



Men's experiences and perceptions of HIV testing services in Gugulethu Township, Cape Town

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NDLSIT010

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DECLARATION

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Date: 13 March 2017

DEDICATION

This mini-dissertation is wholeheartedly dedicated to my late beloveds: my mothers, (Nelisiwe and Thoko Ndlovu); my father Bigboy Molefe; and my late sister, Thobekile Ndlovu.

May your souls rest in eternal peace. I will always love you.

ABSTRACT

South Africa continues to have the highest number of people living with HIV/AIDS in the world. HIV testing remains vital in the prevention and management efforts of the pandemic. Despite the efforts by the government, and local and international organizations to prevent the spread of HIV in men, HIV testing uptake in men continues to remain significantly low in the sub-Saharan Africa, including South Africa. Several factors, including experiences and perceptions of HIV testing services contribute to a low uptake and men's willingness to use HIV testing services in South Africa. This mini-dissertation explores men's experiences and perceptions of HIV testing services from a qualitative perspective. This mini-dissertation is divided in the following three parts. A research protocol (*Part A*) focuses on understanding men's experiences and perceptions of HIV testing in Gugulethu Township, Cape Town. A literature review (*Part B*) identifies literature on HIV testing in South Africa, gender norms and their impact on HIV testing uptake, men's perceptions of HIV testing, confidentiality issues, perceived benefits of HIV testing, and gaps in current literature. Lastly, a qualitative journal "ready" manuscript (*Part C*) focuses on men's experiences and perceptions of HIV testing services in Gugulethu Township, Cape Town. Desirably, this mini-dissertation will inform health interventions that are specific to men's health needs while also aiming to focus on health policies that are inclusive of men. This study will in part address the core issues men encounter when testing for HIV in Gugulethu Township.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	: Acquired Immuno Deficiency Syndrome
ART	: Antiretroviral Therapy
ARV	: Antiretroviral
CDC	: Centre for Communicable Diseases
DTHF	: Desmond Tutu HIV Foundation
ETC.	: Etcetera
HBM	: Health Belief Model
HCT	: HIV Counselling and Testing
HCP	: Healthcare provider
HIV	: Human Immunodeficiency Virus
HREC	: Human Research and Ethics Committee
iALARM	: Using Information to Align Services and Link and Retain Men in the HIV Cascade
LMICs	: Low-Middle Income Countries
MSM	: Men who have sex with men
MWC	: Men's Wellness Centre
NGO	: Non-governmental organization
NIH	: National Institutes of Health
PCA	: Patient-Centred Approach
PHC	: Primary Health Care
PLWHA	: People living with HIV/AIDS
PMTCT	: Prevention of Mother-to-child transmission of HIV
SCT	: Social Cognitive Theory
StatsSA	: Statistics South Africa

SGJ : Sonke Gender Justice
SSA : sub-Saharan Africa
STIs : Sexually Transmitted Infections
UCT : University of Cape Town
UNAIDS : Joint United Nations Programme on HIV/AIDS.
USAID : United States Agency for International Development
VMMC : Voluntary Medical Male Circumcision
WCDoH : Western Cape Department of Health
WHO : World Health Organization

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PART A: RESEARCH PROPOSAL

Introduction and problem statement

The Human Immunodeficiency Virus and Acquired Immuno Deficiency Syndrome (HIV/AIDS) pandemic continues to remain one of the major global public health issues (1). The pandemic has killed over 34 million people, and in 2014, an estimated 39.9 million individuals were living with HIV (1). Furthermore, 2 million people were diagnosed with HIV in the same given year. South Africa remains the country with the largest HIV pandemic profile globally, with approximately 6.2 million people living with HIV/AIDS (PLWHA) and a prevalence rate of 11.2% of the entire South African population by 2015 (2).

By 2013, sub-Saharan Africa (SSA) accounted for 71% of total HIV new reported cases due to various reasons, such as engaging in risky sexual behaviours, perception of HIV risk by individuals, lack of knowledge, among others (3).

One of the solutions to reduce HIV/AIDS infection is the uptake of HIV testing. Given the significance of HIV testing by individuals, there remains a pivotal need to understand HIV testing barriers, enablers and perceptions in order to make a significant contribution to lessen the number of undiagnosed individuals (4).

A South African nationwide HIV behavioural survey in 2012 indicated that approximately 66% of the South African population has never tested for HIV (5). The study further reported that 54% of the population of men at 50 years and older believed they were not at risk of HIV infection compared to 31% of women; and an estimated 42% of men within the 25-49 age range were reported to have similar belief (5). This survey further highlighted the barriers that delay people's uptake of HIV testing in the country (6). The barriers included fear of testing

for HIV associated with stigma and discrimination of PLWHA in the communities, and perceived low risk of HIV contraction among male research participants. The primary researcher's focus on the barriers and enablers of HIV testing while exploring perceptions and experiences of men is informed by the above percentage; the fact that only 12% of men in the SSA region has ever tested for HIV by 2007; and that there is a great lack of studies on HIV testing behaviours in South Africa that focus on men (7, 8).

There are various factors that facilitate or hinder the uptake of HIV testing among the population, despite the available HIV services. These include fear of the HIV results being positive, stigma and discrimination in the communities, gender inequality, lack of patient-provider confidentiality and fear of forced disclosure (9). The facilitating factors to HIV uptake include the quality and availability of HIV testing services, community advocacy, health education, awareness programs, and de-stigmatization of HIV in the communities (9).

Health-seeking behaviour of men remains inadequately understood in the HIV/AIDS epidemic context and motivating the male population to get tested for HIV is still a challenge (10). A study on linkage to HIV care and antiretroviral therapy in Cape Town reported that 30% of men of the entire study population of 885 people had tested for HIV (11). Moreover, this research study is also informed by the underrepresentation of heterosexual men in HIV/AIDS research, and there is limited information on men's health-seeking behaviour in South Africa (12). Moreover, there is a great lack of literature that focuses on how men are affected by HIV, getting them to test and retain in care, as well as comprehending their health-seeking behaviour within the HIV/AIDS epidemic context (7). Existing research has predominantly focused on men who identify themselves as men who have sex with men (MSM) (13).

Where research is available, it has been found that men often go for HIV testing when they become symptomatic (14). The following findings are pertinent. Firstly, when men access

available antiretroviral therapy (ART), they are more likely than women to stop their ART treatment due to the denial of HIV diagnosis (11). Secondly, perception of being ill and vulnerable is seen as a sign of weakness in men grounded on the norms of masculinity (7, 11). Thirdly, more often than women, men are lost to follow up (11, 15). Lastly, there have also not been many sufficient interventions for men, and there are limited findings on why men test or do not get tested for HIV (10).

Early HIV testing has been documented to have numerous benefits. HIV testing and appropriate antiretroviral (ARV) treatment assists in the reduction of HIV transmission in both men and women; viral load suppression; and as a result may instil safe sexual behaviour (16). Moreover, testing for HIV offers an “opportunity for preventive education and advice” (9). It also helps to detect and diagnose HIV early in unsuspecting and exposed persons.

Men and the HIV cascade

The HIV cascade is a way to better trace PLWHA in HIV and has been found to suppress HIV and reduces transmission of the virus to a sexual partner (17, 18). In this regard, testing for HIV is a first step that one negotiates to entering the HIV cascade (19). In most cases, men do not have a set entry point to care, go for testing less frequently than women, and they are also less likely to be retained in the HIV cascade than women (20). Moreover, not only do fewer men get tested for HIV than women, they also enter the HIV cascade at a later stage, increasing the risk of re-infection in comorbidity and mortality (19, 21). As a result, men are more often lost to follow up than women within the cascade and less likely to stay adherent to HIV treatment (22). Interventions such as Prevention of Mother-to-child transmission of HIV (PMTCT) as well as policies are often targeted at women and do not involve men (23)

Men’s sexual behaviour influences their perception of HIV testing. A number of studies have reported on the existing relationship between HIV-related sexual behaviours and the norms of

masculinity (24). Women live longer than men globally; and this is due to men's poor health-seeking behaviour, inadequate health knowledge, unwillingness to involve themselves in health promotion activities, and engagement in high risk sexual behaviour (25, 26). The norms of masculinity constitute a pivotal element that make men reluctant to go for HIV tests, and seek HIV care upon diagnosis (19). However, "researchers have recently begun to explore how masculine norms influence men's HIV testing, care and treatment outcomes" (19). Often, the behaviour of men in societies impacts their HIV health outcomes (27). Their sexual behaviours are largely driven by how they construct their masculine identity (24). Particular socially constructed roles of men, such as hyper sexuality, anti-femininity, and toughness contribute to a strong relationship between masculine norms and HIV-related health seeking behaviours, including non-condom usage and multiple sexual partners (24). This relationship has been documented in studies on masculinity as a barrier for men using HIV services which found that HIV testing uptake is severely interwoven with hegemonic masculinities, and strengthened by the powers of the local socio-cultural context and the expectations of PLWHA (28, 29).

The iALARM Research Project

This research study is a sub study of a larger project - iALARM (Using Information to Align Services and Link and Retain Men in the HIV Cascade). In South Africa, men are less likely than women to be tested for HIV and to access HIV care (30). Thus, many men do not know their HIV status and do not start ART; or start treatment later and more sick than women, with worse outcomes. This is due to social and psychological factors as well as the nature of the health system, in which non-governmental organizations (NGOs), province and city health services run separate programmes and use distinct, often incompatible data systems. This means that healthcare workers at these facilities often struggle to support men in getting tested, and in starting and remaining on treatment. Moreover, the iALARM project seeks to address an urgent need to link and retain HIV-positive men in the HIV treatment cascade, improving

HIV testing, treatment and care for men. Early HIV testing leads to better health outcomes that does not only benefit men, but also their partners, and families (30). It further seeks to help understand men's movement through HIV care continuum (HIV cascade) and finding ways to improve their retention in the cascade (30). Men drop out of the HIV cascade for various reasons including "the fragmentation within the health system across its various HIV-related services, a persistent gap between health system- and community-based efforts to support those living with-or trying to avoid-HIV infection" (30).

Purpose of the study

The purpose of this research study is to explore and understand men's experiences and perceptions of HIV testing services in Gugulethu Township in the Western Cape province.

Rationale and significance of the study

The study will explore subjective meanings and interpretations of men regarding HIV testing. The primary researcher wants to know what men's experiences are of HIV testing, as well what they think about the available HIV testing services in Gugulethu Township, Cape Town. This will assist in understanding men's perspectives and experiences of HIV testing within Gugulethu Township. There has not been any qualitative research study that focuses on HIV testing in men conducted in the Gugulethu Township.

Men face a complex set of challenges in accessing HIV testing, and it is important to get a better understanding about what these are so that they can be addressed, particularly since the challenges are more likely to be community-specific. Gugulethu Township was chosen as a research setting given that the broader iALARM project focuses on the Klipfontein sub-district which Gugulethu Township is part of, and that iALARM is partnered with Sonke Gender Justice (SGJ), which is in Gugulethu Township.

