

THE FIGHT AGAINST HIV/AIDS IN SOUTH AFRICA: THE PERCEPTIONS OF MEN WHO HAVE SEX WITH MEN ABOUT HIV/AIDS-RELATED HEALTHCARE POLICIES, SERVICES, AND INTERVENTIONS TARGETING THEM

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A minor dissertation submitted in partial fulfillment of the requirements for the award of the degree of Master of Social Science in Social Development



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COMPULSORY DECLARATION

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THE FIGHT AGAINST HIV/AIDS IN SOUTH AFRICA: THE PERCEPTIONS OF MEN WHO HAVE SEX WITH MEN ABOUT HIV/AIDS-RELATED HEALTHCARE POLICIES, SERVICES, AND INTERVENTIONS TARGETING THEM

ABSTRACT

Men who have sex with men (MSM) and transgender people shoulder disproportionate levels of marginalisation, poor health access and HIV-disease in nearly every nation where reliable data is available. Much of what is known about medical and civil society-based research in South Africa on HIV/AIDS has mainly been on heterosexual or vertical transmission. Comparatively little is known about HIV and MSM despite MSM in Africa being three times more likely (Abdool Karim & Abdool Karim, 2005) to be HIV-infected than the general population (Lane, et al, 2009). In South Africa, strategies to address HIV/AIDS among MSM were included for the very first time in the 2007-2011 National HIV/AIDS Strategic Plan pointing; to the extent to which MSM have been excluded from both national policy and intervention strategies. Using a qualitative approach, this study aimed to explore the perceptions of MSM about HIV/AIDS-related healthcare policies, services and interventions targeting them. Semi-structured interviews were conducted with MSM and key informants about HIV/AIDS responses targeted at MSM in South Africa. Findings show that MSM are generally unaware about specific HIV/AIDS-related healthcare policies addressing their needs. Although the majority of MSM are aware of where to access HIV counseling, testing and treatment services, however discrimination, harassment and insensitivity particularly in public health-care settings impaired client or patient rapport, thereby creating barriers to meaningful access and utilization of HIV-related services thereby marginalizing MSM from the health systems altogether. Stigma, discrimination and perceived homophobia against MSM still persist in the mainstream society and within healthcare systems. Some healthcare workers are reportedly biased towards MSM if their cultural, moral or religious beliefs about sexuality are in contrast to the patient's sexual orientation, behaviour and gender identity. The local, national and regional responses to HIV/AIDS for MSM are still substantially insufficient in South Africa. The clinical curriculum, particularly in mainstream public healthcare facilities has done little to address known knowledge gaps pertaining to MSM. This study recommends the effective monitoring and evaluation of national strategies to address HIV/AIDS among MSM in South Africa.

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CHAPTER ONE

Introduction

This chapter introduces the study and the background, as well as the study's rationale and its significance will be thoroughly discussed in this chapter. The research questions, objectives, concept clarification, ethical concerns and reflexivity are also included. The chapter will conclude with a brief chapter outline of the entire report.

1.0. Background and Context

Recent estimates suggest that nearly 33 million people are infected with HIV/AIDS worldwide (UNAIDS, 2011) with an estimated 5–10% of HIV infections resulting from Men who have Sex with Men (MSM) (UNAIDS, 2011). This figure however varies considerably between countries and regions. In developed countries such as the United States, since 1977, MSM have had an HIV prevalence (the total number of cases of a disease that are present in a population at a specific point in time) 60 times higher than the general population (UNAIDS, 2011). Determining the number of men who have ever had sex with another man is difficult. However, worldwide, at least 3% of men, and maybe as high as 16% of men, have had sex at least once with a man (The International HIV Alliance, 2003). These figures also include victims of sexual abuse in addition to men who regularly or voluntarily have sex with men. MSM have also an increased incidence and prevalence of Sexually Transmitted Infections (STIs) including gonorrhea, herpes virus and syphilis, with these being shown to increase susceptibility to HIV infection in women (The International HIV Alliance, 2003).

South Africa currently has the largest number of people living with Human Immunodeficiency Virus (HIV) in the world (UNAIDS, 2010). In the early to mid-90s, the epidemic in this country was below 10% but a huge increase in HIV cases was recorded in the early 2000s (UNAIDS, 2010). It is estimated that 5.7 million South Africans lived with HIV in 2010 (representing about 10% of the South African population) and an estimated 1.8 million people have died of Acquired Immunodeficiency Syndrome (AIDS)-related disease since the epidemic began (UNAIDS, 2010). In South Africa, HIV is disproportionately associated with lower-income areas with 29%

of people living with HIV residing in urban informal settlements despite only 9% of the South African population aged 2 years and older living in these areas (UNAIDS, 2010).

Much of what we know about medical and civil society-based research in South Africa on HIV/AIDS has been mainly done on heterosexual or vertical transmission (Abdool Karim & Abdool Karim, 2005). Comparatively little is known about HIV among men who have sex with men (MSM) despite reports showing that MSM in Africa, including South Africa are three times more likely (Abdool Karim & Abdool Karim, 2005) to be HIV infected than the general population (Lane, T., Raymond, H. F., Dladla, S., Rasetha, J., Struthers, H., McFarland, W., and McIntyre J., 2009). The issue of MSM was included for the first time in the National HIV/AIDS Strategic Plan 2007-2011 and this gets to show the extent to which MSM have been excluded from both policy and intervention strategies in South Africa. However, taking into consideration the new National Strategic Plan for HIV and AIDS, STIs and TB, 2012-2016, there has been a significant recognition for MSM and the need to have targeted interventions in addition general interventions for prevention, care and treatment (SANAC, 2012). While South Africa currently has the most liberal constitution as far as homosexuality is concerned, the country's social norms form a sharp contrast with its liberal constitution; the level of acceptance of homosexuality in South Africa is reported to be very low (Sandfort, Nel, Rich, Reddy, & Yi, 2008).

Thus, in recognition that MSM may also simultaneously be involved in heterosexual relationships (Lane, et al., 2009; Cloete, Simbayi, Kalichman, Strebel and Henda, 2008), it is of paramount importance that this issue be adequately addressed. Known barriers have been reported to be that the lack of knowledge about HIV testing practices and HIV prevalence in South African MSM. It is thus reported that without an understanding of the extent to which MSM are affected, their treatment needs and the role of homosexual transmission in the overall HIV/AIDS epidemic in South Africa, it is difficult to argue for resources for MSM-targeted prevention and care (Sandfort, Nel, Rich, Reddy, & Yi, 2008). The absence of data about the prevalence is further paralleled by a lack of understanding of the cultural, structural, interpersonal and individual factors that affect protective practices in same-sex sexual activities (Sandfort, Reddy, & Rispel, 2009).

In many countries, including South Africa, laws, policies, discriminatory practices, and stigmatising social attitudes drive MSM underground, impeding efforts to reach MSM with HIV prevention, treatment, care and support programmes. Stigma and discrimination must be effectively addressed; violence and abuse of sex workers including MSM must be reduced; and legal barriers to participation should be revised. Achieving the changes in social and legal conditions that limit access to HIV services will take time, but it is critical to implement needed legal and policy reforms soon. It is thus the focus of this study to investigate the perceptions of MSM about the existence and efficiency of policies and interventions put in place to date in South Africa to deal with HIV/AIDS in MSM. Furthermore, some of the challenges that this group of people is faced with will also be investigated.

1.1. Rationale and Significance of the Study

HIV disproportionately affects MSM communities around the globe and in South Africa (Ripley & Lauer, 2011:3; Lane et al., 2009 and Rispel, Metcalf, Cloete, Reddy, & Lombard, 2011). However, eradicating homosexuality is neither feasible nor an appropriate goal for public health programmes. Effective approaches to HIV prevention in the context of MSM are those that recognise the realities of MSM and enable MSM to protect themselves from the risk of HIV transmission. One of the key aspects of this study is to empower MSM with the knowledge and information they need to protect themselves as well as freely seeking treatment of HIV/AIDS without the stigma of feeling different or ashamed.

In South Africa from the time that a generalised HIV epidemic emerged in the 1990s until recently, very little attention was paid to the on-going HIV epidemic among MSM (HSRC, 2009) despite the big role that they play in propagating the pandemic (Lane, et al., 2009). Lane et al., (2006) revealed that South African MSM engage in high-risk sexual behavior and the stigmatization as gay and fear of knowing one's HIV status present barriers to making use of the available voluntary HIV testing and counseling services. Although MSM in South Africa are recognized to be at risk of HIV/AIDS, this population remains marginalized and to a large extent neglected in current HIV/AIDS-prevention campaigns and research (Cloete et al, 2008; Lane et

al, 2009). HIV prevalence and incidence among MSM in South Africa remains undocumented and literature on the stigma and discrimination they experience is limited although it is known to be widespread (Lane, et al., 2009 and Cloete et al., 2008). In addition, HIV related stigma is also pervasive in the lives of MSM living with HIV given the alarming statistics of HIV among this group (Asia Pacific Regional Analysis, 2011).

Many governments particularly those in Africa continue to criminalise homosexuality and the social stigma about being gay can make it difficult and even dangerous for young men to disclose their sexuality. Many young gay men worry that their family and friends will react negatively if they find out about their sexuality. In summation, despite increasing evidence of the need for HIV-related interventions for same-sex practicing people, there are scarcely more than a handful of formal HIV prevention, testing, treatment, or care programs targeting MSM in South Africa and Africa in general. As the enormity of the HIV/AIDS crisis engulfing Africa has slowly emerged from the fog of silence and denial that surrounds it, the issue surrounding MSM is still an area of much contestation in both cultural and political circles. Therefore, following reports about the lack of reliable data in South Africa about MSM, this study will prove to be significant to policy and practice as it seeks to generate more information about an area of study that has been under-researched. This area is most significant in the fight against HIV/AIDS as a significant number of MSM are reported to engaging in sex with several partners, both male and female. Hence, through this study, the researcher seeks to highlight the importance of removing barriers to health care access whilst promoting more inclusion of MSM in interventions geared towards the alleviating of HIV/AIDS. This information is critical to policy and practice as it would advocate for the vigilant and sustained effort needed to ensure that MSM have access to a comprehensive set of prevention strategies.

1.2. Problem Formulation

1.2.1. The Goal of study

The overall goal of this study is to analyse the adequacy of the policies and effectiveness of interventions that have been put in place in South Africa to specifically address issues of HIV/AIDS among MSM. The perceptions of MSM will be also be explored with the objective

of ascertaining their knowledge of such existing policies and interventions (if any exist) to determine level of accessibility and use. This goal will be addressed by the following questions.

1.2.2. Specific Research Objectives

1. To assess the level of awareness of MSM about HIV/AIDS-related policies that have been put in place to specifically address issues of HIV/AIDS amongst them.
2. To assess the level of understanding by MSM about HIV/AIDS-related healthcare services and interventions that have been put in place to specifically address issues of HIV/AIDS amongst them.
3. To examine the perceptions of MSM about HIV/AIDS-related policies that have been designed to target them?
4. To examine the perceptions of MSM about HIV/AIDS-related healthcare services that have been formulated to target them.
5. To examine if HIV/AIDS-related services/interventions are “MSM friendly”.
6. To determine the level of accessibility of HIV/AIDS-related healthcare services by MSM.
7. To identify the challenges and barriers to the access of HIV/AIDS-related healthcare services and interventions by MSM.

1.2.3. Main Research Questions

The research questions that this study will attempt to answer are as follows:

1. What is the level of awareness of MSM about HIV/AIDS-related policies that have been put in place to specifically address issues of MSM?
2. What is the level of understanding by MSM about HIV/AIDS-related healthcare services and interventions that have been put in place to specifically address healthcare related issues faced by MSM?
3. What are the perceptions of MSM about HIV/AIDS-related policies that have been designed to target them?
4. What are the perceptions of MSM about HIV/AIDS-related healthcare services and interventions that have been designed to target them?
5. Are HIV/AIDS-related healthcare services and interventions “MSM friendly”?

6. How accessible are HIV/AIDS-related healthcare services by MSM?
7. What challenges and barriers are faced by MSM when accessing HIV/AIDS-related healthcare services and interventions?

1.3. Concept clarification/Definition of Terms

1.3.1. Men who have Sex with Men (MSM)

This term “describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This description includes men who self-identify as heterosexual but have sex with other men”. (SANAC, 2012: 6). For this document, MSM includes all males who practice sex with another male, regardless of how they identify themselves in terms of sexual orientation.

1.3.2. HIV

Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). It is transmitted through infected blood, semen, vaginal secretions, breast milk and during pregnancy or delivery. It leaves the body vulnerable to life-threatening infections and cancers by destroying the CD4 T lymphocytes of the immune system (Kaiser Family Foundation, 2012).

1.3.3. AIDS

Acquired Immunodeficiency Syndrome (AIDS) is the “term that is used to describe the various clinical syndromes, specific opportunistic infections or malignancies that occur with HIV infection; signaling those in whom advanced HIV infection has occurred” (WHO, 2005).

1.3.4. “MSM friendly” services

These are services that take into account the context in which risk behaviours by MSM occur, services that make sure that health professionals are adequately trained to understand the special needs and concerns of lesbian, gay, and bisexual youth as well as services that advocate for behavioural health messages tailored accordingly (CDC, 2012).

1.3.5. Policy

This is a purposive and consistent course of action produced as a response to a perceived problem of a constituency, formulated by a specific political process, and adopted, implemented, and enforced by a public agency (Anderson, 2003).

1.3.6. Perception

This is a mental process regarding, understanding and interpreting sensory information in order to represent and understand the environment (Atkins, 1996).

1.7. Structure of Report

The structure that the report takes is as follows:

Chapter 1: Introduction

Chapter 2: Literature review

Chapter 3: Methodology

Chapter 4: Presentation and Discussion of findings

Chapter 5: Conclusions and Recommendations

1.8. Conclusion

This chapter introduced the study by presenting a general background of the topic, research problem, rationale, objectives and clarification of concepts. It concluded with an outline of the entire research report. The following chapter reviews existing literature relevant to the study.

CHAPTER TWO

Literature Review

This chapter presents the literature review that provides the conceptual background to this research study. This review will start by discussing the HIV pandemic, its history as well as the changing trends in South Africa and Africa as a whole. A background of MSM will also be discussed particularly the history of homosexuality and HIV/AIDS trends amongst MSM in South Africa. Furthermore, existing HIV/AIDS-related healthcare policies, strategies and services targeting MSM as well as identified barriers to the success of interventions will be discussed. Finally, some global responses to the plight of MSM will be discussed as well as theoretical frameworks that underpin the study.

2.0. The Global HIV Epidemic

Acquired immunodeficiency syndrome (AIDS) was discovered more than twenty five years ago and has caused an estimated 25 million deaths worldwide (UNAIDS, 2011). AIDS is caused by the Human Immunodeficiency Virus (HIV). More than 90% of new HIV infections occur in developing countries, with Sub-Saharan Africa being the most highly impacted region (Figure 1.1). Furthermore, approximately 67% of all people living with HIV are situated in this sub-region and more than 75% of all AIDS deaths in 2010 occurred here (UNAIDS, 2011).

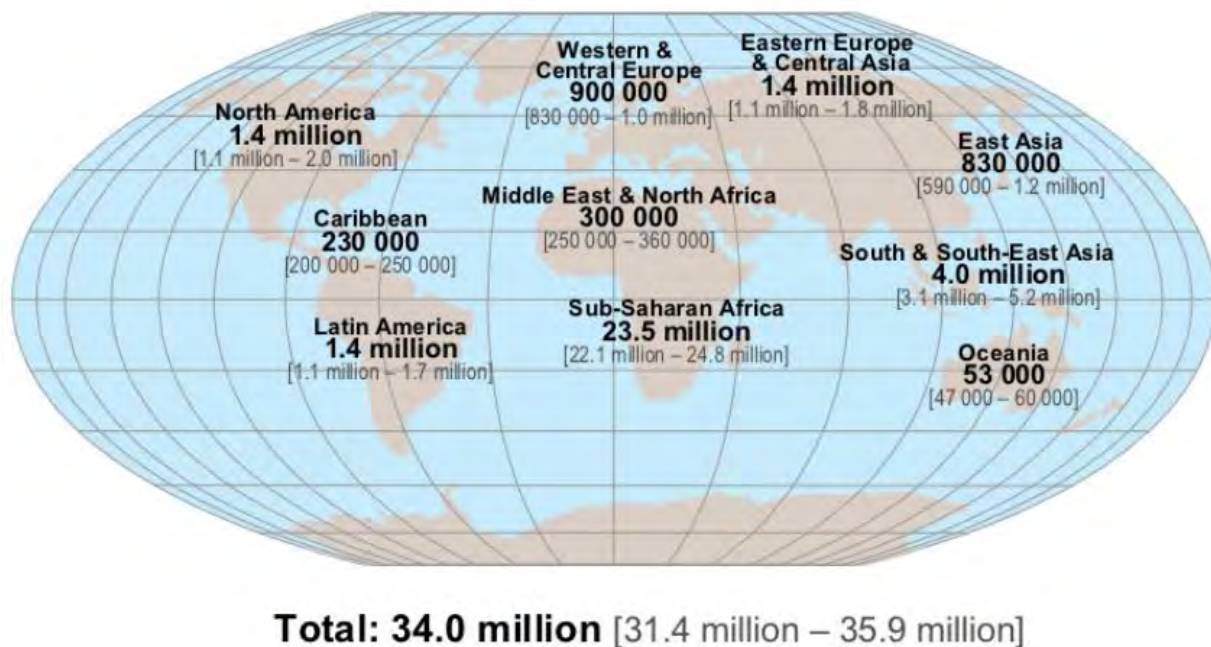


Figure 1.1. The global view of adults and children estimated to be living with HIV (Source: UNAIDS, 2012).

While MSM constitute only 2% of the U.S. population, they accounted for 53% of the overall diagnoses and 71% among men in 2007 (UNAIDS, 2006). According to a 2010 US federal study, (CDC, 2012), HIV infection is increasing at a rate of 12% annually among 13–24-year-old American men who have sex with men (CDC report 2008). Experts attribute this to "AIDS fatigue" among younger people who have no memory of the worst phase of the epidemic in the 1980s and early 1990s, as well as "condom fatigue" among those who have grown tired of and disillusioned with the unrelenting safer sex message. Studies in Africa, Asia, and Latin America have found that less than 5% of MSM have access to HIV-related health care (AIDSTAR-One, 2013).

2.0.1. History of HIV/AIDS in Africa

The awareness of the existence of HIV/AIDS in sub-Saharan Africa arose from 1983 and within a few months later; the syndrome was described in the hospitals in Kigali, Rwanda and Kinshasa, Democratic Republic of Congo (DRC) formerly known as Zaire, then in Uganda under the name slim disease (Denis & Becker, 2006). Since the numbers continued to grow but the authorities

and the African elites including the great majority of the medical fraternity refused to recognize its existence. Instead of HIV/AIDS being treated as a health problem that it was, it became a political and cultural issue, and debates on an African origin of the virus (“African sexual promiscuity”) did not help the situation (Denis & Becker, 2006). In as much as the rest of the world was pointing fingers to Africa, the African elites denounced AIDS as a foreign disease spread on the continent by white homosexuals. Others argued that it was a ploy by Westerners to bring down the birth rate by imposing the use of condoms, as an attack associated with the issues of Christianity in the face of African traditions such as polygamy (Denis & Becker, 2006).

