as promoted by the provider. This means refraining from selecting a portion of the audience to address, with the hope that if their behaviour changes, other population groups will follow suit. Based on the SEMCHB (Kincaid *et al.* 2007), healthcare communication and information strategies therefore need to be tailored in order to motivate MSM patients to seek HCT services as opposed to the general approach.

Other respondents from both study settings argued that knowing one's status depended on the value one placed on relationships or partnerships. With one expressing that "Most individuals, MSM or not, only test depending on how close they are to their partner, but most people don't talk about testing. Some do disclose to their partners if they are HIV positive and some simply don't" (respondent 7, Imbali focus group, 8 May 2015). Using the high national HIV statistics to support this argument, some respondents from eThekweni pointed out that the general population was as 'guilty' of ignorance around the uptake of counselling and testing services as MSM were. Other respondents from Imbali felt that HIV testing-related fear was experienced by all population groups, and that it was everyone's responsibility to take on a more proactive approach to HIV, such as getting tested, practicing safer sex and accessing treatment when necessary.

Taking the above discussion into account, motivating individuals to be more 'visible' at public healthcare facilities requires health policies that are designed around social-psychological theories such as Rosenstock's (1966) Health Belief Model (HBM). The HBM states that health-related behaviour is largely informed by the person's assessment or four key

beliefs: perceived susceptibility, perceived severity, perceived benefits of performing behaviour and perceived barriers of performing the behaviour.

Individuals usually carry out personal self-appraisals within these four key components when confronted by behaviour change interventions. The self-appraisal is usually meant to establish the true risks or benefits that may be related with adopting the suggested behaviours. Initially, the individual formulates internal thought process that influences their perception of personal risk. This factor is very important in motivating behaviour change and “refers to one’s subjective perception of the risk of contracting a condition”, which can be observed in a different way among people (Janz and Becker 1984: 2).

The second key component subscribed by the HBM is the perceived severity an individual believes they may be at risk. For instance, the individual may hold a belief that increased harm can be done by their condition, or may have societal consequences which includes stigma and discrimination or potential job loss. Both the first and second key components of the HBM, as discussed already, are linked to individual level risks. On the other hand, the last two determinants of the HBM largely refer to interventions that are meant to mitigate the risks mentioned at the individual level. Interventions at the third level of the HBM is considered a very critical mediator in facilitating desired behaviour changes. These desired changes or benefits relate broadly to the “value or usefulness” which a newly acquired behaviour is considered to hold against a perceived threat or risk (Hayden 2009: 32).

The fourth key component, identified as the perceived barriers, is considered very instrumental in health behaviour change. These barriers can comprise of environmental barriers such as availability of transport, neighbourhood safety, the presence of safe meeting places or other personal barriers which may include anxiety or stress over negative outcomes.

In a more simplified explanation “perceived barriers describe any negative associations that may curtail the adoption of a recommended course of action” (Rosenstock 1966: 94).

Thus a programme using the HBM might design a needs assessment to include aspects of whether the individual sees themselves at risk for that condition or not. Other elements to consider can be to assess how the intended intervention will engage individuals in adopting risk reduction behaviours as promoted by the programme. Additionally, look at the potential barriers to adopting the desired behaviour. These barriers might include one’s social networks that may encourage or discourage adoption of the desired behaviour. Finally, it will be crucial to look at what type of media does the target population use most frequently in order to advance the intended behaviour change messages (Rosenstock 1966).

***HCWs’ knowledge and practices: Receptive unprotected anal intercourse***

Inquiries were made on the risks associated with anal sex as practiced by MSM. The aim of this question was to assess HCWs’ knowledge, practices and understanding of the risks associated with unprotected anal intercourse and how this differs from vaginal risks. Only a few of the respondents, mainly those from Imbali, were able to clearly describe how receptive unprotected anal intercourse serves as one of the main and greatest risk of HIV transmission among MSM. The inability of most HCW respondents, especially those from eThekweni, to articulate the dangers of anal intercourse was linked to the finding that only a few of them have had sensitisation training; or have had exposure and contact with MSM patients; or had the knowledge needed to adequately address issues of anal STIs.

For example, when asked to explain the uses of an anogenital exam and when this is performed, only three of the sixteen respondents were able to clearly articulate its uses, such as for the examination of “complaints of abnormality or conditions of swelling and discharge” (respondent 5, Imbali focus group, 8 May 2015). Throughout the focus group

discussions, the same three respondents, one from eThekweni and two from Imbali were able to fully explain the extent of damage caused by unprotected anal sex, which they stated includes bleeding, lacerations, and perforations of the rectum. The low articulation levels of anal risks led other respondents from both study setting to acknowledge the need for increased training and sensitisation of HCWs about the sexual behaviours of MSM and associated risks. In general, it is assumed that all HCWs are knowledgeable about anything related to health. From this, it follows that individuals with professional training and knowledge on a particular issue are well-equipped to respond appropriately, which results in the decrease in making wrong diagnostic choices or decisions. In relation to the SEM theory at the individual level, the findings of this study indicate that increased knowledge is indeed a precondition to respond appropriately. Knowledge is an important and necessary step to make individuals aware about an issue. If HCWs do not know how to respond to a particular health issue or topic, they will continue to operate in ignorance regardless of the risks and consequences to them, on others or to the interrelated SEM levels of influence

Once again, as demonstrated in the previous discussion on motivations for health seeking behaviours, some respondents from both study areas leaned towards the generalisation of risks associated with unprotected anal intercourse. For instance, a respondent from Imbali expressed that although unsafe anal practices represent serious threats to MSM individuals; this and other types of unsafe practices are equally damaging to all population groups who practice any type of unsafe sex: “Anal sex is a risky behaviour for everyone and not just MSM. There are other significantly high risk practices practiced by some people, MSM and the like, which may result in physical damage or lead to numerous health problems for the individual and their partners” (respondent 1, Imbali focus group, 8 May 2015).

This is indeed an important discussion considering anal sex and other marginalised behaviours have always been viewed as ‘gay only activities’. Despite all respondents being



able to grasp the concept of MSM as a bridge population (Morris *et al.* 1996), meaning they have intercourse with both men and women; a few participants from both study settings found it difficult to understand that MSM health concerns and levels of risk may differ from that of the general man or gay individuals.

On the question of the differences in risks between anal and vaginal sex, nearly all the respondents who participated in this study understood that anal sex is more risky than vaginal sex. A respondent from eThekweni went on to explain that the rectum is not designed for sexual intercourse, therefore more vulnerable to tearing during intercourse and providing more opportunity for viral penetration and infection compared to the vagina. “ I also want to add that condoms are more likely to break during anal sex than during vaginal sex, so even with a condom, anal sex is not a 100% safe” (respondent 12, eThekweni focus group, 3 July 2015).

### ***HCWs’ knowledge and practices: Commercial sex work***

In relation to receptive unprotected anal sex, a few of the respondents from Imbali indicated witnessing the rise of male commercial sex workers in some townships, with some saying rising inequality and poverty levels were the main drivers for this emerging challenge. As an example, respondent 6 from Imbali stated that the majority of men, especially those who were unemployed, were attracted to commercial sex because of poor socio-economic factors and the prospects of gaining more material “things”. Another respondent adds that “some don’t really go out there and sell their bodies but they do it as a form of repayment for certain material things that they get from their partners or lovers” (respondent 7, Imbali focus group, 8 May 2015).

Such risk behaviours, regardless of motivation, are explained by Kincaid *et al.’s* (2007) SEMCHB that draws attention to presence of interrelated social context influences on

behaviour. This includes many influential variables such as social networks, community and other societal aspects which helps inform one's decisions, responses or behaviours.

The two key features of the SEMCHB model are the assumptions of embeddedness, a state in which one system is nested in a hierarchy of other systems at different levels of analysis, and emergence, in which the system at each level is greater than the sum of its parts. (Storey & Figueroa, 2012: 76)

Additionally, the SEM approach within which this study is framed, acknowledges the influence of the socio-economic environment in which MSM find themselves. That these have a potential to impact their decision or choices to engage in risk behaviours is discussed in this section.

As with female sex workers, most respondents from both Imbali and eThekweni were aware that it may be difficult for MSM sex workers to convince their sex partner to use protective measures such as using a condom. In other instances, they may also accept more money in exchange for unprotected anal sex. This obviously increases their risk of HIV infection or anal STIs. None of the respondents from both study settings, however, reported knowingly treating an MSM sex worker or a male with anal STIs. With one respondent adding that men who buy sex from other men are likely to be financially well off, therefore able to afford private healthcare (respondent 13, eThekweni focus group, 3 July 2015).

The above statement touches more on the issue of the invisibility of MSM in public health facilities, hence the preference of private healthcare providers. At the structural and policy level of the SEM, this signifies the multifaceted nature of healthcare provision in South Africa, which varies from the most basic primary healthcare offered free by the state or by private and registered traditional health practitioners, to highly specialised technical health services available in both the public and private healthcare sectors. The private healthcare

sector tends to attract high-income earners with members of private medical aid organisations or individuals looking for high-quality medical or clinical procedures at somewhat affordable fees.

Though Imbalenhle clinic respondents were sensitised in providing MSM-friendly health services, the comment from respondent 5 (Imbali focus group, 8 May 2015), represents the general consensus that private healthcare serves its customers more efficiently than public facilities. The general assumption is that private healthcare is also overpriced and that only a minority of the South African population can afford to pay. The private healthcare sector also attracts most HCWs due to better wage remunerations and benefits, and due to “lack of acknowledgement and poor working conditions” in the public sector (Wilson and Fairall 2005: 484). Therefore, the provision of effective MSM interventions competes for the scarce supply of trained counsellors and personnel who support other treatment methods. This brings into question the “extent to which resources can be effectively allocated into thorough education and counselling to mitigate potential risk behaviours of the MSM population” (Wilson and Fairall 2005: 484).

The view from Imbali’ respondent 5 makes the assumption that MSM are well off, therefore most likely to make use of private healthcare when presented with an anal STI. This perception provides evidence that MSM are indeed invisible in most public health facilities. Apart from the lack of appropriate services at local facilities, other reasons for being invisible are well documented by the DTHF (2013). This includes preference for private health services to maintain privacy and most importantly, avoid stigma and ridicule by public HCWs. There is also a general perception among the MSM population that coverage of appropriate healthcare services is better at private healthcare facilities. Some MSM patients believe such services are only limited to major urban areas or mainly provided by NGOs funded through external sources. This partially provides an explanation why most HCW

respondents from both study setting reported not having treated any MSM related STIs at public facilities.

***HCWs' knowledge and practices: Multiple concurrent sexual partnerships***

The general opinion from both focus groups was that MSM are 'notorious' for acquiring or keeping multiple and concurrent sexual partnerships or being unfaithful to their partners. Multiple concurrent sexual partnerships a term recently developed by behavioural scientists and defined as: "overlapping sexual partnerships in which sexual intercourse with one partner occurs between two acts of intercourse with another partner" (Thang *et al.* 2002: 41-51). From this definition, HCWs understand that concurrency is not simply about the number of sexual partners an individual has, but about how many overlapping sexual partners an individual has over a given period (UNAIDS 2009).

Examples to illustrate this concept were given where MSM engage in sexual activities with other married men even though they may be in a long-term relationship with a woman. An overwhelming majority of respondents from both study areas expressed concern that this behaviour was generally putting female partners of MSM at risk since they are likely to be unaware of the risk of exposure to HIV and other STIs.

One respondent pointed out that polygamous men who could be MSM, especially those living in rural areas, cohabited with more than one female and expressed that "in the face of the country's HIV epidemic, some of the married MSM are reluctant to use protection with each of their wives... despite the fact they jump from one partner to the next" (respondent 6, Imbali focus group, 8 May 2015). Another respondent strongly disapproved of MSM sexual practices and stated that, "one can't go from a man to a woman from a woman to a man. How do you start that? It is not right, it is unhealthy. If you are with a woman, you stay with that woman vice versa" (respondent 9, eThekwini focus group, 3 July 2015).

There was a general recognition that the practice of concurrent multiple partnerships or ‘sleeping around’ was not appropriate for anyone, regardless of sexual orientation, since this behaviour fuels the spread of STIs and HIV. Given the importance of partnership patterns in relation to HIV transmission amongst MSM as a risk factor, data from this study reveals that HCWs do not have any preconceived assumptions that only heterosexuals have multiple sexual partners. Respondents from both study settings were able to articulate that the increase in HIV infection and transmission among MSM is largely fuelled by the practice of concurrency. This finding is well supported by Halperin and Epstein (2004), who link high HIV prevalence rates with multiple concurrent partners and implications for prevention.

As seen in the previous sections on behavioural risk factors associated with MSM, these risk behaviours do not occur in isolation to the individual, but are also influenced by other levels of the SEM. For example, these factors may include the Zulu cultural practice of polygamy or expectations of manhood which also plays a crucial role and encourages men to prove their manhood through liaisons with women (Leclerc-Madlala 2005: 23):

The Zulu traditional ideal of being an amasoka, a man, is to be popular with women. A man with a reputation of having many previous and current girlfriends wears this reputation as a badge of esteemed Zulu manhood. For men, multiple sexual partnerships are commonly viewed as natural and in many ways as essential to men's nature as men. This model of male sexuality seriously challenges the effectiveness of prevention messages that call for abstinence before marriage, a reduction in the number of sexual partners, or faithfulness and greater trust and mutuality between partners. This macho ideal also contributes to homophobia and the stigmatization of men who have sex with other men. Social stigma forces men who do have sex with other men to hide their sexual activity and deny their sexual risks, thus increasing their own risk as well as their partners, male and female.

Linking Leclerc-Madlala's (2005) excerpt on concurrent partnership practices, Cox and Gallois (1996) suggest that people conform to cultural and social norms, thereby adopting behaviours and attitudes in order to gain access to the benefits of that culture. Frederickson and Roberts (1998) add that persons internalise a social and cultural ideal of physical body, for instance, in order to be accepted within a dominant group. Therefore, social and societal factors play a key role in influencing vulnerability to infections through the practice of multiple concurrent partnerships (Le Grange 2010).

***HCWs' knowledge and practices: Views about tailored MSM health promotional materials***

All the respondents confirmed that at public health facilities, treatment and other health services are accessible to all, including condoms which are given to anyone, regardless of sexual orientation and "no one is asked questions why they needed these" (respondent 4, Imbali focus group, 8 May 2015). However, the provision on these services remains fragmented, and health communication that is intended to intensify the impact of MSM health uptake remains inadequate.

This was well acknowledged by most of the research participants who recognised that national health promotion and prevention strategies were mostly orientated towards heterosexuals. Respondents from both study settings felt this gap ignored appropriate prevention efforts for sexual minority groups, including MSM. Indeed increased efforts are being made to address MSM health issues through interventions funded by major international donors such as PEPFAR; the Global Fund to Fight AIDS, Tuberculosis and Malaria (2009); the U.S. Agency for International Development (USAID) and the CDC. However, MSM healthcare still remains under-resourced in most public health facilities. For instance, facilities which took part in this study reported being inadequately resourced with appropriate equipment, including HIV and counselling protocols and linkages with HIV care

and other relevant services. Finger condoms and dental dams, which are largely used by gay men for safe sex, were cited as being scarcely, if at all, available across all public health facilities. This includes other related health promotion materials such as MSM information pamphlets and other forms of multimedia messaging.

Some of the respondents from both study settings pointed out that coverage of MSM healthcare services are not available in rural areas and not well supported by the state even in urban areas. For example, Imbalenhle respondents added that most of the materials they have received in the past for MSM individuals, such as flavoured condoms, lubricants and information pamphlets, were not from the state but from private institutions. This includes MSM sensitisation training from the MSPH, which is an American private organisation, with a few HCWs reporting they independently seek and receive MSM related information from research reports done by various individuals or seek MSM related materials from private organisations.

It is in this context that during the development of public health communication strategies, BCC and SCC aimed for MSM populations should be considered. BCC is “results oriented, science based, project oriented, patient centred, cost effective [and] tries to encourage people to make informed choices” (Deane 2002: 1). Conversely, SCC is based on the belief that people are:

agents of their own change... [It] emphasises community empowerment, creates an environment of change, is process oriented, and provides a voice for communities and opportunities for dialogue and...is based on a belief that behaviour change is dependent on social change and is a long term process (Deane 2002: 1).

Despite Deane’s (2002) assertion, a few respondents from the focus group discussions remained sceptical about developing tailored prevention services or related materials for

MSM. They expressed that there seems to be a MSM “victimology” casting MSM as victims of the public health system, which removes individual responsibility for practicing safe sex and seeking appropriate help or practicing safer sex, resulting in unnecessary “scapegoating of healthcare facilities or healthcare workers” (respondent 16, eThekweni focus group, 3 July 2015). Other respondents from Imbali echoed the same sentiment and increasingly expressed that a vast majority of MSM remain ignorant about the risks associated with anal intercourse; they view this as “safe sex” (respondent 6, Imbali focus group, 8 May 2015). This finding is echoed in Lynsen’s report (2015) where MSM risk behaviours such as barebacking, were found to be persistent despite MSM being aware of associated risks, while some gay men decry HIV prevention warnings as discriminatory (Lynsen 2015).

Though it is evident that some MSM do generally ignore health warnings related to their sexual practices, sentiments related to MSM ignorance could mean that some HCWs are generally not comfortable accepting the need for risk reduction materials and key messaging specifically tailored for MSM. In this case, this finding calls for the need to address individual level perceptions, institutional gaps and structural factors which all work together to give rise to prevailing HCWs’ KAPs which disservice the MSM population.

Having said this, most of the research respondents from both Imbali and eThekweni called for public health institutions to increase awareness of risks associated with anal intercourse among the MSM population, and increase supplies of free dental dams and especially finger condoms; as these were said to be too expensive for the majority of MSM who live at the margins of society.

When asked which services may potentially reduce MSM risk behaviours and the associated health risks, a few of the respondents from both study settings were able to link this discussion with the initial debate on the diversity of MSM sexual practices, saying that since



MSM and gays are not necessarily the same, they may expose themselves to different risk practices. For example, respondent 7 (Imbali focus group, 8 May 2015) pointed out that, “though anal intercourse may be popularly practiced by both MSM and gay men, both may not engage in anal sex alone, but may engage in other forms of sexual practices which require tailored prevention efforts”.

