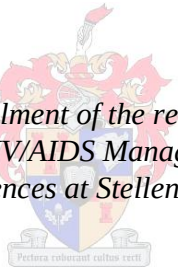
The Impact of Social and Internalized Stigma on HIV Risk Among Men Who Have Sex With Men In Lesotho

by Charles R. Miller



Assignment presented in fulfilment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management) in the Faculty of Management Sciences at Stellenbosch University

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DECLARATION

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ABSTRACT

As the HIV epidemic moves well into its third decade, developing countries like Lesotho are still struggling to come to terms with the effect of this pandemic. At 23.3%, Lesotho is third from the top of an infamous list of countries with the highest HIV prevalence rates. While many gains have been made in this tiny kingdom, multiple concurrent partnerships continue to drive the epidemic and stigma and discrimination exacerbates low levels of knowledge.

This study was undertaken to seek clarity on the challenges of men who have sex with men in Lesotho and how stigma and discrimination might increase HIV risk for an already vulnerable population.

Quantitative data was collected from fifty-one men who self-reported having had sex with at least one other man in the last twelve months via a 47-item questionnaire. Further qualitative data was collected from 16 of these men in semi-structured interviews which sought additional information on HIV knowledge, stigma, discrimination, and HIV risk.

Findings revealed that 82% of men reported multiple concurrent partnerships in the last twelve months, and 33% of men reported those multiple concurrent partnerships included sexual relationships with women. Forty-two percent of men reported sporadic use of condoms when having sex with men and of those men who reported sexual activity with women in the last year, 28% reported only using condoms sometimes or never.

Stigma and discrimination exacerbates an already delicate situation where 52% of men surveyed report knowing Basotho who have spoken derogatorily of men who have sex with men. The same percentage of men also reported knowing someone who had experienced physical abuse due to sexuality. Almost 50% of men reported possible plans to marry a woman in the future and 56% of these men reported doing so in order to meet familial expectations and traditional demands of manhood. Some participants were not aware of the HIV risk involved with unprotected sex between two men and interview participants echoed the need for including this and other information in more comprehensive HIV-knowledge and prevention campaigns which include men who have sex with men.

OPSOMMING

Ontwikkelende lande soos Lesotho probeer nog steeds om die MIV/Vigs-pandemie onder beheer te kry. Lesotho het tans die derde hoogste voorkoms van MIV in die Wêreld en ondanks alle pogings, word die pandemie nog steeds gedryf deur veral meervoudige, gelyktydige verhoudings.

Hierdie studie is gedoen om meer insig en begrip te kry van die uitdagings wat gebied word deur mans-wat-seks –het met-mans en om aan te toon hoe stigma en diskriminasie veral hierdie kwesbare groepe nadelig beïnvloed.

Kwantitatiwe data is verkry van 51 mans wat aangedui het dat hulle seks het met ander mans. Inligting is ingesamel deur middel van ‘n 47-item vraelys en onderhoude is met ‘n verdere 16 mans gevoer.

Ongeveer 82% van die mans het aangetoon dat hulle wel seks met and mans gehad het in die afgelope 12 maande en 33% van hierdie mans het aangedui dat hulle gedurende hierdie tydperk ook gelyktydige seks met vrouens gehad het. Bykans die helfte van die mans het aangetoon dat hulle kondome slegs sporadies gebruik wanneer hulle seks met ander mans het.

Stigma en diskriminasie is baie hoog onder Basoeto mans wat seks het met ander mans. Homoseksualiteit is steeds taboe in Lesotho en dit is nie ongewoon vir hierdie mans om soms selfs fisies aangerand toe word nie.

Hierdie studie geen ‘n seldsame insig in die Wêreld van mans-wat-seks-het –met mans en maak ‘n besondere bydrae tot ‘n beter begrip van hierdie grootliks vergete kwesbare groep binne die groter strewe van die bekamping van die verspreiding van MIV/Vigs in sub-Sahara Afrika.

ACKNOWLEDGEMENTS

The bravery and courage of the sexual minorities in Lesotho inspire me. This research study would not have been possible were it not for those participants who shared their stories and experiences.

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Many thanks also go out to Professor Augustyn and the staff of the Africa Centre for HIV/AIDS without whose assistance and support none of this would be possible.

A final word of appreciation goes out to Prince Shema, my family, and many friends and colleagues who assisted and helped to support me throughout this endeavor.