This research study will identify different factors that either facilitate or hinder men in seeking HIV testing services from public health facilities in their surroundings using qualitative data. This will enhance a thorough understanding of the role that men play in the community, and particularly since they are often not seen as a key population in HIV prevention efforts. Given that there is a lack of health interventions that are male-focused, not only in Gugulethu Township but countrywide, this research may potentially inform future health interventions that are inclusive of men, to effectively address the issues faced by men in the public health facilities, and may result in the uptake of HIV testing in Gugulethu Township.

Research questions

- (i) What are men's perceptions of HIV testing?
- (ii) What are men's experiences of HIV testing?
- (iii) What factors motivate or enable men to seek HIV testing?

Conceptual frameworks

This research study will apply Albert Bandura's Social Cognitive Theory (SCT). SCT is concerned with the learning that occurs within the social context, in this case being Gugulethu Township (31). This framework focuses on the relationship between the personal, behavioural, and environmental factors that play an important role in the decision-making process of an individual to take any decision (31). This framework will explore these factors with respect to men's experiences and perceptions of HIV testing which influence their actions to either undergo or not undergo HIV testing. Although these factors are important in this research study, this conceptual framework will be used along with the Patient-Centred Approach (PCA). The PCA is described as an approach in which health professionals view the world from the patient's perspective to determine the illness and health-seeking behaviour (32). The applicability of the Patient-Centred Approach is a way to understand and explore people's perceptions of health services. In the context of this research study, it will be concerned with a

greater exploration of how men perceive HIV testing services in Gugulethu so to have a deeper understanding of the factors that come into play when men think about utilization HIV services.

Utilizing and combining these two conceptual frameworks will both assist the primary researcher to explore and understand the different factors that facilitate men's decision making to undergo HIV testing, while at the same time enabling the primary researcher to incorporate and comprehend how the available HIV testing services influence men to utilize them. Overall, combining SCT and PCA will help the primary researcher understand HIV testing experiences and perceptions of men. Using one of the two conceptual frameworks would not fulfil the research questions that the primary researcher is exploring which focus on healthcare provider (HCP) approach towards patients and patient-centred approach. They work better intertwined to strengthen each other as they function more on a psychological perspective, and will inform the decision-making process within health services. Moreover, combining these two conceptual frameworks will enable the primary researcher to understand behavioural factors of patient as to why they test or do not test for HIV. The SCT is similar to another theoretical model called Health Belief Model (HBM) as they are both focusing on exploring and explaining the reasons for people to use or not to use public health preventive services, and looks at self-efficacy. However, the primary researcher chose SCT and PCA since HBM does not consider the environmental factors that play a role in people's decision to utilize health services. HBM is more focused on diseased individuals but fails to consider individuals that are not diseased.

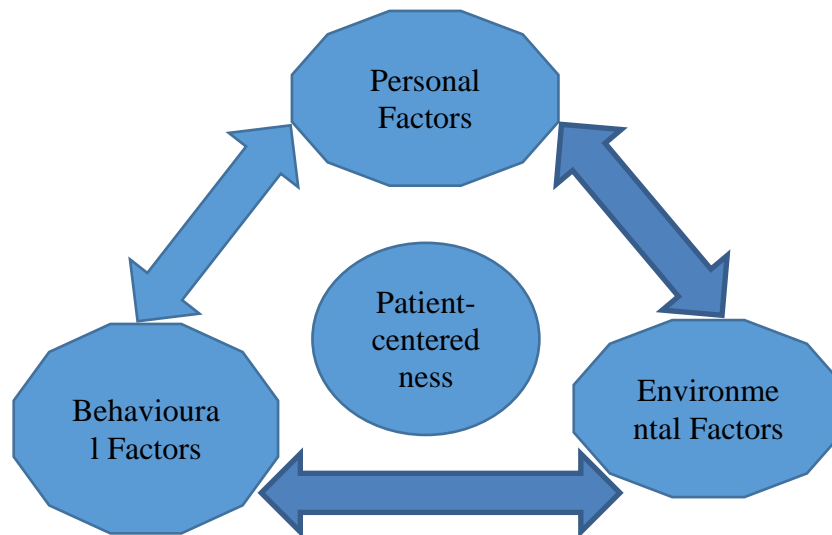


Figure 1: Relationship between SCT and PCA

Methodology

Study design

The study will employ an exploratory study design. An exploratory study design concerns itself with discovering what happens in mostly less understood environmental settings; and thus seeks to generate new insights on experiences while generating explanations of theory (33). It gives a primary researcher an undoubted opportunity to ask open-ended questions to get elaborate responses from participants, which are pivotal in gaining new insights to the phenomenon (33). In this regard, this study design is relevant to bridge the gap in understanding and exploring men's utilization of HIV testing services in South Africa; and there is no evidence of a similar study which has been conducted in Gugulethu Township. Another reason to conduct this research study in the identified township is informed by the fact that findings from other areas might be different depending on the experiences and perceptions of men in other areas. Applying the exploratory study design will permit the primary researcher to gather new insights and perspectives regarding the topic of interest. It will further set a pace in which the primary researcher uncovers the experiences and perceptions of men and their use of HIV testing services.

The study will employ a qualitative research paradigm. Qualitative research paradigm is a way to uncover a greater understanding of how people construct and perceive the world, as well as how they make sense of their lived experiences (34). This research paradigm further allows the researcher to observe understated events that unfold in social settings, such as meanings, perceptions, and experiences from the perspective of research respondents which cannot be fully measurable by quantitative research methods (35). For this research study, the primary researcher finds this paradigm appropriate as it will enable him to explore, describe and give detailed personal narratives of why research participants get tested or do not get tested for HIV, and what informs their decision to undergo an HIV test. The chosen research paradigm is also appropriate for this research study since experiences and meaning are difficult to measure quantitatively, hence the primary researcher's deliberate choice for a qualitative research paradigm.

Study population and sampling

For this research, the inclusion criteria for the main research target population will be 12 men aged 18 and above, who are residing in Gugulethu and have social relationships in the identified areas. These ages were decided upon as the research is concerned with looking at young and middle-aged adults, who are within the reproductive age. Young men are more likely to drop out of the HIV cascade by unsuccessfully negotiating all the steps of the cascade, and more often difficult to track in the HIV cascade (36). They may or may not be using the HIV testing services given that the research seeks to understand perceptions and own experiences. Male participants may or may not be sexually active. With regards to exclusion criteria, men who are not residents of Gugulethu Township at the time of research will not be eligible to participate in the study; as well as men under the age of 18, as they are not the focus of the research study. Furthermore, the iALARM Project's connection with SGJ provides us with a unique opportunity to recruit participants inside and outside clinic, and at events and through

informal networks of Mr. Phumzile Nywagi, the iALARM Project Field Coordinator who has extensive research experience on the research topic and in Gugulethu Township. He has furthermore been trained in taking informed consent, human subjects protection and in interviewing.

The interviews will be held at the iALARM Project field office in Gugulethu Township where SGJ is located, as a safe and private space to conduct interviews, protect research participants, as well as respect the confidential information that they will share with the student researcher. In an event where any of the research participants is not comfortable with the iALARM Project field office, interviews will be held in their homes or private and safe spaces they will be comfortable with.

This research will make use of a non-probability method of sampling, known as purposive sampling. Purposive sampling refers to the sampling whereby the research participants for the research study will be chosen based on the subjective decision taken by the primary researcher, his supervisors, and field coordinator (37). The sample will consist of men who have utilized and those who have not utilized HIV services; those who have successfully followed care and made use of the available HIV services; as well as those who decided to give up on using the services in Gugulethu Township.

Research setting

The main field site for this research study will be Gugulethu Township where Sonke Gender Justice's Men's Wellness Clinic (MWC) and Gugulethu NY3 Primary Healthcare (PHC) Clinic are located.

Gugulethu Township

Gugulethu, an isiXhosa name translated "our pride" in English is a township that is situated approximately 18 km south-east of Cape Town central (38). It is an economically marginalized

peri-urban township which had a population of approximately 98 468 residents by 2011 (39). Most of the population is isiXhosa-speaking and the township is within the Klipfontein sub-district (39).

Data collection

The method of data collection for the study is in-depth face to face interviews. Interviews are the widely used data collection methods in qualitative research (37). Interviews are defined as “a social relationship designed to exchange information between the participant and the researcher” (37). Often, researchers gather information by means of direct interaction with the respondents that are knowledgeable about the research study focus area (35). Also, interviews “consist of several key questions that help to define the areas to be explored, but also allows the interviewer or interviewee to diverge in order to pursue an idea or response in more detail” (40). The identified method of data collection is appropriate for the research study as it gives the research participant opportunity to provide a first-hand account of the subject of interest, and to allow them to elaborate on their responses, which cannot be done using close-ended questions.

Semi-structured in-depth interviews will be conducted with 12 men from around Gugulethu. Each interview will take a minimum of one hour. These interviews will form a focal point to extensively explore research respondents’ experiences and perceptions pertinent to the research focus.

Semi-structured interview schedule will be used to conduct the interviews. For the research study, there will be one interview schedule, which will contain the main research interview questions. The interview schedule will be written in English. However, a translator will provide translations from English to IsiXhosa or Afrikaans where required.

Additionally, a tape recorder and field notes will also be utilized for the interviews. The main reason for the use of a tape recorder will be to gather all the information that will be captured during the interviews for the accuracy of data analysis process. Furthermore, it is important to attain informed consent from all participants for the use of a tape recorder (37). The advantage of this tool is that it allows the primary researcher to collect information that may have otherwise been left out in the event that he may leave out during note (41). Nevertheless, a tape recorder has a potential to result in research respondents' withdrawal from the study should they not feel comfortable with being recorded (37). It is in this nature then that the primary researcher seeks permission. Moreover, field notes that will be taken and kept during data collection are a vital component of research interviews.

Data analysis

Data analysis is defined as a type of analysis which involves breaking down and structuring the gathered data, to give it meaning (42). The main intentions of qualitative data analysis is to bring forth the clarification of the research topic by means of data organization, interpretation, and categorization in order to attain meaning and fully comprehend the phenomenon studied (43).

This research study will employ a thematic analysis throughout its data analysis stage. Thematic analysis is defined as the analysis that is concerned with “identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail” (44). It is often applied in exploratory qualitative research studies and includes the categorization of gathered data into common or recurring themes; looks into the vital elements from research participants' responses; as well as allows for the development of codes from data and the identification of key themes and labels by being identified as codes (45). It is also important to note that the interviews will be transcribed verbatim to get a sense of each

interview without losing any pivotal shared information. The interviews conducted in IsiXhosa or Afrikaans will be translated into English in preparation for data analysis. Moreover, this research study will use an inductive approach where the themes contained in the full data set will be identified and analysed without any use of a hypothesis. It will allow the primary researcher to attain a deeper understanding and exploration of the experiences and perceptions of HIV testing in Gugulethu Township.

