A QUALITATIVE EXPLORATION OF SEXUAL CHOICES, PRACTICES, AND RISKY BEHAVIOURS OF MEN WHO HAVE SEX WITH MEN IN THE AREA NORTH-WEST OF PRETORIA.

By

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DECLARATION

I, Mildred Ramaisela Sebogodi, hereby declare that the work on which the dissertation is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or shall be submitted for another degree at this or any other university, institution for tertiary education or examining body.

________________________    __________
Mildred Ramaisela Sebogodi                                        Date
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ABSTRACT

Background: The World Health Organisation (WHO, 2018) identifies men who have sex with men (MSM) as a high-risk population for STIs and HIV. The median estimates for HIV prevalence range from 4.3% in South East Asia to 14.9% in the African region (WHO, 2018). In South Africa (SA) the prevalence of STIs and HIV/AIDS amongst this population is 14% for STIs, and for HIV it ranges between 750 000 and 1.4 million, and they are understudied qualitatively. Previous studies focusing on persons with STIs and HIV have mainly been quantitative. This is a concern as the subjects' sexual choices, practices and risky behaviours need to be described, as these factors are some of the most critical determinants of the sexual health of MSM, as they contribute to the high prevalence of HIV and STIs.

The aim of the study: The aim of the study was to explore the sexual choices, sexual practices, and risky behaviours of men who have sex with men in North-West Pretoria.

Methods: A qualitative, explorative approach was used. A total of 30 in-depth interviews were conducted on MSM who were 18 years and older. Only the subjects who signed the informed consent and were willing to participate were enrolled in the study. A convenience sampling method was used. An interview guide and recorder were utilised to get the participants to express their views and experiences. The data collection took place in a private room to ensure privacy. The demographic details were collected from the main quantitative study in order to link it with this study.

Results: 30 MSM participated in the study, majority of whom self-identified as being gay and very few as bisexual. The mean age of the sample was 26, with a range of 18 to 44 years. The high-risk behaviours noted among the majority of the MSM in this study were having multiple sexual partners, alcohol abuse, inconsistent condom-use, and having unprotected anal sex. Transactional sex in exchange for money was found in some relationships. There was a lack of emotional attachment amongst the participants, and the exchange of partners, and having multiple partners was common practice for majority of the participants. Stigmatisation and discrimination resulting in physical and sometimes sexual violence was experienced by some participants. The disclosure of their sexual orientation by some of the
participants had resulted in mixed reactions from their family, friends and community, ranging from non-acceptance to acceptance and sometimes anger.

**Conclusion**: The findings indicate that young MSM in the North-West of Pretoria are practising risky sexual behaviour such as inconsistent condom-use, having multiple sexual partners, having unprotected anal sex, and having high level of alcohol use, and are at great risk of acquiring HIV and sexually transmitted infections. These findings shed light on the need for health promotion on STIs and HIV among young MSM in places such as taverns and pubs as well as in health facilities for MSMs in the North-West of Pretoria. There is also a need for health professionals to be trained in MSM-related programmes.
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<th>Description</th>
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<tbody>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IAI</td>
<td>Insertive Anal Intercourse</td>
</tr>
<tr>
<td>MSM</td>
<td>Men having sex with men.</td>
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<tr>
<td>RAI</td>
<td>Receptive Anal Intercourse</td>
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<tr>
<td>SMU</td>
<td>Sefako Makgatho University</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>UAI</td>
<td>Unprotected Anal Intercourse.</td>
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<tr>
<td>UCSF</td>
<td>University of California, San Francisco</td>
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<td>UNAIDS</td>
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OVERVIEW OF THE STUDY
CHAPTER ONE

1.1 Introduction and background

The term “men who have sex with men” (MSM) refers to males who have sex with males irrespective of whether they also have sex with women or not (UNAIDS, 2011; UNAIDS, 2015). The term was coined by the UNAIDS and recommended for use in place of offensive names such as “homosexual” and “gay” men. MSM are regarded as a key population because of their sexual choices, risky behaviour and practices, which result in an increased risk of contracting, and a heightened vulnerability to sexually transmitted infections (STIs) and the Human Immunodeficiency Virus (HIV) (Koblin et al, 2006; Jin et al, 2010; Baggaley et al, 2010; Beyrer et al, 2012; McIntyre et al, 2013; Patel et al, 2014; UNAIDS, 2015). An increased prevalence and incidence of STIs such as gonorrhoea, chlamydia and syphilis are seen in MSM as compared to the general population. Even though the global HIV epidemic is decreasing, MSM still remain at high risk. This is mainly associated with their sexual choices, practices and risky behaviour, which are regarded as some of the most critical determinants of their sexual health. The other reasons for the uneven infection burden are complex, and include biological and sociocultural factors (Mayer, 2011).

The risky sexual behaviour and practices of young MSM contribute significantly to the HIV and STI prevalence. In South Africa, the HIV prevalence is four times higher among MSM than among the general male population, but due to the increased effectiveness of the management strategies for the HIV infection this has led to a loss of the fear of it. This is exacerbated by miscommunication and misperceptions about both HIV and STIs, which is why MSM feel comfortable to engage in unprotected sex. They do not perceive themselves to be at risk of contracting HIV and STIs, as noted in their continuous engagement in risky sexual behaviour, practices and choices (Aho et al, 2014; UCSF, 2015; Sullivan et al, 2016).

The literature from South Africa and elsewhere has reported associations between STIs and behaviours. Behaviours such as alcohol or drug abuse are associated with having multiple sexual partners and the practice of unprotected sexual intercourse.
There is an increase in the use of substances such as crystal methamphetamine, dagga, erectile dysfunction drugs and other recreational drugs among MSM, which impedes their judgement, especially when it comes to safe-sex practices such as condom-use with every sexual act (Colfax et al., 2005). The most commonly used drug among African MSM is dagga, which like other drugs is used in conjunction with sex (Sandfort et al., 2017). Condom-use is regarded as the most prevalent safe sex measure, but due to their weak perception of the risk of infection, inconsistent condom use among MSM is apparent. MSM often give the reasons for their not using condoms as their reduced sexual pleasure, condom failure, their distorted knowledge about how to use a condom, and their trust in the sex partner (Siegler et al., 2014; Musinguzi et al., 2015).

In some cases the risky behaviours are related to transactional sex. Rewards such as alcohol and money are traded in exchange for sex (Lane et al., 2011; Masvawure et al., 2015; Sandfort et al., 2015b). An increase in the use of alcohol and drugs among MSM is also associated with transactional sex (Sandfort et al., 2017). The reasons for engaging in transactional sex are often desire of the money, the pleasure and the excitement, but this makes the MSM who engage in transactional sex more vulnerable to the risk of acquiring STIs and HIV. The level of vulnerability of MSM in transactional sexual relationships differs, based on the frequency of the transactional sex, whether it is a regular or casual sexual encounter, non-condom use, and the type of sexual relationship in the sexual relationship (Oldenburg et al., 2015). Some transactional sexual relationships become sexually violent and result in abuse and physical violence. This is further exacerbated by stigma and discrimination because of the subjects’ sexual orientation (Dunkle et al., 2013). The physical violence among MSM has resulted in their social vulnerability, and this has created a barrier against accessing healthcare or disclosing their sexual orientation to their family, peers and relatives (Brignol et al., 2015).

Most of the MSM practising risky sexual behaviour are young, being 14 years to 50 years old (Outlaw et al., 2011). However, this behaviour declines with age because of their decrease in sexual activity and desire (Cooperman et al., 2007). There is limited information on older MSM, as the literature focusses mainly on adolescents
and young adults (Pilowsky and Wu, 2015). The sexual debut among young MSM in other countries is reported to be as young as 14 years and is associated with high-risk sexual behaviour (Outlaw et al, 2011). In South Africa the age of the initial sexual encounter among youths is often earlier than 15 years (GARPR, 2015). However, there are limited data on sexual debut among MSM in South Africa. Young MSM engage in unprotected anal intercourse and are more likely to have multiple sexual partners. This is due to their seeking adventure and pleasure. This behaviour makes them vulnerable to infections (Lyons et al, 2012).

In rural South Africa, young MSM report to non-exclusivity to MSM because of traditional, cultural and religious norms in the rural community which they are part of. This impedes the disclosure of their MSM status to their family, friends and community, again making it difficult for them to seek health-care (Imrie et al, 2013). Young men are more vulnerable to HIV and STIs because of their lack of knowledge especially of safe-sex practices (Lyons et al, 2012). Their lack of awareness of the importance of safe-sex practices results in their indulging in risky behaviour and sets a pattern for their future behaviours (Lyons et al, 2012).

MSM believe that there are methods other than condom-use to prevent infection, and they practise them widely, believing that they are risk reduction practices that supposedly reduce primary HIV transmission during sex. Such common practices include serosorting, withdrawal, and strategic positioning (Parsons et al, 2005, Golden et al, 2008, Jin et al, 2009). While these practices have been found to be less risky than unprotected receptive anal intercourse, they are not overly effective in averting primary transmission because of the heightened risk of HIV infection in unprotected anal sex, as against the use of external protection such as condoms (Parsons et al, 2005; Golden et al, 2008; Jin et al, 2009).

MSM are understudied (Baral et al, 2007, Evans et al, 2016). Studies in South Africa on MSM have mostly concentrated on HIV and few are qualitative studies in which their sexual choices, practices and risky behaviours are described. This lack of qualitative research may limit the effectiveness of sexual health programmes for MSM because of the lack of the perspective of the men themselves. The sexual choices, practices and risky behaviours amongst MSM have also been found to vary greatly in different social contexts (UNAIDS 2007, de Voux et al, 2016).
This study uses a qualitative approach to explore the sexual choices, practices and risky behaviours of MSM in the North-West of Pretoria. No known qualitative research on MSM has been conducted in this area, so the results of the study will provide locally relevant information. Behaviours are not necessarily uniform in different contexts; hence the need for an independent study in this setting. The results of the study will also add to the body of knowledge on MSM, which is still lacking in South Africa.

1.2 Problem statement

Sexual choices, practices and risky behaviours among MSM remain insufficiently explored qualitatively in South Africa. This is despite their evident association with risky sexual practices that predispose them to STIs. This is because of the heightened biological susceptibility in anal sex as well as their engagement in high-risk sexual behaviours and practices (Varghese et al, 2002; Jin et al, 2010; Patel et al, 2014).

The high-risk behaviours include having multiple sexual partners, the abuse of alcohol and drugs for facilitating sexual practices, unprotected anal intercourse even without knowledge of the partner’s HIV status, and transactional sex (Parry et al, 2008). Risky behaviours such as the practice of unprotected anal sex are associated with STIs and HIV transmission among MSM (Johnson et al, 2008; Parry et al, 2008; Williams et al, 2016).

Research has not focused on understanding these risky behaviours, sexual choices and practices. For MSM, this means addressing the alcohol and drug abuse, the multiplicity of sexual partners, and the other environmental factors that have been shown to increase the frequency of unprotected sexual behaviours (UCSF, 2015).

If these behaviours are not clearly understood and interventions put in place, this will exacerbate the rapid spread of STIs, especially HIV among MSM (Johnson et al, 2008) and this will catalyse the growth of the STI and HIV epidemic among MSM. The UNAIDS report of 2013 states that one of the indicators of the Millennium Development Goals is to address the sexual risk behaviour of key populations such as MSM, and to the choices and practices which contribute to the disease burden in sub-Saharan Africa.
1.3 **Aim of study**

The aim of the study is to explore the sexual choices, practices, and risky behaviours of the MSM in the area North-West of Pretoria.

1.4 **Research questions**

1. What are the sexual choices of MSM in the area North-West of Pretoria?
2. What are the sexual practices of MSM in the area North-West of Pretoria?
3. What are the risky sexual behaviours among the MSM in the area North-West of Pretoria?

1.5 **Study objectives**

1. To explore the sexual choices of MSM in the area North-West of Pretoria.
2. To determine the sexual practices of MSM in the area North-West of Pretoria.
3. To explore the risky sexual behaviour among the MSM in the area North-West of Pretoria.

1.6 **Rationale of the study**

A better understanding of MSM sexual practices, choices and risky sexual behaviour will ensure that the community of MSM is targeted for health services and preventive programmes. MSM will be empowered to seek health services without being discriminated against. The health-care workers in the North-West of Pretoria in health facilities, will benefit from the findings of this study by being better able to formulate health education interventions where MSM can be addressed and assisted. The results are specific for MSM residing in North-West of Pretoria and may not be necessarily be used to generalise for the whole country.
CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviews existing literature related to the sexual choices, practices and risky sexual behaviour of MSM. The review will take the form of describing each identified sexual choice, practice, and risky sexual behaviour, using literature published locally and elsewhere. A distinction is made between sexual behaviours, practices and risky behaviours.