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CHAPTER 1: Introduction

The HIV/AIDS pandemic is now in its third decade, yet the fight to overcome this disease for which there is no cure rages on. Although significant gains have been made in the prevention, care and treatment of HIV and AIDS, many of the challenges to HIV prevention are deeply rooted in culture, (Tuju, 2005) which greatly influences our behaviors, as well as our attitudes and beliefs. (UNAIDS; UNESCO, 2002) Where else is this felt so much as on the African continent where 23.5 million people were living with HIV in 2011 – 70% of the world total? While HIV incidence continues to decline, the majority of new HIV cases are found in sub-Saharan Africa. (UNAIDS, 2012)

With a prevalence rate of 23.3% according to UNAIDS, the HIV epidemic in Lesotho is among the worst in the world (UNAIDS, 2011). While there are many factors influencing these high rates, one of the greatest contributors to Lesotho's exorbitant rate is the practice of maintaining multiple, concurrent partnerships (MCPs). Although this practice is as old as the Basotho's first leader, King Moshoeshoe, MCPs are still a reality in many African countries and beyond.

In Lesotho and many other parts of Africa, it is widely accepted that men will engage in sexual activities with several women concurrently. The number of female partners an African man has helps to demonstrate how masculine he is; hence loyalty to one partner could be interpreted as weakness. (UNDP, 1999 in Ateka, 2001) Swazi culture enables the practice of multiple, concurrent partnerships for men, going so far as to have a local word, which reflects positively on this practice among men. (Sithole, 2001) In Latin America, having sex with women is an important step in the path to manhood. (Munoz-Laboy & Dodge, 2007)

The majority of these multiple, concurrent partnerships occur between members of the opposite sex, for which there are a host of HIV prevention messages. There exists, however, a silent minority who maintain multiple, concurrent partnerships with members of both sexes, and sacrifice personal preferences to accommodate African tradition.

In Africa, the majority of gays and lesbians keep their sexual preferences a secret for fear of persecution. While South Africa has one of the most inclusive constitutions for gays and lesbians, homophobia exists. In some South African townships, corrective rape of lesbians by ruthless gangs is a real threat and forces many to flee to urban centers, leaving jobs, families, and

other support systems in their wake. In West Africa, the President of The Gambia has publicly stated that gays in his country would regret being born. On the eastern side of the continent, Uganda is one of the least tolerant countries in the world when it comes to human rights for gay and lesbian individuals. The "*Kill the Gays*" bill, currently sponsored by Member of Parliament David Bahati proposes the imprisonment of gay and lesbian "first-time offenders" and the death penalty for "repeat offenders." Even heterosexual individuals who know of but do not report known or suspected homosexuals to authorities risk imprisonment in Uganda. (Wasswa, 2013)

Uganda is just one of dozens of countries in Africa where homosexuality is illegal. According to the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGBTIA), there are only 11 African nations where homosexuality is legal. (International Lesbian, Gay, Bisexual, Trans and Intersex Association, 2013) The fear and loathing of homosexuality in Africa, which is fueled in the name of religion fans the flames of fear and ignorance. Persecution of homosexuals is the largest universal human rights issue that has yet to be addressed and it is no wonder that many gay and lesbian Africans remain in the closet, choosing to live double lives, or worse, sacrificing personal desires for the sake of culture and tradition, or just simply to be safe.

Unfortunately denial and persecution of homosexuality in Africa fuels social and internal stigma, and increases the risk of HIV. (Rose-Innes, 2006 (updated 2009)) In Lesotho and other African countries where homosexuality is illegal, HIV prevention messages address sexual risks only between members of the opposite sex, compounding the problem of social and internal stigma towards intimacy between members of the same sex. As a result of stigma towards homosexuality in Lesotho, many choose to live double lives by maintaining MCPs with members of both sexes, thereby increasing the risk of contracting and transmitting HIV and other sexually transmitted infections indiscriminately. One study found that men who feel marginalized because of their secret identities will take greater risks to fit into what they understand as the cultural norm. (Munoz-Laboy & Dodge, 2007) Another study, and presumably the first and only other study focusing on the sexual health needs of sexual minorities in Lesotho found low levels of HIV knowledge and high-risk sexual practices. (Baral, 2010).