The idea of this infection, which was associated in rich countries with homosexual behaviour, prostitution and intravenous drug usage, seemed too farfetched for Africa. Consequently, the governments of many countries in sub-Saharan Africa with the exception of countries such as the DRC, Uganda, Zambia and Senegal denied the reality of the epidemic for a long time (Denis & Becker, 2006). This behavior is still evident in many impoverished communities of sub-Saharan Africa. Sub-Saharan Africa is the region most impacted and ravaged by HIV/AIDS. With an estimated 1.9 million becoming newly infected in 2010 in this region, there is now an estimated 22.9 million people living with HIV in sub-Saharan Africa (UNAIDS, 2011). This is a seriously unfortunate state of affairs and such a cruel stroke of irony that as the African continent grapples with issues of illness and poverty it be the very continent impacted the most by the epidemic, decimating any active effort to deal with fragile medical and social infrastructures.

In South Africa, similar to many other countries, the early history of HIV was first discovered among gay men (AVERT, 2011). Consequently, this initial concentration of HIV within the gay community led to the misconception that HIV/AIDS was a homosexual disease. Hence, the wider population, including the apartheid government, ignored the risks. However, by 1991, the number of AIDS cases attributable to heterosexual transmission equalled those due to homosexual transmission, and since then the former has become by far the dominant transmission route (AVERT, 2011). Therefore, the AIDS agenda started to make headway in the late 80s and early 90s. It is also in this period that the first steps of a more rational, coherent response to the epidemic became evident following the 1990 Fourth International Conference on

Health in Southern Africa. Following from this conference, the National AIDS Coordinating Committee of South Africa (NACOSA) was put together in 1992 to fight this pandemic and its strategy envisioned a broad approach to tackling HIV with action on all fronts including prevention, research, human rights, counselling and welfare, with the involvement of a number of government departments (AVERT, 2011). South Africa's National AIDS Plan was adopted within months of the country's first democratic election in 1994, and there was optimism that an epidemic on the scale experienced by African countries could be avoided.

South Africa's HIV/AIDS epidemic went unchecked for so long and the most rapid increase took place between 1993 and 2000 and it was a time that the country was distracted by major political changes and refusal by key political figures to realize its presence. One wonders if this could have been the reason for the high number of people infected as the government took time to respond.

2.0.2. Changing HIV/AIDS trends in South Africa

In 1982, the first case of HIV infection was detected in a homosexual individual but by 1985, many more other cases were discovered in heterosexually infected individuals. By 1990, the first national antenatal survey to test for HIV/AIDS discovered that 0.8% of pregnant women were HIV-positive and it was estimated that there were between 74,000 and 120,000 people in South Africa living with infected with HIV/AIDS (AVERT, 2011). To put an end to the misconceptions that HIV/AIDS was a disease only found in the homosexual category, by 1991 the number of diagnosed heterosexually transmitted HIV infections equalled the number transmitted through sex between men. Since this point, heterosexually acquired infections have dominated the epidemic. By 1993, the number of recorded HIV infections had increased by 60% in the previous two years and expected to double by the end of the year (AVERT, 2011). Between 1993 and 1997, the HIV prevalence rate grew from 4.3% to 17% and by 1999, 22.4% (AVERT, 2011).

In order to deal with the steep rise in the prevalence of HIV/AIDS, in 2000, the Department of Health outlined a five-year plan to combat AIDS, HIV and STIs. A National AIDS Council was set up to oversee these developments. However, at this point the ruling party was still reluctant to recognize the existence or the severity of HIV/AIDS. It was only in 2003 that the government

finally approved a plan to make antiretroviral treatment publicly available. At that point the HIV prevalence rate among pregnant women had shot up to 27.9% and 17.8% of South Africa's population was infected by HIV/AIDS totalling 5.6 million people (AVERT, 2011). With these figures, South Africa has earned the reputation of having the most people living with HIV than any other country.

2.1. Men who have Sex with Men (MSM)

Sex between men occurs in diverse circumstances and such behaviours can cut across different cultures, races and socio-economic standing. It can also be common regardless of sexual identity. Sex between men is often reported to be normalised in situations where they may be forced to endure prolonged periods of time in all-male environments such as prisons or boarding schools with sex between adolescent males reported to be a part of sexual experimentation (UNAIDS, 2006). The category MSM encompasses a range of sexual and gender identities among people in various socio-cultural contexts and it may involve men who identify as homosexual, gay, bisexual, transgendered or heterosexual (UNAIDS, 2006). In a project in Senegal (Dakar), 88% of men who had sex with men also reported vaginal sex (UNAIDS, 2006). In some cities in central and Eastern Europe, one third of men in gay venues reported having both male and female partners (Hamers & Downs, 2003) and between 3% and 20% of all men are estimated to have sex with other men at least once in their lives in parts of Asia, Europe and Latin America. MSM are often married, particularly where discriminatory laws or social stigma of male sexual relations exist. With this establishment that men who have sex with men may also have sex with women, there is a danger of passing the disease onto their female counterparts.

A study in China showed that half the men who have sex with men reported having sex with a woman, and one third of them were married (UNAIDS, 2006). Sex between men is the most prominent mode of HIV transmission in nearly all Latin American countries, the United States, Canada and some Western European countries (UNAIDS, 2006). Among men who acknowledged having sex with men in Thailand (Bangkok), studies show HIV prevalence increased from 17% in 2003 to 28.3% in 2005 (van Griensven, et al., 2009) HIV prevalence of 17% in India (Mumbai) and 20% in Colombia (Bogotá) has been found among men who have

sex with men (Montano, et al., 2005)

2.1.1. History of homosexuality in South Africa

There seems to be widespread belief that African homosexuality is as old as African cultures themselves. This is evident in the fact that various African languages have words for “gay” and “lesbian”. With this perspective, contrary to popular belief, homosexuality is not a by-product of colonialism. This condemnation of same-sex behaviour only arrived in Africa when Christianity and Islam were introduced (Murray, 1998: 270; and Hoad, 2007). However it is through colonialism and the prejudice of the religious missionaries condemning the act that homophobia was born (Murray, 1998). Looking closely at the Victorian era, when the country and the continent was colonised, sex was severely silenced, the practice of polygamy, intracultural sex, anal sex and anything sexual in pre-colonial and colonial Africa was absolutely wicked in the eyes of the early European missionaries (Murray, 1998).

During apartheid, Smith (2005: 60) reported that gay bashing was an institutionalised right, as the fairly common homophobic bumper stickers such as “kill a queer for Christ” and later “HIV/AIDS is Gods way of punishing queers”. This stigmatisation of homosexuality effectively created stereotypes and false connotations which to date have contributed and encouraged homophobia. During this period in South Africa, black and white gay couples were also seen and believed to be incompatible. The dynamics of same-sex sexuality in Cape Town’s communities as well as South Africa in general was consequently affected by the broader dynamics of race and racial identity. “South Africa remains a homophobic, heterosexist society where, across cultures, homosexuality is pathologised, and where cultural discourses such as the notion that ‘homosexuality is not African’ continue to play themselves out” (ANOVA Health Institute, 2010). Although prejudice and discrimination against homosexual individuals occurs across the spectrum of South African culture, the expression bears racial and socioeconomic distinctions. The spatial and racial segregation imposed under apartheid continues to shape the social and sexual dynamics of MSM communities (ANOVA Health Institute, 2010). Despite the entrenchment of the same-sex clause in the new South African Constitution, homophobia still persists.

2.1.2. HIV/AIDS trends amongst MSMs in South Africa

Despite reports showing that MSM are nineteen times more at risk of HIV than the general population (AmfAR AIDS Research, 2008) until recently, the HIV prevalence among MSM in South Africa has remained undocumented. Little is known about the demographics or risk factors in the local context (Rispel et al., 2011). Data presented at the fourth South African AIDS Conference in 2011 held in Durban provides insight into the HIV prevalence among MSM in South Africa. Three studies presented on preliminary data collected respectively in Cape Town, Durban and Soweto, Gauteng consistently yielded results showing that the HIV prevalence rates among MSM range from 12.6% to 47.2% among different sub-populations (Burrell et al, 2009; Lane et al, 2009; and Rispel et al., 2011). It is estimated that 9.2% of new HIV infections are related to MSM (SANAC, 2012:28).

In South Africa and many other African countries in particular, prevalence rates amongst MSM have continued to soar due to a combination of structural, political, social, and behavioral factors that have made it difficult to accept such behavior (Rispel et al., 2011). Often we hear LGBT behaviour being referred to as being “un-African”, this term particularly shedding some light on the reasons for such resistance by many African leaders and communities alike. Consequently, these groups of people are vulnerable and looking at South Africa in particular, little is known about the demographics, HIV prevalence, or risk factors for HIV among MSM in the local context, making this group of people even more vulnerable. Current HIV policies and programs are also reported to be largely unresponsive to the needs of MSM (Rispel, Metcalf, Cloete, Moorman, & Reddy, 2011, Riepel et al., 2011:69). Below are diagrams that show global prevalence of HIV in MSM with (figure. 1.2.) comparing it to adult prevalence in heterosexuals.

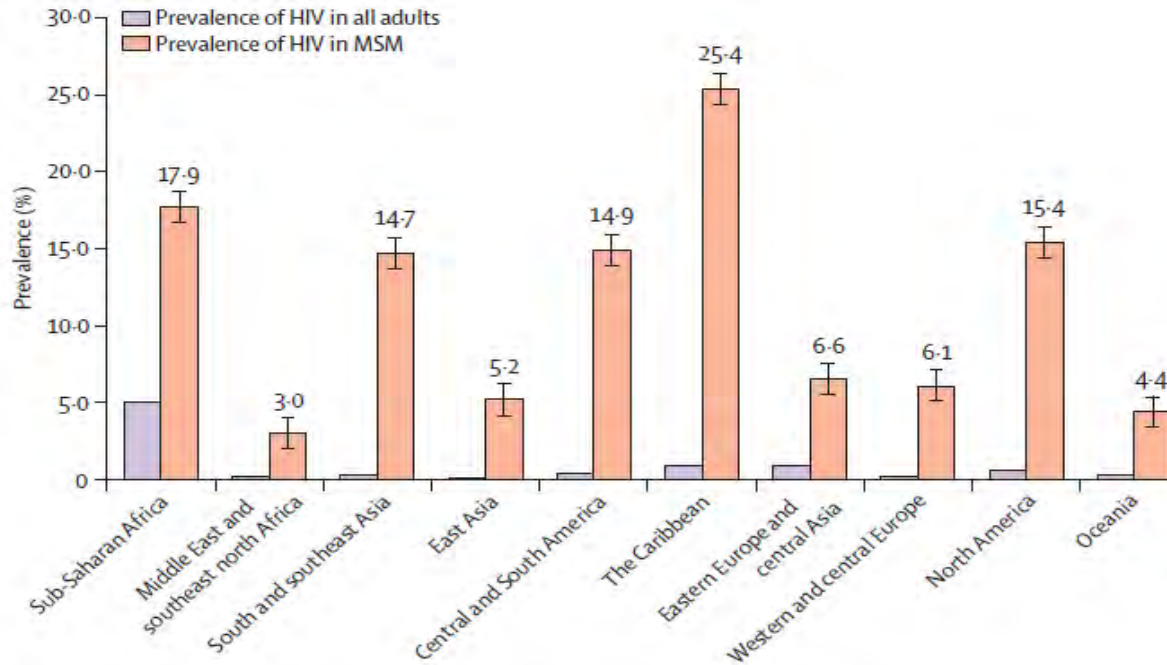


Figure 1.2. Global prevalence of HIV in MSM compared with regional adult prevalence (Source: UNAIDS, 2010).

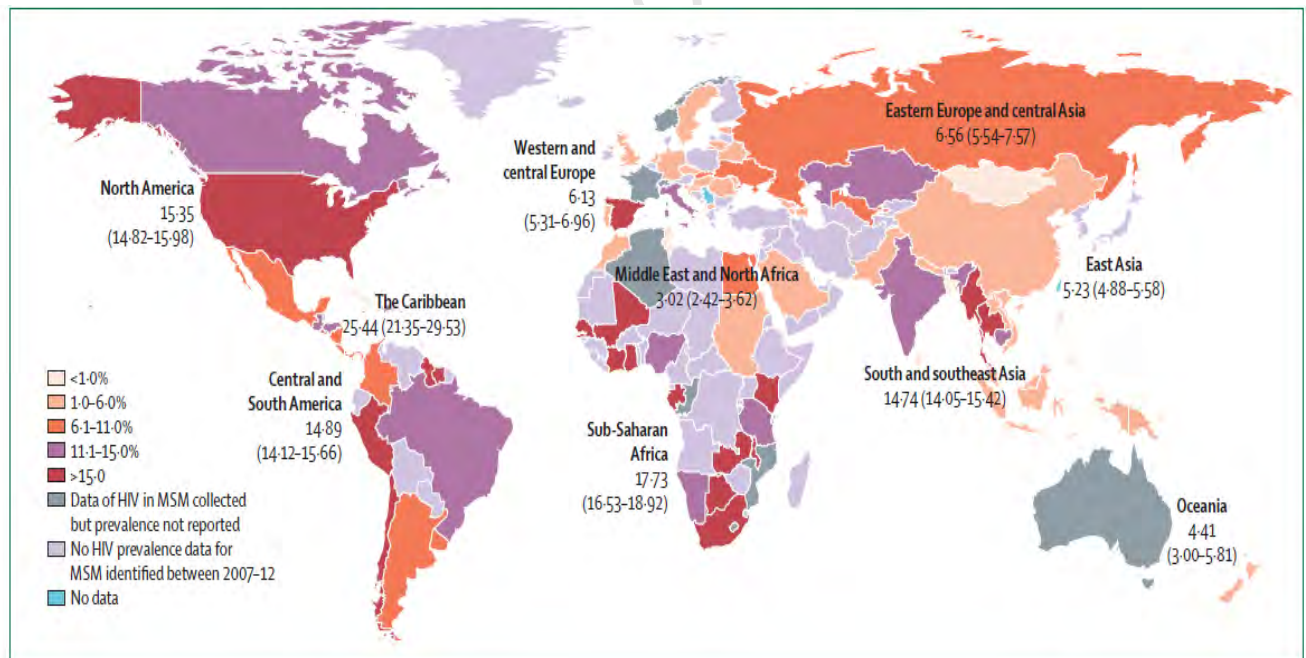


Figure 1.3. Global HIV prevalence in MSM, from studies published 2007-11 (Adapted from Beyrer et al, 2012)

2.1.3. HIV/AIDS Policies, Strategies and Interventions targeting MSMs in South Africa

Taking into account the high prevalence of HIV/AIDS amongst MSM, it is imperative that their needs should form an integral part of the national HIV and AIDS response (Rispel et al, 2011). However, it is sad to report that irrespective of the fact that with the adoption of the Constitution, gays, lesbians, bisexuals and transgenders have equal rights as any other citizens, their needs and rights are still not being recognised. Consequently, South African gay organizations are reported to often rely heavily on foreign donors, with very little support from the government (Nel, 2005). The first move to address HIV/AIDS amongst MSM was made in 2003 when the South African government approved a comprehensive national plan on HIV and AIDS care, management and treatment which was later evaluated and revised in 2006, giving birth to the South African HIV and AIDS and STI Strategic Plan 2007 – 2011 (NSP 2007-2011).

2.1.3.1. The South African HIV & AIDS and STI National Strategic Plan 2007- 2011

The mission and aim of the NSP 2007-2011 was to reduce the number of new HIV infections by 50%; and reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV (SANAC, 2006).

In order to achieve the aforementioned mission and goals its strategy included:

- Prevention

The intention was to ensure that the large majority of South Africans who are HIV negative remain HIV negative by accelerating poverty reduction strategies, by empowering women and educate the society on women's rights and human rights, by increasing the roll out of prevention programmes for higher risk populations and introducing programmes to mitigate the impact of alcohol and substance abuse to name a few (SANAC, 2006).

- Treatment, care and support

The aim was to reduce HIV/AIDS morbidity and mortality as well as its socioeconomic impacts by providing appropriate packages of treatment, care and support to 80% of HIV positive people and their families by 2011 (SANAC, 2006).

- Human and legal rights

The government proposed to ensure knowledge of and adherence to the existing legal policy framework as well as ensuring non-discrimination in access to HIV prevention, treatment and support of marginalized groups. Additional measures were monitoring of HIV-related human rights violations and develop mechanisms for redress (SANAC, 2006).

- Monitoring, research and surveillance.

Through the recognition that monitoring and evaluation (M&E) is an important policy and management tool, the government proposed to implement a monitoring and evaluation framework for the NSP 2007-2011 through the establishment and a functional M&E system as well as supporting the development of prevention technologies (SANAC, 2006).

It is through the NSP 2007-2011 that the issues of MSM made their very first debut in HIV/AIDS intervention strategies and policies. The policy recognised and listed MSM as a most at risk population (MARPs) with very little known about HIV prevalence and incidence amongst them (Anova Health Institute, 2010; Rispel and Metcalf, 2009). As comparatively more heterosexual people are affected by HIV, services and interventions for MSM have been almost non-existent in South Africa (Health4Men, 2011). There is therefore a call for the listing of MSM as being at higher risk and requiring specifically targeted HIV prevention approaches. Although recognition of MSM as a most at risk population, no clear strategy was mentioned to ensure HIV/AIDS prevention and treatment in MSM. However, post 2011, a new National Strategic Plan for HIV and AIDS, STIs and TB, 2012-2016 (NSP 2012-2016) is now in place and it continued to recognise MSM as a most at risk populations.

2.1.3.2. The National Strategic Plan for HIV and AIDS, STIs and TB 2012 – 2016

The NSP 2012–2016 is driven by a long-term vision for the country for HIV and TB epidemics. It has adapted the three zeros advocated by UNAIDS to suit the local context (SANAC, 2012). Through the NSP 2012-2016, South Africa's vision is to ensure zero new HIV and TB infections, zero new infections due to vertical transmission, zero preventable deaths associated with HIV and TB and zero discrimination associated with HIV, STIs and TB (SANAC, 2012).

As outlined by SANAC (2012), the strategic objectives of the NSP 2012-2016 are to:

- Address social and structural barriers to HIV, STI and TB prevention, care and impact. This objective seeks to address societal norms and behaviours through structural interventions that reduce vulnerability and mitigating impacts of HIV, STI and TB.
- Prevent new HIV, STI and TB infections by ensuring a comprehensive approach to HIV, STI and TB prevention which includes all biomedical, behavioural, social and structural approaches in order to reduce new HIV, STI and TB infections.
- Sustain health and wellness by ensuring access to quality treatment, care and support services for those with HIV, STI and TB as well as developing programmes that focus on wellness, inclusive of physical and mental health.
- Increase the protection of human rights and improving access to justice by addressing issues of stigma, discrimination, human rights violations and gender inequality.

Building on the work done through the NSP 2007-2011, the NSP 2012-2016 goes a step further than merely recognizing the existence of MSM to highlighting a few targeted approaches that are specifically meant for MSM in the care, treatment and prevention of HIV/AIDS (SANAC, 2012). The objectives of the plan are to respect and protect the people's rights through enabling access to services by ensuring that no person eligible for the identified services is denied access on an arbitrary basis (SANAC, 2012). It recognises that denial of access may be in the form of services being provided in a manner that fails to address or understand a person's specific needs; including staff attitudes that may discourage people from accessing social services.

Therefore, it proposes that service providers should have some understanding of the difference between transgender persons and gay men, who are often collectively considered to be men who have sex with men for the provision of appropriate HIV-counselling services (SANAC, 2012). In addition, it also proposes social interventions that seek to change cultural and social norms that are reported to increase vulnerability to HIV and STIs. Such a move is premised on the knowledge that certain social norms are drivers of behaviours that place individuals at increased risk of HIV acquisition through elements such as discrimination against members of the

community with certain diseases (e.g. TB or HIV) and against those with different sexual orientations (e.g. MSM and women who have sex with women (WSW) (SANAC, 2012). In addition, as opposed to the NSP 2007-2011, the NSP 2012-2016 recognizes significantly the need to have targeted interventions for MSM in addition to general interventions for prevention, care and treatment.