Data management

All transcripts will be anonymized before storing. To protect research participants, the primary researcher will keep all raw data (interview transcripts, informed consent forms, and field notes). Raw data, both electronic copies of in-depth interviews, informed consent forms, and field notes will require protection and this will be kept in a password protected computer. Recordings, due to their sensitive nature will be held in a different Dropbox folder accessible to only the Principal Investigators, co-supervisor, and the primary researcher working on this project. All data will be archived for three years after the conclusion of the study, and will be permanently erased thereafter.

Ensuring rigor

Trustworthiness: The primary researcher will consider the views of the research participants and ensure accurate interpretation of those to maintain as much raw data as possible, and at the end of each interview session to make sure that the primary researcher collects necessary and thorough information and views of the research participants. A total of 12 individual interviews will be conducted with male research participants who are 18 years and above residing in Gugulethu. Study findings can be used to guide other similar studies in similar geographical areas in South Africa. Regarding confirmability, the primary researcher will be aware of any prospective bias throughout the research study and admit to any preconceived narratives

regarding the research topic under review, and reflect on the interview sessions with his supervisors about the research process.

Reflexivity: Reflexivity is about the researcher's cognizance and the effect he may have on the research outcomes (46). It further encompasses how the entire research process may impact on the researcher. The primary researcher is a young male, aged 25 and comes from a peri-urban cultural setting that is similar to the research setting; and may thus have personal narratives of the research study in relation to his hometown of Ladysmith, KwaZulu Natal. This could impact on the quality of research findings and how the primary researcher analyses them. In this regard, one of the concerns are cultural contexts that the primary researcher needs to observe, particularly when interviewing research participants about sensitive issues such as sexual and reproductive health. Another cultural complexity may arise when interacting with older participants. The primary researcher is very aware of his own position as a young male and will be respectful and sensitive always, mainly when interviewing older men. To bridge the generational gaps that may be encountered, the primary researcher is working closely together with Mr. Nywagi. Mr. Nywagi is an older Xhosa man who resides in the area and has been trained in taking informed consent and human subjects protection and in interviewing. He has extensive experience with male adherence groups in Gugulethu. The assistance of Mr. Nywagi will also eliminate the language barriers that may arise. The primary researcher's native language is IsiZulu, and the research participants will be isiXhosa-speaking individuals. Herein, Mr. Nywagi will assist with translation to IsiXhosa or Afrikaans where needed. Furthermore, the researcher recognizes the cultural differences and negotiate these differences with the research participants. As such, the researcher will explain the overall project, including its purpose; and will allow all research participants to share what they are comfortable with.

Ethical Considerations

Informed consent, anonymity and confidentiality

The primary researcher will provide a brief overview of the research study to the research participants so that they are aware of the context of the research study. Only written informed consent will be sought from research participants. The informed consent form will be translated verbally in IsiXhosa or Afrikaans should the need arise. In an event where the research participant is illiterate, a witness will sign on his behalf. The informed consent will outline the research purpose, research study procedures, risks and benefits, compensation, and the contact information of the primary researcher. A copy of the informed consent form will be attached on the appendices. Also, the research participants will participate in the study voluntarily and their use of any health services will not be effected by choosing not to participate in the research study. Regarding confidentiality, the primary researcher will provide clear explanations to each research participant that shared information will be treated with utmost discretion and confidentiality; only the research supervisors will have access to it. Regarding anonymity, the primary researcher will use unique anonymized identification numbers to identify each participant. The identification numbers will be used for all participant forms.

Ethical Approval

Ethical approval will be required from the University of Cape Town (UCT) Health Science Faculty's Human Research and Ethics Committee (HREC) and the UCT School of Public Health and Family Medicine. Given that this research study is a sub study of a larger iALARM project, ethical approval for the project has already been approved and granted by the Western Cape Department of Health (WCDoH), the City of Cape Town and Sonke Gender Justice Men's Wellness Centre (MWC). The iALARM HREC reference number is 802/2014.

Risks and benefits

The primary researcher understands that research participants might feel uncomfortable speaking about some aspects of HIV infection (such as personal experiences of HIV in one's family, social stigma, etc.). If at any time research participants do not want to answer a question, they will not be pressured to answer. Participants are free to not answer any question or speak about any subject that they do not want to talk about. If they feel upset during or after the interview, they can notify the primary researcher. After the interviews, the primary researcher will summarize main points to ensure that the research participants' narratives were thoroughly understood and captured.

There are no direct benefits for research participants by participating in this study. There may be some longer-term, indirect benefits to them if the project can help with the improvement of male-friendly, male-focused HIV services and community based HIV services for men at NY3 clinic in Gugulethu Township.

Study budget

Item	Cost
Transport	R650.00
Incentives for participants	R600.00
Total	R1250.00

Study period and time frame

Activity	Expected timeline
Protocol submission	<i>November 2016</i>
Literature Review submission	<i>January 2017</i>

Data Collection (individual in-depth interviews with research participants.	<i>August-October 2016</i>
Data Analysis (including transcription)	<i>November-December 2016</i>
Journal manuscript write-up	<i>February 2017</i>
Draft Submission	<i>February 2017</i>
Final write-up and submission	<i>March 2017</i>

Write-up and dissemination of research study findings

The final mini-dissertation (research study) will be submitted in partial fulfilment of the Master of Public Health in Social and Behavioural Sciences degree requirements at the University of Cape Town. The findings will also be submitted to a chosen peer-reviewed journal for publication. Moreover, the mini-dissertation will also be disseminated to iALARM Project researchers and interested parties, such as SGJ, Gugulethu NY3 Clinic Management, WCDoH, National Institutes of Health (NIH) grant and will be online for the public.

Implications for policy and practice

Given that little is known about HIV testing uptake by men in South Africa, particularly in peri-urban areas, information gathered in this proposed study can be used to inform the policy decision-making and move towards more inclusive and comprehensive public health policies and interventions that seek to address the apparent lack of emphasis on men's health needs and HIV testing services and their underrepresentation in such services (47). This research will therefore inform the provision of efficient HIV testing services for men. It could also be used to foster awareness in men about the importance of getting tested for HIV. Moreover, the data gathered will also be useful in assisting and facilitating men's movement through the HIV cascade. The improvement of men-focused and inclusive HIV testing services will contribute

significantly in increasing their quality of life; reduced HIV incidence and mortality rates for both women and men.

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PART B: LITERATURE REVIEW

Introduction

This literature review will identify literature on Human Immunodeficiency Virus (HIV) testing in South Africa, gender norms and their impact on HIV testing uptake, men's perceptions of HIV testing, confidentiality issues, and perceived benefits of HIV testing. The literature review will also oscillate between Africa, the sub-Saharan Africa (SSA) region and South Africa.

The objectives of this literature review are to review the recent academic outputs in HIV testing literature and gain insights on the factors that influence men's decision to test for HIV in Africa. It also seeks to identify HIV prevention strategies targeted specifically to men. In addition, the literature review will examine the extent of current research on the factors that contribute to the use of HIV testing services in South Africa. This synthesis of the available literature and identification of gaps will highlight the importance of HIV testing by men for HIV prevention, treatment and care, inform future research, and ultimately improve HIV testing interventions for men in peri-urban areas in South Africa.

Literature search strategy

Peer-reviewed journal articles were searched on the Web of Knowledge, PubMed Central, Ebscohost, and Google Scholar database platforms. Literature was also searched through various websites, including the World Health Organization (WHO), United States Agency for International Development (USAID), Joint United Nations Programme on HIV/AIDS (UNAIDS), Statistics South Africa (StatsSA), and the South African National Department of Health (NDoH) websites.

Key terms included in the search were "HIV testing", "HIV Voluntary Counselling and Testing", "barriers to HIV testing", "facilitators to HIV testing", "HIV testing AND knowledge", "HIV in South Africa", and "HIV testing in sub-Saharan Africa AND South

Africa”. Additional relevant literature was sourced from the bibliographies of included journal articles. The review was restricted to material published between 2000 and 2017.

Summary of the literature

HIV testing

The SSA region has more new HIV infection cases than any other region in the world (1). South Africa has the highest HIV prevalence rate in the whole world, with about 6 million people living with HIV in 2014 (2). Given the high prevalence of HIV in South Africa, it is important to understand the factors contributing to the country’s high HIV burden. The South African government, in collaboration with international aid organizations such as Centers for Disease Control and Prevention (CDC), have invested significantly in voluntary counselling and testing (VCT) and prevention resources to curb the spread of HIV in the country (3, 4).

HIV testing is used for HIV prevention and as an entry point into care (5). It is one of the most effective ways to manage the HIV epidemic and prevent new cases (6). HIV testing has largely been recognized as a key element in any effective and efficient HIV prevention program, and most African countries have introduced HIV testing in their primary healthcare (PHC) packages (7). Despite the proven relevance of HIV testing to epidemic management, HIV testing uptake in males remains low in SSA, including South Africa (8, 9).

A Tanzanian study on men’s previous HIV testing and knowledge of HIV showed that about 65% of adult men had not tested for HIV and 75% of the sampled men were not aware of their HIV status (10). This is alarming, given that, when men are ignorant of their HIV status, they are more likely to transfer HIV to their partners, which increases the incidence rate of HIV. In South Africa, between 2008-2012, about 40% of all men tested for HIV, compared to approximately 54% of all women, and men are 25% more likely than women to die of AIDS (11, 12). This could explain low uptake of HIV testing and men’s vulnerability to HIV (13).

Gender and access to HIV services

The literature indicates that gender norms is one of the factors that make men to be reluctant to test for HIV. Health behaviours are vital factors to explain apparent discrepancies in the health status of men and women (14). Women often portray more positive health-promoting behaviours than men, and men commonly engage in risky behaviours including unsafe sexual encounters, alcohol consumption and smoking (15-17). Men often utilize their exhibited health behaviours to prove their masculinity (14). It is therefore not surprising that literature has found women to be more likely to access and utilize antiretroviral therapy (ART) compared to men (18, 19). Men access care later than women, and are more likely to only access care when they are experiencing symptoms (20, 21).

Gender norms and masculinity are crucial factors impacting men's health-seeking behaviour and access to care, and contribute significantly to men's low HIV testing uptake. Masculinity prevents men from portraying and expressing their vulnerability for fear of being seen as less manly (19). A study from Tanzania revealed that there are few men at the clinics, and men often suffer in silence by hiding their vulnerability from their intimate partners (14). A Zimbabwean study showed that societal perceptions conceptualise men as holistically independent, strong, and fearless which is negatively associated with men's decision to undergo HIV testing and adhere to their ART treatment (22). Moreover, men's masculinity contributes immensely to men's reluctance to admit to their problems, which informs their decision to test for HIV (23).

Although gender plays a significant role, men's reluctance to utilize HIV services is also a factor of health service delivery. As such, there remains a need for the health system to adequately recognize and accommodate men's specific health needs (9).