HIV first presented itself in the early '80s when several gay men reported to hospitals with similar lung infections. Doctors and scientists originally referred to the illness as a form of "gay cancer" but quickly changed their tunes when the same illness began showing up in other

segments of the population, including women and children. As we came to understand that there were several ways HIV could be transmitted, the exchange of bodily fluids through sexual activity was the predominant route of transmission of the virus. Those original HIV prevention tactics were challenged as HIV spread from the USA to other parts of the world, where labels like “gay” and “lesbian” were narrow definitions or became obsolete considering the sexual partner of a person doesn’t necessarily define the person. New terminology was identified which was much more inclusive of cultural and social contexts, and the terms “men who have sex with men,” (MSM) and “women who have sex with women” (WSW) were born. For the purpose of this research the term “MSM” or “men who have sex with men” will be used unless otherwise noted.

CHAPTER 2: Literature Review

2.1 Cultural Barriers

Discussions about sex and sexuality are taboo in Lesotho, which complicates an already delicate situation given that the HIV pandemic feeds off this conservatism and the lack of education around prevention. According to Populations Services International, an organization working on the social marketing of condoms, many Basotho would rather support HIV positive people than talk to them about safe sex as a means of HIV prevention (Population Services International - Lesotho, 2012). Many HIV/AIDS education programs are not as effective as they could be because of the difficulty in discussing culturally-taboo subjects. (UNAIDS; UNESCO, 2002)

According to Asthana, an African man's success was defined by how many women he could sleep with, and the more powerful you became, the more wives and children you should have (Asthana, 2005). As in India, (Thomas, Mimiaga, Mayer, Perry, Swaminathan, & Safren, 2013) cultural expectations of the Basotho are that each man will marry a woman, placing future female partners at an increased risk of acquiring HIV. Not surprisingly, men who choose to follow a path that differs from this traditional expectation are often shunned from society. Men in this predicament have two logical choices: 1) Stay true to their identity without regard to traditional expectations and risk becoming a social outcast; or 2) lead a double life which puts them at an increased risk of acquiring and/or transmitting HIV and other sexually transmitted infections. Either way, there is risk involved for men in developing countries who do not fit the traditional expectations of what a man should be. (Thomas, Mimiaga, Mayer, Perry, Swaminathan, & Safren, 2013) Twenty-seven percent of Basotho women are HIV positive, compared to 18% of men, providing more justification that Lesotho employ a comprehensive HIV-prevention campaign aimed at all risk factors, not only those that impact opposite sex relationships. (Lesotho Ministry of Health and Social Welfare, 2009)

In the USA, 2013 will go down in history as the year gay rights made the greatest gains. Not since the Stonewall riots of the late '60's has a human rights movement made such progress in a relatively short time. In April 2013, the US Supreme Court heard two cases regarding the legality of gay marriage and access to federal benefits for same-sex married couples, respectively, and by June, gay marriage was legalized in select states and recognized by the federal government. Public support of gay marriage for same sex couples continues to increase and as of April 2013,

more than half of the US Senate supported the right to marry for same-sex couples, as opposed to a fraction just two years earlier. Gay rights groups remain hopeful that US President Obama will sign into law legislation that makes it illegal to discriminate against an employee based on sexual preference. Unfortunately, it is a different story in Africa.

2.2 Social Stigma and HIV Risk

Traditional leaders in Africa have long been charged with ensuring African society follow a moral compass. The Lesotho Times, one of the leading newspapers in Lesotho reported in May 2012 about Zimbabwean traditional leaders expelling gay Zimbabweans after seizing their land, thus it is no wonder many African men and women uncertain about their sexuality would keep their secret from even those closest to them (Africa Review, 2012).

In the same month, another popular newspaper questioned whether homosexuals should be made straight, quoting a variety of sources including the Catholic Church. While Mr. Badges seems to suggest that society tolerate sexual minorities, his last paragraph raises the question whether gays are more likely to molest children (Badges, 2012).