When asked if the use of a non-judgemental approaches to history taking gives patients the opportunity to discuss delicate issues with healthcare providers, some of the Imbali respondents agreed and stated that “as long as you make it clear that you are non-judgemental, they (MSM) will be able to open up and tell you everything” (respondent 7, Imbali, 8 May 2015). Good history taking is described as one which discloses the patient's fears, concerns and medical expectations. This also includes any preconceived or accompanying diagnosis (Tidy 2015).

However, history taking that is specific to MSM was dismissed by a few respondents, more so from Imbali, who said this will serve as an obstacle which may discourage MSM from taking up HIV counselling services. MSM history taking was seen as something which could result in stigma associated with anal STIs; this could deter most men from seeking help to avoid being perceived as gay or involuntary disclosing their sexual practices. The concern of being discriminated against after disclosure of one's sexual orientation during history taking points to poor sensitisation of healthcare workers, and to weak confidentiality principles within healthcare settings.

Patient history taking requires good communication between the HCW and the patient. During this time, the HCW is supposed to identify and determine whether the patient's health concern needs a clinical attention or not. Tidy (2015) states that during the history taking process, the HCW's mandate should be to listen more and not dominate the entire process,

thus allowing the patient's concerns to come through. To some extent, the relative ease or difficulty in dealing with MSM sexual issues between the HCW and patient will depend on how well the history taking process is being conducted. If there is a bad relationship from the beginning of the history taking process, the patient is likely to share less accurate information with the HCW who might or may not be making an attempt to assist (Tidy 2015).

According to Tidy (2015), gaining the correct account and representative information during the history taking process; including a representative account of what is worrying a patient and how the illness may have developed overtime, is not a simply task. Tidy states that it takes patience and practice, empathy as much as attentiveness. The history taking aspect of clinical care is supposed to be a moment where a patient shares their health experience with their HCW. During this time of consultation, patients are able to express themselves freely and be unburdened from whatever that might be worrying them. This includes worries about their health or related conditions, or with the general frustrations of personal life. During history taking, Tidy recommends that patients must be allowed to vent as much as possible about prevailing worries or certain feelings.

Therefore, at the interpersonal level of the SEMCHB, there is need to strengthen patient-HCW relationships as the primary means of acquiring and discussing difficult issues. This includes sharing beliefs and sensitive information that affect care, maintain trustful relations between the patient and HCW. The CDC (2014) states that the quality of patient-HCW relationship is very crucial in determining whether medical treatment is successful or not. Particularly where long-term treatment adherence is critical. Therefore, a strong patient-HCW relationship that is built on trust and confidentiality; is likely to increase treatment and therapy compliance from prospective patients (CDC 2014).

According to the CDC (2014), patient-HCW relationship can be viewed as an agreement between the patient and the HCW. On the basis of the diagnosis, the HCW recommends a given course of action and both parties agree to work together to resolve the patient's health problem. The agreement includes basic principles and rules that each party will uphold during the course of the relationship. These rules include respecting patient-HCW rights and upholding certain responsibilities to each other and to others around them. (CDC 2014). If either the HCW or the patient fails to uphold these rules and principles, the relationship can break down and this may lead to mistrust and misunderstandings, including a lapse in positive health seeking behaviours. The discussion on patient confidentiality is elaborated further in the section analysing the findings on HCW attitudes.

Overall, respondents' sentiments from both study areas were primarily in favour of specialised healthcare services tailored for MSM, especially with regards to HIV counselling and testing and history taking. Though at the organisational level of the SEM, there are efforts by privately funded institutions to sensitise individual HCWs to MSM healthcare issues, sensitization alone remains inadequate due to lack of appropriate medical equipment to examine anal STIs and other health information materials such as condoms and lubricants. As discussed in the literature, availability of MSM appropriate prevention materials at clinics and hospitals can influence the extent to which individuals visit healthcare facilities.

Some participants felt tailored interventions were important since MSM engage in sexual activities with women as well as having occasional sex with men, while others recognised this will assist in the collection of local level data which has positive benefits for the purposes of reporting accurate MSM prevalence rates, which in turn, may be used to effectively address the health concerns of MSM. This calls for interventions which will help HCWs gain more understanding of the specificities of MSM in relation to public health; the different prevalence rates within the different contexts at local, national and global levels; and suitable

healthcare approaches which are tailored to the needs of those engaging in diverse sexual practices. This recommendation corresponds with report findings by the DTHF (2011) that emphasizes the need for a comprehensive contextual understanding of the HIV epidemic among MSM for effective HIV interventions to be developed and implemented, as would also be suggested from the SEM perspective.

***Summary: Knowledge and practices***

Due to the fact that MSM are typically diverse in nature, most of HCWs interviewed initially assumed that all men who actively practice same sex are equally exposed to the same health condition and patterns of risk or require the same kinds of prevention strategies as those who self-identify as gay or the general population. Half of the participants were initially unable to identify the difference between MSM and gays, both in their cultural contexts and behaviours and to some extent, their sexual practices.

The majority of HCWs interviewed in this study were aware of the risks associated with concurrent partnerships among MSM, however, only a proportion of the respondents from both Imbali and eThekweni were able to articulate and identify the risks associated with anal sex. Not all agreed or were aware of the common practices which put the diverse MSM population at risk, stating that the general populace was equally affected by most of the identified risk factors, such as alcohol abuse. This made it difficult for some of the respondents in both study setting to understand how MSM risk factors differ to those who only had female partners or those who self-identify as gay. This leaves an impression that the majority of HCWs generally assume that MSM health issues are not unique to those of the overall population. That to some extent, all MSM health related problems apply to all males, regardless of whether they occasionally engage in same-sex erotic activities or not.

At the individual level of the SEM, there is a pressing need for more HCW awareness raising and sensitisation training to help professionals understand how the sexual conduct of MSM affect their health, and how this differs from the mainstream population or from the gay population. Mannava *et al* (2015) add that the nature of the interrelated factors which influence HCW practices and attitudes means this requires strengthening healthcare systems at the organisational level of the SEM, and workforce development at the individual level, including communication and counselling skills. These are all important in the provision of appropriate and comprehensive healthcare interventions.

Therefore, investing in HCWs' communication skills is crucial for the purposes of meaningful engagement with MSM patients. For instance, while verbal communication with the patient very in establishing relations with a patient; it is not the only means of interaction. This is more especially when the individual is unable to express themselves in the mainstream language of a particular setting, or in which the HCW is taking the history. In some cases the patient may have hearing problems or clinical impairment. In this case, listening alone does not just involve using one's ears, but may include the use of body language such as facial expression. Body language and verbal communication are said to help individual HCWs understand what is really troubling the patient. This is very important especially when the patient is presenting with a psychological problems. This also includes physical symptoms which the patient may be uncomfortable to express or be unconscious about. Therefore through other means of communication, the HCW is able to determine what is troubling the patient. Especially if they are able to notice the patient is hesitant or reluctant to talk about a certain aspect of their health. In addition to the need for communication skills, it is worth exploring the use of communication aids such as posters and other visual aids, including picture boards or drawings done by the patient showing where the pain is, when this is a more appropriate form of discourse.

### ***Attitudinal responses of HCWs towards MSM***

This section will discuss the findings on attitude and related sub-themes which emerged during data analysis, as described in the methodology chapter. Attitudes in this study refer to value-laden social judgements which possess a strong evaluative component (Fielding 2014). These are ways of viewing a particular set of values within a framework of different judgement criteria. We all have attitudes, lots of them, about almost everything, particularly socially-relevant things to do with the behaviour of ourselves and others (Fielding 2014).

According to Fielding (2014), attitudes are constructs that psychologists have defined to help explain the values people hold - they have no real objective existence as such, but can be shown to have different components. These include cognitive (belief), emotional (feeling) and behavioural (predispositional) elements.

The discussions will reveal how HCWs feel about the subject of MSM. The study will also present the different parts of these attitudes into sub-themes and consider what reinforces them in relation to the SEM's level of influences and the SEMCHB. As discussed in literature, these attitudes have potential positive or negative impacts on efforts to tackle HIV/AIDS and other health concerns (Laurino 2011). Respondents were thus asked to complete self-assessment questionnaires to determine positions which they may not have been able to freely express during focus group discussions.

### ***Perceptions of MSM sex***

On the question of how one felt when a man preferred having sex with another man, 45% of the respondents (7 out of 16), expressed that it made them feel uncomfortable, while 8% stated that it did not bother them since people are different and therefore free to have sex with whomever they wish. None of the respondents in both study settings mentioned consciously

avoiding MSM or not being interested in learning about MSM issues. This finding is in contrast to the earlier finding documented in the knowledge and practices section where the majority of respondents stated they had never treated an patient MSM before, especially in relation to anal STIs. The explanation for this contradiction could be related to the lack of tailored healthcare services for MSM at public healthcare facilities. Though 7% of all respondents admitted MSM made them uncomfortable, nearly all, 98% (15 out of 16) of the respondents said that MSM issues do not anger them nor make them mistreat or discriminate against MSM simply because they do not agree with or accept MSM sexual practices. This analysis provides more evidence that HCWs, to some extent, are increasingly becoming tolerant and understanding towards same-sex practices. This could be linked to HCWs' access to sensitisation training as provided by private NGOs such as the MSPH and the DTHF.

### ***Beliefs and values about MSM***

With regards to personal perceptions of MSM, none of the respondents from both study settings believed MSM are confused about their sexual preferences, with some pointing out that MSM sexual behaviours are practiced out of personal choices. 10% of the research respondents believed that MSM sexual behaviours could be cured. This revelation is not surprising as this view may largely be influenced by religious, cultural or 'old fashioned' medical beliefs which were discussed in the literature review section. For instance, the Diagnostic and Statistical Manual of Mental Disorders law (1952) suggested that same-sex practices were a mental illness that could be cured. Though this law is no longer applicable worldwide since 1973 (Klamecki 1999, Kinsey Institute 1977), it is evident from this finding that HCWs still look for a cause, like they would do with any other illness. The phenomenon of corrective rape of South African lesbians, for instance, as one of many examples of the felt

need to ‘cure’ same-sex practices (AIDS Foundation of South Africa 2013) is illustrative. Though there is no association between same-sex practices and mental illness, social marginalisation, rejection and isolation escalates mental health risks or problems among the MSM population (Cochran and Mays 2008). Sustained levels of stress as a result of these social behaviours and attitudes can in turn lead to the co-existence of MSM health complications which are linked to substance use such as mental health issues and possible suicide (Hayes *et al.* 1992).

On the question of whether same-sex behaviours were natural, none of the respondents from Imbali and eThekweni hold the belief that having erotic desires for other men is natural or that those predisposed to such desires were “born that way”. One respondent emphasised that sleeping with other men is not natural, unlike being an intersex, which is a biological condition rather than a sexual behaviour matter. This view is similar to the theologian Thomas Aquinas’ influential condemnation of homosexuality which was based on the idea of natural law, arguing that “special sins are against nature, as, for instance, those that run counter to the intercourse of male and female natural to animals, and so are peculiarly qualified as unnatural vices” (Louis 2003: 187). However, most concerning was the 30% (5) who felt that MSM behaviour is none of their concern and that they have no interest in MSM issues in general. This highlights an unsympathetic attitude towards MSM and their specific health related needs, which may result in increased marginalisation of MSM patients.

One respondent emphasised a strong opinion that MSM are just seeking attention therefore their issues should not be separated from those of mainstream population, or treated “as a special case for attention” (eThekweni questionnaire, 8 July 2015). A possible explanation for this response could be that HIV severity was perceived to be high throughout all population groups and living environments, therefore every patient is a priority, regardless of sexual orientation. This could also be interpreted as a demonstration of the severity of many HCWs’



ignorance around the need to tailor MSM healthcare materials at public facilities or of a lack of exposure to MSM.

### ***Exposure to MSM***

Regarding exposure to MSM at the organisational level of the SEM, this study reveals that despite the sensitisation training on the subject of MSM at the individual level of the SEM, not all HCWs were able to put their acquired knowledge into practice due to lack of sufficient exposure to MSM patients. Therefore, increased exposure to a particular subject or environment and practical experience is a necessary component of behaviour change. Knowledge, on its own, is not sufficient to bring about behaviour change. Though this research notes that a great amount of health communication approaches focusing on the reduction of high HIV prevalence rates have somehow managed to change knowledge, attitudes and perceptions about the epidemic (Govender 2011); however, there has been a lot of critical reflections that have been emerging and opposing the much simple linear focus to behaviour. This linear view plainly advocates a thought that behaviour is established on common-sense and logical processes. This negates the fact that behaviour can spread much further than rational reasoning” (Govender 2011: 68).

The increased HCWs exposure to MSM healthcare needs, via the provision of tailored MSM interventions across all public facilities, can provide motivation for MSM to seek health care, strengthen HCW skills and support to MSM patients, as well as maintain new HCW attitudes and practices. The effect of this new model has the potential of influencing other environmental factors which play a crucial role in informing attitudes, norms, and values.

### ***Views on freedom of sexuality***

In terms of equality of patients, 50% (8) of the respondents from both study settings said that MSM healthcare needs must be considered equal to those of others, despite sexual differences, thus indicating acceptance. However, it was also interesting to learn that 35% (6) of all the respondents said they would advise parents to seek professional advice if a child displays an inclination toward items or behaviours attributed to the same sex. While 30% (5) stated they would insist the child dresses and plays with toys appropriate to their own sex. Only 20% (3) said they will encourage the child to explore (e.g. with toys or clothes) their maleness and/or femaleness as they wish. The analysis shows that nearly all the respondents were concerned with children experimenting or exhibiting MSM behaviours, with the majority stating they will not ignore such behaviours in children, but would rather seek professional advice in order to support the child in the most appropriate manner.

This is attributed to MSM behaviour being seen as an experiential phase in boyhood or in children which should receive early attention in order to discourage continued practice in adulthood. For instance, same-sex practices documented from across cultures show evidence that same-sex behaviour is often carried out in rites of passage. The anthropologist Gil Herdt (Herdt 1984, Boyce *et al.* 2009) described a cultural practice among the Sambia people of New Guinea and in Melanesia where early-adolescent boys fellate and then consume the semen of older men in their tribe as a way of attaining masculinity. In some cultures it was “in fact expected of boys in puberty to experiment with each other” (Epprecht 2004: 32). Epprecht adds that in ancient Zimbabwe, homosexual experimentation among adolescents took place as part of the sexual learning process. He adds that during the herding of cows, out in the bush, sexual play with each other was expected at the age of puberty. However, this experiential had to remain discreet otherwise it became the subject of mockery if it became known. In addition to this, it was expected that this behaviour would wither away as the boys matured. Therefore the study findings show that at the individual level of the SEM, HCWs

view male-to-male sex as a childhood or adolescent experiential phase that will eventually outgrow the child over the years.

### ***HCWs as role models at interpersonal levels of the SEM***

In their parental roles, HCWs are most likely to feel uncomfortable accepting or communicating same-sex issues with their own children. As evidenced in this study, some HCWs deem same-sex practices a taboo subject and are likely to discourage the behaviour by seeking counselling, talking to the children or simply ignoring them. At the family and individual level of the SEM, adolescence marks a period of considerable experimentation and is characterized by increases in risky behaviours including alcohol and drug use, petty crime and risky sexual behaviours (Donovan and Jessor 1985).

According to the United Nations Population Fund (UNFPA 2015), 1.8 billion of the world's population is made up of adolescents and young adults. This means they make up a sizable proportion of the global population, which is a historic high (UNFPA 2015). More than 89% of this population is found in developing countries with more than one-third of the total population of sub-Saharan Africa aged 10 to 24 years (Kedmey 2014, UNFPA 2015). Taking this into consideration, risk taking behaviours during adolescence, especially sexual risk taking, if not addressed by the public health sector, will result in major healthcare challenges in sub-Saharan Africa. Available evidence in the sub-region suggests that adolescents in poor urban settings are particularly vulnerable to risky sexual behaviours and poor reproductive health outcomes (Zulu *et al.* 2002, Dodoo *et al.* 2007). Migration to urban areas, coupled with the increasing urban poverty in sub-Saharan Africa, may expose more adolescents to increased risky sexual behaviours if HCWs, in their parental roles, ignore sex discussions at the family level of the SEM.

Available evidence suggests that frequent, open and positive sexual communication between teens, their parents, teachers as well as peers decreases high risk sexual behaviours and promotes better health outcomes for teens (Mtikrakra, 2009, Meeker 2002). This includes delaying sexual debut (Bastien *et al.* 2011). However research evidence in sub-Saharan Africa shows that communication with adolescents about sex is generally low and marred with discomfort as well as characterized by indirect verbal communication. Socio- cultural norms and values are to a large extent responsible for the lack of openness about sex between parents and their adolescent children. This delays discussions about potential high risk behaviours from the onset and can also deter sexual education (Whitaker and Miller 2000). A few studies have shown that parents would rather initiate sexual communication by talking mostly about the biological aspects rather than the sexual aspects. Other parents would just talk about the risks associated with sex and not discuss topics like oral sex and other alternative sex behaviours or practices (Teitelman *et al.* 2011).

The finding that the majority of HCWs want same-sex experimentation in children to be discouraged or challenged is therefore remarkable. This analysis provides evidence that though HCWs are increasingly becoming tolerant towards same-sex practices due to sensitisation training provided by private NGOs as discussed previously, same-sex practices are still viewed as unacceptable and something that needs to be “discouraged” (eThekwini questionnaire, 3 July 2015). For instance, the findings suggest that lack of acceptance of same-sex behaviour is most likely to manifest itself in various forms of intolerance expressed in the form of abuse, discrimination or harassment which is directed towards the subject MSM.

### ***HCWs’ tolerance towards MSM***

The concern above is echoed in many reports, leading some to believe that intolerance levels against same-sex behaviours is on the increase (Betron and Gonzalez-Figueroa 2009). Contrary to this, this study provides evidence that tolerance of MSM behaviour is increasing among HCWs, while acceptance levels remain very low.

To some extent, tolerance would not have been possible without training from both international and local NGOs, however, acceptance of the behaviour may not be easily achieved through training alone due to factors such as embedded cultural and religious beliefs, to name a few. It therefore seems that there is little correlation between knowledge and practices of HCWs. Though the study reveals increased levels of MSM tolerance, acceptance of the sexual behaviours is indeed very low. This suggests that knowledge and awareness of MSM may lead to some level of tolerance or understanding, but may not necessarily result into acceptance of their sexual behaviours; much like accepting the individual but not their practices or behaviours. Therefore challenging prevailing attitudes of HCWs is an important element in the provision of healthcare since they are influential, both positively and negatively. This has an important impact on how MSM and their partners perceive and experience healthcare.