There is literature on HIV in men; however, there is a lack of literature on heterosexual men as most available literature focuses on men who have sex with men (MSM) (24-26).

Often, men do not perceive themselves as susceptible to the risk of HIV infection, despite the fact that they usually have more than one sexual partner (19, 27). This behaviour is also linked to a higher social status gained by men for engaging in sexual intercourse with multiple sexual partners (4). Factors such as denialism put not only men, but also their partners at risk of HIV infection because they are viewed as high risk takers as they are more likely to engage in unsafe sexual intercourse, yet they are not as willing to test for HIV and seek healthcare before they become symptomatic (20). Ill-health is also perceived by men as a great sign of weakness, which goes some way to explaining men's lower levels of health seeking behaviour (28).

Men's perceptions and attitudes towards HIV testing

Individuals' perceptions of HIV testing services are influenced by a number of factors, including the patient's beliefs in the HIV testing programme (29). Understanding the benefits of HIV testing could facilitate men's willingness to engage with HIV testing services successfully (29).

Individuals' attitudes to HIV testing are influenced by several factors, including the attitudes of healthcare providers (HCPs). A clear example of this is the Tanzanian study which revealed that patients' attitudes towards HIV testing services was largely influenced by improved and pleasant treatment from HCPs conducting HIV tests (30). A South African study revealed that that about 37% of the patients cited that the HCPs' attitudes influenced them to test for HIV, and 9% reported HCPs' attitude as a barrier to HIV testing (31). It can be argued that HCPs attitudes are part of the reason for men's low uptake of HIV testing.

Confidentiality

The lack of confidentiality in health facilities is another barrier to HIV testing uptake among men in developing countries (32). This is consistent with the findings by Matovu and Makumbi which demonstrated that lack of confidentiality delays and restricts individuals' access to HIV testing services (33). People are often discouraged from testing due to lack of trust in HCPs to keep an HIV test or an HIV positive diagnosis confidential (32). Confidentiality is another factor that is key to encouraging men to visit healthcare facilities and utilize HIV testing services (31). In addition, assuring that patients' HIV test results will be kept confidential is a significant facilitator towards the uptake of HIV testing (34).

Patient perceptions of the benefits of HIV testing

HIV testing benefits can be individual and community-oriented (35). An Ethiopian study revealed that the benefits of HIV testing as perceived by individuals included knowing HIV status so to protect themselves and their sexual partners; increased support and care access to ART upon knowing their status, including medical treatment to prevent opportunistic infections (35). Improved knowledge of these could catalyse the uptake of HIV testing in the SSA region (36). This is consistent with the research findings from western Uganda which revealed that understanding the benefits of knowing the HIV status is the main motivator for individuals to test for HIV (37). At community level, improved uptake of HIV testing, and knowledge of ones' own HIV status, could aid communities in mobilizing against the HIV epidemic, reduce stigma against infected individuals (38, 39). For PLWHA, testing for HIV serves as a gateway that enables them to access the available HIV testing services (6).

HIV testing has been reported to improve one's capacity for risk reduction and prevention of HIV transmission (40). Furthermore, HIV testing serves as an important element to provide emotional support, enhances capacity to manage HIV-related apprehension, and helps

individuals avoid risky behaviours that make them vulnerable to HIV infection (41). Much research conducted in the SSA region shows that individuals who test negative for HIV, particularly men, often subsequently engage in risky sexual behaviour as they perceive themselves to be less susceptible to HIV infection given their recent HIV test result (42, 43). Research on factors that enable and disable men in the informal sector to test for HIV in Pretoria demonstrated the importance of a positive perception of HIV testing where about 50% of men mentioned that testing for HIV was a responsible thing to do as it allowed them to know their HIV status and live a healthy life (13).

The knowledge and awareness of HIV testing may be vital towards the decision to test for HIV. This was evident in studies which found that most research participants who had tested for HIV were very much aware of the HIV testing benefits (29, 44).

Knowledge of one's HIV status is an important factor that could aid an individual to change their behaviour intended to curb HIV transmission risk (45). People who are more knowledgeable about HIV testing are more likely to test for HIV than people with little to no knowledge of testing for HIV (46). This is consistent with the findings on the awareness of HIV testing services and likelihood to test for HIV (47).

Educational attainment has been noted as a protective factor against HIV infection as educated individuals are more aware and likely to use available HIV testing services than uneducated individuals (48). A clear example of this is a South African study done in Cape Town which found that men who were more educated about HIV transmission tested more than those who were less educated (49). Given the significance of the knowledge of how HIV is transmitted and prevented, there remains a need for education and support following an HIV test targeted at men who tested HIV negative in a bid to assist them in retaining their HIV negative status (49).

Identification of research gaps

The current HIV interventions in most African countries, including South Africa focus predominantly on women, children and youth, and MSM (13, 24, 50). Although MSM are a key population, it has also been very challenging to target this population for prevention (51). One of the reasons for the focus on the aforesaid key populations is because these populations are reported to be more at risk to contract HIV, and women especially are more at risk of HIV infection due to their reduced autonomy in sexual-related decisions with their intimate partners (12, 52). One of the contributing factors in this regard is hegemonic masculinity and cultural practices which subordinate women where men are seen as family heads in charge of all decisions pertinent to their families and intimate partners (20, 53).

Currently, men have received little attention with regards to the HIV-related intervention programmes and there are little HIV programmes that focus on heterosexual men (50). There remains a need for men-specific HIV and health-seeking interventions in South Africa to prevent transmission of HIV.

Furthermore, the acceptability of HIV testing in most African countries remains poor, and is often hampered by the barriers such as fear, death, stigma and others (54). South African studies on the acceptability of HIV testing revealed a low acceptability of HIV testing in both men and women (55, 56). These studies have mostly been quantitative. As such, there is a research gap in terms of qualitative inquiry on the acceptability of HIV testing in South African men.

Besides the HIV testing acceptability in men, there is lack of concrete evidence of how the current HIV testing interventions translate to the uptake of HIV testing in South Africa. Existing literature have reported on the possibility of HIV interventions to improve HIV testing uptake, but there is a lack of studies to assess and confirm this uptake (13, 57). There is a further

lack of research in South Africa that focuses specifically on the barriers and facilitators to HIV testing in men in general.

Conclusion

This literature review showed that there are various factors that influence men's willingness to test for HIV, in South Africa, and in the African continent more broadly. The factors that contribute to testing for HIV are complex and often intangible. Research on the topic has been conducted in several countries; however, gaps of the current literature were identified, and there is a need to explore them further to understand men's HIV testing behaviour from a qualitative research perspective.

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PART C: JOURNAL “READY” MANUSCRIPT

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Men’s experiences and perceptions of HIV testing services in Gugulethu Township, Cape Town

Abstract

South Africa remains the country with the highest rate of people living with HIV and AIDS in the world, where men are more likely than women to drop out of HIV care, be lost to follow up, and where most men only utilize HIV testing services when they become symptomatic. Health-seeking behaviour of men remains inadequately understood and motivating the male population to get tested for HIV is still a challenge in many low-middle income countries. Even though testing for HIV in men in South Africa is vital in the management and prevention of the pandemic, men remain a forgotten population in HIV prevention efforts. It is therefore important to focus on the experiences and perceptions of men towards HIV testing in South African peri-urban areas. This study was conducted through the qualitative research paradigm and employed an exploratory research study design. Twelve men from Gugulethu Township were purposively sampled and in-depth face-to-face interviews were conducted over a period of two months. The analysis revealed that all men who were interviewed had tested for HIV at some point in their lives, although some had not tested again for many years. The data indicate that health information sharing plays a significant role in getting men to decide to test for HIV through their social spaces and media, and that social support, mainly from peers and family is important to men choosing to get tested for HIV. In addition, despite the literature indicating that the gender of a healthcare provider does matter, the findings indicated that gender of a healthcare provider conducting the HIV test does not necessarily influence the decision of whether to test or not as much as professionalism might. Fear of a positive test result stops men from testing for HIV; citing denialism and the inability to cope because of a positive result. Furthermore, a lack of male-focused HIV interventions makes it difficult for men to utilize HIV testing services. More awareness, educational and

door-to-door HIV campaigns were identified as key interventions towards increasing the uptake of HIV testing in men. Moreover, it was revealed that, despite being knowledgeable and aware of the HIV testing services, some men still engage in risky sexual acts which heighten their chances of contracting the virus. Additionally, it was shown that most men also believe females utilize HIV testing services more than they do, citing various reasons, including the mandatory HIV test during pregnancy. In sum, a variety of psychosocial factors impact the decision for men to test for HIV and affect their perceptions of HIV testing. Men are aware of the contextual barriers that inform their willingness to undergo an HIV test. Based on these findings, there is a need for the government to take the experiences of men into consideration in the design of health policies to make them more inclusive. Moreover, psychosocial and interpersonal factors need to be considered in the design of HIV-related interventions. Men are aware of the HIV testing services, but their testing behaviour does not match their awareness and knowledge of HIV testing. As such, prevention campaigns should appeal to and target men's specific needs.

Keywords: HIV testing, men, experiences, perceptions

Background

It has been well established that Human Immunodeficiency Virus and Acquired Immuno Deficiency Syndrome (HIV/AIDS) is a major public health challenge on a global scale. HIV/AIDS has claimed the lives of more than 34 million individuals worldwide (WHO, 2016). Despite an observed decline in HIV incidence and prevalence rates globally, in 2012 and 2013, sub-Saharan Africa (SSA) still constituted about 71% of global HIV incidence rates, even though it is just 12% of the global population (UNAIDS, 2014). South Africa remains the country with the highest burden of HIV/AIDS worldwide, and in 2015 there were more than 6 million South Africans living with HIV/AIDS (PLWHA) (StatsSA, 2015). In 2015, approximately 380 000 new HIV cases were reported in South Africa (UNAIDS, 2016). The prevalence of HIV remains high with 19.2% of the entire adult population of South Africa infected with the virus (UNAIDS, 2014), and heterosexual sexual intercourse remains the dominant mode of transmission in the SSA region, and South Africa in particular (Leblanc & Andes, 2015). The South African National Department of Health (NDoH) has developed and implemented numerous strategies to reduce the burden of HIV in the country. Although there has been noticeable declines in the HIV rates of children and individuals between 15-49 years old, it cannot be ignored that the overall prevalence rate of HIV in the country remains unacceptably high (Mambanga, Sirwali, & Tshitangano, 2016). Strategies to reduce HIV include educational campaigns, voluntary medical male circumcision (VMMC), and condom distribution (Avert, 2016; Chimoyi et al., 2015).