Men who have sex with men are at an increased risk of transmitting or acquiring HIV because of social stigma and discrimination (Centers for Disease Control, 2013). Muñoz-Laboy and Dodge found that Latino men who have sex with both men and women in the USA are at a significantly higher risk of HIV than are men who have sex solely with men or women. (Munoz-Laboy & Dodge, 2007)

Regardless of human rights advances for gay men in the US, HIV prevalence among African American men has started to increase, due in part to a resurgence of risky sexual practices because of the availability of life-prolonging anti-retroviral drugs. A phenomenon common in some circles is men on the “down low” where men live double lives, marrying women to meet cultural or familial expectations while maintaining sexual relations with other men concurrently. This subculture is not new and effectively connects HIV risks normally associated with gay men to heterosexual women (Centers for Disease Control, 2006). Although stigma and discrimination against gays and lesbians in the USA still exists, comprehensive HIV prevention programs aimed at eliminating all transmission routes has helped to bring the HIV pandemic in the USA under control.

Echoes of these challenges and successes exist in Australia. According to Dowsett, while Australia has one of the lowest HIV prevalence rates in the world, more than 85% of HIV cases are among male homosexuals (Dowsett, 2003). Australia has some of the most progressive and gay-friendly health policies and programs however homophobia exists and threatens the safety and security of those unwilling to hide their sexual identities. While the "land down-under" celebrates gay and lesbian pride events, culture and tradition influences much of the homophobia that exists.

UNAIDS indicates that 50% of those that are HIV infected are unaware of their HIV-positive status (UNAIDS, 2012). Unfortunately, the Chinese Centers for Disease Control and Prevention conducted a study which revealed that 80% of Chinese gay men are unaware of their risk to HIV and are among the most vulnerable in the most populous country in the world. Complicating this problem is the fact that 12% are married to women and another 17% also have sex with women. This is largely a result of failing to take a comprehensive approach to HIV prevention and the absence of health services uniquely positioned to meet the needs of this minority. (News Guangdong, 2004)

2.3 Internalized Stigma

Stigma is a by-product of culture and creates an environment of self-loathing among those who fall outside the traditional norms of society and impacts one's self esteem and self worth. Social stigma is a predictor of internalized stigma, which can preclude positive health-seeking behavior among sexual minority populations. (Thomas, Mimiaga, Mayer, Perry, Swaminathan, & Safren, 2013) For men who fall outside of the traditional definitions of masculinity, demeaning terms are often assigned or assumed. (Niang, et al., 2003) Self-deprecation may lead to alcohol or drug abuse, both of which affect good decision-making, leading possibly to increased exposure to HIV and other sexually transmitted infections. (Niang, et al., 2003) When these men are engaged in multiple, concurrent partnerships with men and women the possibility of an explosion of HIV within a community increases exponentially.

Lesotho's population of 1.8 million, of which 25% live in urban areas, creates an environment where men who prefer to have sex with other men must meet very discreetly. Social media websites in Lesotho are used for much more than professional networking. Social stigma associated with same sex relationships leads many men to search social media websites looking

for sex partners, increasing exposure to HIV and violence. (Garofalo, Herrick, Mustanski, & Donenberg, 2007) Niang Et al. found that almost half of the Senegalese men interviewed in their study had been sexually assaulted at least once (Niang, et al., 2003). Lack of access to healthcare, condoms and lubricants, as well as insensitive health care workers are all barriers to healthy living faced by men who have sex with men. (Niang, et al., 2003)

Men who have sex with other men are likely to exhibit psychological distress, due to social or internalized stigma, which may increase one's HIV risk if alcohol or drugs are used as coping mechanisms, both of which have detrimental effects on one's ability to make healthy decisions. (Thomas, Mimiaga, Mayer, Perry, Swaminathan, & Safren, 2013)

"The future direction of this pandemic depends on the level of knowledge of how the virus is spread and changes in sexual behavior." (Lesotho Ministry of Health and Social Welfare, 2009, p. 159) Unfortunately, the Ministry fails to back this statement up since there is only one mention of the risk of HIV transmission among men who have sex with men in their 2009 Demographic and Health Survey, and in the multitude of surveys and interviews conducted, not one question asked anything about knowledge, attitudes or beliefs about HIV risk and relationships between members of the same sex. Because of the relatively small network of men who have sex with men in Lesotho, an HIV-positive status of one person could have devastating consequences on the entire population, erasing significant gains made in the last decade.