2.1.4. Barriers to the Effective Implementation of MSM Interventions

LGBTI organizations are reported to be the main providers of services catering specifically for people in same sex relationships (Rispel and Metcalf, 2009). Healthcare services in South Africa have been criticized for remaining largely unresponsive and the government criticized for not having dedicated funding allocated to meet the targets outlined in the NSP 2007-2011 (Rispel and Metcalf, 2009). Moreover, the progress of interventions and access to health care services is further hindered by the stigma and discrimination to which LGBTI communities are subjected. Several studies and the media have reported on the countless incidences of homophobic verbal harassment experienced by LGBTI communities at the hands of healthcare workers as well as the communities in which many reside (Anova Health Institute, 2010; Rispel and Metcalf, 2009).

In a study conducted in Soweto and Mamelodi, MSM reported that their rights to privacy and confidentiality are often threatened by healthcare workers engaging in gossip and homophobic verbal harassment (Anova Health Institute, 2010). As a result, many MSM were forced to delay seeking treatment; a prospect that increases the risk of contracting HIV or passing it on to other unsuspecting individuals. The general lack and access to supportive MSM friendly VCT services has also resulted in MSM lacking awareness of effective risk reduction strategies specific to the risk behaviours that they engage in (Anova Health Institute, 2010).

Responsiveness in overall health service provision for MSM is generally lacking and an attempt at investigating certain behaviours amongst healthcare workers which are deterring MSM from seeking services, it is reported that many of them simply do not have required necessary training to respond to the specific physical and psychological needs of patients with same-sex partners and compassion (Rispel and Metcalf, 2009; Anova Health Institute, 2010). Moreover, homophobia, discrimination and the general demonising of homosexuality has further created

major barriers to effective HIV programming with MSM. From both a public health and human rights perspective, an active stand still needs to be made to ensure that these elements are brought to an end.

2.1.5. HIV/AIDS-related Stigma

The UN has taken a position to protect the rights of MSM whilst at the same time advocating for the removal of barriers to their access to HIV/AIDS services after recognizing that the discrimination and criminalization they still face in some countries is a hindrance to the efforts that are being made to mitigate the pandemic. In both the 2001 Declaration of Commitment and HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, UN member states unanimously committed themselves to this goal (UNAIDS, 2011). An individual's dignity, respect and right to fully participate in their community particularly in persons living with HIV/AIDS is often undermined by stigma which is borne from misunderstanding and fear of the unknown. Stigma often manifests in discriminatory behaviors that serve to limit or restrict access to education, health or even employment; resulting in isolation or complete isolation.

HIV/AIDS-related stigma has not only been documented to reduce individuals' willingness to be HIV tested, to disclose their HIV status, to practice safe sex and to access health care but it has also been identified to impede the efforts of services to reach those most in need of prevention, treatment and care (Cameron, 2011). Consequently, it impacts the individuals' capacity to acknowledge and manage their own health. This further leads to social inequalities and discrimination

Although HIV related stigma has not been isolated to any one area but that it is a global phenomenon, it however manifests differently and in varying degrees in different locations. Drawing heavily from work done by Cameron (2011), which is vital in showing the varying degrees of stigma existing within families, communities, health care facilities and in places of work. The study was carried out in nine countries in the Asia/Pacific Region and the results showed that "HIV stigma based exclusion was reported within many family environments (3% to 26%) and many respondents also reported psychological pressure, manipulation and harassment by their spouse, with reference to their HIV status (10% to 36%)" (Cameron, 2011: 5). Within

the communities, reports were that many times HIV-positive statuses were disclosed to friends and neighbours without the respondents' consent (9% to 50%) and between 4% and 31% experiences exclusion from social gatherings in all countries. Such exclusion often resulted in the loss of power, respect and identity through the removal or diminishing of community roles and social standing. Between 5% and 20% of respondents had been forced to move or had been unable to rent accommodation during the previous 12 months as a result of their HIV positive status (Cameron, 2011: 5).

In the work place, stigma and discrimination was also reported to be the key factor or had played a role in respondents' loss of employment or income (16% to 50%), loss of opportunity to work (9% to 38%), loss of opportunity for promotion (8% to 52%), withdrawing from work (3% to 38%) and deciding not to apply for a job or promotion (10% to 31%) (Cameron, 2011: 6).

Evaluating the access to health care, HIV-related stigma reduced respondents' access to healthcare (4% to 33%) and in spite of needing medical care, many people living with HIV avoided clinics (7% to 35%) and hospitals (7% to 25%) because of their HIV-positive status (Cameron, 2011). Although a considerable number of health care workers were supportive upon learning of respondents' HIV positive status, a significant percentage was not (3% to 29%) (Cameron, 2011). Between 37% and 90% of the respondents reported not to have had constructive discussions with health care professionals about HIV related treatment options (Cameron, 2011).

Moving on to focus more specifically on stigma in Africa, particularly sub-Saharan Africa, Smith, Tapsoba, Peshu, Sanders, and Jaff (2009) reported that in recent years, laws against homosexuality have been strengthened by governments in several countries, while certain political and religious leaders have even publicly denounced MSM as immoral and not deserving attention from the state. From their study, most of the respondents from ten sub-Saharan African countries that they sampled stated that society should reject homosexuality. Such views have exacerbated the problem of stigma that MSM are faced with in their everyday lives. Similar to the experiences of MSM in the study carried out by Cameroon (2011) in nine countries in the Asia/Pacific Region, Smith et al (2009) reported that African MSM who disclose their

orientation either through choice or necessity reported family rejection, public humiliation, harassment by authorities, and ridicule by health-care workers. Although the consequences of stigma on HIV risk and access to prevention and care for African MSM are unknown largely due to the fact that studies of MSM are generally lacking, low self-esteem, and loss of family and community cohesion were found to mediate an association between social oppression and sexual risk-taking behaviour (Beyrer, Sullivan, Sanchez, Dowdy, Altman, Trapence, Collins, Katabira Kazatchkine, Sidibe, Mayer, 2012; Smith et al, 2009). In addition to similar forms of stigma that both African MSM and Asia/Pacific MSM are dealing with, Smith et al (2009) went further to report that African MSM might also be dealing with another forms of stigma that may not be an issue for other MSM elsewhere. Smith et al (2009) draw attention to the expectation of the production of children as a predominant social pressure on homosexual men.

To conclude, the political, cultural, and religious hostility towards MSM has maintained a significant barrier to the implementation of effective HIV research, policy, and health programmes for African MSM (Beyrer et al, 2012; Smith et al, 2009). Consequently, the successful engagement with and delivery of the few interventions to known MSM significantly tempered with, with the recognition that many, probably most, MSM are forced to conceal their behaviour for fear of repercussion and remain beyond the reach of such interventions. As HIV related stigma is not innate, hope should not be lost that with the probable increase in understanding of the pandemic and circumstances, discrimination will also significantly reduce. Proactive efforts should be made and the efficient measures put in place to address this.

2.1.6. MSM perceptions about strategies to address HIV/AIDS

Courtenay-Quirk, Wolitski, Parsons, Gomez, & Seropositive urban men's study team, (2006) in a study whose participants were from New York and San Francisco showed that blame, increased anger, and decreased sympathy toward an HIV-positive person occur more frequently if that person is a gay or bisexual man. Such results give some insight into some of the issues that MSM have to deal with on a day to day basis. Such hostility, prejudice and harassment has been linked to heightened risk for self-harm, unsafe sexual behaviors, suicidal thoughts, and substance use (Courtenay-Quirk et al, 2006). The stigma, discrimination and criminalization of same sex relationships impedes the many attempt that are being made to alleviate HIV/AIDS.

From a global study done by Wilson, Santos, Herbert, & Ayala (2011: 12), the results showed that “access to HIV treatment for MSM was fairly low, with only 36% reporting it was easily accessible, while 27% said it was available but almost impossible to access or that they never heard of this.” In response to the easy accessibility of treatment and information centers available to them in their respective countries, although close to half (48%) of participants reported having easy access to free HIV testing, sex education programs were reported not to be so easily accessible (Wilson et al, 2011). Half of the respondents also expressed that media campaigns to reduce homophobia were not available (30%) or unheard of (20%) (Wilson et al, 2011). Moreover, 27% expressed that health facilities for MSM were not available whilst 25% said they had not heard of any (Wilson et al, 2011). This shows that over half of the participants (52%) did not have the platform to access services that could otherwise make all the difference in combating HIV/AIDS.

2.1.7. Global responses to the plight of MSM

Ayala, Beck, Sundararaj, & Lauer (2011) in their brief reported that after the plight of MSM in accessing services was taken into consideration, the Global Forum on MSM and HIV (MSMGF) together with MSM advocates from around the world developed a list of five core operating goals that needed met if HIV/AIDS was to be mitigated in this category of people. They are taking the initiative to ensure “increased investment in effective HIV prevention, care, treatment and support programmes for MSM, expanded coverage of quality HIV-related services for MSM, increased knowledge on MSM and HIV through the promotion of research and its broad-based dissemination, decreased stigma, discrimination, and violence against MSM and strengthened, linked regional, sub-regional and nation networks of MSM around the world” (Ayala et al, 2011: 1).

In an area where previous conclusive research was missing, for the first time, in July 2010, work presented by Dr. Chris Beyrer of the Center for Public Health and Human Rights at Johns Hopkins University’s Bloomberg School of Public Health substantiates the need to reach MSM with HIV services as a necessary component of any effective overall HIV strategy (Ayala et al, 2011). From a study that utilised epidemiologic data from 133 prevalence studies, representing

130 unique reports with data from 50 countries, Dr Beyrer demonstrated that providing 100% coverage of comprehensive HIV prevention, care, treatment and support services for MSM, sustained over time, would lead to declines in the epidemic among the general population (Ayala et al, 2011). This is a powerful message that HIV program implementers, policymakers, and donors need to hear loud and clear. By meeting this group's needs, not only are human rights being fulfilled but this serves the broader public as a whole by greatly accelerating reduction in overall HIV burden.

2.2. Theoretical Framework

Theories attempt to explain the reasons for the vast array of characteristics and interpretations that society holds on different subjects. They serve as frameworks of empirical evidence used to study and interpret social phenomena. It is thus the purpose of this section to provide theoretical frameworks that will enable the reader to engage more with this research by understanding the core issues and forces at work. The theories discussed below seek to offer some explanation into the factors that have served to exclude people in same sex relationships from enjoying benefits that are being enjoyed by people in heterosexual relationships. The theories below also offer some insight into what some of the consequences have been as a result of excluding and denigrating non-heterosexual relationships, behaviours, and identities. Although each theory is built on different assumptions they all concur on the fact that positive behavioral changes are bound to occur by altering potential risk-producing situations as well as when there is positive change on the perception of risk, attitudes, self-efficacy and social relationships with regards to MSM. The first theory discussed in this section is Role Theory.

2.2.1. Role Theory: A Structural-Functional Perspective

Role theory can be examined from five theoretical perspectives which include functionalism, symbolic interactionism, structuralism, organizational psychology, and cognitive social psychology (Jackson, 1998 & Biddle, 1979). An in-depth summary of role theory from each of the five above perspectives is beyond the scope of this paper. However, functionalism will be discussed to provide a foundation for the critique presented by this paper. Role theories are primarily concerned with describing the mechanisms by which individuals are socialized to assume appropriate societal roles in a manner that sustains a stable social order (Jackson, 1998 &

Biddle, 1979). Although functionalism will be the specific focus, it should not go without saying that all five theoretical perspectives are organized around the notion that individuals occupy a variety of social roles or positions, each of which specifies certain normative behaviors and attitudes.

Assumptions made by the Role Theory are that people spend much of their lives participating as members of groups and organizations and within these groups, people occupy distinct positions for which each of these positions entails a role, which is a set of functions performed by the person for the group (Biddle, 1979). Furthermore, groups often formalize role expectations as norms or even codified rules, which include what rewards will result when roles are successfully performed and what punishments will result when roles are not successfully performed. Individuals usually carry out their roles and perform in accordance with prevailing norms; in other words, role theory assumes that people are primarily conformists who try to live up to the norms that accompany their roles. Group members often check each individual's performance to determine whether it conforms with the norms; the anticipation that others will apply sanctions ensures role performance (Biddle, 1979).

This theory is anchored in the belief that roles are “behavioral repertoires characteristic of a person or a position, a set of standards, descriptions, norms, or concepts held for the behaviors of a person or social position” (Ito, 2007). In simpler terms, what this means is that through socialization, people are assigned to play certain roles and behave accordingly based on their personal characteristics or the positions they fill. Such personal characteristics include race, sex and age which are relatively fixed in comparison to other behavioral characteristics which are more malleable (Ito, 2007).

Because such characteristics are relatively fixed, there are specific expectations that people need to satisfy these behavioral roles and in exchange there are also consequences. People who follow the expected behaviors anticipate being rewarded, while those who violate them anticipate punishments. This theory is relevant for this study as it explains some of the reasons why people engaging in same sex relations have faced many difficulties in accessing services and benefits

that people in heterosexual relationships have enjoyed over the years. As it has been clearly articulated that social behavior expectations rely heavily on issues of sex and gender categorizations, the latter being definitive of the shared expectations about appropriate behaviors, relationships by MSM are considered to be in violation of “normal behavior”; leading to prejudice by heterosexual individuals who form the majority of the population in any country.

As a result, in the case of trying to access health care services in cases where MSM might have sexually transmitted diseases or may merely be in search of information that may make all the difference between contracting HIV/AIDS or not, it becomes very difficult for this minority group to seek help taking into account that the service providers may be engaged in heterosexual relationships and may therefore according to role theory hold certain prejudices against MSM.

From the secondary data collected, not only have these held notion affected service providers but even policy makers to the extent that numerous polices and interventions have excluded this group of individuals and not recognizing their existence. To further reiterate this point as well as shedding more light on the effects that prejudices against people who do not adhere to heterosexual relationships, the following theories shows how other sexual preferences other than those heterosexual are considered as deviant and warranting punishment.

2.2.2. The Theory of Reasoned Action and Planned Behaviour

The Theory of Planned Behaviour (TPB, Ajzen) is an extension of the earlier Theory of Reasoned Action (TRA, Fishbein & Ajzen, 1980; 1969) (Hausmann-Muela, Ribera, & Nyamongo, 2003). In an attempt to understand the relationship between attitude and behaviour, the Theory of Reasoned Action was first introduced in 1967 by Fishbein (Ajzen & Fishbein, 1980; 1969). TRA was based on the idea that humans are rational and that the explored behaviours are under volitional control. TRA attempts to explain the relationship between beliefs, attitudes, intentions and behaviour.

Through TRA, Fishbein demonstrated that attitude toward the behavior (for example attitude towards seeking medical attention by MSM) is a much better predictor of that behavior than attitude toward the object (HIV/AIDS) at which the behavior is directed (Fishbein and Ajzen,

1969). With that line of thinking, the assumptions of TRA were that the most important direct determinant of behaviour is behavioural intention. However, success of the theory in explaining behaviour depends on the degree to which the behaviour is under volitional control (that is individuals can exercise a large degree of control over the behaviour) (Fishbein and Ajzen, 1969).

As it was not clear whether TRA components were sufficient in predicting behaviours where volitional control was reduced, Ajzen & Driver (1991) added perceived behavioural control to TRA to account for factors outside individual control that may affect intentions and behaviours. It was this addition that created the TPB. Both the TPB and TRA have been widely used in HIV/AIDS research. They centre on factors which lead to a specific intention to act, or behavioral intention, which the TPB puts between the attitudes and behaviour (see Figure 2.1.).

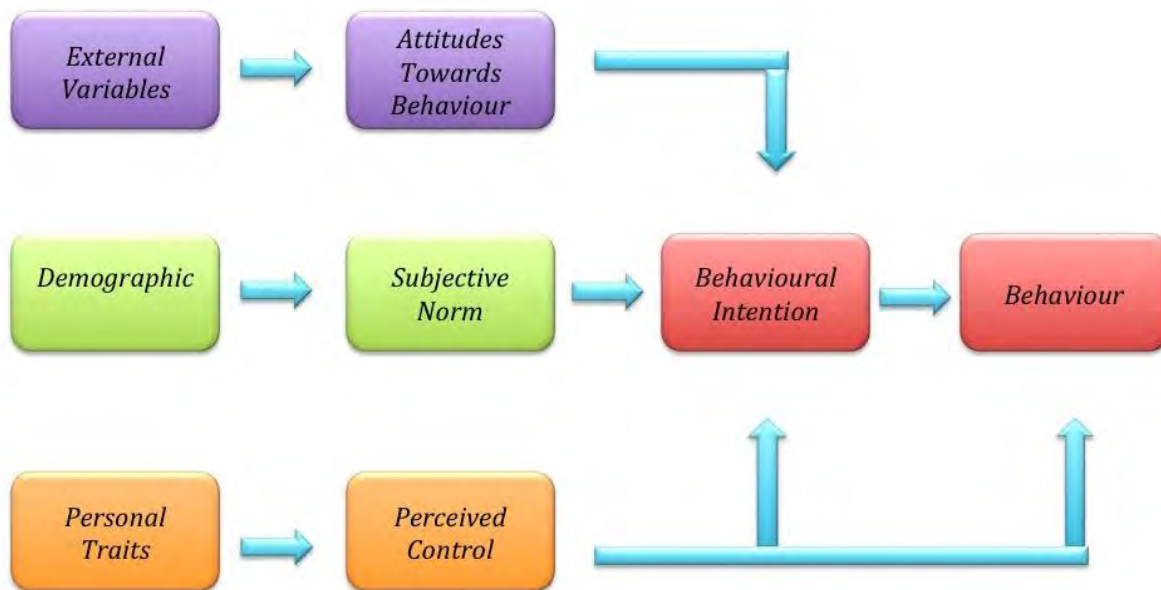


Figure 2.1. Theory of Planned Behaviour (TPB) (Adapted from Conner & Sparks, 1995)

According to Hausmann-Muela , Ribera, & Nyamongo (2003:11), using the TPB, behavioral intention is determined by:

- Attitudes towards behavior, determined by the belief that a specific behavior will have a concrete consequence and the evaluation or valorization of this consequence.

- Subjective norms or the belief in whether other relevant persons will approve one's behavior, plus the personal motivation to fulfill with the expectations of others.
- Perceived behavioral control, determined by the belief about access to the resources needed in order to act successfully, plus the perceived success of these resources information, abilities, skills dependence or independence from others, barriers, opportunities etc.).
- Socio-demographic variables and personality traits which condition attitudes, subjective norms and perceived behavioral control. These are the same as in the HBM.

MSM living with HIV/AIDS have been reported to be reluctant to disclose their health status because of the shame and stigma not only associated with HIV but also their sexual orientation. As a result, the failure to disclose may be denying them an important source of support as well as health services. Natan, Zeltzer, & Melnikov (2011) reported that disclosure was the catalyst for access to a variety of important and often essential resources.

In an attempt to use the theory of planned behavior as well as the theory of reasoned action to evaluate the intention to disclose and seek medical attention for HIV/AIDS-related illnesses by MSM, components of both theories shed some insight into the variables that exist between intention and action. Prior to performing a certain behavior, the theory of reasoned action postulates that people calculate the implications of the behavior. This theory relates to two factors affecting human behavior and it identifies them as human nature and the effect of the environment (Natan et al, 2011). Human nature components are a person's attitudes toward a behavior and environmental components are how a person perceives the pressure exerted by society to perform or refrain from performing the relevant behavior (Natan et al, 2011).