2.2 MSM

The term “MSM” refers to biological males who have sex with one another without taking into consideration behaviour (Caceres et al, 2009). The global population of MSM is largely unknown. In South Africa, however, the MSM population reputedly ranges between 750 000 and 1.4 million (Dunkle et al, 2011; McIntyre et al, 2013; Lewis, 2013; UCSF, 2015). These reports do not break down the distribution by race.

There are set factors which make MSM more vulnerable and susceptible to health problems than other populations (Brignol et al, 2015), such as their biological transmission routes, their sexual behaviour, and social factors such as alcohol use, stigma and discrimination, and having no access to health services (Brignol et al, 2015). Major contributors to the burden of disease among MSM are behavioural and social factors such as the use of drugs and the excessive use of alcohol, risky sexual behaviour such as having many sexual partners, having unprotected sexual intercourse and using condoms inconsistently (Brignol et al, 2015). These choices and behaviour are known as indirect risks and include behaviours such as having multiple sexual partners, a reluctance to use condoms, alcohol and drug abuse during sex, and not testing for HIV (McIntyre et al, 2013; Brignol et al, 2015). The behaviours are also seldom mutually exclusive. For instance, men who use alcohol to facilitate sexual intercourse may also be reluctant to use condoms and may have multiple sex partners. A lack of information about the modes of
acquisition of HIV and STI or the level of awareness of HIV risk among MSM also plays a role in the risky sexual behaviour (Sharma et al, 2008).

2.3 Multiple sexual partners

Relationships between MSM are rarely monogamous, unlike heterosexual relationships (Jin et al, 2010). Such relationships have been found to pose the risk of STIs and HIV transmission because of the high prevalence of unprotected sex (Morris & Kretzschmar, 1997; Sandfort et al, 2015a). Different provinces in South Africa indicate high proportions of multiple sexual partners. In the North West Province of South Africa, where 70% of MSM reported having between two and three sex partners in the past six months, 35.8% had unprotected sex with a new partner (UCSF, 2015). In Gauteng and KwaZulu Natal Province, 55.6% MSM reportedly had at least three sex partners, compared with 37% in Mpumalanga who had two sexual partners (UCSF, 2015). More specifically for Gauteng, Sandfort et al (2015a) found an even higher proportion (73%) of MSM with “concurrent” male sex partners in Soweto, a township of Gauteng. More than half of these men also had female partners, and it is also reported that they are often ignorant of their HIV status (Sandfort et al, 2015a). In another South African study, which was conducted in two cities, Durban and Johannesburg, it was found that MSM had had an average of six partners in the previous 12 months, double the number reported for the 6-month period above (Rispel et al, 2011). Further stratification in this study also found that HIV-positive MSM had significantly more sexual partners than HIV-negative MSM. A lesser number and proportion of males with multiple partners have been reported in the general male population. The South African national HIV survey of 2012 found that 20.1% of all males aged 15 years and older had had more than one sex partner in the past 12 months of the research (Simbayi et al, 2014).

2.4 Unprotected anal intercourse (UAI)

The consistent use of condoms is efficient in reducing the risk of contracting STIs, but the literature indicates that their use is infrequent and inconsistent during receptive and insertive anal intercourse among MSM (Sandfort et al, 2013; Aho et al, 2014; Nelson et al, 2015). Literature from various countries
in Africa shows that the prevalence rate of UAI is high among MSM (Lane et al, 2008a; Kalubi et al, 2008; Baral et al, 2009; Wu et al, 2014). In Cameroon a study conducted by Henry et al (2010) on 142 individuals reported that 57% of MSM were practising UAI. In South Africa the prevalence of UAI is also high. Different studies in South Africa have reported varying estimates. In a study conducted in Soweto, 24% of the men self-reported UAI (Arnold et al, 2013). Another report also found the prevalence of UAI to be 38.5% in the North West Province, and five out of eighteen MSM practised UAI in Port Elizabeth (UCSF, 2015). Another study conducted in Gauteng reported that up to 59% of MSMs were practising unprotected sex, a ratio that was greater than that reported for Soweto (Lane et al, 2008a). Older black South African men frequently engage in UAI, a practice which is attributed to a less than positive attitude towards condom use (Kaighobadi et al, 2014).

UAI among MSMs occurs mainly under the influence of alcohol or drugs (Hart & Elford 2010). In addition to drugs and alcohol, other reasons for engaging in UAI are physical constraints and behavioural choices. The physical reasons include the risks of condom breakage during sex, not having a condom immediately available before or during intercourse, reduced sensation during sexual intercourse, and difficulty in maintaining an erection (Aho et al, 2014). The behavioural reasons are mainly perceptions about; (i) the need to maintain trust within the relationship (Knox et al, 2010), (ii) the perceived benefits of serosorting by choosing only partners with the same HIV status (Jin et al, 2009) and (iii) the perceived low risk of contracting an STI or HIV transmission in permanent sex partnerships (Henry et al, 2010).

2.5 Condom use among MSM

In a sub-Saharan study performed by Baral et al (2009), only 3.3% of MSM were found to practise safe anal sex, while studies in South Africa have found high levels of condom use among MSM. In the South African Marang Men’s Project, at least 80% of all men of all ages reported condom use at last sexual intercourse (Cloete et al, 2014). In this study, however, data were not extrapolated to show the consistency of condom use prior to the last instance of sexual intercourse. In addition, there were high levels of alcohol abuse among the males, which could decrease the number of protected sexual acts.
(Cloete et al, 2014). Protected sex, either with a condom or biomedical gels, and accurate serosorting (although this is rare) are the most effective ways of the transmission of STIs and HIV. Other biomedical methods such as microbicidal gels are still under clinical scrutiny and thus may even not be available due to their costs and the lack of funding for MSM-appropriate services in health facilities (Rebe et al, 2013). The use of these safe-sex practices is rendered unlikely or unacceptable by other behaviours and choices that MSM make. The likelihood of condom use was also found to be associated with a good knowledge of STIs among MSM (Sandfort et al, 2013). The more one knows about the risk of contracting STIs, the more likely the use of condoms (Sandfort et al, 2013). Condom-use among MSM is influenced by their knowledge of STIs, their engagement in transactional partnership, and the type of relationships they are in (Nelson et al, 2015).

2.6 Types of sexual relationship

There are different types of partnerships which exist among MSM, which determine the type of sexual practices in their sexual relationship (Sandfort et al, 2013). The four types of sexual partnership identified among MSM have to do with race, transactional relationships, casual partners and regular partners (Sandfort et al, 2013). These sexual partnerships influence the type of sexual act, condom-use and behaviour (Sandfort et al, 2013). The partner who has more money and is older will have more power in decision-making when it comes to sex and the use of condoms (Sandfort et al, 2013). Safe sex is more likely to be practised with a casual partner than with a regular partner because of different relationship dynamics in the two situations. Thus, there would be a lack of trust in a casual relationship (Sandfort et al, 2013). Therefore relationship dynamics such as trust play a huge role in sexual practices and the behaviour of the partners in the relationship (Sandfort et al, 2013).

Money also has a huge effect on MSM, as some MSM stay in a relationship if more money presents itself, even if there is unprotected anal intercourse (Sharma et al, 2008). A great deal of transactional sex is reported in sub-Saharan African countries. The incidence is reported to be 62.6% in Malawi, 37.3% in Namibia and 29.3% in Botswana (Baral et al, 2009). In South Africa
the prevalence of transactional sex ranges from 13% to 53% (UCSF, 2015). In transactional sexual relationships, condom-use is a challenge (Sandfort et al, 2013). This is because of the power imbalance in the relationship (Sandfort et al, 2013). In MSM relationships, masculinity is seen as an ideal preference of sexual orientation as compared to femininity in the MSM relationship (Lanzieri and Hildebrandt, 2011). This is based on societal preference. A subject who prefers to be the “bottom” in the relationship is deemed as weak and feminine, as against the “top”, who is perceived as being strong and masculine (Lanzieri & Hildebrandt, 2011). “Bottom” is used to describe the man who gets penetrated and the “top” is the man who penetrates. This type of power relationship is common among poorer younger men because of their inexperience and inability to negotiate condom use with the partner who is paying for sex, or because the older partner exudes more power than the younger, inexperienced, poorer man (Sharma et al, 2008; Sandfort et al, 2013).

2.7 Alcohol and drug use

Alcohol is the most widely used substance among men MSM in South Africa (Bello et al, 2017). Studies in South Africa have shown a high prevalence of alcohol use among MSM during sexual intercourse. The endemic use of alcohol during sex acts was up to 88% amongst MSM in Gauteng, compared with the 47% reported nationally (Cloete et al, 2014; UCSF, 2015). Cape Town and Durban also reported frequent use of alcohol during sex, the ratios being 55% and 54% respectively.

Using alcohol during sex is independently associated with engaging in unprotected sex (Lane et al, 2008a). Intoxication with alcohol impairs judgement, and this often leads to the practice of unprotected sex (Parry et al, 2008; Lane et al, 2008a; Lane et al, 2011; McIntyre et al, 2013; Cloete et al, 2014; UCSF, 2015). MSM who drink alcohol regularly reportedly have 4.1 times higher odds of engaging in unprotected anal sex than those who do not take alcohol (Lane et al, 2008a). Apart from its recreational use, alcohol is also used to facilitate sex among MSMs by acting as a buffer to the pain that is often experienced by men during anal intercourse (Collier et al, 2015).
2.8 Sexually transmitted infections and HIV among MSM

Anal sex is the most risky sexual practice for the transmission of HIV and STIs among MSM (Jin et al., 2009; Baggaley et al., 2010; Rebe et al., 2011; McIntyre et al., 2013). For MSM, STIs and HIV can be transmitted up to 19 times more readily than in the general population. The risk of HIV transmission differs between insertive and receptive anal sex, with the inserter carrying the highest risk of transmission. Patel et al. (2014) found a per-act transmission of HIV of 138 infections out of 10 000 receptive sexual acts. This was 12.5 times higher than HIV transmission during insertive anal sex, where 11 infections per 10 000 sex acts were estimated (Patel et al., 2014). Despite the increased risk of contracting HIV and STIs, the prevalence of unprotected anal sex among MSM in South Africa is high.

HIV and STIs disproportionately affect MSM (Baral et al., 2007; Lane et al., 2011). Although there are no accurate estimates of the HIV prevalence in South Africa, it is believed that the prevalence of HIV among MSMs could be double that for the general population (Smart, 2009; UCSF, 2015). Self-reported HIV status has been used as the prevalence measure, and it varies between and within provinces. In Gauteng, 33.9% prevalence was reported in Soweto among MSMs who self-identified as gay, as against the 10.1% who reported being bisexual (Lane et al., 2011). A report in Gauteng also found a lower HIV prevalence of 26.8% in Johannesburg and 30.1% in Pretoria (UCSF, 2015). In Cape Town the prevalence was found to be 25.5% in general, rising to 37.3% in black MSMs (Baral et al., 2011). In KwaZulu Natal, an even higher prevalence of 48.2% (than for Gauteng and Cape Town) was reported (UCSF, 2015).

Data from peer-reviewed literature on non-HIV STIs are scarce in South Africa (Baral et al., 2009). The few peer-reviewed studies with some estimates use the history of STIs among MSMs in their studies as a proxy for the prevalence. In these studies. Between 5% and 14% of MSM report a history of STIs (Lane et al., 2011; Baral et al., 2011; Nel et al., 2013; Bello et al., 2017). The 2015 UCSF report on MSM in South Africa, however, provides other estimates of the prevalence of STIs other than HIV. In KwaZulu Natal, 42.7% of MSM reported STI symptoms, 39.2% and 23.9% respectively reported for
Johannesburg and Pretoria in Gauteng, between 3% and 7.2% for Mpumalanga, and 10.4% in Rustenburg in the North West Province. No STI prevalence data was available for the Eastern Cape, the Free State, Limpopo and the Northern Cape (UCSF, 2015).

2.9 Stigmatisation of and discrimination against MSM

MSM are a population group which has been marginalised and continue to be vulnerable to STIs and HIVs because of their risky behaviour and practices. The criminalisation of same-sex relationships in Africa has resulted in homophobia, discrimination against, and criminalisation of the MSM group in some African countries (Baral et al, 2009). In South Africa sexual practices between people of the same sex were legalised in 1996 (Republic of South Africa, 1996), making South Africa one of the few countries in Africa where same sex relationships are legalised. The South African's Constitution prohibits discrimination based on the grounds of sexual orientation (Republic of South Africa, 1996). Therefore the MSM population has a degree of protection in South Africa as compared to other countries where same-sex relationships are illegal. However, despite the legality of same-sex practices in the country, many people who are in same-sex relationships are stigmatised and discriminated against. This results in some of them having limited access to health-care services (Lane et al, 2008b; McIntyre et al, 2013) and has also resulted in the non-disclosure of their sexual orientation (Aho et al, 2014).