In addition, there is an enormous underrepresentation of men in HIV testing, treatment and care efforts in the SSA region (April et al., 2009). This underrepresentation is one of the reasons for poor health outcomes in men in Africa (Hawkins et al., 2011). There is a limited data on the actual burden of disease of HIV in a general male population with more literature focusing on men who have sex with men (MSM) as the prioritised vulnerable male population (Avert, 2016; Cloete, Simbayi, Kalichman, Strebel, & Henda, 2008; Smith, Tapsoba, Peshu, Sanders, & Jaffe, 2009). As a result, the HIV/AIDS response has predominantly targeted women, children and MSM (Mills, Beyrer, Birungi, & Dybul, 2012) with minimal efforts to reduce the impact of HIV/AIDS in men. Although various studies in South Africa have assessed male health behaviour change (Jewkes et al., 2008; Kalichman, Cain, Eaton, Jooste, & Simbayi, 2011), men still remain vulnerable to HIV and face challenges in being retained in care, which subsequently impacts on the mortality rate (May et al., 2010).

According to Scott-Sheldon et al. (2013), the promotion of HIV testing is one of the strategies that the South African government, mainly the NDoH and other regional and international organizations have introduced to mitigate the spread of HIV in South Africa. Day et al. (2003) proclaim that HIV testing is considered the main gateway for treatment for PLWHA in the SSA region (Fleming, Colvin, Peacock, & Dworkin, 2016; Tabana et al., 2012), and has turned out to be an essential element regarding the prevention of HIV in the region (De Cock, Marum, & Mbori-Ngacha, 2003). HIV testing provides individuals with an opportunity to know their HIV status; and teaches them about the importance of making wise health-related decision (Sangiwa, 2004). Furthermore, HIV testing is pivotal in attempts to attain the universal access goal of care, prevention, as well as treatment health services in time. Nevertheless, there remains low uptake of facility-based HIV testing primarily amongst the young males, which undermines potential for effective HIV treatment and prevention methods (Tabana et al., 2012).

Research shows that despite South Africa's largest roll-out of antiretroviral therapy (ART), there is a low uptake of HIV testing amongst men in the country (Snow, Madalane, & Poulsen, 2010; Venkatesh et al., 2011). In 2009, only a third of the male population was likely to test for HIV (Peacock, Stemple, Sawires, & Coates, 2009).

There is a persistent blind spot around HIV prevention and treatment for men and their related burden of disease, justifying the slow uptake of HIV testing practice in men in the SSA region who are also less likely to test for HIV than women (Cornell, Myer, Kaplan, Bekker, & Wood, 2009; Fleming et al., 2016; Hawkes & Buse, 2013; Hensen, Taoka, Lewis, Weiss, & Hargreaves, 2014; Lindegger & Quayle, 2009; Radingwana, 2014; Shand, van den Berg, Peacock, & Pascoe, 2014). In South Africa, 20% of men tested for HIV in 2012 compared to 43% in 2009 (Shisana et al., 2015). This shows a decline in the HIV testing rate in men between the two years (Shisana et al., 2015). These findings were supported by Venkatesh et al. (2011). A possible explanation for the disparity between HIV testing rates among men and women is that women have a set routine point of entry to care; however, there is no similarly routine point of entry into care for men.

In line with the low uptake of HIV testing, men do not often access and utilize health services (Kranzer, Zeinecker, et al., 2010). This leads to higher mortality rate in men. Men often do not seek healthcare, particularly HIV testing, until they present with HIV symptoms, or when the virus has progressed to the advanced stages of AIDS and they only start ART then (Cornell, McIntyre, & Myer, 2011; Cornell et al., 2009). Thus, men are more likely to die even on ART than women, as they are more often lost to follow in ART care (Cornell et al., 2014; Dovel, Yeatman, Watkins, & Poulin, 2015; Ochieng-Ooko et al., 2010; Taylor-Smith, Tweya, Harries, Schoutene, & Jahn, 2010). The mortality rate in men due to AIDS-related illnesses is exacerbated by the lack of effectiveness of ART treatment when it is only accessed at a later stage of the disease (Badri, Lawn, & Wood, 2006). Furthermore, men are more likely to default their ART treatment in every step of HIV care than women (Kranzer, Lewis, et al., 2010; Underwood, Hendrickson, Van Lith, Kunda, & Mallalieu, 2014).

Men face a complex set of challenges in accessing HIV testing, and it is important to get a better understanding about what these are so that they can be addressed, particularly since the challenges are most likely to be community-specific. In studies that have been conducted, men, especially heterosexual men, have not been considered a key population in HIV prevention efforts as most have focused on women, children, and men who have sex with men (MSM). As a result, there are few adequate interventions targeted specifically at men, to address the issue of HIV in heterosexual men (Hensen et al., 2014; Snow et al., 2010). Conducting research among heterosexual men is important as the predominant mode of transmission of HIV is heterosexual sexual intercourse (Snow et al., 2010), putting both men and women at risk.

Based on the findings of low uptake of HIV testing in men, the aim of this research study was to understand experiences and perceptions men have about HIV testing services offered in Gugulethu through in-depth qualitative exploration. The research is focused on how men experience HIV testing services. This research is relevant to improve our understanding of men's perspectives and experiences of HIV testing within Gugulethu Township; and potentially inform HIV-related interventions in Gugulethu Township. The HIV-related interventions could be informed by barriers and facilitators of HIV testing which are contextually and culturally dependent. Additionally, this research study provides new insights for the insufficient literature on men and HIV testing in South Africa by gathering qualitative data from men who utilize the available HIV testing

services in public health facilities. This research study could lay a foundation for future research on how men perceive and experience HIV testing in similar geographical settings as Gugulethu Township, locally, regionally, and internationally; especially since the information on the reasons for low HIV testing uptake in men is limited (Bwambale, Ssali, Byaruhanga, Kalyango, & Karamagi, 2008). The research questions that guided this research study were: What are men's perceptions of HIV testing? What are men's experiences of HIV testing? What factors men perceive as relevant to their HIV testing?

Methodology

Study design

The aim of this study was to improve understanding of men's utilization of HIV testing services in Gugulethu, and because there is no evidence of a similar study ever conducted in peri-urban township, this study was exploratory in nature. This allowed the primary researcher to uncover the experiences, perceptions, and motivations of men regarding HIV testing, as well as their self-reported use of HIV testing services. The study employed a qualitative research paradigm to allow for a better comprehension of individuals' perceptions and constructions of the world, and of how men make sense of their lived experiences. The interview structure allowed men to explore, describe and give detailed personal narratives of why they get tested or do not get tested for HIV, and what informs their decision to test for HIV. Open-ended interviews allowed participants to elaborate on their responses.

Research setting

This study was conducted in Gugulethu Township, a peri-urban township that is situated approximately 18 km south-east of Cape Town Central (South African History Online, 2013). It is an economically marginalized peri-urban township with a population of over 100 000 people. Much of the population is isiXhosa-speaking and the township is in the Klipfontein sub-district. The township is amongst the townships with highest HIV/AIDS prevalence rates in the Western Cape Province (Draper, Pienaar, Parker, & Rehle, 2007).

Research participants

Twelve men, aged between 18 and 54 years old were purposively sampled for this research study. These men were residents of Gugulethu Township; all the men have lived in the township for many years, while some were born and raised in the township. Whether the men had been tested for HIV was not a criterion for inclusion. Even men who have not tested for HIV have experiences and perceptions of HIV testing campaigns. They may or may not have been sexually active. Additionally, the study included men who have successfully followed care and made use of the available HIV services; and those who decided to give up on using the services in Gugulethu Township. On the exclusion criteria, men who were not residents of Gugulethu at the time of research and men who were younger than 18 years were ineligible to partake in the study as they were not the focus of the study. Additionally, due to the collaboration of iALARM project with Sonke Gender Justice (SGJ), the primary researcher had an opportunity to conduct two interviews with men at one of the health promoting events organized by SGJ in a neighbouring peri-urban township of Delft.

Data collection

The primary researcher conducted 12 semi-structured in-depth face-to-face interviews with the research participants by using a semi-structured interview schedule. The schedule contained open-ended questions to enable research participants to further elaborate on their responses. Each interview took approximately an hour. The interviews and the informed consent forms were written in English, and they were verbally translated to IsiXhosa if necessary by the iALARM Field Coordinator who is trained in attaining informed consent and conducting interviews. English was used as an interview language given that the primary researcher speaks IsiZulu and is not proficient and fluent in the local language.

In ensuring privacy and protection of research participants, all interviews were held in private spaces conducive to conduct the interviews. The semi-structured interview schedule consisted of open-ended questions, which permitted the participants to elaborate on their responses, and these were utilized to facilitate the entire interview process. Additionally, before the individual interviews commenced, the primary researcher attained written informed consent from all research participants. Furthermore, every individual interview was audio recorded and additional field notes were taken, with the permission granted by each research participant. All data was kept in a password protected computer on the University of Cape Town property, will be kept for three years after the conclusion of the study, and will be permanently erased thereafter.

Data analysis

The primary researcher translated all individual interviews recordings to English and transcribed them verbatim in preparation for data analysis. This research study used thematic analysis to code and analyse gathered research data. Six stages, guided by the work of Braun and Clarke (2006) were involved in data analysis. Firstly, the primary researcher familiarized himself with the collected data by reading through all the interview transcripts thrice before making notes (Braun & Clarke, 2006). Secondly, initial codes were generated and a preliminary codebook was developed by the primary researcher by identifying predominant themes and sub-themes that emerged strongly from the interview transcripts and spoke to the research topic (Braun & Clarke, 2006). Thirdly, the primary researcher started searching for core themes and sub-themes from the collated data and a long list which contained different codes which needed to be broken down to form major themes and sub-themes that were relevant to experiences and perceptions of HIV testing services utilization (Braun & Clarke, 2006). On the fourth stage, themes and sub-themes that emerged were reviewed and refined by the primary researcher, and this involved eliminating some of the candidate themes that, after a careful review, were found to not be the key themes due to lack of evidence (Braun & Clarke, 2006). On the fifth stage, themes and sub-themes were well-defined and named, and the primary researcher got the overall sense of what each of them was about, linking them to HIV testing experiences and perceptions before writing out the findings. This process necessitated a well thought-out and detailed analysis of the themes and sub-themes. Lastly, the primary researcher wrote and summarised key findings from the collected research data which reflected research participants' perceptions and experiences of HIV testing services. For this research, however, there were only themes and identified codes as there were no clear sub-themes within which data could be substantiated with relevant data.

Findings

Description of research participants

Twelve men, between the ages of 20-54 years were interviewed for this research study. Their education level ranged between high school and tertiary level. Participants' employment ranged from unskilled labourer to educator; however, two of the men did not have formal employment. Ten research participants were from Gugulethu Township. All men had tested for HIV at some point in their lives. Although all had undergone an HIV test, three of them had not tested for HIV in the last 16 and 18 years respectively; four had not tested in a while; one last went for an HIV test in 2011 and had since abstained from sexual intercourse for personal reasons; and four had gone in the last two years (2015 and 2016 respectively). Based on the findings, there was no difference between testing behaviour between younger or older men.

Six themes were developed from the research data. The following table lays out, in summary, the themes that are pertinent to this research study.