Culture is dynamic and changing. Just as a person has it within himself to change his behavior, a society also has the ability to change attitudes and perceptions. Such an environment free of stigma and discrimination could have a tremendous impact on HIV prevention, treatment, care and support, not only for men who have sex with men, but for everyone. (Thomas, Mimiaga, Mayer, Perry, Swaminathan, & Safren, 2013)

CHAPTER 3: Research Methodology

3.1 Research Problem

In Lesotho, organizations working to address the stigma of HIV still cannot claim complete success as evidenced in the 2009 Lesotho Health and Demographic Survey (LDHS) which revealed an increase in the percentages of men and women who would want to keep secret a family member's HIV infection from 2004 to 2009. Unfortunately, social stigma attached to homosexuality also presents a problem with respect to HIV prevention, treatment, care and support. (Lesotho Ministry of Health and Social Welfare, 2009)

Most Basotho do not understand homosexuality and are taught to condemn it. Homophobia is a reality in Lesotho and the 2009 LDHS missed a promising opportunity to educate people about all HIV transmission routes while gathering critical data to help prevent new infections. HIV risk among men who have sex with men merited nothing more than a mention in the 2009 LDHS. (Lesotho Ministry of Health and Social Welfare, p. 159) Considering this, it is possible that social and internalized stigma towards homosexuality in Lesotho, where the HIV prevalence is already the third-highest in the world (UNAIDS, 2009), can exacerbate the HIV epidemic within the sexually-active adult population.

Basotho culture and tradition encourages the practice of maintaining multiple, concurrent sexual partnerships, which is also the main driver of the HIV epidemic in Lesotho. Compounding this problem is the reality that all HIV prevention messaging in Lesotho targets only sex between heterosexuals, which is understandable given the fact that most cases of HIV transmission occur between men and women. However, the lack of truly comprehensive HIV prevention messaging addressing all transmission routes, including sex between men may lead some to believe that HIV cannot be transmitted between members of the same sex. It is difficult to say if this is true because little research has been done in Lesotho in this area.

3.2 Research Question

How do social and internalized stigma towards men who have sex with men in Lesotho increase HIV risk?

3.3 Significance of Study

HIV is indiscriminate and it is only logical that strategies to prevent the spread of HIV also be indiscriminate. In addition to putting themselves at risk, men who have sex with men and women

in order to meet cultural expectations also put families and communities at risk, increasing the HIV pandemic exponentially. (Niang, et al., 2003)

HIV prevention messaging should not be compromised to accommodate traditions and views of yesteryear but should address all possible avenues for HIV transmission. It is believed that social stigma towards homosexuality contributes to internalized stigma among men who have sex with me. The outcome of this research will shed light on the issues of social and internalized stigma and help ascertain if there is a link between social and internalized stigma among men who have sex with men and HIV risk in Lesotho. Further insight into social and internalized stigma could help to influence HIV prevention messaging and better target all forms of HIV risk among sexually active adults.

With HIV prevalence at 23.3% (UNAIDS, 2009), it is imperative that Lesotho and other African countries with exorbitantly high HIV rates take a comprehensive approach to HIV prevention, particularly in countries where the main driver of the HIV epidemic is multiple, concurrent partnerships. The main beneficiaries of this research were men who have sex with men in Lesotho, as they were the primary target population. The benefits could include decreased internalized stigma among the target population, and a potential decrease in risky sexual practices among the MSM community in Lesotho as a result of comprehensive HIV prevention messaging. Since these men who have sex with men will have an increase in knowledge of HIV risk and prevention, it is hoped that they would take necessary precautions to minimize the spread of HIV with all sexual partners, thus secondary beneficiaries would also include female sexual partners of these men.

3.4 Aim and Objectives

It was the aim of this research to establish how social and internalized stigma toward men who have sex with men in Lesotho increases HIV risk, in order to reduce the incidence of HIV in the adult population. The five objectives of this study included the following:

Objective 1: To identify the risky behaviours among men who have sex with men in Lesotho;

Objective 2: To identify types of social stigma that influences risky behaviour among men who have sex with men in Lesotho;

Objective 3: To identify types of internalized stigma present in the MSM population;

Objective 4: To establish links between internalized stigma, social stigma and risky behaviour;

Objective 5: To provide action steps for decreasing risky behavior as a result of internalized and social stigma among the MSM population in Lesotho.

3.5 Research Design and Methodology

This research was comprised of both quantitative and qualitative data collection approaches, via survey and content analysis of transcriptions of semi-structured interviews of men who have sex with men in Lesotho.