As attitudes and beliefs have been shown to be significant in people's choice of action, the theories of reasoned action and planned behaviour are relevant to behaviour change. Although the primary focus of this study is to explore the perceptions of MSM about HIV/AIDS interventions and policies targeting them, it also seeks to give insight into the level of access, utilisation, and quality of HIV/AIDS-related services as well as challenges face by MSM. By applying the TRA and TPB theories to examine the above mentioned questions, the researcher

seeks to offer greater understanding and insight into some of the issues faced by MSM in their fight for their right to access of HIV/AIDS-related health care services and even information that could help reduce the HIV/AIDS prevalence in this group of people.

Another important factor highlighted by the theory and must therefore be taken into account is the significance attached to opinions of others regarding the behavior examined. According to the theory, attitudes are formed as a result of beliefs and if a person's beliefs concerning an intended behavior are perceived as positive, he or she is bound to act accordingly and the vice versa is true. Behavioral beliefs by MSM of the consequences of coming out, getting tested and seeking medical attention are the most significant predictor of behavioral intention. (Natan et al, 2011).

Homophobia, stigma and discrimination put MSM at risk for multiple physical and mental health problems and affect whether MSM seek and are able to obtain high-quality health services (CDC, 2012). As has been previously reported, the negative attitudes about same sex relationships can lead to alienation by friends and family, discriminatory acts, bullying and even violence. All these dynamics making it difficult for some MSM to be open about their sexual orientation, leading to increased stress, decreased access to social support and consequently impacting negatively on their health (CDC, 2012). It is thus the recommendation by this theory that the promotion of positive behavioral attitudes toward MSM behavior and disclosure will lead to an increase in behavioral intentions to openly seek help as is seen one of the mining community in South Africa where it is reported that health promotion among sex workers with the collaboration of committed sex workers who were trained to distribute information as well as offering support to their colleagues provided positive results (Campbell & Mzaidume, 2001 & Hausmann-Muela et al., 2003). In another study, the support of friends and partners has been central for South African adolescents to attend STD clinics (Hausmann-Muela , Ribera, & Nyamongo, 2003).

2.2.3. Heterosexism Theory

Heterosexism theory regards prejudice toward homosexuals not only as a personal problem but also a social structural problem (Ito, 2007). As it has already been made clear by the role theory,

the distribution of rewards, the organization of social structure and everyday life, and individuals' classifications of people into different categories are based primarily on sexual orientation. Through dominant social constructs which are further accentuated by the numerous television programmes, movies, advertisements and song lyrics that endorse heterosexuality as dominant, other forms of sexuality have been portrayed as deviant or somewhat abnormal (Ito, 2007). Therefore, to explain how this theory is relevant to this study, it explains how social constraints such as those alluded to by this theory may lead many men pretend to be only interested in women whilst keeping their interests hidden to avoid prejudice associated with coming out into the open.

Taking into account that numerous HIV/AIDS-related interventions, policies and programmes in many countries particularly those in the sub-Saharan Africa have given priority to people in heterosexual relationships, this state of affairs has reinforced homosexuality as deviant behavior; depriving MSM of the opportunity to freely engage with programmes that would help to alleviate HIV/AIDS in this hidden population. To further reiterate this view, Szymanski and Carr (2008) posited that men who engage in same sex relationships and who are aware that they are regarded negatively by specific individuals or by the wider culture will incorporate those negative attitudes into their self-concept. Consequently they will be less likely to reach out to others for support by limiting their access to social support system and will be more likely to engage in avoidant coping strategies such as restricting awareness of or exposure to information regarding lesbian, gay, bisexual, transgender (LGBT) persons and culture, inhibiting same-sex behaviour and passing as or pretending to be heterosexual; this being the case for MSM.

2.2.4. The Minority Stress Perspective/Theory

This theory is one of the most prominent theoretical and explanatory frameworks of sexual minority health risk. It sheds some light into the impact of homophobia and the subsequent correlates of HIV risk among gay, bisexual men and other sexual minorities (Dentato, 2012). It gives continued understanding of the role that stigma, prejudice, rejection and internalized homophobia play in fuelling HIV and substance use among gay and bisexual men. This theory's relevance to the study is its identification of the relationship between homophobia and its subsequent effect on the affected individuals. It seeks to explain how exposure to and

experiences with homophobia have led to increased substance abuse, risky sexual behaviours, stress as well as limited social support for gay and bisexual men (Halkitis, 2012).

According to Halkitis (2012), experiences with homophobia have been shown to interfere with the ability of gay and bisexual men to establish and maintain long-term same-sex relationships, which protect against HIV acquisition. Moreover, the negative connotations of homophobia have also permeated family, school, and community settings; areas of life that are especially relevant for gay and bisexual young men for the construction process of personal identities (Halkitis, 2012). The relevance of this theory to the study lies in its explanation of how sexual minority health disparities come to being as a result of stressors induced by a hostile and homophobic culture which often manifests itself in a lifetime of harassment, maltreatment and discrimination towards those affected. Ultimately, it is these factors that impact negatively on access to health care as well as having implications for the disproportionate impact of HIV on gay and bisexual men (Dentato, 2012).

2.2.5. Social Inclusion and Exclusion Theory/Framework

The issue of social exclusion is loaded with numerous economic, social, cultural and political connotations and dimensions. In definition, social exclusion is a process by which certain groups of people are systematically disadvantaged because they are discriminated against on the basis of ethnicity, race, religion, sexual orientation, descent, gender, age, disability, HIV status, or migration status (Gurung, 2008). Those who are socially excluded are attributed little social value and viewed as inferiors; not worth much recognition. Consequently, they are not afforded the opportunity to enjoy the economic and social opportunities available to others including access to good health. Exclusion is regarded as one of the major contributors of poverty and other numerous social problems. In addition to infringing on human dignity, exclusion also denies people their fundamental human rights (such as rights to life and liberty, citizenship, education and health to name a few).

Specifically focusing on the plight of men who have sex with men, in many countries of the world irrespective of how advanced they are, sexually diverse populations continue to be among those most marginalized, excluded and discriminated against (Caceres, Aggleton, & Galea,

2008). The issue of HIV/AIDS over the decades has been unevenly distributed and as early as the 1990s, factors such as poverty, gender, sexuality, age, ethnicity, migration, engagement in heavily stigmatized practices (e.g. sex work and injection drug use) and incarceration all affect the risk of infection and in turn HIV-related morbidity and mortality (Caceres, Aggleton, & Galea, 2008). Interestingly, it is individually or in combination, that these same factors determine the extent to which an individual or group is socially included or excluded from access to information and services that can prevent infection or mitigate the impact of HIV at individual or community levels (Caceres, Aggleton, & Galea, 2008). The combination of heightened risk of HIV and social marginalization of homosexual individuals has contributed to their vulnerability to infection and the high prevalence rate. Amongst the forces that render MSM vulnerable are issues of homophobia, stigma, discrimination, human rights violations and the absence of a legal framework that offers them protection (Caceres, Aggleton, & Galea, 2008).

Issues of homophobia, stigma and discrimination are interlinked and they serve as symbolic marks imposed by dominant groups on those who are different; forming the basis upon which certain individuals and groups are significantly discredited in the eyes of others (Caceres, Aggleton, & Galea, 2008). Stigma is both felt and enacted and when it is enacted, it frequently results in discrimination as well as the denial of rights and when it is felt, it can result in self-segregation or shame which can also be equally detrimental. Such is the reality of the lives led by many MSM.

In conclusion, bringing all the theories discussed in this section under one umbrella, the concept of heterosexism and role theory are interconnected. Whilst role theory elucidates that based on personal characteristics such as gender, sex and age, people are assigned to play roles and once the roles assigned, the expectation is that they are fulfilled in already prescribed ways. In the event that roles are not performed as expected, the resulting consequence would be punishment; this situation explaining the position of many MSM and the subsequent challenges facing them.

In many societies particularly those in sub-Saharan Africa, roles and shared expectations are based on heterosexuality making homosexual relationships a violation of expected roles and warranting punishment. In the same token, heterosexism through the forces of socialization in

which heterosexuality is considered the norm; homosexuality is considered deviant and justifies punishment. People in heterosexual dominant societies feel they have privileges over homosexuals and are likely to hold prejudiced attitudes toward them. It is these prejudiced attitudes that the minority stress perspective seeks to show their input in fuelling HIV and substance use among gay and bisexual men. Moreover, the social inclusion and exclusion theory purports that the combination of heightened risk of HIV and social marginalization of homosexual individuals has contributed to their vulnerability to infection and consequently, the high prevalence rate.

2.3. Conclusion

This chapter presented a review of existing literature relevant to the study. It also discussed relevant theoretical frameworks that seek to explain healthcare seeking behaviours amongst MSM. The following chapter will present the research methodology.

CHAPTER THREE

Methodology

The approach to selecting a research design depends mainly on the question being asked. The research question involves exploring the perceptions of MSM about HIV/AIDS-related healthcare policies, services, and interventions targeting them. This means that the researcher must hear the views and beliefs from the group members themselves. Hearing (listening and understanding) is the essence of qualitative research methodology and is the reason why the researcher used this method. In order to gain insight into the perceptions, it was necessary to ask open ended questions so that the informant could identify and explain their subjective views, experience and perceptions.

This chapter considers issues related to the methodology of the study. These issues include a discussion of qualitative research design, population and sampling, data collection approaches and analysis that was utilized for this research, limitations of the study, ethical considerations and finally, reflexivity.

3.0. Research Design

An exploratory qualitative method was used taking into account the nature of the study. It is appropriate given its focus on the subjective meanings and interpretations that MSM gave to their experiences with the HIV/AIDS-related healthcare policies and services currently in place in South Africa. Given the sensitive nature of the topic, in-depth face-to-face interviews were conducted with a total of ten MSM and four key informants. The aim of such exploratory studies is to develop an understanding of human behaviour and complex phenomena through description rather than an explanation (Babbie & Mouton, 2001). Qualitative designs support such a study, as it elicits participant accounts of meaning, experience or perceptions (De Vos, 1998; Babbie & Mouton, 2001).

3.1. Population and Sampling

The study was conducted using snowball and purposive sampling techniques and the size of the sample was determined by reaching the point of saturation. Snowball sampling is a technique that uses a small pool of initial informants to nominate through their social networks other participants who meet the eligibility criteria and could potentially contribute to a specific study. This sampling technique was utilised to identify the ten MSM who participated in the study as this method is most effective in identifying individuals from hidden populations. In practice, when snowball sampling is used, a handful of subjects serve as seeds and these seeds are requested to identify other eligible recruits from their population subgroup. For this study, three eligible MSM were identified to serve as the initial seeds. The age range for the MSM was 18 to 34 years of age with a mean age of 27 years. The study tried to interview MSM from different socio-economic backgrounds with the majority coming from a low socio-economic background. The study also tried to capture perceptions of all MSM including those that identify as gay as well as other males who practice sex with another male and not necessarily identify as gay. Biographical data of the MSM is represented in *Table 2*.

To identify the four key informants, the researcher employed a non-probability sampling technique known as purposive sampling where the units that are investigated are based on the judgement of the researcher. This technique allowed the researcher to focus on particular characteristics of a population that enabled her to answer the research questions as well as triangulating the information received from the MSM. The age range for the key informants was 23 to 40 years of age with a mean age of 32 years. The key informants identified for the study held a managerial, advisory or supervisory position in an organisation providing services to MSM or advocating for the rights of MSM. Biographical data of the key informants is represented in *Table 1*. For both the key informants and MSM, the willingness of the respondents was considered so as to ensure that participation was voluntary.

Two subsets of samples were considered. These respondents were purposively selected based on the following inclusion criteria:

The ten MSM should:

- Atleast have attempted to access healthcare services atleast once in their life.
- Provided informed consent to participate in the study
- Should be able to speak English

Four Key Informants should:

- Hold a managerial, supervisory or advisory role in the organisation/institution that provides services or advocates for MSM.
- Provided informed consent to participate in the study
- Should be able to speak English

The exclusion criteria for MSM who did not qualify to participate in the study included MSM who had never attempted to access any healthcare services at least once in their lives, MSM who had not provided informed consent to participate in the study and MSM who could not communicate in English. Similarly, the exclusion criteria for the key informants included key informants who did not work within an organisation that provided services or advocated for the rights of MSM, key informants that did not provide informed consent to participate and key informants who could not communicate in English.

3.2. Data Collection

The data collection approach will be discussed in this section in terms of the data collection approaches that were used as well as the data collection instruments and apparatus employed to capture verbatim data.

3.2.1. Data Collection Approach

In-depth face- to- face interviews were utilised to obtain information from four key informants and ten MSM in an attempt to gain a holistic understanding of the issues being investigated. This method of data collection affords the researcher an opportunity to gather more information through observation of non-verbal cues, while those being interviewed have the opportunity to ask questions and clarify on certain aspects of the interview process (De Vos, Strydom, Fouche, & Delpont, 2005; De Vos, 1998).

3.2.2. *Data Collection Tools*

Two sets of semi-structured interview schedules were developed and used to guide the data collection process. The semi-structured interview schedule for MSM contained questions on the biography of the respondents, their awareness of HIV/AIDS-related healthcare policies, services and interventions and what some of their perceptions are of the quality and level of accessibility of such services. More questions pertaining to the obstacles that MSM are faced with when accessing such services were also asked. For a more detailed review of the specificities of the questionnaires please refer to the appendix D (pages 101 - 108).

The four key informants using a semi-structured interview schedule were asked to give some insight into their perceived impressions of the quality and adequacy of HIV/AIDS-related healthcare related policies and services targeting MSM and the challenges that MSM face. For a more detailed review of the specificities of the questionnaire used for key informants please refer to appendix C (pages 94 - 100). Semi-structured interview schedules were utilised because they are instrumental in ensuring that all necessary information has been elicited in a semi-structured manner that allows some flexibility in the manner in which questions are asked. Such flexibility provides an opportunity for the interviewer to probe and explore issues further. Rather than dictating the flow of discussion, these semi-structured interview schedules serve as a guide in a conversational two-way communication process that gives both the interviewer and interviewee the opportunity to ask further questions and clarify (De Vos, Strydom, Fouche, & Delport, 2005; De Vos, 1998; Babbie & Mouton, 2001). Moreover, these interview schedules gave the interviewer some discretion about the order in which questions were asked. To determine informants' understanding of the questions and the depth of the research inquiry, the initial interview schedule was prepared and pre-tested in three pilot interviews in order to check whether it was clearly worded and easily understood. Several questions were refined which were found to be unclear to the respondents.

To adequately capture the information from the questionnaires, in addition to brief notes taking, the interviews were recorded using a tape recorder. The use of a tape recorder allowed the researcher to devote their full attention to the respondents as well as the interview process (Babbie & Mouton, 2001).

3.3. Data Analysis

The interviews were transcribed and each transcript was analysed using thematic data analysis which is an open coding system used to reduce the information to themes and categories (De Vos, 1998). The following steps were undertaken in doing so:

- Reading through all the transcriptions carefully
- Making notes of ideas as they come to mind in the margins of each transcribed interview in trying to understand the meanings that they gave to their experiences.
- Clustering together similar themes from the all the transcriptions to formulate themes and categories for preliminary analysis
- Ascertaining whether the categories were mutually exclusive and if they make sense in relation to each other and to the larger themes.
- Designing a table (framework) representing these main themes and appropriate categories, even sub-categories if necessary.
- Using this framework to guide logical sequencing of the discussion of findings.
- The findings were written up using the coding framework as a guideline and actual quotes were used to illustrate the themes, categories and sub-categories. These quotes will also be linked to various authors in the literature review.

3.4. Data Verification

Verification is an important process of checking, confirming, making sure, and being certain of information. Verification refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and, thus, the rigor of a study. Lincoln & Guba (1985) as cited in De Vos (2002) identified credibility, transferability, dependability and confirmability as the four criteria in upholding the legitimacy and neutrality of a study's findings.

- *Credibility*

The issue of credibility seeks to answer the question of how compatible the findings are with reality (Babbie & Mouton, 2001). Prolonged engagement, persistent observation, triangulation,

referential adequacy, peer debriefing and member checks are some of the steps to ensure credibility. More specific to the study, the time that was allotted to interaction with respondents sought to fulfill the first two. The face-to-face interviews ran from an hour to an hour and a half. Triangulation was aimed at by employing a rigorous literature investigation, as well as observations and interviews with individual MSM and key informants. Interviews with the key informants sought to affirm findings from the MSM interviews. Existing literature and external documents were also used to contrast and confirm findings. Moreover, the specific procedures employed, such as the line of questioning pursued in the data gathering sessions and the methods of data analysis were derived from those that have been successfully utilised in previous comparable projects. Furthermore, each respondent who was approached was given the opportunity to refuse to participate in the project so as to ensure that the data collection sessions only involved those who were genuinely willing to take part and prepared to offer data freely. Participants were also encouraged to be frank from the outset of each session, with the researcher aiming to establish a rapport in the opening moments and indicating that there are no right answers to the questions that will be asked.

- *Transferability*

Transferability means, in essence, that other researchers can apply the findings of the study to their own (Babbie & Mouton, 2001). To provide for transferability, the study presented findings with “thick” descriptions of the phenomena which are a requirement for ensuring transferability.

- *Dependability*

Dependability pertains to the sustainability of findings over time or the extent to which the study could yield similar findings when applied to a different context. Thus, the approaches used to ensure credibility were also employed to achieve dependability as well (Babbie & Mouton, 2001). To also ensure dependability, the processes within the study were reported in detail, thereby enabling future researchers to repeat the work and such in-depth coverage also allows the reader to assess the extent to which proper research practices were followed.

- *Confirmability*

This refers to “the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher” (Babbie & Mouton, 2001:278). In meeting this requirement, the role of triangulation in promoting such confirmability was again emphasized by the researcher in this context to reduce the effect of investigator bias. Moreover, a detailed methodological description was given to enable readers to determine how far the data and constructs emerging from it may be accepted. Critical to this process is the “audit trail”, which allows any observer to trace the course of the research step-by-step via the decisions made and procedures described.

3.5. Limitations of the study

Limitations are constraints that inhibit progress of the study and are inevitable; however, the important thing is how the researcher addresses each limitation (Singleton, Straits, Straits & McAllister, 1988; De Vos et al., 2005). In this section, the limitations deemed the most pertinent were examined, as well as how they were dealt with. Due to the qualitative exploratory nature of the study, possible biases were anticipated that could impact the integrity of the data such as respondents being tempted to exaggerate or misrepresent information in order to give off the impression, which they may have thought was best. However, the triangulating of data from various sub-sample sets ensured that some of the biases were offset and a more holistic picture was attained from the varying insights (De Vos et al., 2005).

The use of snowball sampling posed a situation where MSM who share the same social and sexual contexts as each other could have been interviewed; making the generalization of results obtained difficult. However, when a population is unknown and there is little information available about it, snowball sampling can provide a better understanding and more complete characterization of a population. The purposive sampling approach used to target key informants may also raise issues where generalization is also concerned. Moreover, the data collected represents the perceptions and experiences of a small, non-representative population and as it also focused explicitly on the experiences of MSM in two communities in a single South African province; data may not be generalisable to the entire country. The sample of MSM may also

have come out of primarily gay men whose risk behaviours may be different from MSM who are not openly gay. Only one MSM came from a higher socioeconomic status; therefore much of the views came from MSM with a low socioeconomic background.

The interview language was English and it was not the native language for many of the interviewees or the researcher; which could limit the expression of thoughts. The primary researcher is a foreign, heterosexual young black woman and given the sensitive nature of the research topic, it is possible that participants may not have openly discussed certain issues in a manner that they probably would with someone who shares their sexual orientation and background. As a student, the researcher regarded the research as a learning process in itself; therefore this research may not be free from error; pertaining to both the content as well as technical aspects of the study. Furthermore the researcher is not above the challenges that scholars in this area are faced with, such as the lack of available empirical data, particularly with respect to MSM.