THEMES
Health education
Specific knowledge of HIV testing
Denialism and accepting HIV diagnosis
Social support
Preference of HCP
Interventions to improve HIV testing

Table 1: Summary of themes that emerged from research findings

Health education

Health information remains one of the focal points in combating the HIV/AIDS pandemic, particularly the sharing of HIV-related information with other individuals. In this context, health information refers to the sharing of HIV testing information between two individuals or a group of people. Men provided insightful responses regarding health knowledge sharing, and the link to HIV testing was mainly positive. Responses revealed information on where men get information about HIV testing, and how they spread information in their communities. Findings showed that men did share information relating to HIV testing with each other, but it was usually in spaces such as taverns or social pubs when they were consuming alcoholic beverages.

Despite this knowledge, findings showed that there were intangible reasons why men do not test, such as stigma and fear, which affirmed previous findings in literature. There were various channels in which health education would be obtained; such as media platforms; including television and radio shows, community organizations, and schools.

Findings further indicated that all men were aware of the places to test for HIV, such as local clinics, hospitals, health events, and mobile clinics in the township. Despite their awareness of these places, most of the men's willingness to test for HIV was often hindered by the possibility of being tested by the HCPs who resided in the same township as them. Moreover, more than half of the men reported that they obtained knowledge of HIV testing from social gatherings where they discussed HIV with other men than in healthcare settings.

According to the findings, media also plays a vital role in getting health education across. This was evident in a response by one man who said that he first heard about HIV testing from a television programme before his partner went for an HIV test in one of the public hospitals in Cape Town. Reading also proved to be a factor that maximises one's knowledge of HIV testing. One participant said that:

"I am informed about HIV and HIV testing through the books I read" (P#04, early 50s)

This is an interesting finding given that the respondent gave the response but admitted to engage regularly in risky sexual acts. Even though men may be aware, conscious and knowledgeable about HIV/AIDS, they may still engage in unsafe sexual intercourse with the persons they are not in a relationship with, not only putting their lives at risk of contracting the virus but also their intimate partners and only regret after their encounters. From these findings, the amount of health information does not always seem to influence behaviour. Part of health information sharing is creating awareness of and knowing about HIV testing in communities.

Specific knowledge of HIV testing

Research participants were asked if men know and are aware of the HIV testing knowledge. Mixed answers were given by eight of the men and they ranged between complete awareness and lack of awareness. A significant number of research participants reported that men are aware of the available HIV testing services at their local public healthcare facilities. One participant stated that men are aware of HIV testing because at times, when men gather together to drink alcohol with friends, they talk about it. This shows complete level of awareness and one participant said:

"We are fully aware when it comes to HIV testing" (P#08, late 40s)

Some of the participants mentioned that the knowledge of HIV testing and TB was very little. On the other hand, other participants knew about HIV testing because they were living with HIV. In line with this, another participant said men who were more knowledgeable about HIV testing were more likely to be willing to test for HIV than the least knowledgeable. Findings further showed that some men were aware of stigma as a barrier to HIV testing. Consequently, four participants mentioned the stigma attached to talking about knowledge of HIV testing, and further probing revealed that, it was not necessarily the lack of information, but the fear of sharing information relating to HIV testing.

Denialism and accepting HIV diagnosis

Within the findings, the first code that emerged was denialism. Denialism remains a challenge and difficult to breakdown as it is intangible and psychological. Research has reported on denialism in the context of HIV; nevertheless, limited research has focused on how men negotiate and accept the new HIV diagnosis. The fear of being HIV positive

and not accepting HIV status proved to be one of the barriers why men in this study seldom tested for HIV. Half of the men expressed their difficulty of accepting the outcome of a positive HIV test result. A positive HIV test result presented a sad and unhappy emotional state of being, and for some individuals, it may take a long time before they accepted their HIV status. Some men who openly lived with HIV responded that one could never prepare himself for the impact on the HIV test outcome. For some men, it was difficult to accept their HIV diagnosis, thus being in denial for many years. Accepting and disclosing the HIV status was reported as a painful process that men had to deal with. At times, the men suppressed the thoughts of testing positive for HIV but they needed to come into terms with their status. Some of the participants shifted the blame of the new HIV diagnosis to their intimate partners as their adopted coping mechanisms. Some men reported that they had observed their peers who resorted to self-harm, such as injuring themselves because they were unable to accept their diagnosis. Emotional self-harm was also found to be a coping mechanism, particularly when there was no available social support. Another participant said:

“I told myself I accepted myself but in the back of my mind there was all that knowledge that I did not accept myself.” (P#02, mid-30s)

The participant was asked if he had ever tested before his HIV diagnosis, and he had not. Finding out his HIV positive status and accepting it was not an easy journey; however, remaining positive and determined to live a healthy and responsible lifestyle helped him cope with the then new diagnosis. From the findings, feeling positive post-diagnosis was gateway to accepting the HIV status by living a healthy life and adhering to their medication.

Social Support

From the findings, peer-to-peer support serves as an important factor in encouraging the uptake of HIV testing services in men. The presence of persons to offer support is pivotal when one decides to test for HIV. Individuals seek support from different people; however, peer support came up strongly as one of the cited facilitators to HIV testing by most men. Of the four men living with HIV, two preferred to be supported by other men, for comfort and a sense of belonging, while another participant stated that he had received tremendous support from his close relatives. One other participant stated that the best way to get men to test was by supporting each other. Others reported the importance of sharing news with their friends because bottling things up could have done further damage. Another participant gave other reasons. He said:

*“...it’s easy to talk to guys because they are guys and some of them have gone through the same experiences as me or they have also done the things I have done as well.”
(P#03, mid-30s)*

“Yes, but I think in that moment I need another man after testing positive for HIV. ... I think in that moment I need another man who will tell me that such things happen and it’s not the end of the world. Do you understand? A man who will tell me that there are other men who are living with HIV and are healthy. Men who have lived 10, 15 or 20 years with HIV but you just need to do 123 and 123.” (P#03, mid-30s)

Participant 3 did not mention P2P support only, but suggested an older role model who was living with the virus for many years. It was clear that some men looked up to older HIV positive men who encouraged and motivated them to accept their HIV status. This was a clear example that being diagnosed with HIV was not viewed as a death sentence

for some participants, but required the need of remaining healthy and finding adequate support.

From the findings, support from family members also plays a crucial role when one has undergone or decides to test for HIV. This form of support appeared to be more important than any other support structures, including peer-to-peer support. One participant said he would seek for support within his household, be it the mother or siblings. He would tell them because they were the closest to him and they would accept him, regardless of the outcome of the HIV test. Furthermore, one participant said:

“My brother, I can speak from experience. To me when I got my results, the first person I told was my sister and she accepted me you know, irrespective. Yes, and it helped me therefore I can say it helped me in a manner that I can talk with the next person about my status.” (P#02, mid-30s)

The participants who disclosed their HIV status knew their families were going to accept them regardless of the outcome of the HIV test. Several participants said that family support improved their self-confidence and enabled them to talk to other people about their HIV status.

Another participant said:

“My brother, I live with my brother only at my place. So, he is the one I would trust with my test results because he has to know what I am going through or if like, for example if I am sick, he has to know what is happening to me you see. He has to know my problems.” (P#05, 20)

The above example depicted the importance of disclosing health-related problems to family members because of trust and confidentiality that may exist in the family.

Preference of HCP

Men were asked whether they would like to be tested by either a male or female counsellor, nurse or doctor, and if that made any difference in their HIV testing experiences.

Half of the men interviewed, said that being tested by female HCPs did not make any difference in their experience of HIV testing, and the responses were largely influenced by the tester’s competency and education level. Some participants stated that they would be happy with being tested by both male and female HCPs. Reasons for their preference included that female HCPs were more gentle and nurturing towards men than male HCPs. These men viewed male HCPs as more direct in their approaches but would work with them towards reaching a solution following the HIV test. Some participants alluded to the fact that they were not going to have a problem with any HCP if the HCP was qualified. Two participants said:

“It does not matter who tests me, as long as the person conducting the test is professional and conducts himself/herself in that manner too.” (P#04, early 50s)

“So, it does not make any difference whether I get tested by a male, woman, gay, or lesbian as long as they are a professional person to check whether I am infected with this virus.” (P#08, late 40s)

Most of the men interviewed did not think that the gender of the HCP mattered regarding testing for HIV. Men argued that the gender of a HCP is irrelevant when testing for HIV

if the procedure was conducted in a professional and confidential manner. From the findings, confidentiality appeared to be an issue linked with the gender of the HCPs where female HCPs were said to be more likely to break confidentiality than male HCPs by disclosing the patients' HIV test results to others.

Four men indicated that they preferred to be tested by a male HCP since he could relate to their experiences, and it was easier to engage with another man on topics relating to men's sexual lifestyle. These participants further said that they were aware that in most instances, HIV tests were conducted by female HCPs and thus, some men would not feel comfortable with this, especially as testing for HIV would have required them to talk about their sexual encounters which they were not comfortable with. One of them asserted that being tested by another man is much better as he may have gone through similar experiences which would have made it easy for him to talk to the male HCP about his sexual encounters. He said:

“If it was a female nurse for me the barrier was gonna be like so hard to crack. It was gonna be so hard to crack the wall because you find it in most cases it's hard for a male to open up to female, whereas if it's a male to male, he knows what you are talking about and the fact that he knows what you are talking about he can relate to the experiences you have had.” (P#11, 25)

Interventions to improve HIV testing

The South African government and various organizations have implemented different interventions in the attempt to get individuals to test for HIV, such as awareness campaigns and HIV testing campaigns. Men in the study were asked if these interventions were successful. Despite these campaigns, this study findings showed that there remains the need for more educational awareness campaigns on HIV and HIV testing within the community of Gugulethu Township. Participants said that more awareness about the illnesses that were prevalent in the community such as HIV, were needed in Gugulethu Township. Most men said there should be health related workshops and advertisements on health-related issues. To support the above finding, one participant stated:

“... if there were more awarenesses done for men in particular to know about their status, or their health in general, would have been more helpful.” (P#02, mid-30s)

In a different light, one participant said:

“Maybe have South African Breweries (SAB) advertise about, maybe a collaboration between SAB and any HIV/AIDS organization on the dangers of engaging in risky sexual intercourse when under the influence of alcohol.” (P#03, mid-30s)

This collaboration mentioned above, may suggest that taverns are perceived as spaces where men would be more likely to be warned against unsafe sexual intercourse under the influence of alcohol.

Moreover, a significant portion of participants felt a strong need to focus on the door-to-door HIV testing campaigns to increase the uptake of HIV testing in men and teach more men about HIV/AIDS testing. To support this, participants said:

“Go to people door by door...” (P#08, late 40s)

The door-to-door HIV testing would ensure confidentiality and conducted in a safe and private space without going to the health facilities to test for HIV. Similar findings were

observed at an event held in Delft Township where it was found that men were aware of HIV testing and preferred the door-to-door HIV testing campaigns and mobile HIV testing services offered by the Desmond Tutu HIV Foundation (DTHF). They added that more emphasis on door-to-door campaigns would make men more comfortable in their own spaces; however, some research participants felt that there was a lack of door-to-door HIV testing campaigns in Gugulethu Township.