2.10 Disclosure of sexual orientation

According to the literature, stigma, violence and discrimination against MSM have been identified as factors contributing to non-disclosure (Aho et al, 2014). Victimisation and stigmatisation are experienced from family members and health-care professionals as well, not just from the community (Sharma et al, 2008; Narayanan et al, 2013). An African study found that 38.5% of MSM have experienced abuse because of their sexual orientation (Aho et al, 2014). Similarly a study done in South Africa by Dunkle et al (2013) reported 9.6% of male-on-MSM violent victimisation in the Eastern Cape and KwaZulu Natal. The violence often leads to the social vulnerability of MSM as well as their not
seeking health services, and even to their not disclosing their sexual orientation to their families or relatives (Rebe et al, 2013). The lack of social support from relatives, friends or co-workers impacts on the emotional state of MSM after their disclosure of their orientation (Sharma et al, 2008), and this makes the MSM population more socially vulnerable (Rebe et al, 2013; Brignol et al, 2015).

2.11 Conclusion

Literature reviewed indicates the importance of addressing the sexual choices, practices and risky behaviour of MSM especially in South Africa being one of the countries with a high HIV prevalence. Therefore the exploration of sexual choices, practices and risky sexual behaviour of MSM is essential especially in the North-West of Pretoria as no qualitative study has been done in the area.
3.1 Introduction

This chapter outlines the methods used for data collection and analysis. Qualitative research techniques were utilised in this study. Qualitative research investigates and interprets people in their natural environment.

3.2 Study design

The study was primarily exploratory research which aimed at exploring the sexual choices, practices and risky behaviours of the MSM population residing in the North-West of Pretoria, adopting in-depth interviews as the instrument of enquiry. Definitions of in-depth interviews include face-to-face unstructured interviews (Berry, 1999), interviews used by researchers to discover the shared understanding and experiences of individuals in a particular group, and participants providing rich, detailed information about their experiences (Dicco-Bloom and Crabtree, 2006).

3.3 Study setting and population

This qualitative study was conducted at MeCRU Clinical Research Unit (MeCRU), a sub-unit of the microbiology laboratory which falls under Sefako Makgatho Health Sciences University. Sefako Makgatho Health Sciences University, previously known as the Medical University of South Africa (MEDUNSA), is situated 24km North of Central Pretoria. MeCRU is situated in the North West of Pretoria on the premises of Sefako Makgatho Health Sciences University, within a radius of 28km of four townships: Ga-Rankuwa, Mabopane, Mothutlung and Soshanguve.

Several villages including Winterveldt, Mmakau and the north-western suburbs of Pretoria form part of the catchment area. SMU-MeCRU was responsible for recruiting the MSM in the surrounding communities' hot spots where they meet for social gatherings. SMU-MeCRU was chosen as the site for the study, as it was convenient for the MSM participants. One of the consulting rooms in the unit was used for conducting in-depth interviews. The room was well ventilated and its use enhanced privacy and confidentiality.
3.4 Study participants

3.4.1 Inclusion criteria

The participants who took part in the study were all MSM who were 18 years and older, and only subjects who signed the informed consent form and were willing to participate in the study were included.

3.4.2 Exclusion criteria

All MSM younger than 18 years and who did not sign the informed consent form (Annexure B1) were excluded from the study.

3.5 Sampling and sampling technique

As this was a sub-study to the main study, convenience sampling was used to recruit participants who were part of the main study, who were interviewed face-to-face in indepth interviews. Dörnyei (2007) defines convenience sampling as a non-random sampling of a target population where participants are selected for the purpose of the study if they meet criteria such as easy accessibility, availability at that time, and willingness to participate. That is why this method of sampling was used. 30 MSM participated in the study. The sample size was guided by data saturation, meaning that the sequence of in-depth interviews continued until the researcher observed that there were no new responses from the participants.

3.6 Recruitment method

The recruiters from SMU-MeCRU were responsible for recruiting the participants from hot-spots in the North-West of Pretoria. The contact details of the participants were taken by Sisters at SMU-MeCRU. On a particular day the potential participants were contacted and requested to either come in or be collected to come to SMU-MeCRU to take part in the study. Potential MSM participants who had been recruited were invited to participate in the qualitative study. The researcher and one research assistant who had been trained in qualitative data collection were responsible for the data collection.
3.7 Data collection

According to Berry (1999), in-depth interviews can be used to understand the participants’ points of view of a situation, and also to uncover ideas for further investigation. Hence in-depth interviews were chosen for this study as an appropriate method of establishing individuals’ perspectives on the sexual choices, practice and behaviours of MSM in the North-West of Pretoria.

In-depth interviews were the method of data collection in this study. The first step in the data collection was to conduct a role-play with the supervisors and research assistants to test the interview guide. The questions in the interview guide were taken from various literature (Lane et al, 2011; Imrie et al, 2013; Williams et al, 2016). The aim of the role-play was to assess whether there was a clear understanding of the questions in the guide, and to determine how long each interview would take. Changes were incorporated after the role play.

Prior to the data collection, an appointment was made with the sisters in charge by the co-supervisor to introduce the researcher to the sisters in charge at SMU-MeCRU. The researcher and supervisor were informed of the approximate number of participants being seen daily. The sisters alerted the researcher telephonically when participants were in the unit, and the researcher also enquired telephonically from MeCRU if any participants were available for the day. On several occasions the participants had already left the premises, so could not be interviewed.

The data were collected over a period of nine months, September 2016 to May 2017, using face-to-face in-depth interviews of 30 MSM participants, 18 years and older, using an interview guide. The data collection involved explaining the purpose of the qualitative study to the potential study participants, and if they were willing, they were invited to participate in the qualitative study.

Permission was sought from the participants prior to the interview to use a recorder. The interviews took less than 30 minutes each. They were conducted in both English and Setswana (Annexure A2 and Annexure A1) to give the participants the opportunity to express themselves in their own language. The data collection took place in a private room to ensure privacy. The room was quiet to ensure that the recording would be audible. The demographic details (Annexure A1) were obtained
from the main quantitative study in order to link them with the qualitative data and use them in the analysis. This study was part of the main study with the clearance certificate SMUREC/H/129/2016 (Annexure C1). The demographic data were also emailed to the researcher upon request. The demographic findings were captured into a Microsoft Excel spreadsheet, where after being validated they were imported into STATA 13 software for analysis. Descriptive analysis using STATA 13 was used on the demographic data to obtain summary statistics. Regular debriefing sessions were held by the supervisors with the researcher to review the transcripts and emerging themes throughout the process of collecting the data.

### 3.8 Data management and analysis

The In-depth Interviews were recorded using a good digital recorder and subsequently transcribed into a notebook in verbatim, translated into English and transcribed into a Microsoft Word document and typed by the researcher (who is bilingual) into a Microsoft Word document. The audio files were downloaded into a computer, saved using synonyms instead of the participants' real names, given a number to maintain confidentiality, and then given to the supervisor as a form of back-up for the data. The translated transcribed interviews were verified by the researcher. The supervisors also verified them. The researcher met with the supervisors several times to read the transcripts, identify the codes occurring most frequently across the transcripts, and develop a code book (Annexure D1). Manual coding was initially done by the researcher with the assistance of the supervisors to verify the coding. The transcripts were then imported into NVivo version 10, a qualitative analysis software package for the application of codes. The code book was then entered into NVivo. The transcripts were coded by the researcher and analyzed using a thematic approach. A content analysis approach for data analysis was adopted. The data were initially coded manually on the transcripts to identify the codes and analyzed in a way that reflected the opinions of the study participants, and ensured that another person would be able to understand the themes and arrive at similar conclusions.
3.8 Measure to ensure trustworthiness

Trustworthiness looks at validity and reliability in qualitative research and the strategies such as transferability, credibility and dependability which enhance trustworthiness (Patton, 2002). Credibility is whether the researcher accurately presented the participants’ views, how they feel or think. This was ensured in this study by submitting the raw data to the supervisor constantly for verification. The supervisors also ensured content validity after the interviews. The in-depth interviews were recorded using a good digital audio recorder to facilitate the verbatim transcription of the interviews and to ensure dependability. The in-depth interviews audios were downloaded and saved to a computer. The audios were then also given to the supervisors to ensure their trustworthiness. The supervisors assisted the researcher to identify the codes and create the code book to ensure credibility. The data were managed using NVivo qualitative software, which was used to analyse the coded data to attain credibility, dependability and transferability in this study.

3.9 Bias

Convenience sampling is subject to selection and recall bias. To eliminate bias during coding and data analysis, the supervisors were involved in the data analysis and reporting.

3.10 Ethical considerations

The research proposal was submitted to the Sefako Makgatho Health Sciences University Ethics Committee (SMUREC) to obtain its approval and clearance certificate (Annexure C1), and was given the SMUREC Ethics Reference Number: SMUREC/H/129/2016

Prior to the in-depth interviews, the participants were informed about the purpose of the study. They were required to sign a standard informed consent form provided by SMU-MECRU in the main study. The subjects were informed that their participation was voluntary and that they could withdraw from the study at any time if they wished to do so. All the data collected were treated as confidential and the anonymity of the participants was maintained. Names of the participants were not included in the
transcripts, synonyms name and numbers were given to participants to maintain confidentiality.

3.11 Conclusion

This chapter has given a detailed description of how the study was conducted, including the research design, the study setting and site, the data collection methods and the analysis plan. The chapter also described the ethical considerations dealt with in the study in relation to the data collection process.
CHAPTER FOUR
PRESENTATION OF STUDY FINDINGS

4.1 Introduction

This chapter presents the findings distilled from the data qualitative and quantitative data. The first section of the chapter presents the demographic profile of the participants, and the second section details the themes identified during the analysis.

4.2 Section 1: Demographic information

The participants in the study were black MSM residing in the North-West of Pretoria. A total of 30 subjects participated in the in-depth interviews. Their ages ranged from 18 to 44 years. The mean age was 26.83 years.

Only one of the 30 participants reported to be bisexual, while rest were homosexual. The only participant who reported to being bisexual also reported to engaging in vaginal sex, while the rest reported only anal sex.

Regarding educational level, 1 had completed only primary school and 2 had tertiary education. 8 of the participants had not completed secondary school and 19 had secondary school education. With reference to employment status, 15 of the total sample were unemployed. Only 11 out of 30 were employed, while 4 of the participants were students.

Sixteen of the participants knew the HIV status of their sex partners. Eight of them knew that their partners were HIV-positive and an equal number knew that their partners were HIV-negative. Few of the participants (3 out of the 30) were suspicious of their partners’ status. Ten of the 30 either reported to have had 3 or more sexual partners in the past 6 months or had had only one partner in the past 6 months. Only 7 of the participants had had 2 partners for the past 6 months. Table 1 summarises the descriptive characteristics of the sample:
<table>
<thead>
<tr>
<th>Variables</th>
<th>Means</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Age in years</td>
<td>26.83 ± 7.62, 25</td>
<td></td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>4</td>
<td>(13.33%)</td>
</tr>
<tr>
<td>Employed</td>
<td>11</td>
<td>(36.67%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>15</td>
<td>(50.00%)</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>1</td>
<td>(3.33%)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>2</td>
<td>(6.67%)</td>
</tr>
<tr>
<td>Secondary not complete</td>
<td>8</td>
<td>(26.67%)</td>
</tr>
<tr>
<td>Secondary school</td>
<td>19</td>
<td>(63.33%)</td>
</tr>
<tr>
<td><strong>Sexual orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bi-sexual</td>
<td>1</td>
<td>(3.45%)</td>
</tr>
<tr>
<td>Homosexual</td>
<td>29</td>
<td>(100.00%)</td>
</tr>
<tr>
<td><strong>Sexual activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal sex</td>
<td>1</td>
<td>(3.45%)</td>
</tr>
<tr>
<td>Anal sex</td>
<td>29</td>
<td>(100.00%)</td>
</tr>
<tr>
<td><strong>Number of sexual partners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>2</td>
<td>(6.67%)</td>
</tr>
<tr>
<td>1</td>
<td>10</td>
<td>(33.33%)</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>(23.33%)</td>
</tr>
<tr>
<td>3 or more</td>
<td>10</td>
<td>(33.33%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>(3.33%)</td>
</tr>
<tr>
<td><strong>Partner’s HIV status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>8</td>
<td>(26.67%)</td>
</tr>
<tr>
<td>Positive</td>
<td>8</td>
<td>(26.67%)</td>
</tr>
<tr>
<td>Do not know</td>
<td>11</td>
<td>(36.67%)</td>
</tr>
<tr>
<td>Suspicuous that positive but do not know</td>
<td>3</td>
<td>(10.00%)</td>
</tr>
</tbody>
</table>

The age of the participants ranged from 18 to 44 years, with a mean and median of 26.83 years and 25 years respectively. This is very important as it shows that the MSM in this study is very young. The standard deviation from the mean was 7.62 years.
4.3.1 Types of sexual relationships

Most of the participants reported to be in a gay relationship when asked about the type of sexual relationship they were in:

“Like I’m in a relationship with this guy. We have been dating for maybe 4 years…we engaged at the moment…So it’s that type of a relationship that I’m in.” (Sipho, 21 years old, student.)