On the subject of tolerance of MSM behaviours, though there is a high level of it among HCWs, one respondent from Imbali (questionnaire, 8 May 2015) said they would distance themselves from an MSM patient, stating they will not want to be associated with someone like that. These views are concerning given that HCWs, through the history taking and consultation processes, are meant to give the patient a chance to tell their own personal perception of their condition. The consultation stage affords a better chance for the HCW to develop trust with the patient while gaining experience of the illness. This includes history of how the condition developed and progressed or grew over time. The HCW is also able to use this opportunity to examine the symptoms that the patient has - which is after all, and from a

patient's point of view, what the HCW should use their skills and knowledge to diagnose and treat. Another respondent from eThekwin (questionnaire, 3 July 2015) said they are likely to disapprove of MSM patients, and therefore convince the patient to come to their senses, with 50% (8) stating they would privately encourage the patient to seek counselling and advice as they may be confused about their sexuality.

None of the respondents from both study settings agree they will not be curious and leave an MSM patient alone or not be 'concerned' about their sexuality. One specific respondent expressed that if a patient reveals they sleep with other men, they will not react but "pretend as though the revelation does not bother me" (Imbali questionnaire, 8 May 2015). This implies some level of self-control in terms of not wanting to show one's true feelings about the subject at hand, or wanting to be seen as interested and attentive to the patient, thus putting the patient's needs first.

Another respondent said they will accept the individual's sexuality but will be inclined to give the patient "appropriate" advice (Imbali questionnaire, 8 May 2015). One more HCW said if a patient disclosed they sleep with other men, they would "freak out" (eThekwin questionnaire, 8 May 2015) and be completely "helpless" (eThekwin questionnaire, 8 May 2015). These feelings of helplessness reveal the need for a guided mastery in MSM health issues. This is where expertise is needed to effectively deal with the presented health issue. Expertise, in the form of knowledge or skills has the potential to guide the individual's practice or performance in a given context.

However, and as discussed previously, while equipping HCWs with appropriate knowledge and skills is a good approach, if HCWs institutional environments are not supportive of these skills in the form of appropriate materials and tools, the skills will be useless and will not be applied, no matter how well they have been trained.

At the organisational level of the SEM, this study reveals that in addition to individual skills, success in dealing with MSM health issues requires a strong belief in HCWs individual capabilities to master new problems. This is known as self-efficacy as described by Rosenstock (1988). For instance another ‘helpless’ response from a HCW was that they would not know of appropriate places or resources that could possibly assist an MSM patient in the event they are unable to help with the patient’s health problem. This response brings us back to the issue of HCW self-efficacy (Rosenstock *et al.* 1988); which is defined as the specific stimuli necessary to trigger appropriate behaviour, and relates to the degree of confidence a person has about being able to perform a certain task (Mattson 1999). Self-efficacy has both a cognitive and a behavioural dimension. For instance, attitudes about not being able to provide appropriate help when needed are likely to influence one’s self efficacy about performing a task that is difficult to do, or changing an old belief system or behaviour. (Janz and Becker 1984). At the same time, self-efficacy may be increased through practicing a skill or a behaviour by watching others perform a similar task or behaviour.

Bandura (1986) details four various ways an individual can establish their self-efficacy. This is documented as: enactive attainments, vicarious experience, verbal persuasion, and one’s psychological state (Bandura 1986). Enactive attainments “are the most influential sources of efficacy information because they are based on personal mastery experience” (Rosenstock *et al.* 1988: 180). The next important source of self-efficacy is listed as indirect experiences. For instance, when a person contemplates changing a behaviour, the intention is to commit to carrying out a particular behaviour. This intention can either produce strong or weak behavioural results, or they can improve or delay self-efficacy (Schwarzer 1992). Third in its capability to enhance self-efficacy is detailed as verbal persuasion. This aspect promotes and advances health education through mass media or interpersonal communication or dialogue. Ranked in the last place is the person’s psychological state which can determine the

individual's degree of self-efficacy. As an example, a cultural or religious stigma about homosexuality can bring up difficult emotions for a HCW, therefore rendering them less likely to carry out a particular task (Schwarzer 1995).

In demonstrating self-efficacy, a few, 20% (3) of the 16 respondents said if a patient discloses their sexual practices, they will be supportive of the individual's choices since everyone has a right to choose what they want to do with their lives, thus they will treat the patient in the same fashion they would with "normal" patients (Imbali questionnaire, 8 May 2015). Aside from this 20% who seem a bit more understanding and accepting of MSM patients, the rest of the respondents from both study settings are clearly prejudiced against MSM. The findings also demonstrate there are very few public HCWs that have had contact or exposure to anal STIs, perhaps as part of their attitudes towards sexual minorities. This finding corresponds with the focus group discussion around HCWs' practices regarding the treatment of anal STIs. For instance, participants were asked if a male patient reports having male partners, would they also ask about anal and genital symptoms, the majority reported they had never come across such a situation before. This shows there is a need to move beyond tolerance and acceptance of MSM patients, to a comprehensive understanding of gender related issues.

At the organisational level of the SEM, we witness the lack of understanding of MSM health related issues. These are manifested through the inability of many HCWs' to provide comprehensive healthcare services to MSM patients. The lack of skills to handle MSM healthcare needs is evident in that the majority of respondents resort to giving MSM patients "appropriate advice" (Imbali and eThekwini questionnaire), regarding their sexual practices. The need to give patients 'appropriate' advice can be seen as a form of bullying, depending on the context and tone of the advice. Bullying can be defined as any type of repetitive abuse in which the victim of the bullying behaviour suffers verbal abuse, threats, humiliating or intimidating behaviours, or behaviours by the perpetrator that interfere with his or her job



performance and are meant to place at risk the health and safety of the victim (Center for American Nurses 2007, Felblinger 2008, Longo and Sherman 2007). Patient bullying or victimisation involves abuse or misuse of power and authority within the healthcare setting or the organisational level of SEM. Bullying or victimisation behaviours create feelings of defencelessness in the individual who is at the receiving end of the treatment. This behaviour extremely undermines the individual's right to dignity within any given environment (Longo and Sherman 2007).

According to Griffin (2004), bullying in the healthcare setting is a silent epidemic which is usually driven by the individual's need to maintain overall authority or control of another individual. This is with obvious disregard of the feelings or suffering imposed on their victim. Murray (2008) adds that the perpetrator methodically plans who their target will be, how and when their victim will be targeted, and how the abuse will be executed. The individual who is carrying out these acts strategically involves others, be it fellow employees, friends family members or peer members in the bullying behaviours. This can either be voluntarily or by coercing them into the abusive behaviour. Very frequently the accomplices may cooperate out of fear of being the next victim (Griffin 2004). Therefore, from this study, it is possible that HCW negative attitudes and behaviours towards MSM could be learned from fellow HCWs, or could be an assertion of certain HCWs on their control and authority over patients. This shows that it is possible to tolerate or understand MSM behaviour but not accept it.

It is also possible to accept behaviour of a person but fail to understand it, or even fail to grasp all three concepts – understanding, tolerance and acceptance. For example, in this study, 50% (8) of the overall respondents tolerate MSM behaviour because the law states that everyone has equal rights and is therefore free to express their sexuality. On the other hand, 45% (7) expressed that they are likely to privately encourage a MSM to seek counselling and advice for their behaviour, showing that though they may tolerate the behaviour, they do not

necessarily endorse or accept the behaviour. Another example of lack of acceptance of MSM behaviour is that 45% of the total participants said they would privately encourage their family members who have MSM tendencies to seek counselling and advice to be absolutely sure they are probably not ‘confused’ about their sexual behaviour. However, a high level of tolerance and understanding of MSM behaviours is demonstrated by the fact that none of the respondents will resort to disowning any of their MSM family members or de-associate from them due to their sexual behaviour.

Though, tolerance and understanding is desirable, it is not a substitute for acceptance, as demonstrated by one respondent who stated that though they understand and tolerate MSM, they would still give an MSM family member a good beating “to set them straight” (Imbali questionnaire, 8 May 2015). This indicates some level of discomfort in having, or taking care of a family member who is a MSM. However, one respondent was able to demonstrate all three concepts: tolerance, acceptance and understanding by stating that, “If I found out that a family member is sleeping with other men, I would sit down with him or her and find out exactly how he is feeling, then refer him or her to access appropriate professional help if needed as well as give him support” (eThekwini questionnaire, 3 July 2015).

### ***Views on patient confidentiality***

According to the CDC (2014), protecting patient information and other private details related to their health is known as confidentiality. This largely entails protecting patient information and illness account which is usually documented during HCW-patient initial consultation stages. The CDC states that all written and electronic records should be kept confidential as this is an important matter in terms of maintaining and retaining patients in healthcare and in aspects of mitigating the HIV epidemic. Additionally, when patient confidentiality is broken, patients may put this experience as a concern that prevents them from seeking additional

healthcare. People who live in communities where same sex behaviour is frowned on, for example, are more likely to prioritise confidentiality issues than seeking medical care when needed (CDC, 2014)

When inquiries were made on whether HCWs discuss confidential information of MSM patients with other HCWs, findings from this study reveal that 45% (7) of HCW respondents would advise their fellow HCW colleague to respect the patient's privacy. This indicates that HCWs understand the importance of keeping patient information confidential. A similar 47% of respondents elaborated that HCWs who are unable to provide the necessary assistance to a patient, due to skills gap or other reasons, are obligated by law to refer the patient to someone who can provide the required clinical care. This finding points out that not all HCWs are aware of their responsibility to protect the patient's private information and ensure that only those persons who need to know the information have access to patient's records (CDC 2014). Having only 47% response rate instead of a higher positive rate indicates that the majority of HCW remain unclear about their responsibility to protect the patient's confidentiality. This confirms the notion that HCWs are prone to openly gossip about MSM patients and their conditions thus voluntarily disclosing patient's confidential information with another HCWs (Lane *et al.* 2011).

Disclosure of patient information when it is not necessary to do indicates that HCWs are not aware that though one should refer a patient when necessary, protecting patient confidential information remains a priority for each HCW. That only persons directly involved in the care of the patient should have access to a patient's private and confidential information.

Expanding on this finding, confidentiality is a very important issue in healthcare promotion (CDC 2015) because the diagnosis of any disease is potentially damaging to patients. In the context of MSM patients, a diagnosis of an anal STI can lead to stigmatization or rejection by

family, friends, or co-workers; the loss of a job; and possibly eviction from housing. Therefore, the CDC emphasises that patient confidentiality require special attention by HCWs and the recognition that patients have certain rights that must be protected and respected. The CDC elaborates that great care must be taken to ensure that patient rights, especially rights to privacy, are protected to the fullest extent possible. This will ensure the patient-HCW relationship is not compromised and remains strong enough to encourage increased uptake of healthcare services among the MSM population.

When testing the notion that MSM avoid public healthcare facilities to maintain their privacy, avoid stigma and ridicule by public HCWs, none of the respondents from both study settings disclosed having privately or publicly ridiculed an MSM patient ‘to set them straight’. This finding also illustrates that most HCWs are either respectful of MSM patients, or are subconsciously not aware of own attitudes or negative behaviours as experienced and witnessed by MSM patients during consultation at clinic level. However, 25% (4) of respondents from both Imbali and eThekweni said they are likely to privately encourage an MSM patient to seek counselling and advice in case they are confused about their sexuality. One HCW stated they would discuss with the patient as professionally as possible the implications of their lifestyle on their medical history, while at the same time clarifying to the patient that “their personal life is not for me but their choice” (eThekweni questionnaire, 3 July 2015). This indicates some level of comfort in communicating with a patient about their sexual behaviour. This also highlights a positive attitude manifested in the form of being sympathetic, caring, friendly and understanding towards the patient. These attributes help to promote healthcare seeking behaviours among MSM patients (Atuyambe *et al.*, 2009), and has been confirmed by a few other studies which noted improvements in HCW self-esteem and HCW-patient interactions following training on interpersonal and communication skills, including patient engagement in other clinical environments (Misago *et al.* 2001).

### ***Overall perceptions of MSM***

Inquiries into the overall perception of MSM reveal that 25% (4) of the research respondents believe that MSM behaviour is morally wrong. Another 10% (2), mainly from Imbali said they were not at ease with men sleeping with other men under any circumstance and that this is against the laws of nature. None of the respondents from both study areas agree that MSM activities are acceptable whether practiced by adults or minors. This finding demonstrates that the majority of HCWs, both from township and urban settings, remain uncomfortable or disapprove of MSM behaviours whether practiced by adults or not. In addition, the findings reveal strong beliefs at the individual level of the SEM, which are at play in influencing HWC choices and behaviours. Beliefs are the convictions that we generally hold to be true, usually without actual proof or evidence (Fielding 2014). Beliefs are sometimes associated with one's religion or cultural values. Such religious beliefs could include a belief that God created Adam and Eve or the entire universe, or that Mohammed was the prophet of God. Religious denominations, other than Christianity, also have their own accompanying principles and beliefs.

Individual beliefs at the SEM level of influence can also include non-religious beliefs or a set of principles. These could include the belief that everyone is equal before the law. This study reveals that such non-religious based beliefs are more predominant in healthcare settings and serve as a guiding principles informing HCWs' attitudes and behaviours. For instance, the majority of respondents from both Imbalenhle and eThekwini focus group discussions believed that all patients regardless of sexual practices must be treated equally as per the law provisions, and to uphold the principles which protect individuals from discrimination and marginalisation based on sexual practices. Conversely, other HCWs from both eThekwini and Imbalenhle believed that MSM practices are morally wrong or sinful. Both views

demonstrate basic assumptions that HCWs make based on a particular set of beliefs or values - values are things that individuals deem important. These can include concepts like equality, honesty, effort, perseverance, loyalty, faithfulness, conservation of the environment and many other concepts (Fielding 2014).

Only 10% (2) said they were 'okay' with an MSM if it helped the individual live a life that corresponds with how they feel, with one respondent adding that "it is their (MSM) right to live the way they live and their right to express their true feelings" (Imbaili questionnaire, 8 May 2015). An additional response (Imbali questionnaire, 8 May 2015) expressed that: "I will not judge the person if I came across them". These responses points towards non-judgemental acceptance and being comfortable with MSM patients. One respondent was partially supportive and emphasised being "okay if they (MSM) don't sleep with women as well" (Imbali questionnaire, 8 May 2015). Another echoed the sentiment and said that "MSM behaviours are not okay, but if they (MSM) are having single partner and protected sex and they feel well, it is up to them" (eThekwini questionnaire, 3 July 2015). This could be interpreted in a similar fashion of tolerance and understanding of MSM behaviour but does not display acceptance of the behaviour.

Another respondent held that MSM behaviours were "none of my business and I would not want to know about it" (eThekwini questionnaire, 3 July 2014). This is a good example of not being comfortable with the behaviour, and being unwilling to tolerate, understand or accept it.

### ***Summary: Attitudes***

Using the SEM (Sallis and Owen 1997) as this study's framework, it has been illustrated that HCWs KAPs are a complex or multifaceted phenomena. These are shaped by several interconnected factors such as the wider structural contexts, organisational and community conditions and interpersonal and individual factors.

At the interpersonal level of the SEM, the findings of this study reveal that the majority of HCWs are inclined to give MSM patients advice of a sort, expressed in broad terms such as 'professional advice' or 'appropriate advice'. There is broad consensus that advice given should serve the interests of the patient thus taking precedence over those of the HCW. However, as discussed earlier, it was evident that some of the respondents from both study settings were most likely to put their own moral or religious principles first, compared to the needs of the MSM patient. Therefore, HCWs cannot effectively provide non-discriminatory physical and emotional health services to MSM individuals. Especially when issues of religion or personal values that impact on healthcare provision are not adequately addressed.

Alongside cultural values and norms, religious principles remain very influential at the SEM individual and societal levels of influence. Comments like 'MSM practices go against nature' and are 'morally wrong' or that the HCW 'freaks out' and becomes 'completely helpless' reveals strong stigma towards MSM. These behaviours, attitudes and beliefs are largely linked to sociocultural or religious influence. Furthermore, though South Africa is a secular state, religion, whether indigenous, Christian, Islamic, Hindu or other; plays a major, even a dominant, role in every sphere of the SEM model. Any form of sexuality, except heterosexuality, is widely seen as irreligious (AIDS Foundation of South Africa, 2013).

At the community and individual levels of the SEM, the study findings show that HCW beliefs grow from what individuals see, hear or experience in their communities or at household levels. Individuals may develop an opinion that they hold to be true and unmovable at that time. This is evidenced by the earlier statement that MSM behaviour ‘is unacceptable’ and needs to be ‘cured’. Therefore, individual beliefs inform HCW behaviours at the organisation level of the SEM.

Likewise, prevailing HCW attitudes towards MSM at clinic level may be driven by structural factors. For instance, the lack of HIV counselling and testing protocols that are tailored for MSM at public health facilities may result in the poor capacity of HCWs to respond appropriately. Lack of materials or equipment at the organisational level of the SEM, in this case, the healthcare facility, sustains the increased marginalisation of MSM individuals and violates human rights based on sexual practices. Therefore, lack of appropriate resources within the healthcare setting may confirm the view that stigma and discrimination against MSM patients is perpetuated; or simply condoned by public health institutions. This is as far as HCWs’ ability to respond appropriately to MSM healthcare is concerned.

Additionally, expression of structural resistance may reveal a political stance. For instance, the societal level of the SEM reflects the broader national determinants that ultimately influence behaviour. Factors within this cluster are varied but can be inclusive of relevant policies and programming, the enactment of legal provisions and state leadership, cultural environments as well as predominant power dynamics and relations, as is advised in the SEMCHB (Kincaid *et al.* 2007)



## CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

### *Introduction*

The concluding chapter summarises the findings and make recommendations based on how much HCWs know, believe and practice regarding the subject of MSM. Recommendations will be based on the collected data and aim to help decision-makers to set programme priorities and make strategic decisions (WHO 2008). The KAP findings from this research project may also assist healthcare facilities to evaluate their current interventions and make strategic decisions about future treatment practices for MSM. The discussion will follow a format whereby each key finding identified by the KAP results is addressed in relation to the SEM and provides the conclusions deduced during data analysis. Recommendations and implications for MSM health are highlighted where relevant.