Objective 1: To identify the risky behaviours among the MSM population in Lesotho, using a combination of convenience sampling and snowball sampling methods. Information sought focused on risky behaviours of a minimum of 50 Basotho men, who speak English and who self-reported having had sex with men within the last year.

Objective 2: To identify types of social stigma that influences risky behavior among men who have sex with men in Lesotho, again using a combination of convenience and snowball sampling methods. This objective sought to identify types of social stigma and discrimination among a minimum of 50 Basotho men who speak English and who had had sex with men within the last year.

Objective 3: To identify types of internalized stigma present in the MSM population in Lesotho. Using a combination of convenience and snowball sampling methods, this objective aimed to identify types of internalized stigma among a minimum of 50 Basotho men who speak English and who reporting having had sex with at least one other man within the last year.

Objective 4: To establish a link between social and internalized stigma and risky behaviour. Utilizing information collected through quantitative (survey) and qualitative data collection methods, this objective sought to identify and establish links between social and internalized stigma and risky behaviours by men who speak English and who reported having had sex with another man in the last year.

Objective 5: To provide action steps for decreasing risky behaviour as a result of internalized stigma among the MSM population in Lesotho. Considering the information gathered in

objectives one, two and three, this objective sought to identify and provide action steps for decreasing risky behavior as a result of social and internalized stigma among men who have sex with men.

3.6 Target Group

The target group for this research was Basotho men who speak English and who self-reported having had sex with at least one man within the last year. Because of the difficulty in identifying participants due to social stigma, participants were solicited through Matrix, a support and advocacy group for gays and lesbians in Lesotho. Matrix staff also helped to identify safe spaces where surveys and interviews were completed discreetly. Since one-fourth of the population in Lesotho live in urban areas, the primary urban center of Maseru, the capital city was targeted as a higher priority. The farthest data collection point was within Maseru District, approximately 25 minutes outside Maseru at the National University of Lesotho.

Utilizing a snowball sampling approach and the use of an informational flyer, Matrix staff and survey participants were asked to assist in identifying other willing participants to complete a survey questionnaire anonymously. Using a systematic sampling approach, approximately[1] every third participant was asked to participate in a semi-structured interview, immediately following completion of the questionnaire. The semi-structured interview provided more insight into attitudes of stigma and high-risk behaviours.

3.7 Sampling Method/Inclusion Criteria

Convenience sampling and snowball sampling were utilized, providing a minimum target of 50 participants for the quantitative part of the study, for which the primary objective was to collect information on the level and types of HIV risk present in the target population.

The qualitative research provided additional information on HIV risk and internalized stigma through semi-structured interviews, of which a minimum target of 15 men were asked to participate, through the use of a systematic sampling approach.

At the end of the data collection process, 51 men had completed the survey of which 50 men met the qualifications of a) must be from Lesotho; b) must be 18 years of age or older; c) must speak

[1] It was the aim of the researcher to interview every third participant however due to time constraints, some of the intended participants weren't available to, or chose not to be interviewed. In that case, the next available participant was interviewed.

English; and d) must have engaged in sex with another man within the last twelve months (self-reported). Two other participants expressed interest in completing the survey; however they did not meet the minimum age requirement and were not allowed to continue.

For the qualitative data collection, semi-structured interviews were conducted with sixteen men, all of which provided verbal permission for the interviews to be recorded. Interviews were recorded and transcribed by the principal researcher.

3.8 Data Collection

Quantitative data was collected via a survey from the target population using Likert-type scale response options to assist in measuring knowledge and attitudes of HIV, risk and stigma. Using a systematic sampling approach, every third participant was asked to participate in the qualitative data collection process using semi-structured interviews, immediately following the completion of the questionnaire. These interviews were recorded with the permission of each participant. Interview questions were designed to collect qualitative information about HIV risk and stigma, using information collected during the literature review.

Information gathered from both data collection processes helped to identify links between social and internalized stigma and risky behavior, for which action steps have been formulated and included in the chapter on recommendations which aims to decrease risky sexual behavior as a result of social and internal stigma.

3.9 Data Analysis

Following the data collection process, the information gathered from the surveys was entered into a Microsoft Excel spreadsheet and data analysis was completed by the principal researcher for which conclusions have been drawn and recommendations have been provided.