In addition, the use of media was a powerful tool to get the message across. Although there have been HIV media campaigns, more than half of the participants felt that by placing advertisements on HIV testing through print media, television, and distributing flyers would help promote HIV testing in men.

Discussion

This research study explored various factors that contribute towards men's experiences and perceptions of HIV testing services in Gugulethu Township in Cape Town. The contributing factors that were found included health education, accepting HIV diagnosis, the importance of social support, knowledge of HIV testing, preference of a HCP, and interventions that are specific to men's needs.

Health education

For men, the availability of the services is not the only problem. The findings indicated that men are aware of where they could obtain information about HIV testing in their community. Health education appeared to be vital in the attempt to get men to talk about HIV testing with their significant others and they were receptive towards their contribution towards disseminating such information not only to their friends but partners as well.

From the research findings, it was clear from the men that were interviewed that there is a lack of sharing of HIV testing information and HIV test results with their intimate partners and family members. In this regard, the sharing of HIV testing information will not only be beneficial to other men, but their significant others as well towards curbing the spread of HIV by educating those close to them. What was striking during the conversations with the men is the apparent lack of communication between them and their families, which acts as a barrier to the extent to which such information is shared amongst them.

Other platforms, such as media are common ways to access information, but it did not emerge as an overarching method of sharing HIV testing information amongst men in the findings. In addition, given that public health facilities are environments where information regarding HIV testing is available, the study conducted by Bwambale et al. (2008) showed that most men received information about testing for HIV through HCPs; but findings revealed that only one man received HIV testing information from a HCP in a public hospital. With that said, there is not much said about men who do not consume alcohol and where they may share their HIV testing information.

From the findings, men feared the possibility of their HIV status being disclosed to others and being identified with their HIV status hence they test when they show symptoms of being HIV positive (Kalichman & Simbayi, 2003; Meiberg, Bos, Onya, & Schaalma, 2008). Furthermore, it was found that there is no difference between age and HIV testing knowledge, as well as between age and the frequency of testing for HIV amongst the men who participated in the research study in Gugulethu Township.

Specific knowledge of HIV testing

The findings revealed that the men who were part of the study were all aware and knowledgeable about HIV testing, and these findings are consistent with the findings on the awareness and knowledge of HIV testing services in South Africa which revealed that men are often aware and know about HIV testing (Day et al., 2003; Matseke, Peltzer, & Mohlabane, 2016). The importance of testing for HIV was also highlighted and acknowledged by men; however, they still hardly test for HIV and it was noted that HIV testing uptake remains low. This supports the findings by Johnson, Rehle, Jooste, and Bekker (2015) that by 2012, the percentage of undiagnosed men in South Africa was approximately 32% compared to 19% of women. Furthermore, despite the available knowledge and awareness of HIV testing in their disposal, they still engage in risky sexual encounters with multiple partners whom they, at times do not use protection with as previously mentioned. Findings further showed that HIV testing is important as it enables them to know their status, and serves as a motivator to lead a responsible sexual lifestyle by protecting themselves and their intimate partners; which is consistent with the findings by Manirankunda, Loos, Alou, Colebunders, and Nöstlinger (2009). Furthermore, it was clear that men were aware of the benefits of accepting their HIV diagnosis. These benefits include awareness of one's HIV status as well as responsible and healthy living post-diagnosis.

Denialism and accepting HIV diagnosis

Findings showed that it takes time for men to accept their HIV diagnosis. This finding is supported by Horter et al. (2017). The findings further revealed that men think that they are unable to cope with an HIV-positive diagnosis. This is synonymous with research findings that men go through traumatic experiences before they could accept their diagnosis; and this does not mean they do not want to start with ART (Horter et al., 2017). From the findings, an HIV diagnosis brings about negative emotions which could affect one's self-confidence. In this regard, they would isolate themselves from their peers due to the new diagnosis. Some of the interviewed men who are currently living with HIV have been fortunate enough to be supported by their friends and families which has made it less challenging for them to accept their diagnosis.

Social support

The importance of social support remains key in making the infected individuals accept their HIV diagnosis. It plays a critical role in health-seeking behaviour and HIV testing of individuals in resource constrained settings (Drain et al., 2015). Social support is linked to men's difficulty to accept HIV diagnosis as it contributes to how men make sense of the diagnosis. Peer-to-peer and family support emerged strongly for men interviewed as coping mechanisms. The findings revealed that men prefer seeking support from the people they trust, and in whom they can confide. Adequate social support is linked with more pleasant behavioural outcomes (McInerney et al., 2008) and less risky sexual behaviours (Qiao, Li, & Stanton, 2014). The study findings are in line with the literature on the topic which shows that social, psychological and emotional support is important for men living with HIV, and helps men to cope better with their circumstances (Schrimshaw & Siegel, 2003). Men are often afraid of not receiving support and encouragement from their loved ones should one test positive for HIV, as previously reported by Njau et al. (2014). Positive social support can increase men's chances and willingness to test for HIV, and regardless of the outcome, they know they have a support system (McInerney et al., 2008). It also has a potential to enhance men's confidence and

acceptability of the HIV status. Lack of support may have negative consequences, such as inhibiting men from disclosing their status to their intimate partners, which potentially allows for continued engagement in risky sexual activities and hinders one's willingness to test for HIV (Admassu & Fitaw, 2006). There remains a research gap on the importance of social support prior to HIV testing in South Africa (Drain et al., 2015). Based on the findings, individuals that men may seek support from do not have to be their significant other, but someone who may have been recently diagnosed with HIV or healthy men who have been living with the virus for many years. Also, having a men-to-men talk could assist men who may want to test for HIV through shared experiences by men who are already living with HIV. Men could utilize those experiences to prevent themselves from making similar mistakes. Seeking support is not only about who men seek it from, but also about the distance between the person and those he may seek support from. Per the findings, it showed that having physical contact and access to the support system is critical to help one navigate around the idea of undergoing an HIV test. Given all that has been said, there is a research gap on men's acceptability of HIV diagnosis in South Africa.

Preference of HCP

The findings indicated that the gender of HCP when testing for HIV appeared to be irrelevant to most men who took part in the research study. Therefore, it can be assumed that the gender of a HCP does not impact on men's willingness to test for HIV in Gugulethu Township. These results were very interesting given that a significant number of men mentioned the importance of having a conversation with another man, in this context a male HCP; yet more than half of the men who participated in the research study would get tested by any HCP, regardless of gender. The findings by (Radingwana, 2014) conducted in Pretoria, which found that, upon clinic visits, about 40% and 30% of men preferred to be assisted by male doctors and nurses, respectively compared to 8% and 26% who preferred female doctors and nurses. Having a conversation with a male HCP is a support structure. Also, decision of several men to test for HIV is informed by the competency of the HCPs. The findings revealed that several factors contribute to decisions by men who preferred to be tested by a male HCP, including finding consolation throughout the ordeal and the possibility of relating to each other's past experiences should one test positive for HIV. These findings were synonymous with the study by Green (2015) in a similar and neighbouring peri-urban township of Khayelitsha in Cape Town which found that 198 men of the 200 that were interviewed preferred male-only clinics regardless of the possible long waiting time. However, it was not clear whether the preference of a male HCP increased HIV testing uptake in Khayelitsha. In this regard, a male-only clinic could be an option for men in Gugulethu Township in a bid to attract men into HIV care and increased HIV testing uptake. There is a need for more research on the extent to which existing theories prove that men prefer same-sex HCPs, and why some of them do not take gender of the HCP into consideration when seeking healthcare. There are various reasons that make being tested for HIV by a female HCP challenging. According to the findings, these include fear of breach of confidentiality from female HCPs as men believe females are more likely to break confidentiality by involuntarily disclosing their HIV statuses to other patients in the health facility without being cognizant of the impacts such a disclosure may have in male patients. A study conducted in Khayelitsha further revealed that about half of the men did not attend general clinics due to the fact that they were not comfortable with the presence of female HCPs, and were more happy in a male-only clinical setting (Green, 2015). Given that, none of the men mentioned the possibility of a male HCP breaking a patient-HCP confidentiality or involuntarily disclosing their status. This implicitly implies a certain degree of trust that

male patients often have towards male HCPs. This further portrays subjective views held by men which portray female HCPs in a negative light. However, it was not clear from the men as to what inform their views, and this necessitates further exploration. The findings revealed that there is a need to explore men's HCP preference for HIV testing and the factors that inform their preference in Gugulethu Township.

Interventions to improve HIV testing in men

Per findings, there are insufficient health interventions for men regarding HIV prevention. Current HIV-related interventions are focused on women, children, and youth as key populations (Mills et al., 2012). Consequently, men have received less attention in the efforts to prevent HIV in Africa, including South Africa (Mills et al., 2012). Furthermore, given the proposed interventions that men mentioned, it was clear that there is a need for more HIV prevention interventions for men in Gugulethu Township. The findings also showed that there is also a need for more male focused dialogues in Gugulethu Township.

From the findings, men mentioned intervention strategies such as media platforms and door-to-door HIV testing that could improve HIV testing in men. Moreover, these platforms would highlight the importance of undertaking an HIV test, not only for the men but their loved ones as well. Door-to-door HIV testing could be seen as a strategy that could attract more men to test for HIV as the procedure would be conducted in the men's households, at a time convenient to them, and will ensure patient-provider confidentiality (Krause, Subklew-Sehume, Kenyon, & Colebunders, 2013). The findings revealed that men are aware of the benefits of door-to-door testing HIV testing campaign, which includes the awareness of HIV status and accessible HIV testing services. In a study conducted in Malawi, door-to-door HIV testing was also preferred given its convenience and immediate results (Angotti et al., 2009). Subsequently, these interventions may further create opportunities for more voluntary disclosure from men, and more education on HIV and the importance of testing for HIV. Additionally, there should be more HIV-related specific campaigns targeted at men to promote men's health-seeking behaviour. As such, there is a need for more research on men's acceptability of HIV interventions, particularly for the uptake of HIV testing.

Limitations of the study

The sample size for the research study was small; and therefore, the findings are not a true representation of the entire male population of Gugulethu Township. Furthermore, the study was conducted in Gugulethu Township and may not be generalizable to the male population of Cape Town. The length of the interviews may have affected the participants' concentration in engaging with the primary researcher. Also, incentivising the research participants may have impacted on the research study by sharing information the research participants may have felt the primary researcher wanted to hear.

Conclusion

The study found that a variety of psychosocial factors impact the decision for men to test for HIV and affect their perceptions of HIV testing. Men are aware of the contextual barriers that inform their willingness to undergo an HIV test. There is a need for the government to take the experiences of men into consideration in the design of health policies to make them more inclusive. Moreover, psychosocial and interpersonal factors need to be considered in the design of HIV-related interventions. Furthermore, the study

showed that men are aware of the HIV testing services, but their testing behaviour does not match their awareness and knowledge of HIV testing. As such, prevention campaigns should appeal to and target men's specific health needs.