### *Invest in sensitisation and gender training*

In order to adequately address widely held perceptions of discrimination in public healthcare facilities, experiences of under-service, and ignorance in the delivery and provision of MSM health information, treatment and care, King Edward VIII hospital focus group respondents unanimously identified the need for all public HCWs to be made aware of the biological components of diverse sexualities. This includes facilitating a deeper understanding of gender constructions and its impact on sexual behaviours, and understanding the diverse emotional, psychological and physical health risks that arise from this diversity. This was also echoed by respondents from Imbali who expressed interest in gaining more knowledge on sexual orientation issues and sexual identity.

All respondents emphasised the significance of sensitising HCWs to other sexual practices; that apart from heterosexuality, there exist practices which have negative implications on

health and risk reduction efforts. As discussed in this study, building the capacity of staff is the cornerstone of any facility's ability to address issues of discrimination in an ethical and effective way. This study also shows that in resource-poor settings, staff do not receive adequate training and support and if they receive training at all, such as the Imbali respondents, it is often a single training initiative with limited to no follow-up.

Therefore, in general, policy makers or healthcare facility managers should consider sensitisation training for all staff, from administrators to professional service providers to security staff. They should first be sensitized about issues related to MSM and related threats to public health. Staff also needs to have a basic understanding of the nature and scope of the dynamics of abuse, risk factors and consequences. The results from this study show that efforts to sensitise HCWs for increased awareness on MSM health led some HCWs to become more tolerant and accountable to the principles of human rights as well as being more transparent about their practices around MSM healthcare. From this, it is safe to deduce that increased knowledge through access to information has the potential to increase understanding and tolerance of MSM issues, thereby reducing negative practices of discrimination at public healthcare facilities.

Professional healthcare staff, including all medical professionals providing direct services to MSM, should receive additional and ongoing training on key elements related to intake, examination, history taking and record keeping. Specialized staff should also receive ongoing support to manage potential challenges of working with MSM, through supervision, in-service trainings, and case reviews.

However, the above training recommendations do not ignore the fact that other influences such as family, the society or one's beliefs and values might make the HCW individual revert back to unacceptable choices, even if they are knowledgeable about a particular issue. For

instance, the reasons for continued attitudinal stances, as this study reveals, are religious, cultural and societal values; while the high tolerance levels (not acceptance levels, though) were largely due to availability of information which dispelled misconceptions about MSM issues. Therefore affirming the SEMCHB's need for HCWs to be equipped with extensive communication and information to increase their knowledge on diverse sexual behaviours - especially 'gay', 'lesbian', 'transsexual', 'bisexual', and 'intersex' or 'MSM'. Respondents, throughout both focus group discussions, expressed the need for increased MSM information as this has been credited with limiting levels of perceived homophobia within healthcare settings, and in encouraging trust between patient and HCW.

Fostering effective practices at the organisational level of the SEM is a good way to change negative organisational culture and foster behaviour change. Through a series of interventions which ensure success, HCWs can learn to increase their self-efficacy. Together with increasing self-efficacy, modelling and guided practice are good ways to foster behaviour change efforts. All that remains is the need to demonstrate benefits from maintaining the new behaviour which outweighs negative influences or benefits of returning to the previous behaviour (Fielding 2014). This will hopefully trickle down and influence aspiring and young HCWs. As seen from the organisational and community levels of the SEM, behaviour is influenced and modelled by old influences and by the more experienced members of a community. Various incentives and disincentives traditionally helped people to adhere to strict protocols of desirable behaviour (Fielding 2014).

***Challenge family, group and societal norms to effectively address prevailing HSWs' KAPs***

Behavioural and epidemiological data indicates that MSM in South Africa have high levels of HIV risk behaviour and high HIV prevalence, due to the high levels of stigma, discrimination, and violence faced in communities in which they live (Sandfort 2011). This is

also echoed by Beyrer *et al* (2011), who suggest that epidemics of HIV among MSM in low and middle-income countries are partly driven by discrimination, human rights abuses, cultural and religious influences, and a lack of appropriate healthcare and prevention strategies.

In relation to the SEM, data from this study highlights that prevailing HCWs' attitudes and behaviours towards MSM do not occur in isolation to the individual, but are also influenced by social pressures. For example, in terms of being open minded about different sexual orientations within their communities, the majority of respondents from both study settings acknowledged that in general, people did not easily accept MSM behaviours. Some of the reasons cited for the non-acceptance were lack of knowledge about sexual minority groups and the perception that all men who have sexual relations with other men were 'not normal' in terms of cultural perspectives and religious values.

At the organisation level of the SEM, lack of respectful care and support from HCWs at clinics may discourage or undermine the adoption or maintenance of positive health seeking behaviors among MSM patients (WHO 2014). In addition, HCW KAPs might directly affect the wellbeing of MSM patients and the relationship between patients and HCWs (WHO 2005). Furthermore, negative attitudes and practices of HCWs could undermine the quality provision of care and the effectiveness of MSM promotion prevention and treatment efforts, in addition to compromising their essential right to dignified and respectful healthcare (WHO 2014). Therefore the KAPs of HCWs are an important determinant of MSM health seeking behaviors and outcomes (Buttiens *et al.* 2004). This includes their ability to enjoy their basic rights and freedom from HCW ridicule and discrimination, and the access to high standards of holistic interventions which include physical and mental healthcare. A recent statement by the WHO (2014) calls for greater attention, research and advocacy around the maltreatment of all patients in public health facilities.

***Address structural factors in addressing HCWs' attitudes and practices***

In relation to the SEM's four levels of influence and as discussed throughout this study; various factors hinder effective provision of healthcare to the MSM population. These include cultural and religious norms, HCW KAPs and most importantly, the lack of a rights based approach which highlights the significance of human respect and dignity. A human rights based approach also pays attention to the needs of individuals and if implemented correctly – coupled with appropriate training, can address HCW KAPs and the inadequate and poor access to comprehensive MSM healthcare.

The latter, access to comprehensive healthcare, has recently received greater attention as a key reason for high HIV incidences in South Africa (Sandfort 2011). Therefore, there is a need for a conscious effort to be made by healthcare policy makers to ensure there is a coherent understanding among HCWs on the existing policy provisions that equally apply to MSMs. This might require establishing zero tolerance and legally binding policies and obligations at clinic level, which guides the conduct and practice of all public HCWs in upholding the rights of MSM patients.

Importantly, a rights-based approach must be adopted across all interrelated public sectors when designing and delivering MSM services. The WHO (2014) defines such an approach as one where human rights norms and principles are included in the design, implementation, monitoring and evaluation of programmes and policy. These norms and principles include human dignity, addressing the needs and rights of vulnerable and marginalized populations, accessibility to comprehensive healthcare systems, and freedom from discrimination based on sexual practices or gender identity (WHO 2015). The recognition and the upholding of human rights in service design and implementation requires addressing the SEM's multiple

and interrelated factors, especially those which potentially lead HCWs to deny MSM their basic and fundamental human rights.

Evidence from this study also shows that though there are increased efforts to sensitise HCWs, most are not adequately equipped to provide advice on the risks of anal sex and the acquisition of STIs. Though some HCWs received additional technical training from private institutions, not all public facilities benefited, because government-supported training programmes remain scarce. Thus, coverage of MSM friendly healthcare services is still very limited, or invisible in most public facilities, including those who received training.

To address issues of resource limitations and staff shortages in public facilities, and as discussed at the beginning of this study, a recommendation of contracting independent specialists or experts should be considered. These specialists and experts must be specifically orientated and supported to provide appropriate healthcare for MSM patients at public facilities. Collaboration with qualified specialists in the field of MSM health can reduce the skills and expertise gap as currently experienced in the public sector, and encourage MSM individuals to seek health interventions as provided through state health spaces.

Structural and policy related interventions are often difficult for one agency to successfully implement on their own. Therefore collaboration among several agencies, groups or organisations including private general practitioners and individual healthcare professionals is needed (McDonald *et al.* 2012).

“Disagreements and conflicts” over roles and role boundaries and a lack of shared decision-making suggest that “issues of power and authority are important factors in these relationships and influence the patterns of collaboration” [Kirby *et al.* 2008:77). Therefore “trust and respect are also important enablers of collaboration and mistrust and perceived lack of respect are barriers” (Bradley *et al.* 2008:387–398). Van de Ven and Walker (1984) argue

that, in the health context, relationships established for the purpose of referring patients are developed on a case-by-case basis. The authors add that these relationships should ideally be “less formalised and rely more on personal knowledge and trust among interacting parties” (Van de Ven and Walker 1984:598–621). However, referring MSM patients elsewhere may discourage them from seeking public health interventions and risk disempowering public HCWs to learn and apply new skills related to sexual minority healthcare needs. Therefore the best solution may be to embark on introducing a nursing curricular related to MSM health for aspiring nurses, or introduce extensive sensitization training programs for existing public HCWs. This strategy will ensure that every HCW is held accountable when dealing with sexual minority groups or with MSM patients.

In addition to being held accountable for their practices, HCWs represent one of the more highly educated and influential groups within African societies (Elwyn *et al.* 2012). Undoubtedly, HCWs’ perspectives of MSM individuals impact their professional interactions with this population. Their social responsibilities to MSM issues, independent of their provision of medical care, may influence others at all the interrelated levels of the SEM. Apart from their role as provider of healthcare, HCWs are an important factor in determining how communities view MSM individuals. Therefore, as role models or influential opinion leaders at all levels of the SEM, HCWs must foster downward accountability as advocated for by the Batho Pele Principles. Not least because it builds trust between HCWs and patients, but also helps to model good practice for MSM communities to be more accountable for their own healthcare.

At the structural level of the SEM strong political leadership that invests more in healthcare workers is desirable, since HCWs are instrumental in closing the gap between health policies at a structural level, and implementation at the organisational levels. Though the DoH is in the process of implementing some reforms in terms of strategy, infrastructure, service

delivery and increasing the staff complement by over 17 000 new employees for the year 2015/16, this sector remains overstretched to an extent (Barron *et al.* 2009)

While government's spending on health matches that of the private healthcare sector, it must be noted that many HCWs are not adequately equipped to address issues of same-sex practices. This may result in MSM avoiding public health services out of fear of being ridiculed (Bodibe 2011). This study reveals that when public HCWs are supported through knowledge and availability of appropriate tools and resources, such as those provided by the private healthcare sector, they were more likely to be tolerant and understanding towards MSM. Especially when they had prior training and knowledge about MSM health issues, or were aware of other types of sexual behaviours.

It is clear that negative KAPs are often related to poor working conditions, which include heavy workloads, long working hours, and shortage of equipment appropriate to MSM health provision. Other key factors influencing negative attitudes and practices were individual attributes such as beliefs and personal values, as well as perceptions of negative patient behaviors which include delayed testing and counselling and prevention seeking, or apparent lack of compliance with healthcare information advice. Mannava and fellow researchers (Mannave *et al.*, 2015), states a similar conclusion was reached in a USAID review which reported that factors such as health worker status, prejudice and demoralization related to poor working conditions contributed to disrespect and abuse of patients in healthcare facilities (Bowser and Hill (2010).

In addition to this, and as discussed in the literature review, competent public HCWs are required to strengthen the national government's potential to meet its strategic objectives on HIV, STI and TB plans. HCWs need to be well supported to effectively fulfill their duties in



the provision of services to the general public, including effectively providing appropriate MSM healthcare.

At the policy level of the SEM, there is also a need to use key moments like the review of the NSP on HIV/AIDS, STIs and TB more effectively to extract commitments and hold key players to account. This calls for disaggregated health budgets to be made available by policy makers in order to track how MSM health allocation is being addressed through national budgets. This includes availability of MSM friendly resources and services such as HIV treatment, free condoms, mental health services, circumcision, and mass-media campaigns to reduce both HIV ignorance and homophobic attitudes.

Even where there are weak, absent, or ineffective MSM healthcare practices, public healthcare facilities should enforce and strengthen whatever government policies that exist. This include the Batho Pele principles, the NSP on HIV/AIDS, STIs and TB and the South African Constitution, among others. Such policies must be made operational to lay the foundations for current and future HCW practices as well as model good practice. Health facility managers need to ask themselves how these models can be fully utilized to effectively balance dynamics between HCWs, patients, families, relationships, friends, and communities. There are obviously other factors which need to be identified and greatly explored, analysed and understood in terms of how the adaptation of these principles in public facilities will entail.

### ***Address power dynamics at all levels of SEM***

Power is understood as the ability to influence decisions and control resources. This is generally in line with the definition of power in the literature (Black 2005, Branigan 2006, Brown 1989). According to an article titled *Patients and nurses: A powerful force* (1964), though the ability to influence is intimately linked to the concept of power, it is important to

clarify the difference between influence and power. Influence is the capability to make others do what you want them to do. Power is the source of that influence. Having power does not mean one has influence because power must be converted into influence. The latter is important when we examine the extent to which individuals and or healthcare facilities within the broader structural context have power, which they do or do not use to influence how decisions are made. For example, HCWs play a significant role in influencing relationships at all levels of the SEM. Their attitudes also play a large role in influencing the behaviours of individuals at household, individual and community levels (McLeroy *et al*, 1988).

It is also important to emphasize at the outset that power should not be seen as something negative. What is important is how it is used. It can be used to achieve the country's NSP vision for healthcare or it can be exercised in a manner that undermines what public health policies seek to achieve. The focus of the recommended power analysis is the use of power, which should be aligned to the country's Constitution and facilitates achievement of the country's strategic health objectives.

This study has recognized that if governments are to effectively address unequal power relations in society and within communities, it must do the same closer to home: within their own departments. This calls for a power analysis within all government departments as interrelated entities. Power imbalances between the structural level to the organisational level are manifested through the disjuncture between policy recommendations and approved strategies and implementation of these. This is increasingly being manifested at the individual level of the SEM through the ineffective provision of services to MSM, which increasingly results in high HIV infection rates.

This study recognizes that unequal power relations are present at the organisational level of the SEM and the individual level and these are often hidden or exercised informally. It is

therefore important that an analysis of power dynamics at different levels of the SEM be undertaken with concrete strategies to address the issues arising.

Public health provision is a complex issue reflected in the number of governance structures at different levels, diversity in specific policies, a wide variety of healthcare specialists and a significant number of healthcare programmes to combat diverse health issues across the nine provinces. The issue of power is equally complex: “Power is dynamic, relational and multidimensional, changing according to context, circumstance and interest” (Just Associates 2015: 3). Despite the complexity of MSM health issues and the issue of power, the analysis which needs to be done must be simple and practical.

The analysis should also take into account that healthcare policies are sometimes overly focused on the public sphere (government and formal duty bearers) but need to do more to challenge cultural, traditional and religious power, building critical analysis and understanding of hidden and invisible power in the healthcare sector. Therefore, there is a need to challenge the most deep rooted and internalised oppression – the most difficult to change – through a sustained process of conscientisation. There is a need to value small changes in attitudes and social norms which may take a long time – and this is not always easy when the NSP on HIV/AIDS, STIs and TB reflects on its outcomes. There is also a need to do deeper analysis of how power dynamics play out in the area of MSM healthcare and marginalization.

Power analysis needs to encompass the policy level, the implementation level, the community level and the individual level of the SEM. Individual policy makers, managers, other HCWs and MSM patients must be part of this process to ensure that all parties are the change they want to see - to be coherent, to reflect on and transform their own privileges and how power is exercised. As evidenced from this study, MSM health needs are never straightforward, so

there is a need to continually support both understanding and communication of distinctive practices with MSM patients, communities, governments, and donors.

### ***Improve internal systems***

More time needs to be spent critically discussing HCWs' KAPs and its relation to internal healthcare facility systems and processes, exploring how these KAPs facilitate or hinder the Batho Pele principles. At the same time, whilst there is need to be culturally sensitive towards MSM, there is also a need for strong leadership to foster HCW practices which build long term sustainability and trust among MSM communities at the levels of the SEM. According to the CDC (2014), trust between HCWs and patients means that the patient is comfortable entrusting personal and private information to the HCW. As HCWs interview patient, patients may divulge information about lifestyle and personal choices which may be deemed risky behaviors, or even illegal such as sex work or injection drug use. In addition, some MSM patients may reveal that they reside in South Africa illegally and fear being deported or marginalized. It is therefore extremely important that HCWs protect all MSM confidential information, including the patient's diagnosis, and assure the patient that this information will not be shared with others, other than required by the law (CDC 2014).

### ***Invest in monitoring and evaluation activities***

Finally, a constant reinforcement of how HCWs contribute to monitoring and evaluation of service provision to MSM is needed. Monitoring and evaluation of MSM interventions at clinic level is important in order to determine the effectiveness of healthcare interventions. This includes assessing whether healthcare policies have achieved intended behavioral outcomes, determining the cost effectiveness of such programmes.

In summary, there are three important reasons HCW should be part of the broader monitoring and evaluation processes of healthcare interventions: to be accountable to communities (and thereby empower MSM patients to hold HCWs and policy makers accountable); to build momentum and evidence behind innovative alternatives; and to learn new health trends that are happening and testing policies.

At the same time, many sectors have been experiencing an increase in public pressure for accountability. The public in ‘donor countries’ want to know how their governments are distributing and accounting for aid, how beneficiary countries are using their resources and how communities benefit from investments made. This increased demand for results is compounded by austerity measures imposed by conservative governments and by a narrative adopted by some political parties which blames foreign aid for the consequences of those austerity measures.

Healthcare facilities need to be more accustomed to concepts such as ‘value for money’, ‘quality of data’, and ‘results’, which have become more prominent in both donor accountability frameworks and in everyday language. At the same time, communities and individuals are more aware that governments receive funding that is meant to benefit them and they are somehow disillusioned about their accountability. People lacking health services demand evidence of how externally funded healthcare programmes are helping them directly.