As the research was coming to an end, the researcher recognised that certain objectives of the study were closely aligned. As a result there was some overlapping of data, which gave some sense of repetition in both the discussion and concluding chapters. Although this was discovered at the end of the research process, this has however served as an important lesson curve for other studies to come in the future. In spite of these limitations and potential sources of bias, the hope is that the study can contribute to some of the gaps requiring further attention in respect to issues of HIV/AIDS-related healthcare efforts that are critically needed to reduce the prevalence of HIV/AIDS amongst MSM in South Africa.

3.6. Ethical Considerations

The issue of ethics should not only be taken into account but should be dealt with the utmost importance. Ethics are meant to protect the welfare of the participants and social research should not harm or injure the people being studied. Researchers must therefore take all the necessary precautions to ensure that the respondents are neither emotionally nor physically harmed

throughout the research process (Babbie & Mouton, 2001). To ensure that this happens, ethical approval was obtained from the Department of Social Development at the University of Cape Town. The researcher sought to:

3.6.1. Prevention of Harm

MSM are not only hard to reach but combining issues of HIV/AIDS and MSM makes it even harder to reach individuals dealing with both phenomena due to the sensitive nature of both issues. The research presented some significant potential to evoke emotional responses from participants. However, to ensure that no physical or emotional harm came to the participants, the researcher took necessary precautions such as informing the respondents that they were in control of the extent to which they could respond to questions to ensure that harm was minimised. In addition, before the commencement of each interview, the respondents were made aware of the nature and goals of the study as well as making participation completely voluntary and informing that they could terminate the interview if they bid it necessary.

3.6.2. Informed Consent

A written informed consent was sought from each and every participant. The researcher provided all participants full disclosure of all information necessary for making an informed decision of whether to participate or not in the research. Information on the consent form included an invitation to participate, a statement of the research purpose in plain language, the identity of the researcher, the identity of the institution from which the researcher is from, the expected duration and nature of participation, a description of research procedures, and an explanation of the responsibilities of the participant. An assurance was also given to prospective participants that they will not be under any obligation to participate and can freely withdraw at any time without prejudice to pre-existing entitlements. Before commencement of each interview, the researcher ensured that each respondent gave consent by signing the consent form. Moreover, the researcher also took necessary steps to the best of her ability to ensure that all individuals concerned had adequate reasoning faculties to be able to make the decision to participate.

3.6.3. Voluntary Participation

Voluntary participation is one of the basic principles of research and this principle prescribes that people should not be coerced into participation (Babbie & Mouton, 2001). Therefore, to ensure that this happened, all participants were thoroughly made aware of the entire research process and their right not to participate if they were not comfortable to do so in the beginning of the interviews. They were also made aware of their right to withdraw any time they were not comfortable with continuing with the interview. The participants were also made aware that withdrawal of consent will neither result in any penalties or loss of benefits that the participants may be entitled to from any organisations nor excluded from any benefits that may arise from the publication of this research.

3.6.4. Privacy Issues

The issue of privacy includes two very important dimensions with the first being the concern of exposure of views and actions that may have damaging consequences for the respondents and the second being that the research may probe into areas that constitute private space, thus overstepping the customary between self and the environment (Kelman, 1977). To ensure that these concerns are adequately addressed, the researcher was comprehensive and truthful in providing information about the possible uses of the data to the respondents to ensure voluntary participation in the study. Further information was also provided about the researcher, the institution under which the research will be conducted, to whom the research findings will be reported and who would have access to the data. In respect to this study, the data was only accessed by the researcher and her supervisor. The researcher ensured that the interviews were carried out in an environment that enabled respondents to be free to answer any questions without fear of being overheard or victimised. In the case of overstepping certain boundaries that respondents may not be comfortable with, the participants were made aware of their right to withdraw if they became uncomfortable with the interview.

3.6.5. Anonymity and Confidentiality

The issue of anonymity and confidentiality is about protecting participants' interests and identity (Babbie and Mouton, 2001). Confidentiality refers to the researcher safeguarding the

respondent's answers within the interviews and anonymity refers to withholding the respondent's names (De Vos et al, 2005). Taking into account the sensitive nature of this research, in order to ensure anonymity and confidentiality, the participants were encouraged to make use of aliases to conceal their real identity. This also ensured that the respondents freely expressed themselves. Although a tape recorder was used to gather information with the consent of the participants, the researcher made it clearly known to the respondents that only the researcher and her supervisor will have access to the transcribed data and that all the precautions were taken to ensure that data was protected at all times.

3.6.6. Debriefing of Respondents

In order to minimise harm to the participants, it is always necessary to have a debriefing period after an interview (De Vos et al, 2005). The researcher therefore ensured that the respondents had enough time to express any comments, concerns or questions once the interview was completed.

3.7. Reflexivity

Coming from Zimbabwe where the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community is not recognized and is highly persecuted, I was thus motivated to pursue studies around this issue with the goal of shedding some light on why turning a blind eye to these communities could be detrimental for many countries particularly taking into consideration issues of HIV/AIDS. Moreover, my personal and academic experiences also developed my interests in issues of HIV/AIDS and the research topic provided opportunities to delve into a critical area that is under-researched. Altogether, this research endeavor presented an exciting challenge as well as an area of convergence for my personal aims and interests.

The lack of studies around this subject in many African countries further heightened my enthusiasm for such a research endeavor. However, this also created certain challenges in collecting data and maintaining a focused study particularly given the reality of certain constraints on my capacity and resources. Accessing the respondents proved to be challenging as well as overwhelming. Being female and also Zimbabwean made it difficult to easily gain access and trust of the respondents.

Nonetheless I was greatly inspired by the research and the information gained. Reading through the interviews shed a lot of light on various issues that need to be addressed and hopefully my research could be instrumental in lobbying for the rights of the LGBTI communities as well as adding to the body of work on MSM that is highly lacking.

3.8. Conclusion

This chapter detailed the methodology that was adopted. A clear overview was provided with regards to what research design was used, how the sampling strategy was carried out and how data collection and analysis was done. Finally, some limitations inherent to the study were discussed. The following chapter presents and discusses the main findings.

University of Cape Town

CHAPTER FOUR

Presentation and Discussion of Findings

This chapter provides an in-depth analysis of the data collected from a total of fourteen interviews (ten with MSM and four with key informants) carried out with people residing in Cape Town, South Africa. First, a profile of all respondents in the various sub-samples will be presented followed by the framework for analysis. Secondly, the discussion of the findings outlines the major themes, categories and sub-categories that emerged from the analysis of data collected. Direct quotes from the transcriptions will be used to illustrate the respondents' perceptions and this will be discussed with reference to existing literature. Finally the researcher will add their own short critical commentary where pertinent.

4.0. Profile of Respondents

Below are the profiles of four key informants and ten MSM interviewed according to the sampling criteria. Aliases were used to conceal their real identity so as to protect their privacy while honouring the confidentiality clause of the study.

Table 1: Profile of Key Informants

Alias	Position/Role	Age	Race
Key Informant 1	Project Manager	40	White
Key Informant 2	Advocate	35	Black
Key Informant 3	LGBT society representative	23	Coloured
Key Informant 4	Programmes Coordinator	30	Coloured

Table 2: Profile of MSM

<i>Alias</i>	<i>Age</i>	<i>Education</i>	<i>Employment Status</i>	<i>Relationship Status</i>	<i>Place of Residence</i>
Francis	24	Completed secondary school only	Employed part-time	In several relationships	Woodstock
Peter	27	Completed secondary school only	Employed	In two relationships	Mowbray
Mark	18	Secondary school not complete	Unemployed	Not in a relationship	Mowbray
Pedro	32	Post-secondary	Employed	Married	Observatory
Marlowe	26	Secondary school not complete	Self-employed	In a relationship	Wynberg
Andile	26	Secondary school not complete	Unemployed	In a relationship	Wynberg
Tim	34	Secondary school not complete	Unemployed	In several relationships	Woodstock
Rodrigo	30	Completed secondary school only	Self-employed	In a relationship	Salt River
Steven	29	Post-secondary	Employed	Not in a relationship	Sea Point
Lucas	23	Completed secondary school only	Unemployed	In several relationships	Khayelitsha

4.1. Framework for Analysis

In this analysis stage, the data that was gathered was sifted, charted and sorted in accordance with key issues and themes that are illustrated in *Table 3* below. This process involved a five step process of familiarization, identifying a thematic framework, indexing, charting and finally mapping and interpretation (Ritchie & Spencer, 1994). Familiarization was the process during which the researcher became familiar with the transcripts of the data transcribed from the audiotape used during the interviews. After familiarizing, the researcher engaged the other processes until the final stage where the key ideas and recurrent themes became evident through the analysis of the key characteristics. It was through this analysis that a schematic diagram of the event/phenomenon was designed to guide the researcher in their interpretation of the data set keeping in mind the objectives of qualitative analysis. Concepts were clearly defined, the range was mapped, categories were formed and associations were investigated to provide explanation and develop strategy.

Table 3: Framework

<i>Themes</i>	<i>Categories</i>
1. Awareness of MSM about HIV/AIDS-related policies targeting them	<ul style="list-style-type: none">▪ Lack of awareness
2. MSM's Understanding of HIV/AIDS-related healthcare services and interventions targeting them	<ul style="list-style-type: none">▪ Limited and under-resourced healthcare facilities▪ Lack of privacy and confidentiality▪ Inadequate information and services

3. Perceptions of MSM about HIV/AIDS-related policies targeting them	<ul style="list-style-type: none"> ▪ Lack of visibility and involvement by the government ▪ Ineffective and insufficient ▪ Wrong message being sent
4. Perceptions of MSM about HIV/AIDS-related healthcare interventions targeting them	<ul style="list-style-type: none"> ▪ Unsatisfactory ▪ Inadequate expertise and lack of capacity
5. How MSM-friendly are HIV/AIDS- related healthcare services and interventions?	<ul style="list-style-type: none"> ▪ Insensitive healthcare workers (HCW) ▪ Lack of privacy and confidentiality ▪ Inadequate and inappropriate services
6. How accessible are HIV/AIDS-related healthcare services to MSM?	<ul style="list-style-type: none"> ▪ Negative attitudes ▪ Inappropriate services and information
7. Challenges and Barriers faced by MSM in accessing HIV/AIDS-related healthcare services and interventions	<ul style="list-style-type: none"> ▪ Stigma ▪ Discrimination ▪ Homophobia ▪ Lack of expertise in generalised healthcare facilities

4.2. Awareness of MSM about HIV/AIDS-related policies targeting them

4.2.1. Lack of Awareness

With regards to the knowledge and awareness by MSM of any existing policies in place to address their HIV/AIDS-related healthcare issues, the general consensus amongst MSM (8 of 10) was that they did not know of any. Most of the respondents gave a simple ‘no’ as an answer. However, in an effort to give some insight into what they did know, one of the respondents said they were just aware of the procedural requirements after taking an HIV test and another simply said all he knew was that homosexual people were not allowed to donate blood.

If there are any policies I am not aware of them. I just know of a separate series of questions after you go for an HIV test where they ask if you're gay - Francis

I don't know of any. All I know is that blood donating is not allowed for MSM because we are more likely to have HIV/AIDS - Mark

I am not aware of or knowledgeable of any policies relating to MSM, which as I have said before speaks to the lack of visibility of the policies and services – Andile

Despite South Africa being the only country on the African continent that legally recognises same-sex relationships and outlaws discrimination on the basis of sexual orientation, it is sad to learn that MSM are still distinctly neglected in HIV/AIDS-related prevention and treatment strategies. If policies targeting MSM were as popular as those targeting people in heterosexual relationships, expectation would have been that at least some of the respondents should have been aware of some policies available to serve their needs. This marginalisation and neglect of MSM is also evidenced in the lack of tailored HIV/AIDS-related prevention campaigns and research. HIV prevalence and incidence among MSM in South Africa has largely remained undocumented. The South African National Strategic Plan (NSP) on HIV & AIDS and STIs 2007-2011 acknowledged the existence of MSM and that there is currently very little known about the epidemic amongst MSM (Rispel and Metcalf, 2009; Rispel, Metcalf, Cloete, Moorman and Reddy, 2011). The plight of MSM with HIV/AIDS was also recognized which led to the stipulation of certain HIV program targets for MSM as well as other vulnerable groups (Rispel and Metcalf, 2009; Rispel et al, 2011). However, MSM have largely remained excluded from national HIV and AIDS interventions due to the lack of a specific national HIV policy for MSM (Rispel and Metcalf, 2009; Rispel et al, 2011). As a result, there has been little, if any progress on the implementation of actions pertaining to MSM (Rispel and Metcalf, 2009; Rispel et al, 2011). The new National Strategic Plan 2012-2016 is still to yield results and much remains to be seen.

To further reiterate the state of affairs in African nations as far as the exclusion of MSM is concerned, the Panos London Illuminating Voices (2012) reported that the majority of African nations have no MSM tailored initiatives for risk reduction as evidenced by the lack of MSM data in their country reports. Formal Country HIV-related policies, strategies and programs are reported to be designed to address generalized epidemics and not targeted epidemics among MSM (Panos London Illuminating Voices, 2012). Brazil is the only country that is reported to have a government action plan to specifically address MSM and transgender people in HIV rhetoric (Panos London Illuminating Voices, 2012). Furthermore, nearly 80 nations around the world, 32 of which are in Africa, criminalise same-sex acts between consenting adults with penalties ranging from fines, imprisonment and, in seven countries, death (MSMGF, 2010). Such punitive laws coupled with stigma from families and society can and has forced MSM to engage in risky sexual behaviour, thus increasing their vulnerability to HIV.

4.3. MSM's Understanding of HIV/AIDS-related healthcare services and interventions targeting them

4.3.1. Limited and under-resourced healthcare facilities

All the MSM interviewed were aware of their right to receive HIV counseling, testing and STI treatment as well as where to access services. However, it was clear that prevention interventions for MSM are more limited than for heterosexual individuals. Issues of public facilities being under-resourced to meet demand were brought up as a barrier to accessing health services. MSM are a marginalised group with special needs such as MSM specific healthcare and counselling, which can only be provided by skilled personnel with the knowledge and tolerance required for this group. However, due to the lack of such skilled personnel, many times MSM end up getting services that are too generalised for their specific needs. Public hospitals and clinics are also characterised by long queues with predominantly heterosexual individuals, which in most communities are homophobic. As a result, the majority of MSM end up forfeiting appropriate healthcare services. Therefore, there is a need for expansion of healthcare facilities that specifically cater for such groups with special needs.

The high demand for medical care amongst MSM currently seems to be outstripping the ability of local, regional and national governments to deliver medical care services that are consistent with generally established standards of care – Key informant 2

Although it is true that demand is far outstripping the ability by the government to provide services to MSM, one tends to wonder if this is merely an issue of limited resources or simply lack of understanding and capacity to deal with MSM-related issues by the government. The available literature shows that both in South Africa and many other African countries in particular, prevalence rates amongst MSM have continued to soar due to a combination of structural, political, social, and behavioral factors that have made it difficult to accept such behaviour (Rispel et al., 2011). Often we hear LGBT behaviour being referred to as being “un-African”, this term particularly shedding some light on the reasons for such resistance by many African leaders and communities alike. Such held notions not only affect service providers but also policy makers to the extent that numerous polices and interventions have excluded this group of individuals and not recognizing their existence; thus leaving this group of people vulnerable.

4.3.2. Lack of Privacy and Confidentiality

The majority of MSM (70%) interviewed felt that HCW particularly in public clinics and hospitals were providing services to them as a matter of obligation as opposed to actually caring for their health. During testing, some of the MSM reported that various staff members would be going in and out of the testing rooms. Moreover, they also reported that in some cases although not frequent, doors to the examination rooms were left open during consultation; this being a clear lapse in standard protocol that would prohibit patients from discussing their health issues in the full view of other waiting patients.

Furthermore, 30% of the respondents reported to have witnessed records of results being left out where anyone could get access. Several of the MSM (60%) also complained that the physical setting and layout of some VCT clinics could be more discreet. All these factors attributed to the strong feelings that their privacy and confidentiality is often threatened.

When people are sitting there waiting to go in it's very obvious that they are being tested for HIV - Francis

Because the demand is high, nurses are so overworked and they end up turning their anger on us. They stop doing their work properly. Once when I was waited for my results, I saw one of the nurses come out of the testing room where she was obviously testing another someone. I don't know if it was a mistake but she just left the results on the desk and anyone could have taken a look if they wanted – Lucas

It is very hard for me to go to the local clinics because I always feel like someone there will recognize me. Most of the people who work there are from my neighborhood and we go to the same church. If only the community was tolerant things could have been easier for us. Now I am forced to seek transport money to get to places where no one knows me just to get help – Peter

The results obtained in this study echo those that were previously obtained from a study that was conducted in Soweto and Mamelodi, South Africa. MSM in these two locations also reported that their rights to privacy and confidentiality are often threatened by healthcare workers engaging in gossip and homophobic verbal harassment (Anova Health Institute, 2010). As a result, many MSM were forced to delay seeking treatment; a prospect that increases the risk of contracting HIV or passing it on to other unsuspecting individuals. The general lack and access to supportive MSM friendly VCT services has also resulted in MSM lacking awareness of effective risk reduction strategies specific to the risk behaviours that they engage in (Anova Health Institute, 2010). Such a finding is critical as it is successful in highlighting that not only are these isolated to one area of the country, but these are issues that are being reported by MSM in other parts of the country.

4.3.3. *Inadequate Information and Services*

Although MSM recognized HIV/AIDS information to be good and widely distributed in public clinics and hospitals, they however felt that the content was too generalised for their specific needs. Many felt that more needs to be done to address issues that they deal with in their everyday lives. Other than HIV testing and the procedural counseling that comes with it, STI treatment and provision of Antiretroviral Therapy (ART), none of the MSM interviewed were aware of any other services provided in the majority of public healthcare facilities. However, LGBTI Community Based Organisations (CBOs) were cited by most of the interviewed MSM to be the go-to-places where extra support was given to them such as psychosocial support services, MSM targeted education on HIV/AIDS-related prevention and transmission, mental healthcare services as well as coping strategies and mechanisms. The people working in these LGBTI CBOs were reported to be more understanding, tolerant, sensitive and empathetic to MSM and genuinely cared about their well-being. However, although critical to the healthcare service provision for MSM, such organisations and centers are reported to be too few and far in-between.

Through its ratification of gay rights, South Africa showed that it is a progressive thinking and dynamic place and although visibility of efforts being made by the government is still limited we are much better than our African counterparts. That being said, however, people have not found it easy to talk about MSM or about the several breakthroughs that have been made to curb HIV amongst these groups such as Pre-Exposure Prophylaxis (PrEP). Such interventions are met with huge mental walls and people are also uncomfortable talking about rectal microbicides due to the entrenched cultural and religious beliefs that anal sex is a taboo. Publicly available HIV information in the form of pamphlets or targeted counseling services are mainly directed at heterosexual couples yet MSM are a group of people who are at an even greater risk. I am still yet to come across an advertisement either on TV or radio that talks about MSM and HIV. Clearly we are being left out – Key Informant 1

I feel there is so much information available on HIV but whenever I read the information it's always about men who are in relationships with women. It is frustrating because sometimes I have questions that I cannot exactly ask anyone and can only try to investigate on my own and so you can imagine how difficult it is. I feel embarrassed asking people because you never know how they are going to take it – Marlowe

The organisation that I go to has really really helped me. I have found it hard to talk to my family or anyone around me about my sexuality because I know they will never accept it. Sometimes I need to go to the clinic for something but I cannot just go because I don't have the money and that means I have to ask for money. The problem with asking is that I have to explain why I need to go there. I can't keep up with the lies sometimes – Mark

To corroborate what the MSM had reported, several of the key informants were of the same perception that the experiences of MSM particularly in public clinics and hospitals where tolerance towards gay men is questionable left little to be desired.