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APPENDICES

APPENDIX 1: Interview schedule

My name is Sithembiso Ndlovu, a 2nd year Master of Public Health (MPH) student from the University of Cape Town. As part of the MPH, I am required to submit a mini-dissertation on the topic I feel needs to be explored. My research study is a sub-study of a larger project called iALARM (Using Information to Align Services and Link and Retain Men in HIV Cascade) and the sub-study particularly looks at men's experiences and perceptions of HIV testing in Gugulethu township which falls under the Klipfontein sub-district.

For my sub-study, I am very interested to explore what men think about HIV testing, their experiences with HIV testing, particularly at the health sciences they go, as well as the reasons for testing or for not testing for HIV. The reasons for these is to improve male-focused and inclusive HIV testing services which will contribute largely to increasing men's quality of life.

In going about conducting the interviews, I will always seek informed consent from participants to abide by ethics. Part of this involves ensuring confidentiality whereby your personal details such as name and surname will not be used or mentioned anywhere in the study. To control for this, I will assign a number to identify our interview. Part of the ethics is voluntary participation and as a participant, you will not be forced to take part in the study, and can leave the study should you not want to proceed with the interviews. All that will be shared between the interviewer and interviewee is confidential and only my supervisors will have access to the interviews. With me is Phumzile (or Mandla) who are also from UCT but stay in Gugulethu. They are assisting me with conducting interviews, particularly in IsiXhosa since I am Zulu and do not fully comprehend IsiXhosa.

Please let me know if you have any questions so far? If not, I would like to start with filling in the consent form where after we can start the interview.

Part 1: Knowledge and referrals

1. Where can men go for an HIV test?
→ Where do you think most of them go? Why?
2. Do you know of any of these places in Gugulethu? What are they?
3. How did you come to know about HIV testing?
4. What do you think of men's awareness and knowledge of HIV testing services at the clinics?
5. What do you think can be improved?
6. How would you like to get test results?
7. Who would you tell/trust with this information?

Part 2: Motivations and perceptions

1. Why do you think some men test for HIV and others don't?
2. Who, in your opinion, do you think goes for HIV testing frequently between men and women?
3. What would you say are the biggest barriers to HIV testing in men?
4. What do you think of HIV testing in general?
5. What, in your opinion, would you say increases men's uptake of HIV testing in Gugulethu?
6. What do you think discourages men from getting tested for HIV?
7. What do you have to say about the practice of men getting tested for HIV?
8. In terms of gender of the health professionals, would you prefer a man or woman? Why?

Part 3: Experiences

1. Have you ever tested for HIV? If yes, how often?
2. Where did you go when you tested for HIV? Mobile/private GP/Clinic?
3. What has been your experience with HIV testing?
If unpleasant, why was it so?
4. When you went for your HIV test, who helped you? Was it difficult for you, and if so why?
5. Did you have a male or female nurse? And do you think that made a difference in your experience?
6. If you would go for a test, which improvements would you like to see?

APPENDIX 2: Informed consent form for research participants

Consent to Participate in Research

Using Information to Align Services and Link and Retain Men in the HIV Cascade

University of Cape Town

Qualitative Formative Research Sub-Study

1. WHO IS DOING THIS STUDY AND WHY?

My name is Sithembiso Mngqobi Sthandwa Ndlovu, a 2nd year Master of Public Health (MPH) student from the University of Cape Town. My research project is a sub-study of a larger project called iALARM (Using Information to Align Services and Link and Retain Men in HIV Cascade) and looks particularly at men's experiences and perceptions of HIV testing.

For my sub-study, I am very interested in exploring what men think about HIV testing, their experiences with HIV testing, particularly at the health facilities they went to, as well as the reasons for testing or not-testing for HIV. The reasons for these is to improve male-focused and inclusive HIV testing services which are male-friendly. Therefore, I am interested in your personal experience as well as your existing knowledge of the services currently available.

2. WHAT WILL YOU DO IN THIS STUDY?

As a primary researcher, I would like to ask to kindly answer the questions on the interview schedule to the best of your ability and honesty. The questions enable you to talk about your personal experiences, motivations and perceptions, as well as knowledge and referral of HIV testing.

It is an imperative duty as a primary researcher to seek informed consent from you as a research participant to abide by ethics. This informed consent form will be translated verbally in from English to IsiXhosa or Afrikaans where needed. Verbal translation of the informed consent will be provided by Mr. Phumzile Nywagi, iALARM Field Coordinator, who is trained in taking informed consent and in interviews Using this consent form is a way of ensuring confidentiality whereby your personal details such as the name and surname will not be used or mentioned anywhere in the study. To control for this, I will assign a unique anonymized identification number to identify our interview. Part of the ethics is voluntary participation and as a research participant, you will not, in anyway be forced to take part in the study, and you can leave the study should you not proceed with the interviews. All the information shared is confidential and only my supervisors will have access to the interviews.

The interviews will take at the iALARM field office in Gugulethu, and it is particularly set up as a safe and confidential space to conduct interviews. The interview may take place elsewhere should you choose a different location. Moreover, all the interviews will be formal and in-depth

and will last one hour each. Kindly tell the primary researcher of possible time limits should you need to leave at any point during the interview.

I would also like to attain permission from you to record the interview, however, you have an option of allowing the researcher to or to not record the interview.

3. ARE THERE ANY RISKS IN THIS RESEARCH?

The primary researcher understands that you may feel uncomfortable speaking about some aspects of HIV infection (such as personal experiences of HIV in one's family, social stigma, etc.). If at any time you do not want to answer a question, please tell the primary researcher and you will not be obliged to answer. You are free to not answer any question or speak about any subject that you do not want to. If you feel upset during or after the interview, please tell the researchers. Furthermore, your use of any health services will not be effected by choosing not to participate in the study.

4. ARE THERE ANY BENEFITS OF PARTICIPATING FOR ME?

There are no direct benefits to you for participating in this study. There may be some longer-term, indirect benefits to you if the project can help with the improvement of male-friendly, male-focused HIV services and community based HIV services for men at the public health facilities.

5. WILL I BE PAID TO PARTICIPATE?

Research participants will be reimbursed with R50 and light refreshments for participation in the study.

6. WILL MY NAME BE SHARED WITH ANYONE?

The primary researcher will not share your name with anyone and when they write about the research, they will not use your name. Only the number of the interview will be used to identify the interview. All the information from this project will kept in a password protected computer on UCT properties and will be removed permanently after data transcription process has been completed. The recording will be archived for three years and will be erased three years after the conclusion of the study. No person outside the iALARM Project sub-study research team will have access to your information. Extracts from your interviews may be published in research reports using the unique number.

7. WHO ARE THE RESEARCHERS?

The Principal Investigators are Dr. Colvin from the School of Public Health and Family Medicine at the University of Cape Town and Prof. Mark Lurie from Brown University in the United States. The primary researcher conducting this interview is Sithembiso Ndlovu. **If you have any questions or concerns about the research, please feel free to contact:**

Associate Professor Christopher J. Colvin

Tel: 021 406-6706 (during office hours) or 084-684-7202 (anytime)

E-mail: cj.colvin@uct.ac.za

or

Professor Mark Lurie, mark_lurie@brown.edu

or

Sithembiso M.S Ndlovu

Cell: 073 4934 317

E-mail: Sithembiso.Ndlovu@alumni.uct.ac.za

8. WHAT ARE MY RIGHTS AS A RESEARCH PARTICIPANT?

You may withdraw your consent to participate in this study at any time and stop participating without any penalty. When you participate in this study, you are not giving up any legal claims, rights or remedies that you may have. **If you have questions about your rights as a research participant, contact the Human Research Ethics Committee (HREC) at the Faculty of Health Sciences at the University of Cape Town at 021 406 6338.**

SIGNATURE OF RESEARCH PARTICIPANT
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The information above was described to me by _____. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Participant

Signature of Participant

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the participant*]. [*He/she*] was encouraged and given ample time to ask me any questions.

Signature of Investigator

Date

APPENDIX 3: Research study ethics approval- HREC



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 404 7682 • Facsimile [021] 406 6411
Email: post.team@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

24 February 2017

HREC REF: 847/2016

A/Prof C Colvin
Public Health & Family Medicine
Falmouth Building

Dear A/Prof Colvin

PROJECT TITLE: MEN'S EXPERIENCES AND PERCEPTIONS OF HIV TESTING SERVICES IN GUGULETHU TOWNSHIP, CAPE TOWN (Master's candidate-S Ndlovu)

Thank you for submitting your response letter to the Faculty of Health Sciences Human Research Ethics Committee dated 06 February 2017.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 28th February 2018.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student Sithembiso Ndlovu will be involved in this study.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval before the research may occur.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Yours sincerely



PROFESSOR M. BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

HREC 847/2016

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines.

The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

APPENDIX 4: iALARM Qualitative Formative Research ethics approval

UNIVERSITY OF CAPE TOWN
HEALTH SCIENCES FACULTY
FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938)			
This serves as notification of annual approval, including any documentation described below.			
<input checked="" type="checkbox"/> Approved	Annual progress report	Approved until/next renewal date	30.12.2017
<input type="checkbox"/> Not approved	See attached comments		
Signature Chairperson of the HREC		Date Signed	2/12/16

Comments to PI from the HREC

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	02/12/2016		
HREC REF Number	802/2014	Current Ethics Approval was granted until	31/12/2016
Protocol title	Using Information to Align Services and Link and Retain Men in the HIV Cascade		
Protocol number (if applicable)			
Are there any sub-studies linked to this study?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, could you please provide the HREC Ref's for all sub-studies? <i>Note: A separate FHS016 must be submitted for each sub-study.</i>	320/2015		
Principal Investigator	Dr Christopher Colvin		
Department / Office Internal Mail Address	Division of Social and Behavioural Sciences cj.colvin@ucl.ac.za		

1.1 Does this protocol receive US Federal funding?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
1.2 If the study receives US Federal Funding, does the annual report require full committee approval?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
1.3 Has sponsorship of this study changed? If yes, please attach a revised summary of the budget.	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

APPENDIX 5: Journal of Social Aspects of HIV/AIDS (SAHARA-J) author guidelines

SAHARA-J: Journal of Social Aspects of HIV/AIDS: Submissions 3/9/17, 9:07 AM

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2. The submission file is in Microsoft Word, RTF, or WordPerfect document file format.
3. Where available, URLs for the references have been provided.
4. The text is single-spaced; uses a 12-point font; employs italics, rather than underlining (except with URL addresses); and all illustrations, figures, and tables are placed within the text at the appropriate points, rather than at the end.
5. The text adheres to the stylistic and bibliographic requirements outlined in the [Author Guidelines](#), which is found in About the Journal.
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