This calls for strong commitment to invest in monitoring and evaluation of healthcare activities intended for MSM. Though these discussions are held by the national, the provincial and district governments, there is not enough discussion taking place as to what sort of monitoring and evaluation tools are being adopted. Therefore these need to be clearly visible and communicated if power is to be shifted. The changes advocated for in the NSP on HIV/AIDS, STIs and TB are not impossible to achieve and measure but they certainly

represent a challenge especially if there are no clear monitoring and evaluation processes to monitor progress and impact. There has been a countrywide genuine willingness to understand what difference South Africa is making in achieving the NSP on HIV/AIDS, STIs and TB's main priorities, which are: first, to reduce new HIV infections by 50% and, secondly, to reduce the impact of the epidemic by extending access to appropriate treatment, care and support to 80% of people diagnosed with HIV (DoH 2012). However, it still remains unclear what is the best way to assess or monitor this. As this study pointed out, the process of change is far from linear thus simple measurements of cause and effect do not adequately capture the messiness of long-term, complex social change programs. In addition, in order to have meaningful monitoring of change at local level, there is a need for contextual data collection and interpretation adding to the complexities of measuring change at national level.

### ***Final remarks***

This qualitative study was limited in its scope, however, data collected uncovered numerous factors which impact HCWs' prevailing KAPs and how these can be mitigated or addressed. This research lays the foundations for further inquiry into other key areas of HCWs' practices within the public health sector and other related government sectors. If additional studies are to benefit MSM, these should take into consideration that practices, behaviours and attitudes of HCWs towards MSM are far from being an individual perception alone. Rather, they exist within the broader structural, organisational, cultural, social, political and religious frameworks which are exposed at the organisational level through interactions with patients.

One of the key overall reflections that arose from my analysis was the need to acknowledge that these multiple and intersecting factors or elements of the SEM are somehow woven together and influencing HCWs' practices and attitudes in a myriad of ways.

## BIBLIOGRAPHY

### *Primary sources*

The list of individuals interviewed in focus groups, and those who participated in the self-administered questionnaires and recorded during the research process are not listed here due to ethical reasons. Healthcare workers requested that their names not be mentioned in the study thesis; hence respondents from both study settings were allocated numbers and referred to as “respondent 1” all the way to the sixteenth respondent, followed by their location and date of interview.

### *Secondary published sources*

Adam, B. D. and Bereket, T. 2006. ‘The emergence of gay identities in contemporary Turkey’, *Sexualities*, 9 (2), 131–151.

Adam, P. T. I. Wit, B. Mathers, M. Nashkoev, I. Zablotska, R. Lyerla and D. Rugg. 2009. ‘Estimating levels of HIV testing, HIV prevention coverage, HIV knowledge, and condom use among men who have sex with men (MSM) in low-income and middle-income countries’.. *Journal of Acquired Immune Deficiency Syndromes*: 19 - 99.

Adamo, D.T. 2011. *Christianity and the African traditional religion(s): The postcolonial round of engagement*. Available at: <http://www.ve.org.za/index.php/VE/article/view/285/808> (Accessed: 30 December 2015).

AIDS Foundation of South Africa. (2013). Culture and Health programme information. AFSA. [Internet] Available at: <http://www.aids.org.za/sites/default/files/Gender%20and%20circumcision.pdf> (Accessed on 11/01/2015).

Airhihenbuwa, C.O, Makinwa, B, Obregon, R. 2000. ‘Toward a new communication framework for HIV/AIDS’. *Journal of Health Communication* 5 (supplement): 101-111.

Ajzen, I. 1985. From intentions to actions: A theory of planned behavior. In J. Kuhl and J. Beckmann (eds), *Action control: From cognition to behavior*. Berlin, Heidelberg, New York: Springer-Verlag..

Aldrich, R (ed) (2006). *Gay Life and Culture: A World History*, Thames and Hudson, Ltd

Ali, A.M. and Yusof, H. (2011) Quality in Qualitative Studies: The Case of Validity, Reliability and Generalizability. *Issues in Social and Environmental Accounting*, Vol. 5, Number 1: 25-64.

*American Cancer Society* (2013), "What are the risks of anal cancer," All About Anal Cancer, [www.cancer.org](http://www.cancer.org). (accessed 24 March 2013).

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. (2000). 4th edition, text revised. Washington, DC: *American Psychiatric Association*.

Anderson, L. and Whiston, S. 2005. 'Sexual Assault Education Programs: A Meta-analytic Examination of their Effectiveness'. *Psychology of Women Quarterly*, (29):, 374-388.

Anova Health Institute: The health4Men model. 2014. Available at: <http://www.anovahealth.co.za/homophobia-and-msm-health-the-health4men-model/> (accessed 21 December 2015).

Asthana, S. and Oostvogels, R. 2001. 'The social construction of male "homosexuality" in India: Implications for HIV transmission and prevention', *Social Science and Medicine* (1982)., 5(52).

Atuyambe, L., S. Neema, E. Otolok-Tanga, G. Wamuyu-Maina, S. Kasasa and Wabwire-Mangen. 2008. 'The effects of enhanced access to antiretroviral therapy: a qualitative study of community perceptions in Kampala city, Uganda'. *African Health Sciences* 8: 13–19.

Badimo, K., Follow, KB., Live, E., Pennsylvia, E. (2015). *Using knowledge management practices for transformation in the public health sector*. Available at: <http://www.slideshare.net/KgaboBadimo/using-knowledge-management-practices-for-transformation-in-the-public-sector> (accessed 21 December 2015).

Baggaley, R., White R., Boily M. (2010). HIV transmission risk through anal intercourse, systematic review, meta-analysis and implications for HIV prevention. *International Journal of Epidemiology*, 39:1048-1063.

Baldry, AC., Farrington, DP. (1998). Parenting influences on bullying and victimization, *Legal and Criminological Psychology*, 3(2):237–254.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84:191-215.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ, USA, Prentice-Hall.

Baral S, Trapence G, Motimedi F. (2009). *HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana*. PLoS ONE;4(3):e4997.

Barron, P., Gouws, H., Loots, B., Mistry, G., Rispel, L., Snyman, A., Van Nieuwenhuizen, K. (2009). Consolidated Report of the Integrated Support Team



- Bastien, S., Kajula, L.J., and Muhwezi, W.W., 2011. A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. *Reproductive Health*, 8(25), pp. 1-17.
- Becker, M. H. and Janz, N. K. (1984). 'The health belief model: A decade later', *Health Education and Behavior*, 11(1), pp. 1-47.
- Benotsch EG, Kalichman SC, Kelly JA. (1999). Sexual compulsivity and substance use in HIV-seropositive men who have sex with men: Prevalence and predictors of high-risk behaviors. *Addictive Behaviors*.;24:857-68.
- Berger, A. A. (1998). *Media Research Techniques*. Second edition. London, Thousand Oaks: Sage Publication.
- Berger, A.A. (2011). *Media and Communication Research Methods: an introduction to qualitative and quantitative approaches* (2nd ed.) Thousand Oaks: SAGE Publications.
- Bernard HR. (1995). *Research Methods in Anthropology*, Second Edition. London: Sage Publications.
- Berry, D. (2006). *Health communication: Theory and practice: Theory and practice*. Available at: <https://books.google.co.za/books?> (accessed 21 December 2015).
- Berry, D.C. (2006). Informing people about the risks and benefits of medicines: implications for the safe and effective use of medicinal products, *Current Drug Safety*, 1, 121-6.
- Bertrand, I., Hughes, P. (2005). *Media Research Methods: Audiences, Institutions, Texts*. United Kingdom, Palgrave Macmillan.
- Betron, M., E. Gonzalez, A. Eckman, and K. Morrison. (2008). Screening for Gender-based Violence and Other Forms of Stigma and Discrimination among MSM and Transgendered Persons: A Synthesis and Review of Relevant Literature. Report on a Pilot Project in Mexico and Thailand . Futures Group: Washington, DC.
- Beyrer, C., Wirtz, AL., Walker, D., Johns, B., Sifakis, F., Baral. SD. (2011). The Global HIV Epidemics among Men Who Have Sex with Men. The World Bank: Washington, DC.
- Binnie, J. (2004). The globalization of sexuality . London, United Kingdom: Sage.
- Black, N. (2005). Rise and demise of the hospital: A reappraisal of nursing. *British Medical Journal*, 331(10), 1394-96
- Blackmer J. (2013). *Professionalism and the medical association*. [http://www.wma.net/en/30publications/40background\\_docs/White\\_Paper.pdf](http://www.wma.net/en/30publications/40background_docs/White_Paper.pdf). (accessed 24 March 2013).
- Bond, P. (2008). 'Townships'. In: Darity, W. (ed.), *International Encyclopedia of the Social Sciences*, 2nd Edition. Detroit: Macmillan.

Boswell, J. (1980). *Christianity, social tolerance and homosexuality*. Chicago: University of Chicago Press.

Bourne, A. (2012). Drug use among men who have sex with men: Implications for harm reduction. In: Stoicescu, C, (ed.) *Global State of Harm Reduction 2012. Harm Reduction International*, London, pp. 147-155.

Bowser D, Hill K. (2010). *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis*. USAID.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Bradley F, Elvey R, Ashcroft D, Hassell K, Kendall J, Sibbald B, Noyce P. (2008). The challenge of integrating community pharmacists into the primary health care team: A case study of local pharmaceutical services (LPS) pilots and interprofessional collaboration. *J Interprofessional Care* ;22(4):387–398.

Branigan, T. (2006). Racial gap in employment ‘will take 45 years to close’. *The Guardian*. London: Guardian Newspapers Ltd.

Braun, V. and Clarke, V. (2006). *Using thematic analysis in psychology*. *Qualitative Research in Psychology*, 3 (2). pp. 77-101.

Brent Meersman (2012) Available at: <http://thoughtleader.co.za/brentmeersman/2012/03/26/homosexuality-is-african/> (Accessed: 30 December 2015).

Bronfenbrenner, U. (1999). Friedman SL and Wachs TD, ed. *Measuring environment across the life span: Emerging methods and concepts*. Washington, DC: American Psychological Association Press.

Bronfenbrenner, U. (1979). *The ecology of human development: experiments by nature and design*. Cambridge: Harvard University Press

Brown, R A. (1989). *Individualised care: The role of the ward sister*. Royal College of Nursing Research Series. Harrow: Scutari Press.

Bruce, J. 1990. “Fundamental elements of the quality of care: A simple framework,” *Studies in Family Planning* 21(2): 61–91.

Bukowki, W. M., Sippola, L. A., and Newcomb, A. F. (2000). Variations in patterns of attraction to same-and other-sex peers during early adolescence. *Developmental Psychology*, 36, 147–154.

Buoyant L.(2013). When ‘straight men’ have sex with other men does that make them ‘gay or bisexual’ or just normal? Available at: <http://www.sodahead.com/united-states/when->

straight-men-have-sex-with-other-men-does-that-make-them-gay-or-bisexual-or-just-normal/question-3573053/?link=ibaf (Accessed: 29 December 2015).

Burrell, E., Mark, D., Grant, R., Wood, R. and Bekker, L. (2010) 'Sexual risk behaviours and HIV-1 prevalence among urban men who have sex with men in Cape Town, South Africa', *Sexual health*, 2(7).

Butt, G. (2008). 'Stigma in the context of hepatitis C: concept analysis', *Journal of Advanced Nursing*, vol 62, no6, pp. 712-24.

Buttiens H., Marchal B., De Brouwere V. Skilled Attendance at Childbirth.(2004). Let Us Go beyond the Rhetorics. *Tropical Medicine and International Health* ;9(6):653–54.

Cáceres, C., Konda, K., Segura, E., Lyerla, R. (2009). Epidemiology of male same-sex behaviour and associated health indicators in low- and middle-income countries: 2003–2007 estimates. *Sexual Transmitted Infections*, 84:49–56.

Cairns, RB, Cairns , BD. (1994). *Lifelines and Risks: Pathways of Youth in Our Time*. Cambridge: Cambridge University Press.

CDC (2008). HIV/AIDS Among Men Who Have Sex With Men,” HIV/AIDS Fact Sheet, May 2007.

CDC, STD Surveillance. (2005). Special Focus Profiles, Men Who Have Sex With Men, 2005 National Report, Available at: [www.cdc.gov/std/stats/msm.htm](http://www.cdc.gov/std/stats/msm.htm). (accessed 31 March 2013).

CDC. (2013). “HIV among gay, bisexual, and other men who have sex with men (MSM)” Department of Health and Human Services.

CDC. (2015). *HIV among gay and bisexual men*. Available at: <http://www.cdc.gov/hiv/group/msm/> (Accessed: 30 December 2015).

CDC. (2015). *Self-study modules on tuberculosis*. Available at: <http://www.cdc.gov/tb/education/ssmodules/module7/ss7reading1.htm> (accessed 21 December 2015).

Center for American Nurses.( 2007).*Bullying in the workplace: Reversing a culture*. Silver Spring, MD: Author.

CHANGE. (2011). Women’s Health Rights Advocates Applaud Court Ruling Against Bush-era HIV/AIDS Policy Against Sex Workers. Press Release: 6 July, *CHANGE*: Washington, DC.

Chauncey, G. Jr. (1982/1983). From sexual inversion to homosexuality: Medicine and the changing conceptualization of female deviance. *Salmagundi*, No. 58-59:114-146.

Chew-Graham C, Slade M, Montan C, Stewart M, Gask L. (2007). A qualitative study of referral to community mental health teams in the UK: exploring the rhetoric and the reality. *BMC Health Serv Res*;7(11):1–9.

Cloete, A., Simbayi. LC., Kalichman, SC., Strebel. A., Henda, N. (2008). Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa. *AIDS Care*, 20 (9):1105–10.

Cochran, S.D. Mays, V.M. (2008). Prevalence of primary mental health morbidity and suicide symptoms among gay and bisexual men. In Wolitski, R.J., Stall, R., Valdiserri, R.O., *Unequal Opportunity: Health Disparities Affecting Gay And Bisexual Men In The United States*. New York: Oxford University Press.

*Constitution of the Republic of South Africa*. (1996). , Available at: <http://www.gov.za/documents/constitution-republic-south-africa-1996> (accessed 21 December 2015).

Cox, S. and Gallois, C. (1996). Gay and lesbian identity development: A social identity. *Journal of Homosexuality* 30(4), 1-30.

Craig, W. M., and Pepler, D. J. (1998). Observations of bullying and victimization in the school yard. *Canadian Journal of School Psychology*, 13, 41–59.

Crompton, L. ( 2003). *Homosexuality and Civilization*, Harvard University. Cambridge, MA/ London: Belknap Press of Harvard University Press.

Dahlberg, LL., Krug, EG. (2002). *Violence-a global public health problem*. In: Krug, E., Dahlberg, LL., Mercy, JA., Zwi, AB., Lozano, R., (eds.) *World Report on Violence and Health*. Geneva, Switzerland: World Health Organisation.

De Swardt, G. and Rebe, K. (2010). From top to bottom: a sex-positive approach for men who have sex with men - a manual for healthcare providers. Anova Health Institute: Johannesburg.

Deane, J. (2002). *Approaches to HIV and AIDS Communication Strategies*. Available at: [www.healthcomms.org/comms/hiv-aids02/html](http://www.healthcomms.org/comms/hiv-aids02/html) (Accessed: 30 December 2015).

Delius, P., Glaser, C.(2005). Disease and stigma in South Africa; historical perspectives. *African Journal of AIDS Research*, 4:29-36.

D'Emilio, J., and Freedman, EB. (1988). *Intimate matters: A history of sexuality in America*. New York: Harper and Row.

Denzin, NK., Lincoln, YS. (eds.) (2005). *The Sage Handbook of Qualitative Research* (3rd ed.). Thousand Oaks, CA: Sage.

Department of Health. (2007). *HIV and AIDS and STIs National Strategic Plan for South Africa, 2007–2011*. Pretoria, South Africa: Department of Health.

Department of Health. (2015). *Umgungundlovu district office (DC 22)*. Available at: <http://www.kznhealth.gov.za/umgungundlovu.htm> (Accessed: 30 December 2015).

Department of Health. (1995). *Batho Pele principles*, Available at: <https://www.google.com/search?q=department+of+health+batho+pele+principles&ie=utf-8&oe=utf-8> (accessed 21 December 2015).

Desmond Tutu HIV Foundation. (2011). Advanced Topics in Combination HIV Research with Men Who Have Sex with Men in Africa, Training Workshop Final Report, Desmond Tutu HIV Foundation: Cape Town.

Dey, I. (1993). *Qualitative Data Analysis*. Routledge, London.

Dickens, BM. (2006). Ethical misconduct by abuse of conscientious objection laws. *Medical Law*, 25(3):513-22.

Dodoo, F.N.A (1998). Men Matter: additive and interactive gendered preferences and reproductive behaviour in Kenya. *Demography*, 35(2), pp. 229 – 242.

Donovan, J.E., and Jessor, R. (1985). Structure of problem behavior in adolescence and young adulthood. *Journal of Consulting and Clinical Psychology*, vol 53, pp. 890-904.

Dupper, D. R., and Meyer-Adams, N. (2002). *Low-level violence: A neglected aspect of school culture*. *Urban Education*, 37, 350-364.

Elwyn G, Frosch D, Thomson R, *et al.* (2012). *Shared decision making: A model for clinical practice*. *J Gen Intern Med*;27(10):1361-1367

Epprecht, M. (2004). *Hungochani: The history of a dissident sexuality in southern Africa*, *Sexualities*. McGill-Queen's university press. 2004.

eThekweni Metropolitan Municipality (2012b). Economic review for the eThekweni Municipal Region 2010/11. Report produced for the Economic Development Unit by Urban Econ Development Economists. eThekweni Municipality: Durban.

Etter, J.-F., Humair, J.-P., Bergman, M. M. and Perneger, T. V. (2000) 'Development and validation of the attitudes towards smoking scale (ATS-18)', *Addiction*, 95(4), pp. 613–625.

Facilitator Notes The Social Construction of Sexual Identities, Created by: Dr Paul Boyce, Thomas, Coram Research Unit, Institute of Education, University of London, and Dr Clare Hemmings Director of the Gender Institute London School of Economics and Political Science.

Fazio, A., Hunt. G., Moloney, M. (2011). "It's one of the better drugs to use": perceptions of cocaine use among gay and bisexual Asian American men, *Qualitative Health Research*, 21(5):625–41.

Felblinger, D. ( 2008). Incivility and bullying in the workplace and nurses' shame responses. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 37(2), 234-242.