It is not a secret that LGBTI individuals are on the receiving end of society's prejudice. We are still engaged in a fight against stigma, discrimination, prejudice, violence and various gaps in service delivery - Key Informant 2

The critical part is that people need to understand the social relations of gender identity and sexuality and LGBTI self-identified centres have a level of expertise when it comes to addressing these issues that no other places have - Key Informant 4

4.4. Perceptions of MSM about HIV/AIDS-related policies targeting them

4.4.1. Lack of visibility and involvement by the government

Stemming from the fact that 80% of MSM interviewed had no knowledge of policies currently available to address HIV/AIDS-related healthcare issues they are faced with, it was not surprising that many of them had very little good to say to that effect; except their disappointment about the lack of visibility and involvement by the government. One of the respondents put it plainly;

The fact that I as a gay man do not know about these policies if there are any tells me that more work needs to be done surrounding these policies. I therefore cannot comment on their efficacy as I have no experience of them - Steven

I think there is a lot of information out there about how one gets infected but I don't think there is enough being done for MSM....I don't know...South Africa is not generally a broadly open minded society and there really needs to be a big big drive by the government in terms of dealing with men is same sex relationships who are infected. The thing is it's not like you are going to discriminate people with diabetes or with high blood pressure yet these are chronic diseases just like HIV/AIDS but the problem comes when it is MSM who are infected. All these are chronic health conditions for which there is medication that they can take to prolong their lives as long as they can get the help they need - Tim

The majority of the key informants interviewed also felt that although MSM have been recognised in both the National HIV/AIDS strategic plans of 2007 and 2012, not enough of this mandate has translated to equitable action on the ground. Moreover, the key informants also felt that these people have been let down by the lack of protection of rights for same sex couples as evidenced by the often recurring violence and brutality against these people because of their sexuality.

We are very fortunate in South Africa to have Constitutional protection but the reality is that on the social level there are still vast inequalities - Key Informant 2

You can almost say that our Constitution happened as a surprise because when we had our new democracy I don't think it brought a change in mentality or that grassroots conscientiousness was ready yet for same sex equality. We got our rights very quickly but a lot of people got left behind. You will still find that in the grassroots communities there is still a lot of homophobic violence and discrimination so it's one of two things; we are very fortunate that we are ahead of the curve as far as gay rights are concerned but at the same time some people still need to be made aware and sensitised towards the LGBT organisation - Key Informant 4

What I find about South Africa is that we are a hurt people and we are still trying to find ways to connecting with each other across race and social economic differences so if you put sexuality on top of that it becomes even more complex - Key Informant 3

I feel with socio economic development people will become more educated and more open to tolerance towards other people who are seemingly different from them. If something that is as basic as basic needs has not been adequately met in South Africa I find it a very difficult thing to expect people to understand issues of diversity in sexuality - Key Informant 1

The sentiments of the key informants are that not nearly enough is being done by the governments to address issues that are faced by minority groups such as MSM as well as continuing to monitor that the rights of MSM are not infringed upon. The assumptions made by the Role Theory which was one of the theoretical frameworks of empirical evidence that was used for this study are that as people spend much of their lives participating as members of groups and organizations and within these groups,

people occupy distinct positions for which each of these positions entails a role, which is a set of functions performed by the person for the group. Therefore, groups often formalize role expectations as norms or even codified rules, which include what rewards will result when roles are successfully performed and what punishments will result when roles are not successfully performed. Therefore MSM are considered to be in violation of “normal behavior”; leading to prejudice by heterosexual individuals and from the secondary data collected, not only did these held notions affect service providers but also policy makers to the extent that numerous policies and interventions have excluded this group of individuals and not recognizing their existence.

4.4.2. *Ineffective and insufficient*

The fact that the HIV/AIDS prevalence has continued to rise amongst MSM is a continued reflection on the ineffectiveness of prevention programmes and mechanisms that have been put in place to address HIV/AIDS-related healthcare needs for this group of people. These were the sentiments by the majority of the MSM and key informants that were interviewed.

I don't think if there are any policies they have been effective at all. For the longest time I struggled to get my hands on any information until a friend of mine helped me out. From him I got information of where to go to get help. I feel as if the government is withholding vital information from MSM with regards to safe sex. The mistreatment and second class treatment we get makes us not want to even discuss our issues with anyone or even go for an HIV test -
Mark

In Africa, policy and programmatic responses to HIV prevention have been tailored to generalised epidemics that focus on interventions that mainly target heterosexual and mother-to-child transmission. What this has done is limit surveillance and response to the burden of HIV in high-risk groups –
Key Informant 4

4.4.3. *Wrong message being sent*

Some of the MSM (40%) interviewed felt that most of the information available seems to insinuate that all MSM are likely to be HIV positive or responsible for the spread of HIV. As a result, they reported that whenever a gay person goes into the clinics or hospitals, people including HCW automatically assume the worst and this kind of treatment is not only offensive but is embarrassing for many MSM trying to seek help.

Most of the people seem to think that every gay male has HIV/AIDS and this is the very kind of treatment that we get especially if you are spotted in a hospital no matter if you are there for a simple problem. But then I ask myself.....Can I really blame these people if that's the message that is being preached? - Tim

Being gay I have already been judged and found to be guilty of all immoral things. HIV/AIDS is just one of those things that I am already judged to have as a result of my sexuality - Francis

Growing up being gay was associated with being bad or being possessed by the devil. It's a wrong message that is being sent which I feel stems from and is systematised and sanctioned by our leaders. You said you are from Zimbabwe right? Even your president says we are worse than pigs. We also have people whose jobs are to discuss issues of HIV in our own parliament who call us names like that even. How then do you think these people will make decisions with our best interests at heart? - Tim

4.5. Perceptions of MSM about HIV/AIDS-related healthcare services and interventions targeting them

4.5.1. *Unsatisfactory*

Some of the major reasons of the high HIV prevalence particularly amongst the vulnerable MSM group include the psychological impact of living in a heteronormative, stigmatising and

discriminating society especially within the healthcare facilities. HCW in some public clinics and hospitals engage in homophobic verbal abuse towards MSM, particularly those who identify as openly gay. Six of the MSM (60%) interviewed reported to have had a firsthand experience with such reported homophobic verbal abuse while the rest were aware of several stories where such harassment had taken place. Such episodes of harassment were reported to be deterring many from seeking essential services provided in public clinics and hospitals.

Just because sometimes we do not react to what people say people think we are stupid and unaware of what is happening around us. If I tell you how many times I have been called a faggot I wouldn't be able to because I myself wouldn't remember. It has happened so many times. Even in the clinics we visit we hear whispers of faggot and see the hatred stares. If this happened to you would you go back? We know we can get HIV testing and treatment for STIs but the environments where we need to go to get these services are unwelcoming. I often feel I am unwanted there but sometimes because you are sick you don't have a choice but to endure it - Andile

The challenges that LGBTI people are experiencing in terms of accessing mainstream services is basically stigma and discrimination. Service providers including the healthcare providers put their own beliefs before what their jobs require them to do - Key informant 4

Assumptions by HCW that men should be involved with women were also said to be resulting in leading questions that make it very hard for MSM to discuss their sexuality. Such situations are not only embarrassing but are highly uncomfortable for most of them. It is difficult to debunk such mentalities and this often results in the lack of full disclosure about sexual orientation; causing widespread delay in accessing treatment of STIs and HIV/AIDS-related illnesses. This situation is further exacerbating the epidemic amongst MSM.

The main focus is on heterosexual infection which has resulted in a message that is heteronormative, the process of addressing risks that are

associated with unprotected anal sex in MSM has greatly been hindered. High risk reduction tools for MSM are limited and ineffective. For example, you find that although condoms are effective, latex compatible lubricants are required for anal sex with a condom but are expensive and not widely available in Africa. – Key Informant 1

In Africa, anal sex is associated with homosexuality and homosexuality in our culture is a topic not everyone is comfortable with. No one is willing to talk to openly about prevention strategies and other related healthcare issues. For example, currently in development are rectal microbicides, which are ARV-based and might reduce the risk of HIV infection when used during anal intercourse. However, such PrEP still remains unavailable to most MSM in Africa. In heterosexual studies, such microbicides have already undergone clinical trials and have been shown to reduce a woman's chance of becoming infected with HIV – Key Informant 4

4.5.2. Inadequate expertise and lack of capacity

To reiterate on some of the points previous mentioned before (section 4.4.), six of the MSM interviewed (60%) emphasized that HCW in mainstream healthcare facilities were ill-equipped to deal with the psychological and physical needs of MSM seeking healthcare.

For someone to be able to assist us with the adequate care that we require, they must be aware of the issues that affect us and only then can understand us. The few times that I have gone to a clinic especially in my neighbourhood I was made to feel that I don't belong there. It was so easy to see that the issues that I was dealing with were foreign to the people who were supposedly supposed to help me. These people don't even want to touch us but they just end up doing it because they are scared of losing their jobs. They otherwise couldn't care what happens to us - Andile

Health services in government hospitals for MSM are very poor. The health care workers are not ready to provide services to us especially if you

go to places where you don't have to pay. They don't even feel the obligation to help and it is not even in their minds that they should help people like me -
Marlowe

The majority of the study participants (80%) pointed out that unless special clinics are created for them, the healthcare system will never be able to adequately handle the issues and needs that MSM are faced with as indicated by one participant's response below:

The health care system will not treat us the same way as others unless we have special clinics for us - Peter

Although in South Africa the rights of people in same sex relationships are upheld by the constitution, the identified gaps in HIV/AIDS-related healthcare services for these people are a reflection of how inadequate the commitment is on the part of the local, regional and national governments. Moreover, this lack of commitment is further evidenced by the limited information and research on the various issues of MSM and transgender communities. Targeted interventions for these groups are disjointed, and many are funded by international donors, with little high-level national governmental support (Lane et al, 2008; Rispel and Metcalf, 2009).

Although global debates and focus is on novel approaches to HIV treatment and prevention and substantial progress has been made, MSM continue to be marginalised and still struggle to obtain the most basic health services - Key Informant 2

To reinforce the need for specialised clinics to deal with HIV/AIDS-related healthcare issues of these minority groups, two of the key informants reported that it is increasingly becoming a challenge to diagnose and treat MSM in a timely manner as many are unwilling to disclose their sexual orientation or source of sickness. This unwillingness was said to be emanating from deeply entrenched perceived and internalised stigma which often results from experienced stigma. Moreover, a perception of lack of confidentiality and privacy which was reported to be a frequent occurrence in government hospitals and clinics is another contributing factor.

Some health workers are reporting that their MSM patients are not forthcoming about their health problems. According to some of the STI clinical officers that we have come across in some of our seminars, time and time again they have reported that it is difficult to provide timeous help to MSM clients because they don't disclose anything about their same sex relations. This often results in long and expensive tests just to determine something that could have only taken a few minutes to find out. This process you find delays treatment and can be detrimental to their health especially when treatment is needed immediately – Key informant 2

Although the general consensus amongst MSM interviewed about the quality of healthcare services in mainstream healthcare facilities was that they needed improvement, it was encouraging that atleast two of the respondents spoke positively about the quality of treatment they have receive.

Health care workers are good people they will treat you as well as any other patient and they do not discriminate as we are all human beings - Steven

Personally I know my rights and the law so I haven't been discriminated against in that sense nor have I ever been in a situation where medical staff has done so. But I do know of other gay guys that have been discriminated against and encountered homophobic attitudes - Pedro

Upon further investigation, it came to light that these two unlike the other MSM interviewed made use of private hospitals and they had medical insurance. Moreover, they had good paying jobs and were the most educated of the group.

4.6. How MSM-friendly are HIV/AIDS-related healthcare services and interventions?

4.6.1. Insensitive healthcare workers (HCW)

The majority of the respondents (60%) in this study reported a lack of confidence in disclosure of their sexual orientation to HCW because of the perception that once they did so, they would be get treatment that is different to their heterosexual counterparts. Four of the respondents (40%) reported to have had a personal experience with HCW that reacted negatively when they revealed their sexuality. Reported reactions included but not limited to shock, discomfort, confusion and surprise. These reactions create an atmosphere that restricts open and honest conversation which is necessary when dealing with issues of HIV/AIDS.

I wonder if I will ever see the day that everyone will start to treat us as normal human beings. Because we have so much experience with people who do not accept gays we are very aware of people's body language even if they try to hide it. Some of these nurses think they are hiding it very well but we can see what is really underneath. It is obvious that many of them get surprised when you tell them you are gay and automatically the treatment changes. As long as they are not sensitized to diverse sexual preferences they are always going to treat us differently – Tim

We have come to terms with the fact that it will take a long time get equal treatment as other people. Many people still struggle with behaviors like ours and do not know how to deal with us. Many have tried to "correct us" but what they don't know is that this is not just a choice for us; we were made like that. If it was a choice do they honestly think we enjoy the treatment that we are subjected to? - Francis

4.6.2. Lack of privacy and confidentiality

MSM are hidden group of people and they are very sensitive to issues of privacy and confidentiality which was reported to be inadequate in some of the public healthcare facilities.

Going to the clinic for me is actually painful if there is such a thing. By painful I mean it mentally and physically torments me. I never feel comfortable and from the looks around me I can tell somehow that I don't belong there. I had a terrible experience when I was 18 back in the township where I used to stay. It was one of those experiences that you will never forget and too bad for me it has scarred me. I was young and naïve and I didn't mind telling people I was gay because I was proud of it. Although I got the help I needed I can tell you that I certainly paid for it in more ways than one. By the time I left I can tell you that almost everyone who worked there knew what I was and why I was there. I could see people giving me the side look trying...I don't know....maybe it was in my head but I don't think so. At first I tried to ignore it to a point when I couldn't anymore. On my way out I could not mistake the disgusted stares and I overheard one of them whispering, "What would possess a man to want to go on his knees. Sis!" I felt so humiliated. It was later when I was talking to my boyfriend that he told me I had made the biggest mistake ever. Apparently people like me never made use of that clinic because it was notorious for not accepting gay people. There was a code of conduct that Xhosa and Zulu men should be strong and act like a "man" and not like those white men in the suburbs who sleep with each other. It finally dawned on me that all that circus was about me. From that day I never became comfortable with going into clinics because I don't know what they could be saying behind my back. Those nasty looks are degrading - Lucas

In an attempt to shed some light insight onto the behaviours of certain HCW like those discussed above, all the key informants agreed that this it all has to do with multiple stigmas that still exist in our communities around issues of homosexuality and HIV/AIDS. African cultures are also still resisting acknowledging and condoning same sex relationships.

Many people still feel that same sex practices are against the laws, culture and traditions of our country. Often I have heard people arguing about how the children of today have lost their way and the way of God by

deviating from what God himself had planned for humanity. Many people still cannot come to terms with same sex practices – Key Informant 3

4.6.3. Inadequate and inappropriate services

The majority of MSM (80%) felt that there are too few government funded clinics that are offering comprehensive treatment packages to MSM. Most of the policy and programmatic responses to HIV prevention have undoubtedly been tailored to generalised epidemics that focus on interventions mainly targeting heterosexual individuals. Consequently, not all MSM are able to access medical attention; a prospect that speaks volumes to why prevalence has continued to rise amongst these individuals.

Health services in government hospitals are not as focused on our issues as they are on issues of men who are married to women. They can go to hospitals freely and get all the help they need without being judged in the way that we are - Andile

The whole set up of the system and procedures in our hospitals are not yet fully adequate to cater for the needs of MSM – Key Informant 4

Although we are very aware of the high prevalence of HIV/AIDS amongst MSM, the availability and appropriateness of health services for this at-risk-group in many healthcare facilities does not seem to reflect this in their quality and quantity. This is what is posing a great challenge to the fight of HIV/AIDS in this group of individuals - Key Informant 1

Such responses from MSM as well as the key informants echo what has been reported in some literature. Although through the NSP 2007-2011 recognition was made of MSM being a most at risk population, there was however no clear strategy that was mentioned to ensure HIV/AIDS prevention and treatment amongst MSM. As a result, there have been limited MSM specific healthcare services to care, prevent and treat HIV/AIDS, thus contributing tremendously to the lack of quality HIV-related healthcare available to them. However, post 2011, in recognition of this fact, the new National NSP 2012-2016 not only continues to recognise MSM as a most at

risk population, but goes a step further than the NSP 2007-2011 to highlight a few targeted approaches for MSM in the care, treatment and prevention of HIV/AIDS (SANAC, 2012). It recognises that denial of access may be in the form of services being provided in a manner that fails to address or understand a person's specific needs; including staff attitudes that may discourage people from accessing social services. Therefore, it proposes that service providers should have some understanding of the difference between transgender persons and gay men, who are often collectively considered to be men who have sex with men for the provision of appropriate HIV-counselling services (SANAC, 2012). In addition, it also proposes social interventions that seek to change cultural and social norms that are reported to increase vulnerability to HIV and STIs.

4.7. How accessible are HIV/AIDS-related healthcare services to MSM?

4.7.1. Negative Attitudes

Negative and judgmental attitudes of HCW were reported by the majority of MSM to be limiting their access to HIV/AIDS- related services.

You know....some of these public hospitals you can't just go and explain that ok.....you slept with another man and you now have an STI. I know of a friend of mine who did that once and I promise you from the treatment he got he has never gone back there again. Apparently one of the sisters (nurse) asked him how a "whole" man like him could sleep with other men. She scolded him for embarrassing his mother and family. He was made to feel worse than a dog – Mark

Such a response as that above by one of the MSM was just one of many that came from the majority of MSM interviewed. Negative attitude as well as homophobic attitudes which served to discriminate and alienate MSM from services was reported to be exhibited by numerous HCW. Such a finding was also evident in other researches that were conducted in the country and what is clear is that responsiveness in overall health service provision for MSM is generally lacking. Rispel & Metcalf (2009) and the Anova Health Institute (2010) all reported that many

HCW simply do not have the required necessary training to respond to the specific physical and psychological needs of patients with same-sex partners and compassion. Moreover, homophobia, discrimination and the general demonising of homosexuality has further created major barriers to effective HIV programming with MSM. Decreased sympathy toward an HIV-positive person was also reported to occur more frequently if that person is a gay or bisexual man (Rispel and Metcalf, 2009; Anova Health Institute, 2010)

4.7.2. *Inappropriate services and information*

The clinical management of procedures in many mainstream healthcare centers was reported to be tailored almost exclusively towards heterosexual individuals; this being another factor that is said to be limiting the access to healthcare services. Information on awareness and behavior change was also reported to be predominantly targeted at heterosexual people.

It is not a secret that gay-identifying people continue to face challenges in accessing services. Information for them is not widely available nor are the services provided by the government appropriately tailored to their health requirements - Key informant 1

Major national HIV/AIDS prevention campaigns have excluded the homosexual population while only targeting the heterosexual community. This lack of targeted health services leaves them particularly vulnerable to HIV infection - Key informant 3

Most of the MSM specific programmes and interventions were reported to be provided by LGBTI organisations, NGOs and other organisations that have been set up to specifically cater for MSM. Mainstream government healthcare services are reported to be less friendly towards MSM due to issues of discrimination based on stigma, homo-negativity and lack of capacity that currently characterizes them. These factors were cited as the main limiting factors to accessing healthcare services. The targeted nature of services provided by the above mentioned organisations have made them popular amongst MSM whose preference seemed to be based on factors quality of services offered, competence of service providers, empathy towards MSM issues and most importantly, no judgement.