“I am gay from childhood. I have sex with other men.” (Lolo, 43 years old, unemployed.)

“I am in a homosexual relationship….” (Pitso, 22 years old, unemployed.)

Some of the participants described themselves as having been in a relationship with a woman at some point in their lives as much as they self-identified as being gay currently. When asked if they had ever engaged in sexual activity with a woman, whether casually or in a relationship, nearly all of them said that had happened prior to their becoming gay:

“Sex with a woman? Yes…I was young.” (Mojalefa, 19 years, single, student.)

“I started with a girlfriend…” (Hlogi, 19 years old, unemployed, bisexual.)

Another participant responded by saying he was in a bisexual relationship:

“I am sleeping with guy, men and women at the same time…but I mostly have feelings for other men….” (Lebo, 19 years, unemployed bisexual.)
Another participant said he was single but having casual sex with other men:

“I’m having sex with someone but it’s not a relationship…” (Khumo, 25 years old, unemployed, bisexual)

4.3.2 Sexual experience of the MSMs

When asked to describe the sexual activity with men, the data showed that nearly all of them reported to engaging in anal sex with men, with the sexual role defined as who is penetrated and who does the penetrating in the sexual act. Many of the participants played the female role, also described as the one who was bottom in the relationship:

“I play female part…men always penetrate me…I don’t penetrate men…” (Tefo, 20 years old, single but having sex, employed.)

“I play the female…Well he penetrates me, and he uses his hand on me for me to reach an orgasm…” (Kitso, 25 years old, unemployed)

“Let me answer it like this, when a person approaches me he knows that Lolo is a woman, when we sleep he comes from behind and he penetrate.” (Lolo, 43 years old, unemployed.)

The participants also reported their first experience of anal sex as being painful:

“I wouldn’t say much…obviously we having anal sex…maybe the times before then it was painful. It is painful like it was painful when you start … now that I’m used to it I see it as a different story…But before when I started it was painful.” (Sipho, 21 years old, student.)

“It was painful…I don’t want to lie…it was very painful because it was my first time…if you take 3 months without sleeping with anyone, first penetration is painful…” (Bongani, 35 years old, employed.)

“At the beginning when you are having anal sex right…Problem is the anus…it feels painful…” (Kitso, 25 years old, unemployed.)

4.3.3 Context of sexual attraction

The participants were asked about their sexual attraction and they described how their feelings for other men made them realise their sexuality. This is illustrated by the following statements:

“Ok from my side you have to be horny…and when you look at this guy you don’t want a relationship with this guy…..you just want to have sex with this guy …. You just want him…and there’s a time when you both want each other…That’s it. It’s just sex for now and then….there’s no relationship. You’re just horny and you need sex.” (Mojalefa, 19 years old, single but having casual sex.)

“Somehow I just knew it…I felt different….I did not have any emotional or sexual excitement if I were to put it that way towards women…they were just people…they were there…and when I looked at a man then I’d feel excited in a certain way, loving and…you know…get excited by the male form…” (Dalton, 44 years old, bisexual.)
“First thing first…what happened is this…I am a people’s people…let me put it like that…So when I was young I used to participate in debating at school. So usually when guys were around me I used to feel like I was attracted in a sexual way…let me put it this way…and then when I was with girls…it felt like I was with my friends.” (Selby, 32 years old.)

The participants also said that they realised about their sexuality when they were young. This is shown by the following statements:

“When I was in middle school one of my teachers called me and told me, ‘why are acting this kind of like girlish way…when you talk’…so I said no that’s how I grew up. She said ‘no you’re gay. Together with your voice it says everything…Just accept that you’re this kind. It’s not like we are going to discriminate against you, criticise you or say anything…just know that we here. Know this you are gay.” (Vincent, 18 years old, versatile.)

“I think I was 13…I just played with girls I guess…and beside that I just never had that thing for women, that feeling I don’t know what other people feel, I believe what I feel towards men is what people feel towards women…because that has always been there….I’ve never actually doubted you know.” (Dalton, 44 years old, bisexual.)

“I realised that I’m gay because I didn’t have any connections or feelings for women…I was only attracted to men…I was 15 years old when I first realised I was attracted to men…I was in middle school.” (Phenyo, 34 years old, bisexual.)

“I just discovered from a very young age cause I just felt different from word go as a child. And I just saw from the fact that I didn’t play with other boys. Most of the time I would sit with girls and when I grew I felt different because every time a boy passes by I would feel butterflies in my stomach that is when I knew that I’m different…” (Martin, 25 years old, unemployed.)

### 4.3.4 Casual relationships among MSMs

It is reported as the consensus among homosexual men in this study that they have multiple sexual partners and engage in casual sexual relationships. When asked about the reasons for their having casual encounters, the participants made the following statements:

“I think it stems from the fact that for me personally I think meeting people who are not generally MSM who are there for whatever reasons they are there for in that relationship…only to find out that no suddenly there’s a girl involved and there are other factors that were not part of the initial agreement…I think that causes …you feel that if you have someone, its fine, it’s great to be in a relationship. But it’s better and less painful if you just have casual sex and carry on with your life.”(Dalton, 44 years old, employed.)

“Maybe it’s because I don’t know…maybe it’s because we guys tend to be greedy and we are never satisfied with one partner I guess…” (Martin, 25 years old, unemployed.)

“As I said those guys are coming to us are bisexual, but the other…they have their own girlfriend on the side…When he comes to you he tells you that he’s got a girlfriend…then but I’ve got feelings for you…they are playing with us…So it’s a challenge which we come across.” (Sam, 27 years old, unemployed.)
Another participant reported on the reason why there was a lot of casual sexual encounters in the gay community:

“That’s why normally we will, most of gays will sleep with one man now...sleep with another one later....do one night stands again and again. And normally we get guys from clubs when we go there....I would say it’s like prostitution in some way...because we go to tavern, we go to clubs we get there and we see a guy...he is drinking this stuff...you start thinking let me buy him his drink...I have cash let me do this to benefit this from him.” (Selby, 32 years old, employed.)

4.3.5 Relationship dynamics within the sexual relationships

In this theme the participants reported that they would exchange partners, had casual sexual encounters, and had sexual attraction towards their friends’ partners. Some participants reported on cheating within the relationship, as is illustrated in the statements below:

“Because the thing is my boyfriend...he was cheating on me with this gay guy...So I did not know for a while you understand. So we were sleeping and we were not using condoms you understand.... So I do know my boyfriend...he doesn’t like ....I have been with him for long time...he doesn’t like to use a condom anymore...he doesn’t feel anything when he uses a condom...so I was stressing because I heard rumours...I don’t know if ever they are true but I heard rumours that gay guy he is sleeping with is positive.” (Sipho, 21 years old.)

“I dated two people at the same time...I’m still dating the second one...I found the second one last year January...It’s with the guy I was dating...so he wanted sex from me and I was not ready ...so I slept with his friend who told him about it.....He confronted me...I denied it....” (Puseletso, 27 years old.)

“But my partner...He’s the one who infected me with this... I am HIV ...I don’t sleep around...like so you know gay community...you can sleep with whoever...you don’t know....with or without condoms...Being gay is something...as long as you are around you can do anything... my partner he’s the one who infected me with this...And I told him...He said we must take a break...” (Tefo, 20 years old.)

With regard to casual sexual encounters, some participants reported on sleeping around within a sexual relationship:

“And then yes then the sex started...we thought sleeping with as many people as you possibly can was the thing you know...you felt wanted you felt needed because people found you attractive then you think you have given them your body.” (Dalton, 44 years old.)

“No I was not practising safe sex, but it came to a point where it was becoming too much and I was sleeping with different people and stuff...” (Pitso, 22 years old.)

“You know once you attach yourself to someone and then you start asking yourself questions like ‘why did this person choose me?’... ‘Is he doing this to get something from you’...or ‘Is he doing this for the fun of it’. Maybe he wants to know how this life goes...But what I do know is that we are afraid of rejection. That’s why normally we will, most of gays will sleep with one man now...sleep with another one later....do one night stands again and again.” (Selby, 32 years old.)
Apart from the multiple sexual partners, casual relationship and the sleeping around, some participants described how they changed partners and moved from one relationship to another:

“I dated 2 people at the same time…I’m still dating the second one…I found the second one last year January.” (Puseletso, 27 years old.)

“I’ve never had like a serious one because everyone who is in the closet doesn’t want to be seen that they are dating gay….so it was one of those things of dating in secrecy…then if others find out we break up and find someone else…” (Bongani, 35 years old.)

“Me and the guy, first guy we dated during December…So when I come back home during school holidays he didn’t have time for me…So I was decided to break up with him…because he’s wasting my time…..After that I broke up with him….So he came back…..saying ‘I’m sorry for not giving you my time and all the things…’ So I accepted the apology and continued to love him…even now I still love him…and then after that I was interested to another guy…” (Mojalefa, 19 years, single but having casual sex.)

4.3.6 Substance use during sexual encounters

The participants reported having had sex while under the influence of alcohol. It was a common occurrence in places such as taverns and pubs:

“Most of the time, because we… let me put it like this…Most of the time…because we might be leaving the tavern then the shy guy will approach me while he’s drunk and then I go for him…” (Sam, 27 years old, unemployed.)

“This thing happens at the tavern…not a pub…at a tavern it happens there only.” (Tefo, 20 years old, employed.)

“Most of the guys I sleep with when I’m drunk I meet them in taverns, pubs…” (Bongani, 35 years old, employed.)

“I slept with my cousin when I was drunk…” (Selby, 32 years old, employed.)

4.3.7 Transactional sex among MSM

Some of the MSM reported engaging in transactional sex for financial or sexual gain. The participants also described the usual sites of such casual encounters. They would have transactional sex because they needed the money:

“Will sleep with one man now…sleep with another one later….do one night stands again and again. And normally we get guys from clubs when we go there….I would say it’s like prostitution in some way…because we go to tavern, we go to clubs we get there and we see a guy…he is drinking this stuff…you start thinking let me buy him his drink…I’m having cash let me do this to benefit this from him.” (Selby, 32 years old.)

“I needed cash and then there was someone willing to offer me cash and then for him it was his first time…..so he wanted someone with experience… Then I agreed we went to have sex. It took a while
“for him to be in the mood because it was his first time….Most of the time it’s because of money…because they pay you to have sex with you…” (Bongani, 35 years old.)

“They call me whoever has my numbers and then I just make an appointment…you make an appointment and then he tells me how much do I want like a sex worker like that…” (Sam, 27 years old.)

4.3.8 Condom use among MSM

Decisions related to condom use were related to the type of sexual relationship and also to the dynamics of the relationship. When asked to describe what they thought safe sex practice was and if they discussed it with their partner/s, a common response from the participants was that safe sex practice involved using condoms and testing for HIV:

“Safe sex for both males is firstly don’t date many guys be with your partner, use condoms and always test, every 3 months…always test…the main point do not date many guys …because if you date many guys problem will come.” (Mojalefa, 19 years old.)

“A lot of times we talk about using a condom and having one partner…I’m HIV-positive, we need to test and check status…go voluntarily to the clinic…because you cannot force a person…so I always emphasize that we use condoms to be sure of the status…” (Bongani, 35 years old.)

“Only I just think they should just use a condom… I think it’s the safest thing. Because let me just say if you sleeping with another person, you don’t know their status firstly…you understand? So it’s like you might get infected.” (Sipho, 21 years old.)

Another participant reported:

“They should use protection, but others don’t want to use it, they want to experiment, they will want to use you.” (Lolo, 43 years old.)

There were frequent reports of the participants using condoms in their sexual relationships:

“Like my status is positive and he is negative…so from the word go I explained that to him and he’s good with that. Always we use protection…” (Kitso, 25 years old.)

“Yes we were using condoms. All the time” (Pitso, 22 years old.)

However, the participants often described using condom inconsistently with their partners:

“In my sexual act sometimes I do use condom…do you know in gay life, as much as the bottom…if this guy I wanted him for so long…when I catch him… even when you are catching a fish you become excited…like I did catch a fish…so the excitement came like I did catch this person…then as time goes on…we tell ourselves let us not use condoms we would rather use lub…. “ (Mojalefa, 19 years old.)