- Fereday, J., and Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, 5(1), Article 7. Retrieved from [https://www.ualberta.ca/~iiqm/backissues/5\\_1/HTML/fereday.htm](https://www.ualberta.ca/~iiqm/backissues/5_1/HTML/fereday.htm) (Accessed: 29 December 2015).
- Fishbein, M. (2000). The role of model in HIV prevention, *AIDS Care*, 12:273–278.
- Fisher, D., Reynolds, G., Ware and Napper, L. (2009). ‘Methamphetamine and Viagra use: Relationship to sexual risk behaviors’, *Archives of sexual behavior.*, 2(40).
- Flannery, DJ., Vazsonyi, AT. and Waldman, ID. (2007). The Cambridge handbook of violent behavior and aggression. Available at: <https://books.google.co.za/books/> (accessed 21 December 2015).
- Fontana, A., and Frey, J. H. (2005). *The interview: From neutral stance to political involvement*. In N. K. Denzin and Y. S. Lincoln (Eds), *The SAGE handbook of qualitative research* (pp.695-728). Thousand Oaks, CA: Sage.
- Forrest, D., Metsch, L., LaLota, M., Cardenas, G., Beck, D. and Jeanty, Y. (2010). ‘Crystal methamphetamine use and sexual risk behaviors among HIV-positive and HIV-negative men who have sex with men in south Florida’, *Journal of Uurban Hhealth* : bulletin of the New York Academy of Medicine., 3(87). Florida, Journal of Urban Health: Bulletin of the New York Academy of Medicine, 87(3): 273–9.
- Fortenberry, JD, McFarlane, M, Bleakley, A, Bull, S, Fishbein, M, Grimley, DM, Malotte, K, and Stoner, BP. (2002). ‘Relationships of stigma and shame to gonorrhoea and HIV screening’, *American Journal of Public Health*, vol 92, pp. 378–81.
- Foucault, M. (1978). *The History of Sexuality: An Introduction*. New York: Random House.
- Foucault, M. (1979). *The History of Sexuality, Volume 1: The Will to Knowledge*. London: Penguin.
- Foucault, M. (1990). *The History of Sexuality, Volume I: An Introduction*. Robert Hurley, trans. New York: Vintage.
- Fredrickson BL, Roberts TA, Noll SM, Quinn DM, Twenge JM. (1998). That swimsuit becomes you: Sex differences in self-objectification, restrained eating, and mathperformance. *Journal of Personality and Social Psychology*; ;75:269–284.
- Garbarino, J. and DeLara, E. (2002). *Emotional violence can kill. And words can hurt forever* (pp. 1-15). New York, NY: Free Press.
- Geibel, S. (2012). ‘Same-sex sexual behavior of men in Kenya: Implications for HIV prevention, programs, and policy’, 4(4).

Gerbert, B., Maguire, B., Bleecker, T., Coates, T. and McPhee, S. (1991). 'Primary care physicians and AIDS. Attitudinal and structural barriers to care', *Journal of the American Medical Association.*, 20(266).

Glick, M., Muzyka, BC., Salkin, LM., Lurie, D. (1994). Necrotizing ulcerative periodontitis: a marker for immune deterioration and a predictor for the diagnosis of AIDS. *Journal of Periodontology*, 65:393–397.

*GLQ: A Journal of Lesbian and Gay Studies*, 8:139–166

*Global Men's Health Forum - men who have sex with men global forum (MSMGF)*. (2015). Available at: <http://msmgf.org/> (Accessed: 30 December 2015).

Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report*, Vol. 8, Number 4: 597-607.

Govender, E. M. (2011) 'Development and health communication for HIV/AIDS prevention'. In: Tomaselli, K. and Chasi, C. (eds.). *Development and Public Health Communication*. Cape Town, South Africa, Pearson.

Graham WJ, Varghese B. (2012). *Quality, quality, quality: gaps in the continuum of care*. Lancet. 2012;379

Green, L., Richard, L. and Potvin, L. (1996). 'Ecological foundations of health promotion', *American journal of health promotion : AJHP.*, 4(10).

Greenbaum, T.L. (1998). *The Handbook for focus group research*. London, Thousand Oaks: Sage Publications.

Griffin, D. ( 2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Education in Nursing*, 35(6), 257-263.

Grov, C., Bimbi, D. S. and Parsons, J. T. (2008). 'In the shadows of a prevention campaign: Sexual risk behavior in the absence of crystal Methamphetamine', *AIDS Education and Prevention*, 20(1), pp. 42–55.

Guba, E.C. (1990) 'The Alternative Paradigm Dialog'. In: Guba, E.C (ed.), *The Paradigm Dialog*. California, SAGE.

Halkitis PN, Parsons JT. (2002). Recreational drug use and HIV risk sexual behavior among men frequenting gay social venues. *Journal of Gay and Lesbian Social Services.* ;14:19–38.

Halkitis, PN., Kutnick, AH., Slater, S. (2005). The social realities of adherence to protease inhibitor regimens: substance use, health care and psychological states, *Journal of Health Psychology*, 10(4):545–58.

Halperin, D. and Epstein, H. (2004) 'Concurrent sexual partnerships help to explain Africa's high HIV prevalence: Implications for prevention', *Lancet* (London, England),. 9428(364).

Hausmann-Muela S, Muela Ribera J and Nyamongo I. (2003). Health-seeking behaviour and the health system's response. DCPWP Working Paper no. 14. Accessed on 31 December 2015 at: <http://www.dcp2.org/file/29/wp14.pdf>.

Hawe, P. and McLaren, L. (2005). 'Ecological perspectives in health research', *Journal of Epidemiology and Community Health*, 59(1), pp. 14–6.

Hayden BY, Platt ML. (2009). Gambling for Gatorade: risk-sensitive decision making for fluid rewards in humans. *Anim Cogn* 12:201–207

Hayes, RB., Turner, H., Coates, TJ. (1992). Social support, AIDS-related symptoms, and depression among gay men. *Journal of Consulting Clinical Psychology*, 60(3): 463-469.

*Health belief model* (2003) Available at: [https://www.utwente.nl/cw/theorieenoverzicht/Theory%20Clusters/Health%20Communication/Health\\_Belief\\_Model/](https://www.utwente.nl/cw/theorieenoverzicht/Theory%20Clusters/Health%20Communication/Health_Belief_Model/) (accessed 21 December 2015).

*Health care in South Africa*. (2010). Available at: <http://www.southafrica.info/about/health/health.htm> (accessed 21 December 2015).

Ivan Toms Centre For Men's Health (ITCMH).(2011) Available at: [http://www.health4men.co.za/clinics/03/25/woodstock\\_clinic/](http://www.health4men.co.za/clinics/03/25/woodstock_clinic/) (Accessed: 30 December 2015).

Herdt, GH. (1984). *Ritualized homosexuality in Melanesia*. Berkeley: University of California Press.

Heywood, M. (2002). From rhetoric to action – an evaluation of progress in relation to priority area 4: *human legal rights, HIV and AIDS National Plan*. Braamfontein: AIDS Law Project.

Hinsch, B. (1992). *Passions of the cut sleeve: The Male Homosexual Tradition in China*. New York: Routledge.

*HIV and AIDS in South Africa* (2014) Available at: <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa> (Accessed: 31 December 2015).

Holland, M. (2007). "Ex-Hiland Mountain prison guard charged with having sex with inmate". *Anchorage Daily News*. Archived from the original on 7 December 2008.

Holt, MK and Keyes, MA. (2004). Teachers' attitudes towards bullying. In: Espelage, DL and Swearer, SM (eds). *Bullying in American schools*. Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

*Homosexuality and mental health* (1973) Available at: [http://psc.dss.ucdavis.edu/rainbow/HTML/facts\\_mental\\_health.HTML](http://psc.dss.ucdavis.edu/rainbow/HTML/facts_mental_health.HTML) (accessed 21 December 2015).



Hulton LA, Matthews Z, Stones RW. (2000). A Framework for the Evaluation of Quality of Care in Maternity Services. University of Southampton, Southampton, United Kingdom.

Human Rights Council (2011) Available at: [http://www.iglhrc.org/sites/default/files/Report\\_UN\\_2011\\_Discriminatory-laws-and-practices-and-acts-of-violence-SOGI.pdf](http://www.iglhrc.org/sites/default/files/Report_UN_2011_Discriminatory-laws-and-practices-and-acts-of-violence-SOGI.pdf) (Accessed: 30 December 2015).

International Lesbian, gay, bisexual, Trans and Intersex association (2013) Available at: <http://ilga.org/> (Accessed: 21 March 2016).

Janz NK, Becker MH. (1984). *The Health Belief Model: A decade later. Health Education Quarterly*; 11(1):1–47.

Jewkes R, Dunkle K, Nduna M. (2006). Factors associated with HIV sero-positivity in young, rural South African men. *Int J Epidemiol*;35(6):1455–1460.

Jin, F., Crawford, J., Prestage, G., Zablotska, I., Imrie, J., Kippax, S., Kaldor, J. and Grulich, A. (2008). ‘Unprotected anal intercourse, risk reduction behaviours, and subsequent HIV infection in a cohort of homosexual men’, *AIDS (London, England)*., 2(23)., 23: 243–252.

Johnson, C.A. (2007) *Off the Map: How HIV/AIDS Programming is Failing Same Sex Practising People in Africa*. New York, USA: International Gay and Lesbian Human Rights Commission.

Joint United Nations Programme on HIV/AIDS and World Health. (2009). AIDS epidemic update.

Joint United Nations Programme on HIV/AIDS (UNAIDS) (2011)\_.[http://data.unaids.org/pub/report/2009/jc1720\\_action\\_framework\\_msm\\_en.pdf](http://data.unaids.org/pub/report/2009/jc1720_action_framework_msm_en.pdf). (accessed 24 March 2013).

Joppe, M. (2000). *The Research Process: Validity*. [Internet] Available at: <http://www.uoguelph.ca/htm/MJResearch/ResearchProcess/Validity.htm> (Accessed on 30/12/2015).

Jung, C.G.(1921) (1971). *Psychological Types* , Collected Works, Volume 6, Princeton, NJ: Princeton University Press.

Kaliyaperumal, I.E. (2004). Guideline for conducting a knowledge attitude and practice (KAP) study, Diabetic Retinopathy Project.

Kandel, DB. (1978) Homophily, selection and socialization in adolescent friendships. *American Journal of Sociology*; 84: 427–436.

Kaplowitz, MD. (2000). Statistical analysis of sensitive topics in group and individual interviews. *Quality and Quantity*, 34:419-431.

Kapp , C. (2007). South Africa unveils new 5-year HIV/AIDS plan. *The Lancet* ;369:1589-90.

- Kapp C. (2007). South African AIDS policy lurches into new crisis. *The Lancet*;370:727-8.
- Kedmey, D. (2014). Global youth population swells to record 1.8 Billion. Available at: <http://time.com/3591947/young-people-united-nations/> (Accessed: 30 December 2015).
- Kiguli, J., Ekirapa-Kiracho, E., Okui, O., Mutebi, A., MacGregor, H. and Pariyo, G. W. (2009) 'Increasing access to quality health care for the poor: Community perceptions on quality care in Uganda', 3.
- Kincaid, DL., Figueroa, ME., Storey, JD., Underwood, CR. (2007). A social ecology model of communication, behaviour change, and behaviour maintenance. Working paper. Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.
- Kinsler JJ, Wong MD, Sayles JN, Davis CE, Cunningham WE. (2007). The effect of perceived stigma from a health care provider on access to care among a low-income HIV-positive population. *AIDS Patient Care STDs*, 21:584–592.
- Kirby S, Chong J, Frances M, Powell Davies G, Perkins D, Zwar N, Harris M.(2008). Sharing or shuffling - realities of chronic disease care in general practice. *Australian Journal of Medicine*;189(2):77
- Klamecki, BJ. (1999). *Medical Perspective of the Homosexual Issue Medical Institute for Sexual Health, Health Implications Associated with Homosexuality, A Monograph*; 57.
- Klein, KJ., Tosi, H., and Cannella, A. (1999). Multilevel model building: Benefits, barriers, and new developments. *Academy of Management Review*, 24:243-248.
- Koblin, B., Chesney, M., Husnik, M., Bozeman, S., Celum, C., Buchbinder, S., Mayer, K., McKirnan, D., Judson, F., Huang, Y., Coates, T. and Study, E. (2003). 'High-risk behaviors among men who have sex with men in 6 US cities: Baseline data from the EXPLORE study', *American journal of public health.*, 6(93).
- Kombo, B., Gichuru, E., Omar, A., Musyoki, H., Graham, S. M., Smith, A. D., Sanders, E. J., Operario, D. and Elise M van der Elst (2015). 'The green shoots of a novel training programme: Progress and identified key actions to providing services to MSM at Kenyan health facilities', 18(1).
- Kong, TSK. (2008). Risk factors affecting condom use among male sex workers who serve men in China: a qualitative study, Department of Sociology, University of Hong Kong: China
- Krueger, R. A. (1988). Focus Groups: A Practical guide for applied research. London, Thousand Oaks: Sage Publications.
- Lamb, D (1982). *The Africans*. New York: Random House

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

Lane, T., Raymond, HF., Dladla, S., Rasethe, J., Struthers, H., McFarland, W., McIntyre, J. (2011). High HIV prevalence among men who have sex with men in Soweto, South Africa: results from the Soweto Men's Study. *AIDS Behaviour*, 15:626–634.

Laurino, M. (2011). *Health care sector unfriendly to gay men living with AIDS # 474*. Available at: <http://www.health-e.org.za/2011/05/23/health-care-sector-unfriendly-to-gay-men-living-with-aids-474/> (Accessed: 29 December 2015).

Le Grange, Z. (2010). The Influence of Gender Identity on Risk Behaviour : A Closer Look at Men Who Have Sex with Men in Africa. *HIV and AIDS in Africa*. January:1–4.

Leclerc-Madlala, S. (2005). *Masculinity and AIDS in Kwazulu-Natal: A Treatise*. University of Michigan Library: MPublishing.

Legman, G. (1966). *The Guilt of the Templars*. New York: Basic Books.

Lesbian, Gay, Bisexual and Transgender Health: (2000). Findings and Concerns, *Journal of the Gay and Lesbian Medical Association*, 4(3):120.

Lester, N., Menguele, F., Karuri-Sebina, G. and Kruger, M. (eds.). (2009). *Township Transformation Timeline*. COGTA. [Internet] Available at: <http://www.shisaka.co.za/documents/TownshipTransformationTLnarrative.pdf> (Accessed: 30 December 2015).

Lickel, B., Schmader, T. and Hamilton, D. L. (2003). 'A case of collective responsibility: Who else was to blame for the Columbine high school shootings?', *Personality and Social Psychology Bulletin*, 29(2), pp. 194–204.

Lindlof, T. R. (1995). 'Qualitative communication research methods'. London, Thousand Oaks: Sage Publications

Logan, C. (1996). 'Homophobia? No, homophobia', *Journal of homosexuality*, 3(31).

Longo, J., and Sherman, R.O. ( 2007). Leveling horizontal violence. *Nursing Management*, 38(3), 34- 37, 50, 51.

Louis, C (2003). *Homosexuality and Civilization*. Belknap Press.

Lynsen, J. (2015). "Barebacking persists despite risks: Some gay men decry HIV warnings as 'discriminatory,'" Available at: <http://www.washingtonblade.com/author/jlynsen/> (Accessed: 29 December 2015).

Manderson L and Aaby P. (1992): An epidemic in the field? Rapid assessment procedures and health research. *Social Science and Medicine* 35(7): 839-850.

- Mannava, P., Durrant, K., Fisher, J., Chersich, M. and Luchters, S. (2015). 'Attitudes and behaviours of maternal health care providers in interactions with patients: A systematic review', 11.
- Mansergh G, Marks G, Colfax GN, Guzman R, Rader M, Buchbinder S. (2002). 'Barebacking' in a diverse sample of men who have sex with men. *AIDS* (London, England);16:653–659.
- Mattson, C.L., Campbell, R.T., Bailey, R.C., Agot, K., Ndinya-Achola, J.O. and Moses, S. (2008). Risk Compensation Is Not Associated with Male Circumcision in Kisumu, Kenya: *A Multi-faceted Assessment of Men Enrolled in a Randomized Controlled Trial*. PLoS ONE, 3(6): e2443.
- Mattison A, Ross M, Wolfson T, Franklin D. (2001). Circuit party attendance, club drug use, and unsafe sex in gay men. *Journal of Substance Abuse*.;13:119–26.
- McCosker, H. (1995). Women's conceptions of domestic violence during the childbearing years. *Masters of Nursing thesis*. Brisbane, Queensland University of Technology: 139.
- McDonald, J., Jayasuriya, R. and Harris, M. F. (2012). 'The influence of power dynamics and trust on multidisciplinary collaboration: A qualitative case study of type 2 diabetes mellitus', 12.
- McIntyre, J (2011). Health care sector unfriendly to gay men living with AIDS. (online) Available at: <http://www.health-e.org.za/news/article.php?uid=20033156> [Accessed 24 March 2013].
- McKirnan, D., Stokes, J., Doll, L., and Burzette, R. (1995). Bisexually active men: social characteristics and sexual behavior. *Journal of Sex Research*; 32:65–76.
- McLeroy, KR., Bibeau, D., Steckler, A., Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. *Health Education Quarterly*, 15(4):351-377.
- Meeker, M., (2002). "High-Risk Sex," Epidemic: How Teen Sex is Killing Our Kids, Washington, DC: Regnery Publishing.
- Health4Men. (2014). Available at: <http://www.health4men.co.za/men-sex/> (accessed 21 December 2015).
- Metcalf, CA., De Swardt, G., Tallis, V., Jobson, G. (2009). Gap Analysis, HIV Programmes for Men Who Have Sex with Men (MSM). GFATM Round 9 Application.
- Metcalf, MJ., Rispel, L. (2009). Exposing a hidden epidemic among men who have sex with men, HSRC Review, 7(2) :1-28.
- Meyer, W., Costenbader, E. C., Zule, W. A., Otiashvili, D. and Kirtadze, I. (2010). "We are ordinary men": MSM identity categories in Tbilisi, Georgia', *Culture, Health and Sexuality*, 12(8), pp. 955–971.

Minichiello, V. and Browne, J. (1996). 'The social and work context of commercial sex between men: A research note', *Journal of Sociology*, 32(1), pp. 86–92.

Misago, C., Kendall, C., Freitas, P., Haneda, K., Silveira, D., Onuki, D., Mori, T., Sadamori, T. and Umenai, T. (2001). , "From 'culture of dehumanization of childbirth' to 'childbirth as a transformative experience': changes in five municipalities in north-east Brazil", *International Journal of Gynecology and Obstetrics*, vol. 75, no. Supplement 1, pp. S67-S72.