The problem that we are facing is that although there are rules that the government has put in place, I think most people are not following those rules. They put laws that gays should be free but at the same time they don't follow it. They don't train their people to understand and know the issues we face. The government and especially the community at large need to understand that everyone has the right to live their lives the way they want to –
Steven

A lot of NGOs provide treatment. In fact, a large percentage of public-sector treatment recipients are actually getting their treatment through NGO-government partnerships. Organisations such as Health4Men, Triangle Project and SWEAT are major service providers to many – Key Informant 4

4.8. Challenges and Barriers faced by MSM in accessing HIV/AIDS- related healthcare services and interventions

4.8.1. Stigma

The majority of MSM (90%) reported often experiencing recurring stigma, which can best be described as layered stigma related to both sexuality and HIV/AIDS. This is one of the most recognised and documented barrier limiting not only the access to healthcare but also preventing MSM to freely live and express their sexual preferences.

It's hard enough to tell people that you are HIV positive. What more when you have to tell them that you got it from having anal sex with another man? My family is so traditional and issues of sex are hardly spoken in my home let alone homosexuality. I will take this to my grave - Tim

Stigma can exist in several forms but to best describe the various forms of stigma experienced by the MSM interviewed, four types were identified, categorised and analysed. These were internalized, perceived, experienced and anticipated stigma (Jacoby, 1994). As a result of the enormous negative things that have been written and spoken about homosexuality, all stemming

from moral, cultural and biblical ideology, homophobia became deeply entrenched in society. As the first HIV/AIDS cases were identified in homosexual individuals, they have thus since been blamed for the spread of AIDS; this further justifying hatred towards these minority groups (AVERT, 2011; Denis & Becker, 2006). The experience by MSM of these beliefs has created what can be called experienced stigma, which in turn has caused widespread internalised and perceived stigma (Jacoby, 1994, Cloete et al, 2008; Lane et al, 2008).

Internalized stigma by MSM has been described as a self-hatred and shame that they have incorporated into their belief systems about how worthless and how wrong their behaviours are (Jacoby, 1994). Consequently, internalised stigma has created certain insecurities about how they think others will respond if they knew of their sexuality, giving rise to what is known as perceived stigma (Jacoby, 1994). Perceived stigma has in turn created anticipated stigma which is an already formed expectation of how people will treat them if they knew about the concealed stigmatised identity (Jacoby, 1994). All these types of stigma are closely linked and play a critical role in the way that MSM live their daily lives.

I think personally the biggest thing that I think stops people from seeking help either from families, friends or hospitals is the fear of what people will think and say. If you take fear out of the equation and replace it with people accepting homosexual people then what could possibly stand in the way of gay people enjoying the same benefits that other people enjoy - Key Informant 3

After a long time of hearing everyone around you say that what you are doing is a sin and how dirty it is, it is easy to give up the fight. All we have left is poor self-worth and for those who cannot fight for themselves, all they can do is try to hide. Without proper support and counselling which I get I'm sure by now I would have killed myself – Peter

People call us names all the time everywhere we go. Faggot and sissy are popular ones. We have learnt to live with it but it is hard. Instead of defending yourself against that abuse you actually turn it inwards...that's

when the demons actually get into you...that's when you actually turn into someone that even your family is not even proud of - Mark

Even in healthcare centers where MSM should feel safe to reveal their sexuality, these various forms of stigma seemed to take over. The fear of being treated differently which can be categorised under perceived and anticipated stigma limited disclosure.

I think it's always best to keep it to yourself until a time when you really have to say something. I always want to avoid the awkwardness that always happens after telling someone you are gay especially if you are talking to someone who is not open to these things. The difficult part is always trying to anticipate how the other person will react. We are always playing these "cat and mouse" games - Andile

Having grown up in the townships I know the hardships of being gay. I have been abused and called all sorts of names. From such happenings it becomes very difficult to trust people and personally I find it difficult to just tell people things about myself. If they can't pick up that I am gay I don't say anything. I find that people are too judgemental and some of those nurses are not even friendly. Something different needs to be done because clearly what is currently being done is not working. People need to be taught that hating someone just because they are different from you is unacceptable. There are also things that those other people do that I think is unacceptable but do I judge them? No. There needs to be a drastic change in the system and if the government can show the people that they will not tolerate abusive behaviours towards MSM in the same way that they show that they do not tolerate murder then maybe we can start to see a change. It is also important that people responsible for making such changes are themselves not homophobic! - Marlowe

4.8.2. Discrimination

Similar to issues of stigma, MSM also reported to be experiencing discrimination which according to Cloete et al (2008) can be categorised as double, multiple or even super-discrimination; all stemming from issues of sexuality and HIV status.

Gay and lesbian marriages have been legalised but the fact is it doesn't really mean anything because if you are in your house and have a constant fear of something bad happening to you today, tomorrow or next week just because you are different, would you really have time to think oh...I wanna get married tomorrow?. This story of fear is the story of our lives. Anything can happen to me any day so I am living for each day - Lucas

Most of us can't even find work because employers are scared of that we will tarnish their organisation's image. I once went for an interview and they were very honest with me which I appreciated. They came right out and told me that they were happy with the way the interview had gone and that I had the skills they were looking for but they were worried some their clients would have a tough time dealing with me. So yah....i didn't get the job even though I was clearly qualified for it - Pedro

From a young age I knew I was different and I acted differently also. It was hard because I became socially excluded from the rest of the kids at school. Many people especially the boys didn't want to be seen playing with me. I moved so much between schools because of all the bullying until one day I just decided that enough was enough. I just stopped going and at first my parents didn't know until they were called to come in. They were so upset to the point that they stopped paying school fees. I am a school dropout with nothing to do - Mark

4.8.3. Homophobia

The majority of MSM interviewed reported to have experienced various forms of homophobic attitudes in the communities they live and work. These experiences for some of the MSM even

extended to healthcare centres; serving as barriers to effective access to much needed services. The general consensus amongst the MSM was that there is an urgent need for MSM specific centres where healthcare services and providers are equipped and sensitised to the issues and health concerns of this at-risk-group.

I have heard people say homosexuality is like a disease and if not eradicated is going to spread like wildfire. This is the most uneducated thing I have ever heard and the most wishful thinking if I should say so myself because homosexuality is never going to go away. People including the government should come to terms with this and the sooner this happens the better. Homophobia is just amazing and it's sad that people don't see the damage it's causing – Key Informant 4

As a gay community we are calling on the police to be partners and not perpetrators. We want to see an end to police brutality and homophobia. Gay and lesbian people are continuously being brutalised by the police...and even the judicial system has failed us. Who do we run to when these are the very same people who ought to be protecting our rights? If this is happening at that level how then can we expect the ordinary citizen to treat us differently? – Key Informant 2

As a proudly gay man I have fully embraced my “femininity” and a lot of people do not like that but who cares! Many have said they are disgusted by me but then again; who cares! I don't understand what their problem is when God himself made me like this. So my message from me is - a luta continua (the struggle continue)! - Peter

4.8.4. Lack of expertise in mainstream healthcare facilities

The general consensus amongst the interviewed MSM was that there are too few places that are currently offering comprehensive MSM specific HIV/AIDS-related healthcare services. Other than a few clinics which are in partnership with the provincial government, some LGBTI organisations, CBOs and NGOs were cited to be providing essential services that are missing in

mainstream healthcare facilities. Clinical management in many of the public healthcare centers was reported to be tailored almost exclusively towards heterosexual individuals and that HIV/AIDS awareness information on behavior change is also predominantly targeted at heterosexual individuals. This one-sided focus has ensured a lack of knowledge in many HCW about the various aspects relating to diagnosis, care and treatment of homosexual individuals. Consequently, HCW are treating MSM for what they know even though it might be inappropriate.

How we survive as a gay community is that we stick together and rely on each other. Although notable steps have been made to try to change mentalities, many people still do not understand why or how we come to be the way we are. Most of us continue to be vilified and treated as people needing some divine intervention. The things we hear people say are so hurtful and belittling and the communities where this comes from are the same communities where the nurses who treat us also come from. Homophobia is still deep-rooted so you can imagine what happens when one grows up surrounded by it. Even if training is available to sensitise them I still feel that those feeling of hatred do not just miraculously go away. They are still there and although they might do their job, they are not happy and it shows no matter how hard they try to hide it. It simply becomes a case of wanting to put the food on the table - Francis

Most of the time I have problems I got to [CBO]. It is the only place I feel people really understand. I feel safe to open up because I am around people who are like me. Most of the workers are like me. We are able to engage and learn from each other and I have made a lot of friends - Andile

If this place wasn't here I honestly don't know how my life would have turned out. I came here so desperate for help and they helped me. Ever since, I am a regular here. I have found it hard to find work but this organisation

tries to help whenever they can. I get food three times a week and when they have part-time work they always call me - Mark

4.9. Conclusion

This chapter has outlined the researchers analysis of the data collected for the study. Major themes and categories were illustrated using direct quotes from the respondents and whether these findings were consistent with the existing literature was also discussed. The conclusions emanating from the above analysis will be discussed in the following chapter.

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CHAPTER FIVE

Conclusion

The main conclusions in relation to the research objectives and findings of this study will be discussed in this chapter. Drawing from the conclusions, corresponding recommendations will be made and the report will be drawn to a close with a concluding statement

The majority of MSM interviewed failed to identify any HIV/AIDS-related healthcare policies specifically enacted to address the HIV/AIDS-related healthcare issues faced by them. Consequently, many had very little to say pertaining to their perceptions of them but the majority expressed their widespread disappointment of the lack of visibility and involvement by the government. Although this was a disturbing discovery it was however not surprising as MSM have largely remained marginalised and not considered to any great extent in national HIV/AIDS interventions regardless of the pressing need. Despite South Africa being the only country on the African continent that legally recognises same-sex relationships and outlaws discrimination on the basis of sexual orientation, it is sad to learn that MSM are still distinctly neglected and marginalised in HIV/AIDS prevention and treatment strategies as well as research. The majority of the key informants concurred around the fact that although MSM have been recognised in both the NSP 2007-2011 and NSP 2012-2016, not enough of this mandate has translated to equitable action on the ground. Moreover, the key informants also felt that MSM have been let down by the lack of protection of rights for same sex couples as evidenced by the often recurring violence and brutality against same sex couples simply because of their sexuality.

Formal national HIV/AIDS-related healthcare policies, strategies and programs are biased in favor of addressing generalized epidemics in heterosexuals and mother-to-child transmission. Such neglect has continued to spur on the epidemic amongst MSM. The scarcity of targeted HIV/AIDS-related prevention and treatment services for MSM particularly in mainstream healthcare facilities is a serious cause for concern; particularly considering the fact that this minority group is at a higher risk of contracting HIV/AIDS and other sexually transmitted diseases and illnesses than heterosexual individuals. Another area of concern was that other than HIV/AIDS testing and counseling, STI treatment and the provision of Antiretroviral Therapy

(ART) which is often limited due to high demand, no other services were said to be provided in public clinics or hospitals for MSM. It was a recommendation by the majority of MSM that the government needs to step up efforts to ensure that a more comprehensive package be made available in the form of more targeted services for MSM. By a more comprehensive package MSM wish to see in addition the above mentioned interventions greater support in the form of targeted education on HIV/AIDS prevention and transmission, targeted sexual health information, mental healthcare services, and coping strategies and mechanisms. Such extra services are currently being visibly provided by the country's few LGBT CBOs and NGOs. The staff working in these organisations was also commended for being more understanding, tolerable, sensitive and empathetic towards MSM and their issues. LGBTI CBOs and NGOs were identified to be playing an integral role in the fight against HIV/AIDS for MSM although they are too few and too small to meet the high demand placed on them. Issues of lack of adequate financial support were also cited as hindering their progress.

The marginalisation and neglect of MSM is also evident in the lack of MSM specific HIV/AIDS prevention campaigns and research. Consequently, HIV prevalence and incidence among MSM has largely remained undocumented. Although the NSP 2007-2011 and most recently the NSP 2012-2016 acknowledges the need to focus on MSM HIV/AIDS-related health issues to prevention and treat HIV/AIDS and other related illnesses, the former yielded very little results and showed little progress on the implementation of MSM specific services (Rispel and Metcalf, 2009; Rispel et al, 2011). However, the results from the new NSP 2012-2016 are still to yield results and much remains to be seen.

Moving onto the level of awareness of MSM about HIV/AIDS-related services and interventions, all MSM seemed to be aware of their right to receive HIV counseling, testing and STI treatment as well as where to access services. However, a troubling concern was that they are faced with numerous obstacles that hinder them from exercising such a right. Issues of public facilities being under-resourced to meet demand were brought up as well as MSM-specific prevention and treatment interventions which were reported to be more limited than those available for heterosexual individuals. The fundamental characteristic of MSM being a marginalised and hidden population with special needs lends them as a group of individuals

requiring tailored services and interventions which can effectively be provided by skilled personnel possessing the necessary knowledge, expertise and most importantly tolerance for this group. However, a reported lack of such skilled personnel in mainstream healthcare facilities was cited as another obstacle causing many of the MSM to get services that were too generalised for their specific needs.

Despite reports that lack of resources and lack of adequate expertise, the majority of MSM also reported that there were too few public healthcare centres where they could go to get comprehensive HIV/AIDS-related healthcare services. Clinical management and HIV/AIDS awareness information on behavior change in many public healthcare facilities as reported before to be tailored almost exclusively towards heterosexual individuals. Consequently, many HCW are reportedly inadequately trained to deal with the various issues of diagnosis, care and treatment of sexual minorities. HCW are said to be treating everyone in a uniform manner even though this might not be appropriate for MSM; a situation that is attributed by many to be caused by the type of training that these HCW receive, which may not be conducive to dealing with cases of individuals in same-sex relationships. LGBTI CBOs and NGOs were however commended for being the only visible organisations that are providing more comprehensive services to this sexual minority group.

Although MSM recognized HIV/AIDS information to be widely distributed in many public clinics and hospitals as well as advertised through media, consensus was that the content was too generalised to meet their specific needs and was therefore useless to them. The majority reiterated that much needs to be done to address this issue which is highly problematic and disturbing because for many, this may be an avenue for them to get the information that could make all the difference between getting infected or staying HIV free. The scarcity of targeted HIV/AIDS prevention and treatment services for MSM was a dominant theme and an area of grave concern for both the MSM and key informants interviewed. Most of the policy and programmatic responses to HIV prevention have undoubtedly been tailored to generalised epidemics that focus on interventions mainly targeting heterosexual individuals and mother-to-child transmission. Consequently, not all MSM are able to access medical attention; a prospect that speaks volumes as to why prevalence has continued to rise amongst these individuals. As a

result, many MSM are unable to get the help they need; a situation that leaves one wondering where the surplus could be getting their help if any at all.

Another issue that came up about public healthcare facilities was of long queues which more often than not have come to characterise them. These long queues especially in some communities that may not be accepting of homosexuals are reported to often be made up of predominantly heterosexual individuals who haul homophobic verbal abuse at the MSM especially those that identify as openly gay. This kind of treatment was cited as another obstacle to accessing healthcare services due to the victimisation that takes place while waiting to be attended to and this behaviour sometimes extends to HCW. This is causing MSM to be excluded appropriate healthcare services for fear of homophobic verbal abuse and discrimination. Not only has the experience of such verbal abuse been isolated to healthcare centres, but it also extends to the communities MSM live and work. Widespread perceptions by MSM was that although some HCW declare neutrality and acceptance toward homosexuality, some of them still display homophobic attitudes; a clear breach in ethics standards that compromises the effective delivery of healthcare for sexual minorities. Homophobia in healthcare settings is making it particularly difficult for MSM to access vital care and support critical to ensuring targeted services for MSM. This highlights that HCW may be ill-trained to deal with issues faced by this at-risk-group.

Popular perception by MSM of HCW in mainstream healthcare facilities was that they merely provide services to them as a matter of obligation because they need to earn a salary as opposed to genuinely caring for their health. The adverse result has been that a reduction in the quality of services provided to them. Experiences by MSM in public clinics and hospitals have included various HCW walking in and out of testing rooms during consultation, doors being left open during consultation and vital information being left out in the open for anyone to see. All these factors being clear violations of standard protocol of doctor-patient confidentiality and privacy, which can strongly prohibit patients from openly discussing the various healthcare issues they may have, which are often sensitive especially pertaining to MSM.

Expectation by many HCW that the people they come into contact with are in heterosexual relationship is another factor that was noted as being problematic for MSM. These expectations are resulting in leading questions during diagnosis by HCW that make it difficult for MSM to discuss their sexuality. Once such assumptions are made, it becomes difficult for MSM to demystify such mentalities especially if they themselves are in hiding and not comfortable about their sexual predisposition. This is leading to a lack of full disclosure about sexualities and illnesses; a situation that is delaying treatment of STIs, STDs and other HIV/AIDS-related illnesses; further exacerbating the epidemic amongst MSM.

Another attributing factor to the lack of confidence in sexual orientation disclosure has been spurred on by a perception by many MSM that once they did so, the treatment they would receive will be prejudiced. A considerable number of the MSM interviewed reported to have at least once encountered and experienced situations at the hands of HCW that made disclosure a daunting task. Some HCW lacking the expertise to deal with SMS were reported to have been caught off-guard when they heard information that they were not expecting. They exhibited behaviours such as shock, discomfort, surprise, confusion and disbelief. Such behaviours serve to create an atmosphere that is awkward and not conducive to open and honest conversation which is necessary when dealing with delicate issues such as sexuality and HIV/AIDS. The discomfort and awkwardness is what many MSM try to avoid by not seeking much needed medical attention.

Another issue of HCW in mainstream healthcare facilities being ill-equipped to deal with the psychological and physical needs of MSM was highlighted by some of the MSM. This brought up suggestions that unless special clinics were made available, it will be very difficult for the healthcare system to adequately address MSM specific healthcare needs. Although South Africa has done extraordinary work to ensure that the rights of people in same sex relationships are upheld through its constitution, not enough has been done by the national and regional governments through their policies and interventions to adequately address issues of HIV/AIDS within the LGBTI community. Although recognition of this minority group and its plight with the HIV/AIDS was first made in the NSP 2007-2011, it is not very clear what its efforts amounted to possibly due to the lack of research around this area. The gaps in HIV/AIDS-

related healthcare services for this population are evident and are a reflection of how much work still needs to be accomplished and how inadequate the commitment has been on the part of the local, regional and national governments.

In an attempt to investigate the level of MSM friendliness of healthcare services, several HCW were reported to be lacking the adequate skills and empathy necessary when dealing with the LGBTI community. Moreover, no visible systems seemed to be in place to monitor what is happening in public healthcare facilities. The lack of surveillance studies is a continued concern for many of the people that were interviewed which they have attributed to a lack of commitment by government. Targeted interventions for MSM are also disjointed, with many of them being provided by international donors and very little high-level national governmental support being visible.

The issue of the physical setting and layout of some VCT clinics was also brought into question with suggestions that if testing and counseling is to be encouraged amongst MSM they should be more discreet. Many times people have to queue up where anyone can see them and it is often obvious why they are there; a situation that some may not be too comfortable with especially when there are other factors at place such as insecurities about one's sexuality. This again brings the issue of privacy and discretion into question. MSM are a hidden group of people who are very sensitive about issues of privacy and confidentiality which should be adhered to if health seeking behaviours are to be encouraged.