“In this situation by the time we get home, I’m not very drunk…so I would have…I normally keep condoms around…and I keep in mind that whoever this is I don’t want them to infect me with whatever they have…and I don’t want to infect them with whatever I would have…so I try not to as
much as possible fight for condoms…and I’ve had situations where people say ‘No you don’t trust me’ and so on…and I was like ‘No I don’t know you…. So I don’t trust you’…but I’ve had burst condom on number of occasions.” (Dalton, 44 years old.)

4.3.9 Non-condom use among MSM

Their sexual behaviours relating to non-condom use depended on the type of sexual relationship they were in, as condom use was more common with casual partners than with their regular, steady partners. Some participants made statements illustrating this:

“I won’t lie…we don’t often use condoms…we used a condom from the start when we started dating…from then on like we just stopped…” (Sipho, 21 years old.)

“It might be alcohol abuse sometime or just that you tell yourself you have been using a condom all this time…today let us not…. The big challenge now is to convince my sexual partners that we have to use condoms. I also have a challenge of using condoms all the time because I sometimes don’t feel like it…” (Bongani, 35 years old.)

“But you know sometimes maybe when you’re at the house or on the road or public space and we don’t have a condom…” (Kitso, 25 years old.)

The participants reported non-condom use for oral sex. A participant described using lubricant in conjunction with a condom:

“We use condoms and lubricant…” (Vincent, 18 years old.)

4.3.10 STIs among MSMs

Some of the participants had had the experience of acquiring STIs at some point in their sexual relationships. Some knew the type of STI they had had, while others reported the type of symptoms they had had. The participants described their experiences in the following statements:

“The important thing is like after having sex with this other guy, I started to get warts…from the guy who I slept with at the beginning…after having sex….after a week…….it was without a condom….. You see….So I started experiencing the warts and everything. So I told the guy that this is what happened ….Then I went to the clinic, then they injected me…Again even now like I am having a problem…I don’t know why…” (Tefo, 20 years old.)

“The other time this guy who was having sex with me, we had sex and I got sick. I had discharge from my anus, I was frightened.” (Tshepo, 37 years old.)

“It was around 2013….So yes…I was a versatile because I only wanted to find out and test how it felt. They do us….So after he did me, I did him…So when I was having sex….I discovered some discharges on my penis and other things.” (Mojalefa, 19 years old.)
The lack of knowledge of STIs was evident in the in-depth interviews when the participants were asked about common STIs they know. A lot of them did not know of STIs among MSM. The common response from the participants was:

“I don’t know STIs.” (Pitso, 22 years old.)

One of the questions asked in the interview was whether the participants thought there was a chance they could get an STI specific to women. A lot of the participants did not know. Thus, a participant’s response was:

“I don’t know….STI for women….Maybe if you give me an example I would understand…” (John, 25 years old.)

However, when the participants were asked about the transmission risks of STIs among MSM, they were quite knowledgeable about that. The participants said:

“What kills us is that we don’t have stable partners. So whenever we go out, we get drunk and have unprotected sex, things like that….” (Kitso, 25 years old.)

“I think multiple partners and not using condoms, not using condoms properly or safely and just don’t know if you get it from people giving blow jobs…” (Dalton, 44 years old, versatile.)

“I think it’s not using condom…being drunk and sleeping around with everyone.” (Tshireletso, 30 years old, bisexual.)

Another participant reported his views regarding the risk of STI among MSM:

“Well from my perspective most of the gay guys out there, from what I’ve experienced, like having sex its first thing that comes to mind…being intimate with some guys. Even when you go to clubs. Everyone wants to OK…’I just want to have sex’, so that’s the main problem. And that’s the reason why STIs so spreading so much…..” (Motsumi, 25 years old.)

When the participants were asked about accessing a health-care facility for the treatment of STI, they had this to say:

“It was around 2013….So yes… because I only wanted to find out and test how it felt. They do us….So after he did me, I did him….So when I was having sex….I discovered some discharges on my penis and other things, went to clinic, they gave me treatment and they said ’Do you have a partner?’ I said ‘Yes I do’ and OK fine….’I want you guys to come here and all the things. Then there is the letter give him the letter and all the things…”’ (Mojalefa, 19 years old.)

“Because I didn’t understand what it was they treat me well…because they explained to me the disease what kind of disease it is…because I thought of piles. They told me no it’s not piles, it’s a cauliflower…then I said ok, fine…” (Sam, 27 years old.)
4.3.11 MSM health-seeking behaviour

Some participants delayed seeking healthcare when it came to getting treatment for STI.

“It took…2 weeks because when it shows it shows like sores at first…and that I didn’t know what it is….” (Sam, 27 years old.)

“I didn’t go immediately. I stayed a long time because this thing it’s on the inside…I saw when I had abscess and the smell which I didn’t understand …and then I started like swelling on the sides…Then I went to consult…” (Bongani, 35 years old.)

The data also show that some participants found it easy to access the health facility as an MSM:

“It was easy because there are so much gays who work at that clinic and then they know about gays…So I just got…walked in and out easy. Nobody was looking at me…nobody was watching me….they even though I was working in those place…” (Amo, 18 years old.)

“They had nice treatment and then they told me to do this and that. Use condoms, for safe sex, avoid to have STIs. "(Khumo, 25 years old.)

However eleven participants felt that it was not easy to access health facility below of the non-acceptability of the health professionals as an MSM. The data below illustrates this:

“Clinics and these other places… think the attitude of the nurses they are a bit harsh, brash and you feel like there’s no confidentiality in those health facilities…because they chat amongst themselves and we happen to live with them in the community as well so….it is…when she goes you’re just not comfortable…” (Dalton, 44 years old, versatile.)

“They judged me at the clinic…especially at the local clinics….they judge people like me….So when I’m sick and I go there…they judge me." (Puseletso, 27 years old.)

“Because let me just say that, I come and go to clinic. They are going to see I am gay. I have a problem I have something in my anal area…They are going to be like "You guys sleep with other men." you understand? So for me it’s not like it bothers me…It doesn’t because I came with what I came with its either you help or you don’t." (Sipho, 21 years old.)

“Because there are people in this day and age who have not accepted and are still stereotype about it. They tell you it’s a sin and all that. And they discriminate against you…you find that I would come to you to explain and then you react in a certain way…” (Donald, 31 years old.)

The participants described the health professionals’ reaction as follows:

“Because first thing they asked me what was wrong with me…. And I had to explain I have a discharge, I’m swelled up in the anal area…then I had to undress…and those sisters didn’t understand gay life or gay community…they started telling me to stop this lifestyle I was living….It’s against religion…they told me to change my sexual behaviour…I stopped going to that clinic…I went to another one and it was the same.” (Bongani, 35 years old.)
“You know how they are...they ask such question ‘What happened?’ Things like that. For me I would be open and speak about the problem...for her she would look at me first and say ‘This person.... for real? So I don’t get how they take it....They judge me first before they help me....so they judge me before they advise me.... From my side it wasn’t right the way like her whole reaction was....” (Tefo, 20 years old.)

4.3.12 HIV testing among MSMs

With a worrying proportion of MSM not knowing their partners’ HIV status, a minority reported having been tested for HIV in the past year. This is illustrated by the following statements:

“But me and my partner we like test regularly. We have been dating for a long time so we came to a point where we stopped using condoms because I just felt freer with him...he felt free to be with me and we saw results, our test results. I don’t know if ever he is sleeping around or what...I haven’t found anything otherwise...” (Sipho, 21 years old.)

“I heard of HIV...when I looked back I saw how I’ve been sleeping around with a lot of men...so I thought I should go check my status...When I went to test it was because I was coughing....So they said that if you coughing it might be TB...you must test for TB....so I then checked for HIV...” (Thabang, 42 years old.)

A participant mentioned fear as one of the reason why MSMs do not test:

“Most of gay people are afraid to test that is why....Because some they know that they don’t use condoms. They don’t...and even you can see the percentage of gays who died they cannot tell you he did die/he did die because of the disease...they will tell you he was sick...You know... when you look at the story about the person he was busy floating especially like bottoms....those who love to be women....even they find the top guy, they don’t even care about the condom had burst.” (Mojalefa, 19 years old.)

The data also shows that some participants were reluctant to test even when encouraged to do so by their family because they were sick at the time:

“When I discovered that I am positive. I am working at the salon, I was amazed, and how did it come that I become positive? When I got it from some of my clients will not mention names as they are dead. It was through old worn out gloves i wore at the salon. My gloves were finished and it was during December. It was busy. As time went by after that I started to lose weight. My aunt told my mom that “Do you see how Lolo is, he is losing weight. He is not the Lolo that I know,’ but I was aware because my weight reduced from 36 kg to 34kg. My aunt wanted us to go to the Doctor to test. I was reluctant.” (Lolo, 43 years old.)

“It's not easy because you get to a clinic and they want to test you...That is why most people are running away from clinics...” (Phenyo, 34 years old.)
4.3.13 Disclosure of HIV status

The participants were asked about the disclosure of their HIV status to their partners in their sexual relationships. The data show that some of them did disclose their HIV status to their partners and also enquired about their partner’s status:

“Normally I do before I sleep with them. I tell them how my status is like… I do ask them ‘What is your status because I am clean and I want to know where you stand?’” (Vincent, 18 years old.)

“My last partner we spoke about it…and he was also positive…so we spoke about it…it’s easier to speak about it…” (Dalton, 44 years old.)

“In most cases, outside people I never ask…the serious one I ask…” (Phenyo, 34 years old.)

4.3.14 Disclosure of MSM status

The process of others becoming aware of the MSM status of the participants involved direct disclosure where the participants told their families or friends, or indirect disclosure where the others were aware or suspected the MSM status but did not confront the participants. The data show that the disclosure of MSM status by the participants to their families was common:

“It was in 2015… the time I met a serious relationship with a guy. He was a bottom. He used to come to my house…now and then then they asked why does he sleep at home, my mom she asked me…She sat me down and asked me if I was sleeping with this guy…I told her ‘Yes he’s my boyfriend.’” (Khumo, 25 years old.)

“I sat mom and my sister down….they had already noticed…they were scared to ask me and confront me…” (Puseletso, 27 years old.)

However, some participants had not disclosed their MSM status to their family, friends or community for various reasons:

“I’ve never had like a serious one because everyone who is in the closet doesn’t want to be seen that they are dating gay…so it was one of those things of dating in secrecy…I’m still keeping them a secret because I’m that person that respects always…so whenever I’m doing my things I make sure that there’s no one in the house or I go to their places…” (Bongani, 35 years old.)

“Because like a lot of people I was sleeping with, they were heterosexuals….They are straight men….It’s a secret. That’s why at the end of the day I had a challenge after having sex with them…” (Pitso, 22 years old.)

“They don’t know anything those ones…because my partner has a wife and children.” (John, 25 years old.)
Other participants received support in the form of encouragement to share an awareness of the participants’ orientation without confrontation, and said the following:

“I started communicating with girls, so there was this friend of mine. Then I communicated with her not telling her what was happening…just communicating…so the first guy that I met I went to her and just said to her…‘You know I met someone’….I didn’t just tell her that I’m talking about a guy. So I just said to her ‘This person she’s so cute like I love her so much’…She said she wanted to see her… I just said ‘Not right now ….I’m not prepared for me to introduce you to that person…it’s just a fresh start…As time goes on I will tell you’. So she kept on asking about the person…So I told the guy how I feel about him, then he said he felt the same about me, but he wanted us to take things one step at a time. Not to rush into things. So I told the girl after that about the guy and she said she knew I was lying to her. She knew I was gay…So my mom and dad they don’t know.” (Vincent, 18 years old.)

“Because I haven’t told them anything I can’t say it’s a secret… Let me say that when my partner passed on in June they were there at his funeral. But when I introduced him I said this is David my friend….But you could see the way our friendship was like….you could sense that there was more to our friendship.” (Donald, 31 years old.)

Some participants did not want to disclose for religious reasons or because they were embarrassed by their sexual orientation:

“I have to follow what they say. If they don’t want me to wear skinny tops, I have to wear what they want. And I had to go to church. These church I’m attending now, it doesn’t want people like us homosexuals…” (Peter, 19 years old.)

“I was embarrassed because I would dress like a drag at night only….during the day I would look normal….but when I went out with my friends I would wear weaves and stuff…” (Puseletso, 27 years old.)

Some participants expressed their own difficulty in understanding or accepting that they were gay. The following statements illustrate this:

“I didn’t know there was this gay thing…So I just said to him, no I’m not that kind of a person…so when I was in middle school one of my teachers called me and told me, why are acting this kind of girlish way…when you talk…so I said no that’s how I grew up. She said no you’re gay. Together with your voice it says everything…Just accept that you’re this kind. It’s not like we are going to discriminate against you, criticise you or say anything…just know that we’re here. Know this, you are gay. It took some time for me to accept it due to some family circumstances and family background so even now…still in the closet…” (Vincent, 18 years old.)