3.10 Ethical Considerations

In Africa, men who have sex with men are a silent minority, often maintaining relationships with women while secretly cavorting with men. Because of social stigma attached to homosexuality and bisexuality in Africa, most of these men are not open about their sexual relationships with other men. Although homosexuality is not aggressively prosecuted in Lesotho, same sex relations are not talked about openly. Homosexuality, bisexuality and men who have sex with men are stigmatized in Lesotho, thus it was critical that the anonymity of participants were a top

priority. Men who participated in the study did so anonymously, therefore it was critical that participants were given options as to where the data collection took place, including in a public place or in a private environment. Verbal rather than written consent was sought and obtained from each participant to reassure anonymity, with only numbers (*Participant 1, Participant 2, etc.*) being linked to the data collected. The principal researcher explained the consent form for which each participant provided consent by placing "X" on "name of participant" and the date of participation. In addition, participants who took part in the semi-structured interviews provided verbal consent to participate in the semi-structured interview and provided consent for the interview to be recorded.

Participants were each given ZAR 30.00 each to assist with travel costs for getting to and from the data collection venue and received information on referrals to sites for free anonymous HIV testing and free medical male circumcision for anyone interested. Participants were also provided with information on HIV prevention for men who have sex with men and referrals to locations where condoms and condom-compatible lubricants could be accessed for free.

CHAPTER 4: Findings and Discussion

Data was collected from December 16 to December 20, 2013, with 51 men completing a 47 item questionnaire. Additionally, 16 of those men participated in semi-structured interviews which were designed to collect information about knowledge about HIV, transmission routes and prevention; sexual practices and HIV risk; and finally, stigma and discrimination. Matrix Support Group staff, namely their MSM project coordinator assisted in identifying and mobilizing participants for the data collection.

Data collection took place in a variety of safe-space venues with participants and the Matrix MSM project coordinator identifying the spaces. The same questionnaire was used for all participants, which consisted of 47 questions, each with Likert-type responses.

A template was followed for the semi-structured interviews, which consisted of five sets of questions. Additional questions were posed to each participant depending on their responses. The average duration of the 16 interviews was 22 minutes per interview. Interviews were conducted in a private space with only the principal researcher and the participant being present. Interviews were recorded with the consent of each participant. The study was explained to each participant in English and in order to insure anonymity, consent was obtained from each participant with a simple "X" and the date on each consent form. Interview participants also provided verbal consent at the beginning of each interview to be interviewed, as well as consent for the interview to be recorded. Recordings were transcribed and analyzed by the principal researcher.[2]

What follows are the findings from the data collection process.

4.1 Participant Demographics

As indicated in Table 4:1, fifty-three Basotho turned out to participate in the research study however only fifty men qualified for the study. Two were under the age of 18 and thus were not allowed to complete the questionnaire. A third participant, who self-identified as MSM indicated that he had not had sex with another man within the last twelve months. His responses to the questionnaire are not included in the findings, nor were they included in qualitative data collection.

[2] To protect anonymity, names of participants were not collected; hence, participants have been cited by "Anonymous Participant # …."

All other respondents and participants[3] met the qualifications for participation in the study, which included:

a. Basotho male (male citizen of Lesotho)
b. Eighteen years of age or older
c. Speaks English
d. Self-identify as a man who has had sex with another man in the last twelve months

I am a male and my age is between:	Frequency	Qualified for study	Valid Percent[4]	Cumulative Percent
Under 18	2	0[5]	0.00	0.00
18 – 25 years	30	29[6]	58	58
26 – 30 years	17	17	34	92
31 – 40 years	3	3	6	98
41 years or above	1	1	2	100
TOTAL	53	50[7]		

Table 4:1 Ages of Respondents

Sexual Activity with Men

Forty-three respondents self-reported against question two in the survey as having had sex with at least one man within the last twelve months. Seven respondents reported negatively to this question however, each man indicated that he had, in fact, had sex with another man within the last 12 months during the consent phase of data collection. Several respondents sought clarification on this question, asking how to report if they had participated in sex with more than one man within the last twelve months. Each of their responses was cross-referenced with Question 16 (see Addendum B), "In the last year, I have had sex with:" where possible responses ranged from "Only one man;" to "I lost count." The responses of all seven men were either

[3] The term "respondent" is used to describe those that completed the questionnaire/survey while the term "participant" is used to describe those that participated in semi-structured interviews.