Morgan, D. (1993). *Successful Focus Groups: Advancing the State of the Art*. Newbury Park, London, New Delhi: SAGE Publications.

Morris M, Podhisita C, Wawer MJ, Handcock MS.(1996). *Bridge populations in the spread of HIV/AIDS in Thailand*. AIDS;10:1265–1271.

Murray, J. S. (2007). Creating ethical environments in nursing. *American Nurse Today*, 2(10), 48-49.

Murray, S. O., Mutongi, K., Anton, T., Whitehead, J. C. and Rimmerman, C. A. (2015). *Homosexualities*. Available at: <http://press.uchicago.edu/ucp/books/book/chicago/H/bo3643465.html> (Accessed: 29 December 2015).

Murray, W, Roscoe, S.(2012). *Boy-wives and Female-husbands*. Available at: <http://www.arcados.ch/wp-content/uploads/2012/06/Murray-Roscoe-Boy-Wives-Female-Husbands-98.pdf> (Accessed: 30 December 2015).

Mtikrakra, A. (2009) Available at: [http://146.230.128.141/jspui/bitstream/10413/103/1/Mtikrakra\\_A\\_2009](http://146.230.128.141/jspui/bitstream/10413/103/1/Mtikrakra_A_2009) (Accessed: 2 January 2016).

Nadel,SF. (1947). *The Nuba*, London: Oxford University Press.

Nakamura, N., Mausbach, B. T., Ulibarri, M. D., Semple, S. J. and Patterson, T. L. (2009) 'Methamphetamine use, attitudes about condoms, and sexual risk behavior among HIV-Positive men who have sex with men', 40(2).

National Association for Research and Therapy of Homosexuality (NARTH). (2005). "Two New Studies Describe Gay Barebacking, Circuit Parties and Spread of HIV." *The Journal of the International Association of Physicians In AIDS Care (JIAPAC)*, Vol. 4 (2) 2005. Available at <http://www.narth.com/> (accessed: 29 December 2015).

National Strategic Plan on HIV, STIs and TB 2011–2016. (2013) <http://www.doh.gov.za/docs/stratdocs/2012/NSPfull.pdf/>. (accessed 24 March 2013).

Ndulo J, Fixelid E, Tishelman C, Krantz I. (2000). "Shopping" for sexually transmitted disease treatment: focus group discussions among lay persons in rural and urban Zambia Sex; (9):496-503

Nel, D. (2009). Lessons learned from current South African HIV/AIDS research among lesbian, gay and bisexual populations. In: V. Reddy, T. Sandfort and L. Rispel (eds.) *From Social Silence to Social Science: Same-Sex Sexuality, HIV and AIDS and Gender in South Africa*. Cape Town: Human Sciences Research Council Press.

Ngo, DA., Ross, MW., Phan, H., Ratliff, E., Trinh, T, Sherburne, L. (2009). Male homosexual identities, relationships and practices among young MSM in Vietnam: *Implications for HIV prevention, AIDS Education and Prevention*, 21:251–65.

Niang C, Tapsoba P, Weiss E, Diagne M, Niang Y, Moreau AM. (2003). ‘It’s raining stones’: Stigma, violence and HIV vulnerability among men who have sex with men in Dakar, Senegal. *Culture, Health and Sexuality*. 2003;5:499–512.

Nichter M. (2008). Global health. *Why cultural perceptions, social representations, and biopolitics matter*. Tuscon: the University of Arizona Press.

Nuwaha F. (2006). *Determinants of choosing public or private health care among patients with sexually transmitted infections in Uganda Sex*; 33(7):422-7

Obrist, B., Iteba, N., Lengeler, C., Makemba, A., Mshana, C., Nathan, R., Alba, S., Dillip, A., Hetzel, M., Mayumana, I., Schulze, A. and Mshinda, H. (2007) ‘Access to health care in contexts of livelihood insecurity: A framework for analysis and action’, *PLoS medicine*., 10(4).

Olweus, D. (2001). Peer harassment: A critical analysis and some important questions. In J. Juvonen and S. Graham (Eds.), *Peer harassment in school: The plight of the vulnerable and victimized* (pp. 3–20). New York, NY: Guilford Press.

Online Library, W. P. (2015) Men who have sex with men | world public library - eBooks | read eBooks online. Available at: [http://www.worldlibrary.org/Article.aspx?Title=men\\_who\\_have\\_sex\\_with\\_men](http://www.worldlibrary.org/Article.aspx?Title=men_who_have_sex_with_men) (Accessed: 30 December 2015).

Ontario Consultants on Religious Tolerance (2005). "Islam and Homosexuality"

"Roman Catholics and Homosexuality" (2006).

Open Society Institute. (2004) *.Breaking Down Barriers: Lessons on Providing HIV Treatment to Injection Drug Users*

Orji, R., Vassileva, J., Mandryk, R.L. (2012). Towards an Effective Health Interventions Design: An Extension of the Health Belief Model. In *Online Journal of Public Health Informatics*, vol. 4 (3),

OUT. (2013). LGBT well-being - OUT clinic. Available at: <http://www.out.org.za/index.php/what-s-hot/services/56-out-clinic> (Accessed: 31 December 2015).

Parker, D., Stradling, S.G. and Manstead, A.S.R. (1996). Modifying beliefs and attitudes to exceeding the speed limit: an intervention study based on the Theory of Planned Behaviour. *Journal of Applied Social Psychology*, 26, 1–19

Parle, J. and Noble, V. (2014). ‘New directions and challenges in histories of health, healing and medicine in South Africa’, 58(2).

Parry, C., Peterson, P., Dewing, S., Carney, T., Needle, R., Kroeger, K. (2008). Rapid assessment of drug-related HIV risk among men who have sex with men in three South African cities, *Drug and Alcohol Dependency*, 1:45-53.

Pascoe EA, Smart -Richmond L. (2009). *Perceived discrimination and health: a meta-analytic review*. *Psychol Bull* ;135(4):531–554

Pateraki, L., and Houndoumadi, A. (2001). Bullying among primary school students in Athens, Greece. *Educational Psychology*, 21(2), 167-175.

*Patients and nurses: A powerful force.* (1964). Available at: [http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No1Jan07/tpc32\\_416093.html](http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No1Jan07/tpc32_416093.html) (accessed 21 December 2015).

Pellegrini, A. D., and Bartini, M. (2001). *Dominance in early adolescent boys: Affiliative and aggressive dimensions and possible functions*. *Merrill–Palmer Quarterly*, 47, 142–63.

Pellegrini, A. D; Long, J. D. (2004). Part of the solution and part of the problem: The role of peers in bullying, dominance, and victimization during the transition from primary school through secondary school. In Espelage, DL and Swearer, SM (Eds.), *Bullying in American schools* (pp. 107–117). Mahwah, NJ: Erlbaum.

Pettman, C. (1913). *Africanderisms; a glossary of South African colloquial words and phrases and of place and other names*. Longmans, Green and Co. p. 298.

Population Council. (2008). The overlooked epidemic: addressing HIV prevention and treatment among men who have sex with men in sub-Saharan Africa, report of a consultation, Nairobi, Kenya, 14–15 May 2008, Consultation report. Nairobi: Population Council.

Powell KE, Mercy JA, Crosby AE, Dahlberg LL, Simon TR. (1999). Public health models of violence and violence prevention. In: Kurtz LR, editors. *Encyclopedia of Violence, Peace, and Conflict*. Vol. 3. San Diego (CA): Academic Press;1999:175-87.

Prestage G, Jin F, Kippax S, Zablotska I, Imrie J, Grulich A. (2009). Use of illicit drugs and erectile dysfunction medications and subsequent HIV infection among gay men in Sydney, Australia. *Journal of Sexual Medicine*. 6:2311–2320. ,

Prestage, G. (2011). The Term ‘mSm ’ demeans us all. University of New South Wales: The Kirby Institute (formerly the National Centre in HIV Epidemiology and Clinical Research).

*Prison sexuality* (2015). in Wikipedia. Available at: [https://en.wikipedia.org/wiki/Prison\\_sexuality](https://en.wikipedia.org/wiki/Prison_sexuality) (accessed 21 December 2015).

Puri, J. (2002). Nationalism has a lot to do with it: Unraveling questions of nationalism and transnationalism in lesbian and gay studies. In S. Seidman and D. Richardson (Eds.), *Handbook on lesbian and gay studies* (pp. 429–442). London, United Kingdom: Sage.

Ragin, C.C. (1994) *Constructing Social Research: The Unity and Diversity of Method*. California, SAGE.

Rakesh Singh, Sharika Mahato. Depression, Human Right Abuses and Sexual Risk Behaviour among Men who Have Sex with Men in Nepal: A Cross-Sectional Study. *American Journal of Science and Technology*. Vol. 1, No. 5, 2014, pp. 229-237.

Ramello, S. (2013). Behind the Mask: A Typology of Men Cruising for Same-Sex Acts. *Identity* 13, 73-94.

Rebe, Brian, K., Swardt, D., Elizabeth, H. and Alisdair, J. (2014). Towards ‘men who have sex with men appropriate’ health services in South Africa. Available at: <http://www.sajhivmed.org.za/index.php/hivmed/article/view/78/120> (Accessed: 29 December 2015).

Rebe, KB., Struthers, H., De Swardt, G., McIntyre, JA. (2011). HIV Prevention and Treatment for South African Men Who Have Sex With Men, *South African Medical Journal*, 101:708-10.

Reddy, V., Sandfort, T. and Rispel, L.C. (2009). *From Social Silence to Social Science: Same Sex Sexuality, HIV and AIDS and Gender in South Africa*. Cape Town, South Africa: Human Sciences Research Council Press.

Republic of South Africa. Country progress report on the declaration of commitment on HIV/AIDS—2010 report. (Reporting period: Jan 2008–Dec 2009). Available at: [http://data.unaids.org/pub/report/2010/southafrica\\_2010\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/report/2010/southafrica_2010_country_progress_report_en.pdf). (accessed 24 March 2013).

Review of Health overspending and macro-assessment of public health system in South Africa. Available at: <http://www.health-e.org.za/uploaded/b84d2bf80d57112f177cd4057a762329.pdf> (Accessed 12 September 2013).

Riessman, C.K. (1993). Narrative Analysis. *Qualitative Research Methods Series*, No. 30. Newbury Park, CA: Sage.

Rispel, L. C., Metcalf, C. A., Cloete, A., Moorman, J. and Reddy, V. (2011). ‘You become afraid to tell them that you are gay: Health service utilization by men who have sex with men in south African cities’, *Journal of Public Health Policy*, pp. 137–151.

Rispel, LC., Metcalf, CA. (2009). *Breaking the silence: South African HIV policies and the needs of men who have sex with men*, *Reproductive Health Matters*, 17:133-42.



Rodkin, P. C., and Hodges, E. V. E. (2003). Bullies and victims in the peer ecology: Four questions for psychologists and school professionals. *School Psychology Review*, 32, 384-400.

Rosario, M., Schrimshaw, E., Hunter, J., and Braun, L. (2006). Sexual identity development among lesbian, gay, and bisexual youths: Consistency and change over time. *Journal of Sex Research*, 43(1), 46–58.

Rosenstock, I.M. (1966) Why people use health services. *Milbank Memorial Fund Quarterly*, 44: 94-124.

Rousseau, D.M. and House, R.J.(1994). Meso organisational behavior: Avoiding three fundamental biases. *Journal of Organisational Behavior* (1986-1998), p.13.

Rutter, D. and Quine, L. (2002). *Changing Health Behaviour: Intervention and Research with Social Cognition Models*. Milton Keynes: Open University Press.

SafAIDS (2013). Available at: [http://saf aids.net/files/Gay Men\\_Booklet.pdf](http://saf aids.net/files/Gay_Men_Booklet.pdf) (Accessed: 30 December 2015).

Sallis, J.F. and Owen, N. (1997). Ecological models. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds.). *Health behavior and health education: Theory, research, and practice* (pp. 403-424). San Francisco: Jossey-Bass

Salmivalli, C., and Voeten, M. (2004). Connections between attitudes, group norms, and behaviour in bullying situations. *International Journal of Behavioral Development*, 28, 246–258.

Sandfort, TGM., Nel, J., Rich, E., Reddy, V., Yi, H. (2011) HIV testing and self-reported HIV status in South African MSM: results from a community-based survey. *Sexually Transmitted Infections*, 84 (6):425–9..

Sayles, JN, Ryan, GW, Silver, JS, Sarkisian ,CA, Cunningham, WE. (2007). Experiences of social stigma and implications for healthcare among a diverse population of HIV positive adults. *J. Urban Health* ;84:814–828.

Schoeps, A., Gabrysch, S, Niamba, L, Sie,A, Becher, H, . (2011). The effect of distance to health-care facilities on childhood mortality in rural Burkina Faso. *American Journal of Epidemiology*, 173(5):492-8.

Schwarzer, R. (1992). Self-efficacy in the adoption and maintenance of health behaviours: theoretical approaches and a new model, in R. Schwartz (ed.), *Self-efficacy: Thought Control of Action*. Washington, DC: Hemisphere.

Schwarzer, R. and Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, and M. Johnston, *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp. 35-37). Windsor, UK: NFER-NELSON.

Semple SJ, Strathdee SA, Zians J, Patterson TL. (2012). Factors associated with experiences of stigma in a sample of HIV-positive, methamphetamine-using men who have sex with men. *Drug Alcohol Depend.* 125:154–159.

Senior, K. (2010). HIV, human rights, and men who have sex with men, *The Lancet Infectious Diseases*, 10 (7):448–9.

Sepkowitz, KA. (2001). *AIDS—the first 20 years*, *Sexualities* 9: 131–51. Available at: <http://www.desmondtutuhivfoundation.org.za/documents/Key-Populations-Key-Solutions-report.pdf> (accessed 21 December 2015).

Shafran, A. Jewish Law. (2012). Jewish Law Commentary: *Examining Halacha, Jewish Issues, and Secular Law*.

Shefer T, Strebel A, Wilson T, Shabalala N, Simbayi L, Ratele K. (2002). The social construction of sexually transmitted infections (STIs) in South African communities *Qual Health Res*; (10):1373-90

Shisana, O., Rehle, T., Simbayi, LC. (2009). *South African national HIV prevalence, incidence, behaviour and communication survey 2008: a turning tide among teenagers?*. Cape Town: HSRC

Singh, R., and Mangat, N.S. (1996). *Elements of Survey Sampling*. Netherlands, Kluwer Publishers.

Smith, A. D., Gichuru, E., Wahome, E., Musyoki, H., Muraguri, N., Fegan, G., Duby, Z., Bekker, L.-G., Bender, B., Graham, S. M., Operario, D. and Sanders, E. J. (2013). *Men who have sex with men sensitivity training reduces homophobia and increases knowledge among Kenyan healthcare providers in coastal Kenya*. Available at: <http://www.jiasociety.org/index.php/jias/article/view/18748> (Accessed: 30 December 2015).

South African National AIDS Council (SANAC). 2011. *End of term review of the NSP 2007–2011—final report*, 4 November, 2011. [http://www.sanacws.org.za/.../4ec9ee5e49213-review-of-nsp-2007-2011-final\(1\).pdf](http://www.sanacws.org.za/.../4ec9ee5e49213-review-of-nsp-2007-2011-final(1).pdf) . (accessed 24 March 2013).

South African History Conference. Rondebosch, Cape Town. October 2002.

South African Nursing Council (SANC) regulations. (2005). *Acts or omissions*. Available at: <http://www.sanc.co.za/regulat/Reg-act.htm> (accessed 21 December 2015).

Sprague, C., Chersich, M. F. and Black, V. (2011). *‘Health system weaknesses constrain access to PMTCT and maternal HIV services in South Africa: A qualitative enquiry’*, 8.

Smith, G. D. (2016). *Posts about MSM on from eternity to here*. Available at: <http://dgsmith.org/tag/msm/> (Accessed: 5 January 2016).

Stall, RD, Purcell ,DW. (2000). Intertwining epidemics: A review of research on substance use among men who have sex with men and its connection to the AIDS epidemic. *AIDS and Behavior*.;42:181–192.

Statistics South Africa, Statistical release (P0302). (2010) Mid-year population estimates. <http://www.statssa.gov.za/publications/P0302/P03022010.pdf> (accessed 24 March 2013).

Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion, *American Journal of Health Promotion*, 10(4):282–98.

Storr, W (17 July 2011). "The rape of men". *The Observer* ([Guardian.co.uk](http://www.guardian.co.uk)). Retrieved 17 March 2013.

Storey, D. & Figueroa, M.E. (2012) 'Toward a Global Theory of Health Behavior and Social Change'. In: Obregon, R. & Waisbord, S. (eds.), *The Handbook of Global Health Communication*. Hoboken, NJ, USA, Wiley-Blackwell.

Strauss, L. (1997). "Homosexuality: The Christian Perspective,". Available at: <http://www.bible.org/docs/splife/chhome/homo.htm> (accessed 29 December 2015)

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strengthening the cascade: Current work and new ideas on the cascade of care for HIV, TB, and HCV - A Boston university research workshop (2014). Available at: <http://www.bu.edu/cghd/our-work/projects/assessing-and-identifying-hiv-transmission-in-most-at-risk-populations-in-ghana/> (accessed 21 December 2015).

Swearer, S. M and Espelage, D. L. (2004). A social-ecological framework of bullying among youth. In D. L. Espelage and S. M. Swearer (Eds.), *Bullying in American schools: A social-ecological perspective on prevention and intervention* (pp. 1–12). Mahwah, NJ: Erlbaum.

Swearer, S. M., Espelage, D. L., Koenig, B., Berry, B., Collins, A., and Lembeck, P. (2012). *A social-ecological model of bullying prevention and intervention in early adolescence*. In S. R. Jimerson, A. B. Nickerson, M. J. Mayer, and M. J. Furlong (Eds.), *Handbook of school violence and school safety* (pp. 333–355). New York, NY: Routledge.

Swearer, S.M., Doll, B. (2001) Bullying in schools: An ecological framework. *Journal of Emotional Abuse*, 2:7-23.

Teitelman, A. M., Ratcliffe, S. J. and Cederbaum, J. A. (2011). 'Parent–Adolescent communication about sexual pressure, maternal norms about relationship power, and STI/HIV protective behaviors of minority urban girls', 14(1).