“Yes relaxing the hair and stuff like that…so they used to call me by names like Betty you know such things…They made me feel like I was kind of like a woman. When the guys started saying let’s do this, I enjoyed it….but I didn’t understand what was going on….so when this term of someone being gay when it started…when they were busy saying it the teacher and everyone, it was hard….It was hard because it took me from 2000 to 2007. In 2007 I went for counselling so that I would be able to process everything because I didn’t accept being gay…” (Selby, 32 years old.)

The people to whom they disclosed their MSM status were slow to accept, accepted, confrontational or non-accepting. The following statements illustrate this:
“My dad is taking it slow to accept that I'm gay...and my brother doesn't care. And both my father's side they pretend when I'm with them, like they pretending. But only I can see that they do not accept it though. My aunt and uncle....but my cousin's there's a joy. There's a joy even my mother's side both my auntsies, cousins they did. Even my two other cousins. The other one I don't spend time with him. But the other one I do...and he's a Christian...because first time when I introduced them to my partner, they were happy.” (Mojalefa, 19 years old.)

“At the beginning there were issues because my mom didn't want to accept. She ended up accepting after hearing something on the radio show...then she started understanding.” (Kitso, 25 years old.)

“My mother had a problem before...I was talking to my sisters about this so they made it possible for my mom to accept...They said to her 'Listen you cannot change this person. It's the way he is so just let it go...” (Phenyo, 34 years old.)

Responses towards MSMs ranged from rejection, anger and non-acceptance to acceptance:

“Some rejected me and then some pretended that they accept me...but for them to benefit something from me. They didn't accept me as being gay. Some accepted me completely because they also made jokes about my life like saying things like 'Look at this guy....don't you want him?’ They were there for me. (Selby, 32 years old.)

“They didn’t accept it... they didn’t accept it because they said that in their home there’s no such a person like this...So why me? So they asked themselves questions that they could not get answers for at the end…” (Sam, 27 years old)

Some participants received negative reaction from their communities:

“Another one it’s this thing discrimination ...stigmatism in communities whereby they don’t accept relationship of two guys getting involved.” (Selby, 32 years old.)

“Community, yes... We were called names for starters...your family wouldn’t understand what you were doing once you started what you were doing...so that was a major challenge....even work-wise wasn’t a major challenge...but mostly in the community you were called names once they found out what you were doing...family were not happy with you....” (Dalton, 44 years old.)

The data also show that some participants experienced anger from their families after their disclosure of their MSM status:

“No the thing is I was dating my first boyfriend. It was this guy...from next door at home...so it happens that he came over to my house and we had sex...so while we were busy my grandmother came in the room...she had knocked off early...while we are busy she saw us.....She didn't take it well...she was upset then started shouting outside...I heard her shout....she was upset and angry for two whole weeks...” (John, 25 years old.)

My dad...we're not that close...He heard people saying your child is doing this and that... He once confronted me if it was true...He got angry. (Khumo, 25 years old.)

Several participants had experienced sexual violence at some point in their lives. The following statements indicate this:

“We went out drinking with my friends...and then this guy, very old guy, he was buying us drinks...so my friends they were more wiser than me...so they left...suddenly when I looked around they were
gone…when I tried to leave this person pulled me back…and hit me with a bottle on the head and said… “Your friends have left so…you're coming with me.” So I was dragged to his shack and kept there for a while whilst he went out drinking…and then he came back….and then I tried to run away …they grabbed me and pulled me back, beat me up…and had sexual intercourse with me….”(Dalton, 44 years old.)

“I was with the guy I was dating….so he wanted sex from me and I was not ready …so I slept with his friend who told him about it…..He confronted me…I denied it…..until I finally admitted it. So he told me that he wanted to have sex with me it's been a while….I kept on refusing…then he slapped me and forced me.” (Puseleto, 27 years old.)

“In 2014…or 2011…there was this guy I didn’t know very well. People said that he was rough naturally…He was Xhosa. What happened was that one night when I was going home….he came from behind me saying nasty things to me…I took it lightly not seriously…then next time I ran into him again….that day he pulled me…pulled me behind the toilet where he forced himself on me….” (Donald, 31 years old.)

The data also show that some participants experienced physical violence from their communities because of their sexual orientation:

“I was once beaten when I was in Pretoria…I went to this club in Pretoria…I was sitting with this guy… we were communicating and stuff like that. After that this guy he told his friends about me…they came as a mob…I was beaten, and they dumped me at Pretorius where there’s a bridge there…they dump me there and they left me there…I was found by the Police the following day. And then another incident it happened when I was at school. Couple of boys they beat me on my way back from school…They took me and dumped me in a thorny bush. It was this grandfather who was a farmer who found me there. And then another incident was at church …I remember there was this pastor…I’m a Methodist so while he was preaching he realized that I’m gay so he started doing examples but based on me. I confronted him and it became something big…” (Selby, 32 years old.)

“When I was out of the tavern when I’m coming out of the tavern then I met a guy, after meeting the guy…on the street…He wanted to have sex with me only at night….in the morning he pretends like he doesn’t want to be with me, but at night he will beat me before he has sex with me and questioned me why am I not working…So I must give him money….and all the stuff…so we did that only once…. ” (Sam, 27 years old.)

4.4 Conclusion

From the themes that emerged from the data it can be concluded that MSM have multiple casual partners, exchange sexual partners, change partners frequently and have unprotected sex, especially after alcohol use. The themes also reveal a common lack of STI knowledge among MSM, which highlights the need for preventive and health promotion programmes on the topic of STIs, and that condom use is inconsistent among MSMs. Their disclosure of their MSM status produced mixed reactions from their families, relatives and friends. The data also show that whether or not they disclosed their HIV status to a partner depended on the type of relationship that existed between the partners. MSM fear being tested. The data
also reveal that discrimination against and violence towards the gay community still occurs, and that some MSM still engage in transactional sex.
5.1 Introduction

This study aimed to explore the sexual choices, sexual practices and risky behaviour of MSM in the North-West of Pretoria. The findings of the study are discussed below, as well as its strengths and limitations.

5.2 Discussion

The findings of the study suggest that the 67% of the MSM in the North-West of Pretoria tend to be young men, with a mean age of 26, which is consistent with studies in which the average age of the participants is about 25 (Baral et al, 2009; Baral et al, 2011; Imrie et al, 2013). The sexual debut for the majority of the men occurred when they were about 15 years old, which is in line with the findings of other studies that sexual debut occurs at about 15 years old (Glick et al, 2012). This indicates that the young men in the study when they became sexually active at the young age, they were experimenting and discovering their own sexual identity. This is concerning, because it sets of a pattern for the future of risky behaviour among young men who are not knowledgeable about safe-sex practice (Lyons et al, 2012).

The high-risk behaviours among MSM in North-West of Pretoria such as having multiple sexual partners, inconsistent condom use and unprotected anal sex are quite apparent in our data. Such findings have been reported world-wide (Narayanan et al, 2013; Sandfort et al, 2013; Aho et al, 2014; Williams et al, 2016)

Having many sex partners is a common practice, with a significant proportion of the MSM reporting on having more than one partner at the time of the investigation. This accords with the opinions of Wagner et al (2012) and Aho et al (2014), who found that high-risk behaviour such as having multiple sex partners is common among MSM. The data also indicate that the reasons for engaging in a multiplicity of sexual relationship include a desire to feel good because of being wanted by many men, and a desire for physical pleasure. Therefore this corroborates the findings in the literature that MSM eschew monogamy (Jin et al, 2009).
The findings in this study highlight, like those of other studies of MSM in other areas in the world, that the sexual relationships that exist among MSM are unstable, and that this culture of instability influences the behaviour of individuals (Wagner et al., 2012; Sandfort et al., 2013). The relationship dynamics which exist among MSMs in this study strongly indicate a culture of cheating, mistrust in relationships, sharing partners, and the passing on of sex partners. The findings also show that there is a lot of dishonesty between partners, which may be why MSM prefer to have more than one partner. Moreover, dissatisfaction with having only one partner and a desire to use the partner for financial or sexual gain were also apparent in the data.

The data show that financial challenges induce MSM to engage in transactional sexual relationships for financial gain. Engagement in transactional sex is multifactorial. Socio-economic factors have an influence on such engagement among MSM, and this is seen in our data where MSM report occasionally engaging in sex for financial freedom. Narayanan et al. (2013) report that MSM use sex as their primary source of income. This corroborates the findings of Oldenburg et al. (2015), who conclude that there are various factors associated with engagement in transactional sex, unemployment being one of them. We also find that a subject has reduced power in a situation where he is being paid to have sex, and an increased difficulty in negotiating condom use. Transactional sexual relationships therefore involve high-risk sexual behaviours (Sandfort et al., 2013; Aho et al., 2014). The MSM in such relationships are vulnerable to STIs and HIV transmission.

The findings in this study indicate that the MSMs were in various type of relationships, and that the nature of these relationships influenced condom use within the relationships. As most of the MSMs interviewed played the female role (were the “bottoms”) in the relationships, this made them vulnerable when it came to decision-making pertaining to condom-use. This is also found in other studies on partnerships among MSM (Morris & Kretzschmar, 1997; Sandfort et al., 2013). We also find that MSM are more inclined to use condoms with casual partners than with regular partners. Usually non-condom use with a regular partner indicates the commitment of both partners to the relationship. Condom use with a casual partner reflects the fact that the relationship is still in its early stages, and that trust has not yet developed. Once the casual partner became a regular partner, the use of condoms
was often discontinued. Such decisions pertain to interpersonal relationship factors such as trust, commitment, and a perception of the risk of contracting diseases that comes with sexual relationships. This suggests that those in committed relationships are more at risk of contracting STIs and HIV than those involved in casual relationships. All of these findings are similar to those recorded in the literature (Knox et al, 2010; Hoff et al, 2012; Sandfort et al, 2013; Aho et al, 2014).

The chief reason we find for the casual relationships among MSM is the difficulty in maintaining relationship because of a fear of rejection by their partners, a lack of trust, or not being ready for commitment. Trust and commitment were the overriding factors which made it difficult to maintain a relationship, which was why the MSM in our study easily left their partners or interchanged partners or were sharing their partners, which was common practice among the MSM in our findings. This is consistent with a study by Sandfort et al (2013) on the types of relationships among MSM.

Data indicate that the MSM engaged in anal sex, with majority of them playing the female role in the relationship. This also suggests the reason for their having many sexual relationships, as far fewer were prepared to play the male role than the female role. The initial experience of receptive anal sex was described by the majority of the participants as being painful. This is consistent with the findings of a qualitative study of MSM conducted in South African townships by Collier et al (2015).

Unprotected anal intercourse among MSM was common among the participants in the study. Most of the participants reported engaging in unprotected receptive anal intercourse, as the majority of the MSM in the study played feminine role in the relationships, which involves being penetrated. Receptive unprotected anal intercourse is still one of the most risky behaviours in regard to the transmission of STIs and HIV. It is sixteen times more likely to transmit HIV than unprotected vaginal intercourse, and those MSM who play the female role are more vulnerable (Baral et al, 2009; Jin et al, 2009; Baggaley et al, 2010; McDaid & Hart, 2010; Rebe et al, 2011; McIntyre et al, 2013).

The fact that only a third of the participants in our findings were aware of their partners’ HIV status poses an even higher risk of the transmission of HIV among the
MSM in the North-West of Pretoria. Our findings also indicate that some participants did not test or were reluctant to test for HIV because of fear of discovering that they are HIV-positive, and yet they continued to practise unprotected sex and inconsistent condom use with a multiplicity of partners. The findings in the study by Sandfort et al. (2015a) are similar. However, it must be noted that the fear of HIV infection and of contracting other STIs had motivated some of the participants in our study to test for HIV.

The health facilities were easily accessible by the participants in our study. However, some also felt discriminated against by the health professional, which impeded their access to the health-care facilities. These findings are confirmed by findings in other South African studies (Lane et al., 2008b; McIntyre et al., 2013), which report that discrimination against MSM impedes access to health-care facilities. However, findings in a quantitative and qualitative study performed by Scheibe et al. (2017) are that there is a shift by health-care workers towards being less judgemental of and discriminatory against MSM because of their sexual orientation.