Another area of concern that continues to put MSM at risk is that much of the information available and being spread to many people is that MSM are likely to be HIV positive or suffering from some sexually transmitted disease than heterosexual individuals. As a result, MSM feel that they have continued to be blamed for spreading HIV/AIDS and this has caused widespread insecurities amongst MSM. Such insinuations are not only offensive but they have deterred many MSM from seeking help for fear of being judged by people including HCW. In addition to the mentioned insecurities, some of the MSM reported to be suffering from often recurring stigma, which is sometimes layered, relating to both sexuality and HIV/AIDS diagnosis itself; making this one of the most significant barriers to seeking health care services.

Stigma was identified to exist in several forms but four types were identified and analysed. The four types were experienced stigma, perceived stigma, internalized stigma and lastly, anticipated stigma (Jacoby, 1994). Experienced stigma which MSM feel has been brought on by the experiences that MSM have had with negative attitudes and connotations about their sexuality. This experienced stigma has led to internalised stigma which is best described as a self-hatred and shame that MSM have incorporated into their belief systems about how worthless and how wrong their behaviour is (Jacoby, 1994; Cloete et al, 2008; Lane et al, 2008). Due to the internalised stigma, perceived stigma takes over and it's best described as the insecurity about how others will respond if they knew about their sexual orientation (Jacoby, 1994). This continued insecurity is what then ensures anticipated stigma which is how an individual expects others to treat them if they knew about the concealed stigmatised identity (Jacoby, 1994). The perceived and experienced stigma has also impacted on their access to healthcare services. Anticipated stigma has created avoidance behaviours in MSM from seeking vital medical care or information on HIV treatment and prevention due to diminished self-esteem.

In addition to the various forms of stigma, MSM also reported to be experiencing substantial discrimination which according to Cloete et al (2008) can be double, multiple or even super-discrimination; all stemming from issues of sexuality and HIV status. Higher levels of discrimination were however identified to be experienced more by visible MSM who openly identify as gay. Another obstacle that was cited as perpetuating the lack of access by MSM is the psychological impact on MSM of living in a heteronormative, stigmatising and discriminating society. Homophobic verbal abuse and gossip in some public healthcare facilities was reported to occur frequently by some of the MSM particularly towards MSM who openly identify as gay.

The fact that HIV/AIDS prevalence has continued to rise amongst the MSM community is a clear indication of the continued failure or rather reluctance by the government to put in place efficient and effective measures and mechanisms to address the HIV/AIDS-related issues faced by this at-risk-group. As prevalence continues to increase, MSM are being put at an even greater risk; a fact that has continued to be ignored in the design of national HIV/AIDS strategies and campaigns, which continue to act in favour of generalized epidemics in heterosexuals and mother-to-child transmission.

5.1. Recommendations

Structural interventions are critical and urgently needed to change both the social climate of HIV/AIDS and sexual politics around sexual practices of MSM. There is a critical need to strengthen capacity of national agencies and individuals working to improve policy, legislation and programming related to MSM sexual and reproductive health. The visibility of MSM issues across various levels such as policy, legislation, communities and service delivery should be increased. More awareness campaigns are required around combined HIV/AIDS and MSM stigmas at the societal level to ensure a reduction in both internalised and perceived stigmas that MSM are living with.

A coordinated and collective effort should continue to be encouraged between the government, NGOs, CBOs and LGBTI organisations working with MSM to combat the persisting prejudice and discrimination of minority groups which is hindering efforts to develop and implement effective HIV/AIDS prevention programmes. Access to greater resources, including technical and financial for better access to prevention, treatment and care services should be advocated for and increased.

The advocacy for protection of MSM from human rights violations is critical to ensure that supportive environments provided for MSM to exercise their basic human rights and the right to openly assume their sexual identity by complementing the legal process with a social and moral process to change the norms of acceptable interpersonal behaviour. This approach will not only benefit those with felt stigma who anticipate exclusion and discrimination but will motivate those who endorse or accept stigma to question their contribution to the process. Lastly but not least important is the need to ensure the creation, facilitation and dissemination of an evidence base for a better public health response on MSM issues.

In conclusion, to tie in the theoretical perspectives from which this study is anchored and the results that emanated from the study, the assumptions made by the Role Theory are that people spend much of their lives participating as members of groups and organizations and within these groups, people occupy distinct positions for which each of these positions entails a role and carry certain expectations. These roles and expectations become the norms or even codified rules

whose successful participation carries certain rewards and failure resulting in punishments. Therefore, individuals normally gravitate towards carrying out roles in accordance with prevailing norms with issues of race, sex and age being relatively fixed in comparison to other behavioral characteristics. Therefore MSM are considered to be in violation of “normal behavior”; leading to prejudice by heterosexual individuals who form the majority of the population in any country. From the secondary data collected, not only did these held notions affect service providers but also policy makers to the extent that numerous policies and interventions have excluded this group of individuals and not recognizing their existence. In the case of South Africa, despite this country being the only African country where discrimination on the basis of sexual orientation is constitutionally prohibited, HIV/AIDS-related healthcare services are still not as accessible by MSM as they ought to be especially taking into consideration that HIV/AIDS prevalence is highest amongst this minority group. Rather than just an issue of lack of information about the right to healthcare, the experience of MSM in this study was of access to such healthcare services particularly in public mainstream healthcare facilities, which was identified to be limited due to certain barriers propagated by discrimination based on sexuality. Stigma and homophobia were some of the identified barriers that have continued to restrict access and leading to various forms of discrimination based on sexuality and HIV/AIDS status.

The perceptions and fear that MSM have justifiably constructed around healthcare access on the basis of actual experiences, are leading MSM to delay or avoid treatment for STIs and HIV/AIDS. Discrimination on the part of HCW was reported to be especially damaging. Avoidance of critical healthcare services is brought on by the fear of encountering situations where sexual identity is brought into question; leading many MSM who do not openly identify as gay to go undetected. HCW behaviours that were reported to be discouraging access may be enforced by the fact that numerous HIV/AIDS-related interventions, policies and programmes in many countries particularly those in the sub-Saharan Africa have given priority to people in heterosexual relationships while turning a blind eye to issues of homosexuality. This state of affairs has reinforced homosexuality as “deviant” behaviour; thus depriving MSM of the opportunity to freely engage with programmes that would help to alleviate HIV/AIDS in this hidden population. These sentiments were echoed by the Heterosexism and Minority Stress

perspective/ theoretical frameworks which were identified by this study as adequately forming the base of explanation of why HIV/AIDS prevalence has continued to rise amongst this minority group. As this theory explains, MSM who are largely aware that they are regarded negatively by specific individuals or by the wider culture have will incorporate those negative attitudes into their self-concept. Consequently they will be less likely to reach out to others for support by limiting their access to social support system and will be more likely to engage in avoidant coping strategies such as restricting awareness of or exposure to information regarding lesbian, gay, bisexual, transgender (LGBT) persons and culture, inhibiting same-sex behaviour and passing as or pretending to be heterosexual.

Although experiences of homophobia and discrimination among non-gay identifying MSM are less direct or severe than gay identifying men, their strategy of not discussing same-sex behaviour with HCW may place them at a greater disadvantage than “out” gay men in their ability to access appropriate advice on STI and HIV prevention and treatment. Non-gay identifying MSM may feel uncomfortable accessing services based on the assumption that public sector HCW are hostile to same-sex sexuality; a situation which may effectively be compromising their own sexual health as well as the health of their male and female partners. This result was in line with the empirical evidence that was provided by both theories of Reasoned Action and Planned Behaviour. These theories shed insight into the variables that exist between intention and action. Prior to performing a certain behaviour, the theory of reasoned action postulates that people calculate the implications of the behaviour based on the significance attached to opinions of others regarding the behaviour examined. According to this theory, attitudes are formed as a result of beliefs and if a person’s beliefs concerning an intended behavior are perceived as positive, he or she is bound to act accordingly and the vice versa is true. In the case of MSM, their behavioural beliefs of the consequences of coming out, getting tested and seeking medical attention are the most significant predictor of behavioural intention. Therefore, the negative attitudes about same sex relationships were found to have an impact on contribute to alienation by friends and family, discriminatory acts, bullying and even violence. All these dynamics have made it difficult for some MSM to be open about their sexualities; leading to increased stress, decreased access to social support and consequently impacting negatively on their health.

The absence of relevant data on MSM reveals a critical research gap and perhaps a lack of willingness on the part of the government to work together with these minority groups. Studies are needed to inform targeted HIV prevention, care, and treatment interventions and to make a case for more open dialogue on these issues. It is also important to remember that MSM encompass a vast array of identities and behaviors. Therefore, programs to address their needs are not a “one size fits all” as that which is currently being employed in many public healthcare facilities. A call needs to be made for comprehensive and MSM specific HIV/AIDS prevention, care, treatment, and support services. The very little context-appropriate resources available for MSM and HIV programming have rendered available services inadequate in catering for the needs of MSM. Moreover, HIV prevention materials as well as VCT protocols are inadequate.

Targeted programmes were said to be provided mostly by LGBTI organisations, NGOs and other organisations catering specifically to MSM. The majority of MSM seemed to prefer getting help from LGBTI CBOs and NGOs based on factors such as quality of services, competence of service providers, empathy towards their issues, and no judgement. Government healthcare services are reported to be less friendly towards MSM based on experiences with stigma, discrimination, homophobia and lack of expertise in public clinics and hospitals. This situation in public hospitals has sustained the limited access to healthcare services by MSM especially those who cannot afford private treatment or who are unable to access LGBTI organisations or alternative organisations. As a result, although overall HIV epidemic trends are in decline prevalence in MSM is expanding in the era of highly active antiretroviral therapy (HAART). This is what has been described as re-emergent of epidemics in MSM; prompting immediate attention (Beyrer, Baral, van Griensven, Goodreau, Chariyalertsak, Wirtz, and Brookmeyer, 2012). Such a reality particularly in South Africa could be explained by the exclusion of MSM in widespread HIV prevention and treatment campaigns. The effects of such exclusion were adequately highlighted as being detrimental to the health of MSM and referring to the previously discussed theoretical frameworks, the social inclusion/exclusion theory highlighted that exclusion is a process by which certain groups of people are systematically left out or discriminated against simply on the basis of ethnicity, race, religion, sexual orientation, descent, gender, age, disability, HIV status, or migration status. Therefore, this theory adequately provided the empirical evidence that those who are socially excluded are attributed little social

value and viewed as inferiors and not worthy of much recognition. Accordingly, they are therefore not afforded the opportunity to enjoy the economic and social opportunities available to others including access to good health. Therefore sexually diverse populations such as MSM continue to be among those most marginalized, excluded and discriminated against. Homophobia, stigma and discrimination are often interlinked and they have served as symbolic marks imposed by dominant groups on those who are different. However, to end on a more positive note, although South Africa has continued to grapple with issues of stigma, homophobia and discrimination towards same-sex-couple, the fact that it remains the only in Africa where discrimination on the basis of sexual orientation is constitutionally prohibited is truly encouraging. Strides have been made but the only message is that more still needs to be done.

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APPENDICES

Appendix A - Letter of Permission - Key Informants

February, 2013

Indemnity Forms for Research Study - Key Informants

Dear Prospective Participant,

My name is Gamuchirai Madzima and I am a Masters student currently studying Social Development at the University of Cape Town. I am conducting research to explore the perceptions of Men who have Sex with Men (MSM) about HIV/AIDS related policies and health care services currently in place in South Africa to specifically address HIV/AIDS issues facing MSM. I would appreciate your input as a valued member of an organisation that is contributing to the fight against HIV/AIDS amongst this minority population. The information you will provide will be used strictly for academic purposes and will strictly be confidential. Confidentiality and anonymity will be respected as well as your names. The interviews will be conducted at any place of your convenience and at any time that you may be available for no more than 60-90 minutes.

Please sign below if you would like to participate:

Name:

Signature:

Gamuchirai Madzima (079 974 9090; gamu.madzima@gmail.com)

February, 2013

Indemnity Forms for Research Study - MSM

Dear Prospective Participant

My name is Gamuchirai Madzima and I am a Masters student at the University of Cape Town currently studying Social Development. I am conducting research to explore the perceptions of Men who have Sex with Men (MSM) about HIV/AIDS related policies and health care services currently in place in South Africa to specifically address HIV/AIDS issues facing MSM. I would appreciate your input as a valued member of the MSM community. The information you will provide will be used strictly for academic purposes and will strictly be confidential. Confidentiality and anonymity will be respected as well as your names. The interviews will be conducted at any place of your convenience and at any time that you may be available for no more than 60-90 minutes.

Please sign below if you would like to participate:

Name:

Signature:

Thank you,

Gamuchirai Madzima (079 974 9090; gamu.madzima@gmail.com)

UNIVERSITY OF CAPE TOWN – DEPARTMENT OF SOCIAL DEVELOPMENT

Interview schedule – Key Informants

Type of Organisation _____

Alias _____

Interviewer _____

Appointment time _____

- (a) Thank you for agreeing to have this interview
- (b) My name is Gamuchirai Madzima and I am a post-graduate student in the Department of Social Development at the University of Cape Town. I am conducting research to explore the perceptions of Men who have Sex with Men (MSM) about HIV/AIDS related policies and services currently in place in South Africa to specifically address HIV/AIDS issues facing MSM.
- (c) Please feel free to talk openly. If you feel uncomfortable talking about something, or would rather not answer a question, please tell me. You do not have to answer questions you are not comfortable with.
- (d) Time: the interview will take up to one hour, if you are tired or need to stop, please let me know and we can take a break.
- (e) Confidentiality: Everything said in this interview will be treated as confidential as possible by the researcher. When I report on the findings, I will make sure that everybody remains anonymous.
- (f) Recording: Do you mind if I record this interview? It is only for research purposes. That way I do not have to write down a lot of notes while we talk. Nobody except the researcher will listen to the recording (wait for the participant's response). Please speak clearly so that I can hear what has been recorded later.
- (g) Test recording: Before we start, I would like to make sure that the tape recorder is working properly (interviewer: start recording: say your name and date, and say something light-hearted – like an observation about the weather today. Ask the respondent an innocuous question to get their voice – or ask about their age and occupation sitting in their natural position where they will sit for the interview. Stop the recording and play back to make sure it is working and that you can hear both your voices).

4. Are you aware of any HIV/AIDS related healthcare services/interventions that are available to specifically address issues faced by MSM? (Probe: What are they and who provides them?)

5. Tell me about your own thinking about HIV/AIDS related health care services/ any other services available to MSM that you may be aware of. (Probe: What are they? How effective and accessible do you think they are? How appropriate do you think they are? What is the quality of services? If you are not aware of any services, how has this affected the MSM community? Where do MSM usually get healthcare for HIV/AIDS related illnesses?)

6. What are some of the challenges faced by MSM with regards to access and utilisation of HIV/AIDS related health care service? (Probe: stigma, discrimination, homophobic behaviours, HIV/AIDS testing, counselling services, contraception, etc?).

7. What are the key challenges faced by your organisation in the provision of HIV/AIDS related healthcare services to MSM? (Probe: where do you receive your funding from and what assistance comes from the government?)

8. What do you think needs to be done to overcome the challenges/barriers faced by MSM?
(Probe: is there anything that you wish to see done by the government or communities to encourage better access and utilisation of health care services by MSM?)

9. Of all the issues affecting MSM, what issues stand out more for you and what would you like to see done and by whom?

10. Is there anything more you would like to add?

11. What recommendations do you have to ensure better access and utilisation of HIV /AIDS related health care services by MSM?

CONCLUSION

We have come to the end of our interview. Before we close are there any other issues or concerns or challenges other than those mentioned above that pose a threat to the day to day living of MSM?

(a) For each “challenge”: why do you think it exists? Has it always been like this, or do you think the situation is changing?

(b) What is your thinking about the national response to address HIV/AIDS among MSM and the HIV/AIDS prevalence among MSM? What sort of interventions in your opinion do you think are needed?

(c) Is it okay to contact you again for further information and/or clarifications on the issues discussed today?

YES _____ NO _____

12. Thank you for your time.

University of Cape Town

UNIVERSITY OF CAPE TOWN – DEPARTMENT OF SOCIAL DEVELOPMENT

Interview schedule - MSM

Alias: _____

Appointment time _____

Interviewer: _____

- (a) Thank you for agreeing to have this interview.
- (b) My name is Gamuchirai Madzima and I am a post-graduate student in the Department of Social Development at the University of Cape Town. I am conducting research to explore the perceptions of Men who have Sex with Men (MSM) about HIV/AIDS related policies and services currently in place in South Africa to specifically address HIV/AIDS issues facing MSM.
- (c) Please feel free to talk openly. If you feel uncomfortable talking about something, or would rather not answer a question, please tell me. You do not have to answer questions you are not comfortable with.
- (d) Time: the interview will take up to one hour, if you are tired or need to stop, please let me know and we can take a break.
- (e) Confidentiality: Everything said in this interview will be treated as confidential as possible by the researcher. When I report on the findings, I will make sure that everybody remains anonymous.
- (f) Recording: Do you mind if I record this interview? It is only for research purposes. That way I do not have to write down a lot of notes while we talk. Nobody except the researcher will listen to the recording (wait for the participant's response). Please speak clearly so that I can hear what has been recorded later.
- (g) Test recording: Before we start, I would like to make sure that the tape recorder is working properly (interviewer: start recording: say your name and date, and say something light-hearted – like an observation about the weather today. Ask the respondent an innocuous question to get their voice – or ask about their age and occupation sitting in their natural position where they will sit for the interview. Stop the recording and play back to make sure it is working and that you can hear both your voices).

Interview Guide

1. Tell me about yourself (Probe: age, family, education, employment, marital/relationship status, etc).

2. Are you aware of any HIV/AIDS related health care services that are available specifically for MSM? (Probe: What are they and have you ever utilised any of them?)

3. Tell me about your own thinking about the HIV/AIDS related health care services available to MSM that you are aware of. What have been your experiences with these healthcare services? (Probe: How effective and accessible do you think they are? If not aware of any services how has this affected the MSM community? Where do you normally go to get medical assistance for HIV/AIDS related illnesses or any other medical help? How accessible (distance) or effective are these places?)

4. What have been your experiences with these HIV/AIDS related healthcare services? (Probe: Were protocols in place to deal with problems specific to MSM? What kind of treatment were you subjected to by medical staff? Have you ever felt at any one point that you could not access medical treatment because of your sexual orientation and why?).

5. What are some of the challenges/barriers to the access of HIV/AIDS related health care services are you faced with as MSM? (Probe: stigma, discrimination, homophobic behaviours, etc? How aware are you of your right to access health care services? How protected do you feel by the law?

6. What is your own thinking about what needs to happen to overcome the above mentioned challenges/barriers faced by MSM? (Probe: is there anything that you wish to see done by the government or communities to encourage better access and utilisation of health care services by MSM?)

7. Are you aware of any HIV/AIDS related policies that are available to specifically address issues faced by MSM? (Probe: What policies are you aware of?)

8. What is your own thinking about the HIV/AIDS related policies available to MSM that you are aware of? (Probe: How effective do you think they are? If not aware of any policies how has this affected the MSM community? In your opinion, what are the gaps in a particular policy?)

9. Of all the things discussed above, what issues would you like to see addressed the most?

10. Is there anything more you would like to add?

University of Cape Town

11. What recommendations do you have to ensure better access and utilisation of HIV /AIDS related health care services by MSM?

CONCLUSION

(a) We have come to the end of our interview. Before we close are there any other issues/problems/challenges other than those mentioned above that pose a problem to your day to day lives as MSM?

(b) For each “challenge”, why do you think it exists? Has it always been like this, or do you think the situation is changing?

(c) What has the government done and would you like to see more done?

(d) Is it okay to contact you again for further information and/or clarifications on the issues discussed today?

YES _____ NO _____

12. Thank you for your time.