Ten Things Gay Men Should Discuss With Their Health Care Providers, *Journal of the Gay and Lesbian Medical Association* at [www.glma.org](http://www.glma.org) (accessed 24 March 2013).

Thang, N. M., Huong, V. T., and Blanc, M. E. (2002). Sexual Behaviour Related to HIV/AIDS: Commercial Sex and Condom Use in Hanoi, Viet Nam. *Asia-Pacific Population Journal*, 17(3), 41-52.

The Aurum Institute .(2009). Report on an initiative to recruit Men Who Have Sex with Men (MSM) at the Rustenburg Research Centre. The Aurum Institute: Johannesburg.

The Church of Jesus-Christ of Latter-day Saints. (2007). "Teaching about Procreation and Chastity: Homosexuality" . *Home and Family*.

The global fund strategy in relation to sexual orientation and gender identities. (2009). In: Proceedings of the 19th board meeting of the global fund to fight AIDS, TB, and Malaria (Geneva). 5–6 May 2012).

The Global Men's Health Forum on MSM and HIV. (2012). *HIV Prevention with MSM. Balancing Evidence with Right-based Principles of Practice*. A Policy Brief: Oakland

The Mailman School of Public Health. (2013). MSM Health Programme 2011 – 2016.

*The Reporter*, S. (2012). Zwelithini: Gays are 'rotten'. Available at: <http://mg.co.za/article/2012-01-23-zwelithini-gays-are-rotten/> (Accessed: 30 December 2015).

The United Nations High Commissioner for Human Rights. (2011). Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity. Office of the High Commissioner: New York.

Tidy, C. (2015). *History taking. Information about history taking*. Available at: <http://patient.info/doctor/history-taking> (Accessed: 30 December 2015).

U.S. Agency for International Development. (2010). 'Young People Most at Risk of HIV': A Meeting Report and Discussion Paper from the Interagency Youth Working Group

UNAIDS. (2005). *Men who have sex with men, HIV prevention and care*. Report of a UNAIDS stakeholder consultation. Available at: [http://data.unaids.org/pub/Report/2006/JC1233-MSM-MeetingReport\\_en.pdf](http://data.unaids.org/pub/Report/2006/JC1233-MSM-MeetingReport_en.pdf) (Accessed: 30 December 2015).

UNAIDS.(2006). *HIV and Sex Between Men*. Policy Brief. Geneva: UNAIDS.

UNAIDS. (2007). *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes*. Geneva: Joint United Nations Programme on HIV/AIDS.

UNAIDS. (2009). *AIDS epidemic update*: Geneva

UNAIDS. (2011). United Nations general assembly to address sexual orientation and gender identity - Statement affirms promise of Universal Declaration of Human Rights (Press release 12 December 2008). (Accessed 31 March 2013).

UNAIDS. (2012). *Morocco launches new national AIDS strategy*. <http://www.unaids.org/en/resources/presscentre/featurestories/2012/april/20120404morocco/>. (accessed 24 March 2013).

UNFPA State of world population. (2015). Available at: <http://www.unfpa.org/swop> (Accessed: 30 December 2015).

United States Department of Health and Human Services, (1996)

Van de Ven, A, Walker, G. (1984). *The dynamics of interorganisational coordination*. *Adm Sci Q*. 1984;29(4):598–621.

Van Rensburg, H. C. J. and Benatar, S. R. (1993) ‘The legacy of apartheid in health and health care’, *South African Journal of Sociology*, 24(4), pp. 99–111.

Variable, PA, Carey ,MP, Blair, DC, Littlewood ,RA. (2006). *Impact of HIV-related stigma on health behaviors and psychological adjustment among HIV-positive men and women*. *AIDS Behav* ;10:473–482.

Vance, CS. (1982). *Pleasure and Danger: Toward a Politics of Sexuality*. In *Pleasure and Danger: Exploring Female Sexuality*. Carole S. Vance, ed. Pp.1-27. Boston: Routledge and Kegan Paul.

Varjas, K., Henrich, C.C. and Meyers, J. (2009). Urban Middle School Students' Perceptions of Bullying, Cyberbullying, and School Safety. *Journal of School Violence*, 8(2), 159-176.

Walker, L (1979). *The battered woman*. New York: Harper and Row.

Weeks, J. (1981). *Sex, Politics, and Society: The Regulation of Sexuality Since 1800*. London: Longman.

Whitaker, D.J., and Miller, K.S. (2000). Parent-adolescent discussions about sex and condoms: Impact on peer influences of sexual risk behavior. *Journal of Adolescent Research*, 15, pp. 251-273.

WHO. (1980). “WHO Indicators for Monitoring Progress Towards Health for All: Discussion Paper, Geneva March 17, 1980,” HPC/MPP/DPE/80.2, WHO Library, Geneva.

WHO (2011). *Health systems strengthening glossary*. Available at: [http://www.who.int/healthsystems/hss\\_glossary/en/index8.html](http://www.who.int/healthsystems/hss_glossary/en/index8.html) (Accessed: 30 December 2015).

WHO. (2011). 'Prevention and Treatment of HIV and Other Sexually Transmitted Infections Among Men Who Have Sex With Men and Transgender People

WHO, UNICEF, UNAIDS. (2006). *Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted infections*

Wilson D, Fairall L. (2005). Challenges in managing AIDS in South Africa in HIV/AIDS in South Africa (Ed. Abdool Karim SS, Abdool Karim Q). Cambridge University Press, Cape Town.

Wisker, G. (2001). The Postgraduate Research Handbook: *Succeed with your MA, Mphil, EdD and PhD*. New York: Palgrave.

Wouters, E., van Rensburg, H., Meulemans, H. and 1, E. W. (2010). 'The national strategic plan of South Africa: What are the prospects of success after the repeated failure of previous AIDS policy?', *Health Policy and Planning*, 25(3), pp. 171–185.

Wright, KB. (2005). Researching internet-based populations: Advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services, *Journal of Computer-Mediated Communication*, 10:3 - 15)

Yach D, Tollman SM. (1993). *Public health initiatives in South Africa in the 1940s and 1950s: lessons for a post-apartheid era*. *Am J Public Health*. 1993;83(7):1045.

Young, R. M. and Meyer, I. H. (2005). 'The trouble with "MSM" and "WSW": Erasure of the sexual-minority person in public health discourse', 95(7).

Zimmerman, B. and Haggerty, G. (1999). *Encyclopedia of Lesbian and Gay Histories and cultures*. Available at: <http://www.amazon.com/Encyclopedia-Lesbian-Gay-Histories-Cultures/dp/0815340559> (Accessed: 29 December 2015).

Zulu, E.M., Dodoo, F.N., and Chika-Ezeh, A. (2002). Sexual risk-taking in the slums of Nairobi, Kenya, 1993-1998. *Population Studies: A Journal of Demography*, 56(3), pp. 311-323.

## **Appendix 1: Information sheet and consent form**

### **Assessing knowledge, attitudes and practices , practices and prevailing attitudes of KwaZulu-Natal health professionals towards men who have sex with men (MSM): exploring access to mainstream public health care services**

#### **Who I am and what I'm doing**

Hello, my name is Precious Greehy. I am a Masters student at the UKZN. I am working on a study titled: Assessing knowledge, attitudes and practices , practices and prevailing attitudes of KwaZulu-Natal health professionals towards men who have sex with men (MSM): exploring access to mainstream public health care services I am trying to find out more about knowledge and attitudes towards men who have sex with men in your work environment.

#### **Your participation**

I am asking you whether you will allow me to conduct one interview with you about your knowledge and opinions on this group. If you agree, I will ask you to participate in one interview for less than an hour. I am also asking you to give me permission to tape record the interview. I usually tape record interviews so that I can accurately record what is said.

Please understand that **your participation is voluntary** and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to go on. If you do this there will also be no penalties and you will not be prejudiced in any way.

#### **Confidentiality**

Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the ethics committee at the University of KwaZulu-Natal. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to me since I am working on the study, unless you give permission for other people to see the records.

The information you provide will not be published in such a manner that you are identified as having provided the information. All identifying information will be kept in storage at my home for a period of 5 years and subsequently destroyed. Access to this information will be granted only if I was requested to by the University's ethics committee or other researchers. However, when this information is passed on it shall be done such that you cannot be identified as having provided the information to use. If a need for disclosing your identity arises you shall be contacted by me and it shall only be done with your expressed written approval.

In any publications I will refer to you by a code number or pseudonym (another name).

#### **Risks/discomforts**

At the present time, I do not see any risks in your participation. The risks associated with participation in this study are no greater than those encountered in daily life.

#### **Benefits**

There are no immediate benefits to you for participating in this study. However, this study will be extremely helpful in developing ways to deal with societal differences and attitudes towards men who have sex with men.

If you would like to receive feedback on my study, I will record your phone number and/or e-mail address on a separate sheet of paper and can send you the results of the first wave of this study when it is completed sometime in 2014.

### **Who to contact if you have been harmed or have any concerns**

This research has been approved by the UKZN's Research Ethics Committee. If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please call the UKZN's ethics hotline.... (Tollfree when phoned from a landline from within South Africa).

If you have concerns or questions about the research you may call me on (031) 261 3296 or 060 910 9240 or Dr Lauren Dyll-Myklebust, (CCMS, UKZN), 031 2601813, email address: [dyll@ukzn.ac.za](mailto:dyll@ukzn.ac.za).

### **CONSENT**

Assessing knowledge, practices and prevailing attitudes of KwaZulu-Natal health professionals towards men who have sex with men (MSM): exploring access to mainstream public health care services. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.

I understand that my participation will remain confidential.

.....  
**Signature of participant**

**Date:**.....

In signing above I hereby agree to be interviewed and for notes to be written during the interview should the need arise.

In further signing below I hereby agree to the tape-recording of my participation in the study **(Please note that if you do not agree to the tape-recording of the interview you must not sign below.** You will still participate if we have your permission to write notes).



.....  
**Signature of participant**

**Date:**.....

.....  
**Signature of investigator**

**Date:**.....

## **Appendix 2: Interview questionnaire**

**This questionnaire addresses your knowledge around various health issues.**

1. It has been argued that HIV prevalence among MSM is disproportionately higher than among other men in South Africa, what are your views around this?
2. Does discrimination and stigma towards MSM prevent them from accessing health services?
3. What are your views on anal sex?
4. What is the likelihood of HIV transmission from anal sex? Is it higher than from vaginal sex?
5. Can you name a few principles which guide the health care profession in South Africa?
6. What are your views regarding the National Strategic Plan for HIV and AIDS (2012 - 2016) inclusion of MSM as a population group requiring focused HIV prevention, treatment and care services?
7. In your workplace, how do other clinicians act as role models in the provision of inclusive health services?

**This section addresses personal attitudes towards MSM**

**I will say the following sentences and you will complete these after me. Please explain your statement in detail.**

**1. When a man prefers having sex with another man...**

- ☐ it makes me feel uncomfortable, I don't understand men who behave like that
- ☐ it does not bother me, people are different and therefore free to have sex with who they wish
- ☐ I avoid these people and these issues, I do not want to be bothered
- ☐ It makes me angry and aggressive, I do not like it when men do that
- ☐ I will do what is needed (e.g. beat him) to like a man should other \_\_\_\_\_

**2 I believe that MSM...**

- ☐ are confused because God made two sexes and two sexes only
  - ☐ can be cured
  - ☐ are just seeking attention
  - ☐ are born this way and are not to blame for being different
  - ☐ are none of my concern; I have no interest in these issues
  - ☐ are a nuisance to society, they should all just live together somewhere else
  - ☐ We are all equal despite our differences
- Other \_\_\_\_\_

**3 If a child displays an inclination toward items and behaviours attributed to the opposite sex, parents should...**

- ☐ insist that they dress and play with toys appropriate to their own sex
- ☐ be encouraged to explore (e.g. with toys or clothes) their maleness and/or femaleness as they wish
- ☐ I am not concerned with these issues
- ☐ not pay attention to it, if they ignore it, they will lose interest. It is just attention seeking.
- ☐ seek professional advice in order to support the child in the most appropriate manner

other \_\_\_\_\_

**4 If I found out that my patient has sex with other men, I would...**

- ☐ distance myself from them, I do not want to be associated with someone like that
  - ☐ protest and convince them to come to their senses
  - ☐ privately encourage them to seek counselling and advice to be absolutely sure, they are probably just confused
  - ☐ not respond, I do not want to know.
  - ☐ freak out, I would be completely helpless. I don't know of any places or resources that could possibly help them
  - ☐ tell them to do what they want with their life, it's theirs not mine.
- other \_\_\_\_\_

**5 If I found out that someone in my family (male partner, sibling, child, etc.) wanted to have sex with other men, I would...**

- ☐ disown them, I do not want to be associated with someone like that
  - ☐ give them a good beating to set them straight
  - ☐ privately encourage them to seek counselling and advice to be absolutely sure, they are probably just confused
  - ☐ not respond, I do not want to know.
  - ☐ freak out, I would be completely helpless. I don't know of any places or resources that could possibly help them
  - ☐ tell them to do what they want with their life, it's theirs not mine.
- other \_\_\_\_\_

**6 If I a fellow nurse calls me to discuss an MSM patient , I would...**

- ☐ advise them to respect the patient's privacy
  - ☐ Come and give the patient a good talking to, to set them straight
  - ☐ privately encourage the patient to seek counselling and advice to be absolutely sure, they are probably just confused
  - ☐ not respond, I do not want to be associated with men who have sex with other men.
  - ☐ freak out, I would be completely helpless. I don't know of any places or resources that could possibly help them
- other \_\_\_\_\_

**7 Overall I think men having sex with other men is...**

- ☐ morally wrong/a sin
  - ☐ okay if it helps an individual to live a life that corresponds to how they feel
  - ☐ okay if they don't sleep with women as well
  - ☐ not okay under any circumstances, it is against the laws of nature
  - ☐ only okay for adults; but not okay for minors something that does not bother me, I am not concerned
- other \_\_\_\_\_

**This section addresses your professional practice/ exposure to MSM**

1. In your understanding, what is the difference between gay or MSM?
2. The use of a non-judgemental approach to history taking can give patients the opportunity to discuss delicate issues with health care providers. What are your own experiences around this?

3. Have you ever asked a patient to disclose the sex of their partners, or the type of sex they have? Why?
4. If a male patient reports having male partners, do you also ask about anal and genital symptoms?
5. In your understanding what is an anogenital exam? When is this performed?
6. What may cause an anal discharge and bleeding in a male patient?
7. What are the uses of an anoscope?

**Thank you for your participation!**

### Appendix 3: Gatekeeper permission - Provincial health



health

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component  
10 – 103 Natalia Building, 330 Langalibalele Street  
Private Bag x9051  
Pietermaritzburg  
3200  
Tel: 033 – 3953159  
Fax: 033 – 394 3752  
Email: [hkrkm@kznhealth.gov.za](mailto:hkrkm@kznhealth.gov.za)  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

Reference : HRKM 114/15  
NHRD: KZ\_2015RP39\_175  
Enquiries : Mr X Xaba  
Tel : 033 – 395 2805

Dear Ms P.S. Greehy

**Subject: Approval of a Research Proposal**

1. The research proposal titled 'Assessing knowledge, attitudes and practices of KwaZulu-Natal health professionals towards men who have sex with men (MSM): exploring access to mainstream public health care services' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at King Edward and Imbalen'le CHC.

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified facility before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to [hkrkm@kznhealth.gov.za](mailto:hkrkm@kznhealth.gov.za)

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

**Dr E Lutge**

Chair person, Health Research Committee

Date: 28/11/15

uMnyanga Wavumini - Departement van Gesondheid

*Fighting Disease. Fighting Poverty. Giving Hope*

## Appendix 4: Gatekeeper permission – District health



health

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

UMGUNGUNDLOVU HEALTH DISTRICT OFFICE  
OFFICE OF THE DISTRICT MANAGER  
Private Bag X3124, Pietermaritzburg,  
3200  
Brasfort House, 282 Langalibalele Street,  
Pietermaritzburg, 3201  
Tel.: 033-8971000  
Fax: 033-887 1078  
Email: thule.kunene@kznhealth.gov.za  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

Enquiries: Mrs. N.M. Zuma - Mkhonza

Ref No: 15/16

Date: 22 MAY 2014

TO: MS P. S GREEHY  
P.O BOX 50582  
MUSGRAVE Road  
4062

Dear, Ms P: S Greehy

**RE: ASSESSING KNOWLEDGE, ATTITUDES AND PRACTICES OF KWAZULU-NATAL HEALTH PROFESSIONALS TOWARDS MEN WHO HAVE SEX WITH MEN (MSM): EXPLORING ACCESS TO MAINSTREAM PUBLIC HEALTH CARE SERVICES**

I have the pleasure in informing you that permission has been granted to you by the District to conduct research on: *Assessing knowledge, attitudes and practices of KwaZulu-Natal health professionals towards men who have sex with men (MSM): exploring access to mainstream public health care services*

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Office Committee in the Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office / Facility will not provide any financial resources for this research.
5. You will be expected to provide feedback on your findings to the District Office/Facility.

Thank you

MRS N.M. ZUMA - MKHONZA  
THE DISTRICT MANAGER  
UMGUNGUNDLOVU HEALTH DISTRICT

## Appendix 5: UKZN ethical committee letter



health

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component  
10 – 102 Natalia Building, 330 Langalibalele Street  
Private Bag x9051  
Pietermaritzburg  
3200  
Tel: 033 – 3953158  
Fax: 033 – 394 3752  
Email: [hkrkm@kznhealth.gov.za](mailto:hkrkm@kznhealth.gov.za)  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

Reference : HRKM 114/15  
NHRD: KZ\_2015RP39\_175  
Enquiries : Mr X Xaba  
Tel : 033 – 395 2805

Dear Ms P.S. Greehy

**Subject: Approval of a Research Proposal**


1. The research proposal titled 'Assessing knowledge, attitudes and practices of KwaZulu-Natal health professionals towards men who have sex with men (MSM): exploring access to mainstream public health care services' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at King Edward and Imbalen'le GHC.

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified facility before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to [hkrkm@kznhealth.gov.za](mailto:hkrkm@kznhealth.gov.za)

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely



**Dr E Lutge**

Chair person, Health Research Committee

Date: 28/07/15

uMnyango Wazomnin' - Departement van Gesondheid

*Fighting Disease. Fighting Poverty. Giving Hope*