We find that the reasons for the inconsistent condom use among MSMs include a lack of the availability of condoms, and that their sexual encounters are often unplanned or occur under the influence of alcohol. The influence of the nature of the relationship on condom use is well documented in the literature (Sandfort et al., 2013). High-risk sexual behaviour is associated with insufficient negotiation skills and difficulty in using condoms (Sandfort et al., 2013). This finding is replicated in various studies performed all over the world (McDaid & Hart, 2010; Aho et al., 2014; Bello et al., 2017). Lubricants such as Vaseline were used as alternatives to condoms by the participants in this study because of their availability and cheapness. This corroborates the findings in other studies about methods alternative to condoms (Rebe et al., 2013). Water-based lubricants were used but were perceived as being expensive by those who did not use those (Aho et al., 2014).

A great deal of inconsistency in condom use among the men in our study was revealed in our data, which increases the risk of the acquisition of STIs and HIV. This finding is reflected in the high prevalence of HIV among MSM reported in various studies around the world, including in sub-Saharan Africa (Lane et al., 2008a; Mimiaga et al., 2011; UCSF, 2015; Bello et al., 2017). Data show that some MSM had
STIs and had delayed seeking health-care for them. The reason for this was the lack of knowledge of common STIs among MSMs, which was apparent in our findings. This lack of knowledge could result from the syndromic management of STI protocol which is used. Diagnostic management of STI management would be more effective in reducing STIs, as diagnosis of the type of STI would be more accurate. This is validated in a study by Stime et al (2017), which reports that the syndromic management of STI is cost-effective but less accurate than diagnostic management. Furthermore, Nelson et al (2015) find an association between STI knowledge and condom use, which explains the lack of consistent condom use and the poor knowledge found in our study.

The participants in this study consistently reported condom use with casual partners, and also said that they were comfortable with discussing their HIV status with their regular partners, as against their casual partners. This reflects the influence of the dependability of a relationship on the disclosure of HIV status reported in a study by Hart and Elford (2010).

In this study, the use of substances such as alcohol during sexual intercourse was reported to be quite common. This exacerbated the participants’ engagement in unprotected anal intercourse and their poor condom-use negotiation, and increased the risk for the acquisition of STIs and HIV, as judgement is often impeded when there is substance use. This point is made in various other studies (Lane et al, 2008a; Bello et al, 2017). An association was reported between alcohol use and high-risk sexual behaviours such as unprotected anal intercourse and multiple partners by Mimiaga et al (2011). We also find that the abuse of alcohol by the MSM occurred mostly in places such as bars, pubs and taverns. These places were used by the men to pick up casual partners for sex and most of the time non-condom use occurred because of their being under the influence of alcohol. Grov and Crow (2012) found that MSM whose common place of recreation is clubs and bars reported alcohol and drug use while having sex. These findings should encourage the implementation of preventative programmes targeting such places.

The disclosure of their MSM status to family members, relatives and friends by MSM was common among the majority of the participants in the study. This suggests the emotional support which the men received from family and friends. However,
sometimes the disclosure of sexual orientation did not yield the hoped-for emotional support, as the reaction of some families, relatives and communities included anger, non-acceptance, stigmatism and rejection. Data also include that the reasons for non-disclosure by the MSM to their families and friends are the fear of rejection or anger from the family, social isolation and stigma, and being discriminated against by their communities. Twenty-nine of the MSMs in this study had self-identified as being gay at a young age and had, prior to coming out as being gay, been in relationships with women because of their fear of discrimination or rejection by their families. Sharma et al (2008) also found that a lack of support after disclosure by MSM impacts on their emotional state. Some of the participants in our study experienced physical and sexual violence because of their sexual orientation. This again stresses the stigmatisation of MSM and the discrimination against them which still takes place in South African communities, regardless of the existence of a national constitution which protects the human rights of people engaged in same-sex relationships. Data also revealed that some participants experienced violence from their partners because of the lack of trust in the relationship. However, our data also demonstrated that not all MSM experienced such violence, as some of them had good support from their families and communities. Discrimination, violence and stigmatisation found by Aho et al to be were experienced by some MSM after their disclosure of their sexual orientation, and an association was also reported between unprotected anal intercourse and physical abuse because of MSM status and a history of sexual violence (Aho et al, 2014).

5.3 Limitations of the study

Several limitations of the study should be taken into an account. Firstly there was selection bias, as convenience sampling was used and this increases the potential for selection bias, as it is not random. Therefore the participants in this study are not necessarily representative of the whole population in South Africa. The findings are not transferable to the larger population of MSM in the North-West of Pretoria as the sample comprised of younger men, and the study therefore does not represent the experiences of older men. Gay men who identified themselves as playing the female role were more fully represented in this study than those who play the male role. We therefore cannot draw conclusions about MSM who do not identify as being gay or
bisexual. The race mostly fully represented in the townships North-West of Pretoria is black, therefore other races were not represented in the study. The participants might have under-reported on some of the questions. The study was based on in-depth interviews, therefore the responses of the participants to questions about their sexual behaviours may be socially desirable responses. However, the researcher and the research assistant were trained to help the participants feel at ease when answering the questions in order to minimise this tendency.

5.4 Recommendations

The MSM population in the community should first be identified so that they can be comprehensively addressed. Motivational interviews have been shown to be effective in reducing drug use in a study conducted in US (Morgenstern et al, 2009). Advocacy for the MSM should be strengthened in the communities, targeting young MSM. This will ensure that factors such as stigma and discrimination against MSM are addressed. These programmes should also address the social and structural factors in the communities. Health-care facilities for MSM are a necessity, as they are a high-risk population. The facilities should focus on the distribution of information such as access, availability to information about condoms and lubricants. The literature has shown that African MSM are less likely to have UAI if they have been counselled about the risks of UAI (Baral et al, 2009). Health promotion and awareness campaigns on alcohol abuse STIs and HIV preventative programmes targeting young MSM should be mounted for health professionals as well as the community. Young MSM in particular must be targeted in peer-based health promotion programmes to educate them about their risky behaviour and practices. Literature also reports participants are willing to partake in substance risk reduction services as well as preventive services as these services have had a positive outcome such as safe sexual practices and more condom use (Williams et al, 2016).

5.5 Conclusion

In summary, the findings of this qualitative study highlight the individual perspective of the MSM in regard to their sexual behaviour, practices and choices, which had received less attention in previous studies. Our findings indicate that MSM in the North-West of Pretoria practise risky sexual behaviour such as inconsistent condom
use, having multiple sexual partners, unprotected anal sex, and a high level of alcohol use, and are at high risk of acquiring HIV and STIs. The findings shed a light on the need for information about STIs among MSM in places such as taverns and pubs, as well as condoms and water-based lubricants in health facilities for MSMs in the North-West of Pretoria.
REFERENCES


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<td>3. Occupation level</td>
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<td>Masturbation</td>
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<td>Anal sex</td>
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<td>Rimming</td>
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<td>Vaginal sex</td>
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<td>Three or more</td>
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<td>9. HIV status of main partners</td>
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<td>Suspicious but don’t know</td>
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ANNEXURE A1: SOCIO-DEMOGRAPHIC DATA

Date: 
File number:
ANNEXURE A2: ENGLISH INTERVIEW GUIDE

INTERVIEW GUIDE
INTRODUCTION TO THE INTERVIEW

Thank you for agreeing to participate in this interview, my name is XXX, from SMU-MeCru (previously known as Medunsa). We are talking to MSM about their sexual choices and behaviours. Please feel free to tell me when you are not comfortable about any of the questions, but I would appreciate if you could answer as many of the question as possible. The interview will take less than 30 minutes. For purposes of an uninterrupted interview I request to record our discussion so that I do not miss any important information from you and also so that I do not waste time writing down everything and I assure you that all that we are going to discuss will be kept confidential and will only be used by the researchers at SMU.

A. Socio-demographics

The demographic data collected from the participants the main study will be used to enable data linkage for participants who volunteer to participate in this study.

B. Sexual behaviours, practices and sexual risks

1. What kind of a relationship are you currently in?
2. When did you start having sex?
3. Please tell me about the sexual relationship/s you had as you were growing up.
4. What challenges did you experience when you started having sex with men?
   Probe:
   • In the sexual relationship you are in now, who is the man/female?
   • How many men have you slept with?
   • What is your sexual preference?
   • Tell me more about your sexual relationship/s with other men
   • How do you engage in sex with other men?
   • When having sex do you both penetrate each other? Who decides
5. How many sexual partners do you currently have?
   Probe:
   • Does the family know about you being an MSM?
   • How did they treat you?
   • Is you sexual relationship a secret?
6. Have you ever experienced sexual violence in any of your relationship/s?
   • Was condom used?
7. Have you ever slept with another men for money?
   • How often did you sleep with another men for money?
   • Was it with a regular partner?
   • Was it casual encounter?
   • Where did you meet the partner?
8. Have you ever slept with a man while under the influence of alcohol?
   Probe: How often did that happen?
   Did you use a condom?
9. What do you consider as safe sex for MSM?
11. What usually do you discuss with your male partner regarding safe sex?
   **Probe:**
   - Do you practice safe sex?
   - What safe sex practices do you use in your relationship/s with other men?

12. What do you know about sexually transmitted infections (STIs) among MSM?

13. What are the common STIs that you know?
   **Probe:**
   - Which STIs have you had as a MSM?
   - Did you consult for STIs? How long did it take before you consulted?
   - What did you use before consulting?
   - Where did you consult?
   - What were your experiences when consulting for STI?
   - Did you inform your partner after contracting an STIs?

14. Do you disclose your HIV status to your sexual partner whether you are HIV negative or Positive?
   **Probe:** Do you ask about their status before you sleep with them?

15. How easy is it to consult at a health facility as an MSM

16. Do you think that there is a chance that you can get STIs that are specific to women?
   **Probe:**
   - Why do you think that is the case?

17. What are your experiences of using condoms during sex with your male partner?

18. How often do you use condoms?
   **Probe:**
   - Why are you not using condoms always
   - Who decides if a condom should be used or not
   - How do you feel about using condoms for oral sex?
   - Are there any other protective methods that you are using for sexual act?
   - What are the barriers for you to consistently use a condom?”
   - What do you think are the benefits to consistently using a condom?
   - How much confidence do you have to consistently use a condom?
   - Besides the use of condoms, what other ways do you use for protect yourself from contracting STIs during sex?

19. In your opinion, what do you think puts MSM at risk of contracting STIs?

20. What sexual challenges do you have as an MSM?
   - How do you deal with them
   - What makes sex fulfilling for you?

21. Do you have anything else you would like to share which I did not ask?
**ANNEXURE A3: SETSWANA INTERVIEW GUIDE**

Hlahlobelo

Kea le leboha ka go dumela ho buisanoa le nna, lebitso la ka ke XXX, ke tswa ko SMU-MeCRU (na ba ibitsa Medunsa). Re bua le MSM mabapi le thobalano le maitshwaro. Ka kòpo ikutloa o lokolohile go mpolella ga dipotso di sa go tshware pila. Nka rata ge o ka araba tse dintsi ge o ka khonahala. Re tlo tsea metsotso e 30. Ne ke kopa go rekoda puisano ya rona gore ke sa senya nako ke kwala. Ene ke go tshepisa gore tsohle seo re eang google buisana mo' se sala moo ene se tlo sebedisoa fela mo SMU.

B Maitshwaro thobalano, mekhoa le dikotsi tsa thobalano

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<tr>
<td>1.</td>
<td>O mo kamano ya mofuta ofeng byang?</td>
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<td>2.</td>
<td>O thomile leng go robalana?</td>
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<td>3.</td>
<td>Mpolelle tsa mabapi le thobalana ge ne o hola.</td>
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<td>4.</td>
<td>A onkile wa nna le matsapa ge o thoma go robalana le banna?</td>
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<td>5.</td>
<td>O na le molekane/balekane ba kae?</td>
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<tr>
<td>Fatang:</td>
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<tr>
<td></td>
<td>• Mo kamano o leng go yona yanong, kemang monna/mosadi?</td>
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<td></td>
<td>• O robalane le banna ba kae?</td>
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<td></td>
<td>• Wena O rata monna kapa mosadi?</td>
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<td></td>
<td>• O ka mpolelle ka kgalaganyo ya thobalano ya gao le banna ba bang</td>
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<tr>
<td></td>
<td>• O ka mposo ka mkgwana o orobalang le monna o mong?</td>
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<tr>
<td></td>
<td>• O ka mposo ka mofuta ya thobalano le banna ba bang?</td>
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<tr>
<td></td>
<td>• Ge le robalana, ke mang o e kentshang go mo ong?</td>
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<tr>
<td></td>
<td>• Ke mang a etsang queto eo?</td>
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6. Ko lapeng ba itsi ge wena o robalana le banna?

**Fatang**

- Ba ne ba go tshwere yang?
- Kamano ya thobalano ya gao ke sephiri?

7. A O nkile wa ba le ntwa mo thobalanong tsa gao?

8. A O nkile wa robala le monna o mong for chelate?

**Fatang:**

- E etsagetse ga kae?
- A ne ele le molekane wa gao?
- A ne ele le motho a seng molekane wa gao?
- Le kopane ko kae?

9. A nkile wa robala le monna o mong o tlhapetswe?

**Fatang:**

- E etsagetse ga kae?
- Le berekisitse condom?

10. O nagana gore thobalano e sireletsehile bakeng sefeng?
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<tr>
<td>11. O na le go buisana le molekane wa hao mabapi le thobalano e sireletsehileng?</td>
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<tr>
<td>• Le na le goi tshireletsa mo thobalanong ya long?</td>
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<tr>
<td>• Le sebedisa eng go e tshireletsa mo kgolagano le molekane/balekane ba gao?</td>
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<td>12. O itsing ka malwetsi a thobalano mo banna ba robalang le banna?</td>
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<td>13. Malwetsi a thobalano di tloaelehileng hara MSM kea mafeng?</td>
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<td>• Ke malwetsi a thobalano afeng a nkile wa nna le ona wena o le MSM?</td>
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<tr>
<td>• Na o ne wa batla keletso kapa thuso bakeng sa bolwetsi/malwetsi a thobalano?</td>
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<td>• O tsere nako e kanang pele o batla thuso?</td>
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<tr>
<td>• Pele o na le thuso, o sebedisitseng eng?</td>
<td></td>
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<tr>
<td>• O batlile thuso kae?</td>
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<tr>
<td>• Phihlelo ya gao ge o na le thuso, e ne e le yang?</td>
<td></td>
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<tr>
<td>• Na o ne wa itsiisi molekane oa hao ka wena go tshwara ke bolwetsi ba thobalano</td>
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<td>14. A O nkile wa botsa molekane wa gao ka maemo a gao mabapi le bolwetsi ba HIV?</td>
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<td>• Wena wa ba botsa ka maemo a bona mabapi le bolwetsi ba HIV?</td>
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<td>15. A ho bonolo go batla thuso ko kliniking?</td>
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<tr>
<td>• Ke hobane’ng ha seo se le byalo?</td>
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<td>16. Ke eng menahano ea hao ho MSM ba kenweng ke malwetsi a thobalano tse di tswanang le STIs tse tseneng basadi?</td>
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<td>• Ke hobane’ng ha seo se le byalo?</td>
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<td>18. Le sebedisa condom ha kanang?</td>
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<td>• Ho baneng le sa sebedise di condom ka nako tsohle?</td>
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<td>• Kemang a etsang queto ya go sebedisa condom?</td>
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<td>• O utwa yang go sebedisa condom for oral sex?</td>
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<td>• Ntle le ho sebedisa ha condom, le sebedisa ditsela tse feng ge o robalana?</td>
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<td>• Ke eng se se thibellang go sebedisa condom ka nako tsohle?</td>
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<td>• Ntle le ho sebedisa ha condom, le sebedisa ditsela tse feng bakeng sa ho itšireletsa ho tšhwara ke bolwetsi ba thobalano?</td>
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<td>21. O na le se sengwe se ke sa se botsang o batla go mpotsa sona?</td>
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ANNEXURE B1: INFORMED CONSENT FORM

A QUALITATIVE EXPLORATION OF THE SEXUAL CHOICES, PRACTICES, AND RISKS OF MEN WHO HAVE SEX WITH MEN IN THE AREA NORTH WEST OF PRETORIA- SUB-STUDY

We are also asking our participants questions on sexual relationships and sexual behaviours of MSM. Even though you have agreed to participate in the first part of the study, we have to ensure your interest in participating in this second part of the study. Together with the information that we have collected for part 1, the discussions we will be having will be used to support and confirm the finding in part 1 and will also give the researchers an understanding of HVP and other conditions that occur among MSM. If you are willing to participate, you need to know that we will need 30 minutes of your time to and the interviewer will request that the interview be recorded using an audio-recorder.

Also note that the results of this study will be disseminated through publications and conference presentations. At no stage will the identity of any participant be exposed at any stage. Only the findings will be made public. Your confidentiality is assured. To this end, this study is approved by the ethics committee of the SMU whose chairperson can be contacted at this number 012 529 4314 (Prof G Ogunbanjo) should you have any complaints about how the study is conducted.

You also consent that your samples may be stored for further testing later under the same conditions of anonymity:

- Yes
- No

In signing this document you agree to participate and fully understand what it will involve to be part of this study.
ANNEXURE C1: CLEARANCE CERTIFICATE: SMU

Sefako Makgatho Health Sciences University
Research & Postgraduate Studies Directorate
Sefako Makgatho University Research Ethics Committee
(SMUREC)

Molotegi Street, Ga-Rankuwa 0208
Tel: (012) 521 5617/3698 | fax: (012) 521 3749
Email: lorato.phiri@smu.ac.za
P.O. Box 163 Medunsa 0204

02 June 2016
Prof MM Makgatle
Department of Public Health
P.O Box 215
Medunsa, 0204

MEETING:  05/2016

SMUREC Ethics Reference Number: SMUREC/1/2016: IR

The New Application received on 17 May 2016 was reviewed by members of Sefako Makgatho University Research Ethics Committee 02 June 2016 and was approved on 02 June 2016.

Title: A qualitative exploration of the sexual choices, practices, and risks of men who have sex with men in the area North West of Pretoria

Researcher: Prof MM Makgatle
Co-workers: Prof M Ncibela (McCle)
Department: Public Health
School: Health Care Sciences
Research Type: Independent Research

Please note the following information about your approved research protocol:

Protocol Approval Period: 02 June 2016 – 02 June 2017

Please remember to use your protocol number (SMUREC/1/2016: IR) on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modification, or monitor the conduct of your research and the consent process.

After Ethical Review: Please note a template of the progress report is obtainable in the Research Office and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit. Translation of the consent document in the language applicable to the study participants should be submitted.

International Organisation (IORG00008691), Institutional Review Board (IRB0000010386) Expiry date: 09 December 2018, Federal Wide Assurance (FWA000023943) Expiry date: 31 August 2017 and NNREC No: REC 210408-003

Sincerely,

PROF GA OGUNBALO
CHAIRPERSON SMUREC

Date: 02.06.2016

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# Annexure D1: Code Book

## A Qualitative Exploration of the Sexual Choices, Practices, and Risks of Men Who Have Sex with Men in the Area North West of Pretoria

### Categories and Codes

#### Types of sexual relationships
- **Single but having casual sex**
- **Bisexual**
- **Multiple sexual relationship**
- **Gay**
- **Transactional sexual relationship**
  - Experienced transactional sex
  - Have not experienced transactional sex
  - Type of encounter
  - Frequency of transactional sex
  - Place of encounter

#### Context of sexual relationship
 References by the participant to how they feel attracted to potential and existing partners. This will include being horny, having a crush, wanting him, catch him, need sex, being attracted to men, have feelings for men.

#### Disclosure of MSM status
- **Telling**
- **Not telling**
 References by the participant to not telling or telling people of sexual orientation, secret relationship, family knowing or not knowing of being MSM. This will include in the closet, not telling, keeping relationship secret.

#### HIV testing
- **Testing**
- **Not testing**
- **Afraid to test**
 References by the participant to being scared to testing. Fear of testing, non-testing, testing. This will include afraid to test, don’t test, testing.

#### Relationship dynamics
- **Partner sharing**
- **Partner exchanging**
- **Cheating**
- **Hiding information from partner**
- **Friends with benefit**
 References by the participant to exchanging, cheating and sharing sexual partners, helping each other, friends with benefits, lying to partner, hiding information from partner. This will include cheating, lying to partner, exchanging partners, leaving each, moving easily from one partner to the next.

#### Reaction of family, relatives, community to disclosure of being MSM
- **Acceptance**
- **Non acceptance**
- **Denial**
- **Contemplating to accept**
- **Confrontational Indifference**
 All references by participant on family, community and friends reaction to being MSM. This include family or relatives acceptance, slow to accept, pretentious, not accepting, doesn’t care, in denial of MSM, anger.

<table>
<thead>
<tr>
<th>Categories and Codes</th>
<th>Definition of Codes</th>
<th>Inclusion and Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of sexual relationships</td>
<td>References by the participant to kind of relationship they are in, have been in.</td>
<td>This will include single but having casual sex, bisexual, casual, flings, multiple sexual relationship, gay, homosexual, transactional relationship, open relationship.</td>
</tr>
<tr>
<td>Context of sexual relationship</td>
<td>References by the participant to how they feel attracted to potential and existing partners.</td>
<td>This will include being horny, having a crush, wanting him, catch him, need sex, being attracted to men, have feelings for men.</td>
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<tr>
<td>Disclosure of MSM status</td>
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<td>This will include cheating, lying to partner, exchanging partners, leaving each, moving easily from one partner to the next.</td>
</tr>
<tr>
<td>Reaction of family, relatives, community to disclosure of being MSM</td>
<td>All references by participant on family, community and friends reaction to being MSM.</td>
<td>This include family or relatives acceptance, slow to accept, pretentious, not accepting, doesn’t care, in denial of MSM, anger.</td>
</tr>
<tr>
<td>Safe sex practices</td>
<td>References by participant on using addition protective methods beside condoms add lubricants and any other safety methods.</td>
<td>This includes lubricant and other products such as condoms.</td>
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<td>--------------------</td>
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<td>-------------------------------------------------------</td>
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<tr>
<td>Condom-use</td>
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<tr>
<td>- consistent</td>
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<tr>
<td>- non-consistent</td>
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<tr>
<td>- for oral sex</td>
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<tr>
<td>Non-condom use</td>
<td></td>
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<tr>
<td>- for oral sex</td>
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<tr>
<td>Non-Lubricant</td>
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<tr>
<td>Lubricant</td>
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<tr>
<td>Knowing of STIs</td>
<td>All reference of participant on STIs, whether it is naming, or experience or acquisition of STIs.</td>
<td>This will include naming of common STIs, knowing of transmission of STI, female STI, acquisition of STI</td>
</tr>
<tr>
<td>Names of STIs</td>
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<tr>
<td>Lack of knowledge of STIs</td>
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<tr>
<td>Female STIs</td>
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<tr>
<td>- Knowing of female STIs</td>
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<tr>
<td>- Not knowing of female STIs</td>
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<tr>
<td>Knowing STIs risks</td>
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<tr>
<td>Acquisition of STI</td>
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<tr>
<td>STI notification</td>
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<tr>
<td>Sexual experience</td>
<td>All references by participant on sexual experience of anal sex, pain, enjoyment during sex, experimenting, all challenges when starting to have sex.</td>
<td>This include painful, uncomfortable, anal sex, penetration analy, challenges when starting to have sex, oral sex</td>
</tr>
<tr>
<td>Pain</td>
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<tr>
<td>Pleasure</td>
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<td>Discomfort</td>
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<tr>
<td>Challenges when starting to have sex</td>
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<tr>
<td>Sexual behaviour</td>
<td>All references by the participant on no of partners, changing partners, frequency of changing partners.</td>
<td>This will include busy floating, mention of no of partners, changing parting, sleeping around</td>
</tr>
<tr>
<td>No of partners</td>
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<tr>
<td>Changing partners</td>
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<tr>
<td>Sexual role</td>
<td>All reference by participant in terms being penetrated or not, sexual role.</td>
<td>This will include top, bottom, versatile, being penetrated, or penetrating</td>
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<tr>
<td>Being penetrated</td>
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<tr>
<td>Penetrating</td>
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<tr>
<td>Doing both</td>
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<tr>
<td>Disclosure of HIV status</td>
<td>All references by participant on telling partner of HIV status with non-disclosure.</td>
<td>This will include telling or not telling partner of HIV status, reasons why for telling or not telling</td>
</tr>
<tr>
<td>Telling</td>
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<td>Not telling</td>
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<td>Reasons for telling or</td>
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<tr>
<td>Reasons for not telling</td>
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<tr>
<td>Health seeking behaviour</td>
<td>Reference by the participant going to clinic for consultation, protective behaviour, denialism of partner, Partner refusal of healthcare Not going to the clinic, not accepting that they are sick, Dealing with a sick partner, encounter with health professionals</td>
<td>This will include going to clinic, receiving treatment, reaction of health professionals</td>
</tr>
<tr>
<td>Accessing health care - easy</td>
<td></td>
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<tr>
<td>- not easy</td>
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<tr>
<td>Delaying access of health care</td>
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<tr>
<td>Dealing with an STIs</td>
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<tr>
<td>Violence</td>
<td>References by the participant on any violence whether sexual violence of physical violence</td>
<td>This will include physical violence and sexual violence</td>
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<tr>
<td>Experienced sexual violence</td>
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<tr>
<td>Not experienced sexual violence</td>
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<tr>
<td>Physical violence</td>
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</tbody>
</table>