[4] Using qualified-participant total of 50
[5] No data was collected from potential participants under the age of 18.
[6] In spite of meeting the age requirement for the study, one participant indicated he had not sex with another man in the last twelve months and thus was excluded in data analysis.
[7] Using qualified-participant total of 50

"between 2 and 5 different men" or "I lost count." The responses from all seven of these respondents were included in the data analysis and summary except where otherwise noted.

Eighty-one percent of respondents indicated they have sex with men for enjoyment, however responses of the other 19% demonstrates that MSM activity extends beyond sexual desire, as shown in Figure 4:1. Two respondents provided dual answers, for money and enjoyment, and because that is what is expected and enjoyment, respectively.

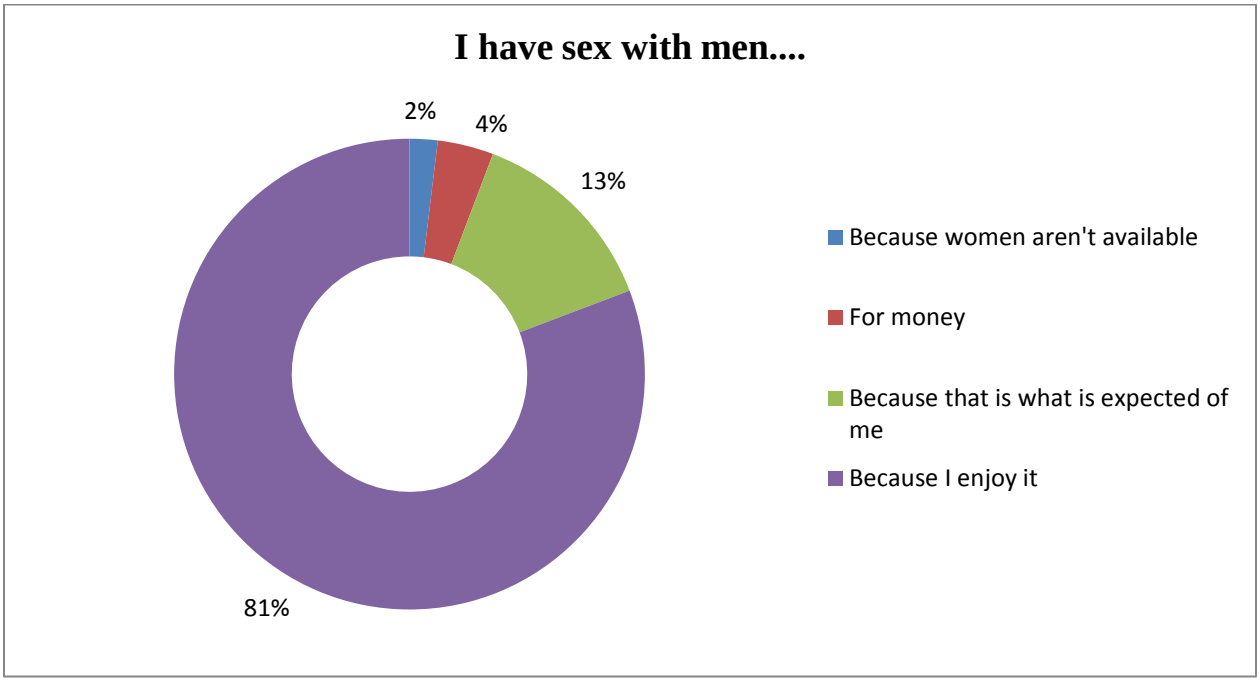


Figure 4:1 Reasons for MSM Activity

One could safely assume that the reasons behind male to male sexual activity would have a greater variation the farther away from capital, where sexual activity among herd boys and within mining camps are more likely to happen "because women aren't available," "because that is what is expected," or "for money."

Only 20% of respondents reported having had sex with only one man, while almost 1/3 of all men surveyed reported sexual activity with five or more different men in the last 12 months. (See Figure 4:2) One interview participant suggested that as many as 75% of all Basotho men had experienced sexual activity with another man. (12, 2013)

Figure 4:3 illustrates that 58% (n=28) of respondents indicated that they prefer to be the passive partner (to be penetrated, anally) when having sex with another man, either always or most of the time. One man provided dual responses ("most times" and "rarely") and was not included in data analysis for this question. Several respondents indicated that they prefer to be penetrated "always" or "most times" while also indicating that they engaged in sexual relations with women within the last year.

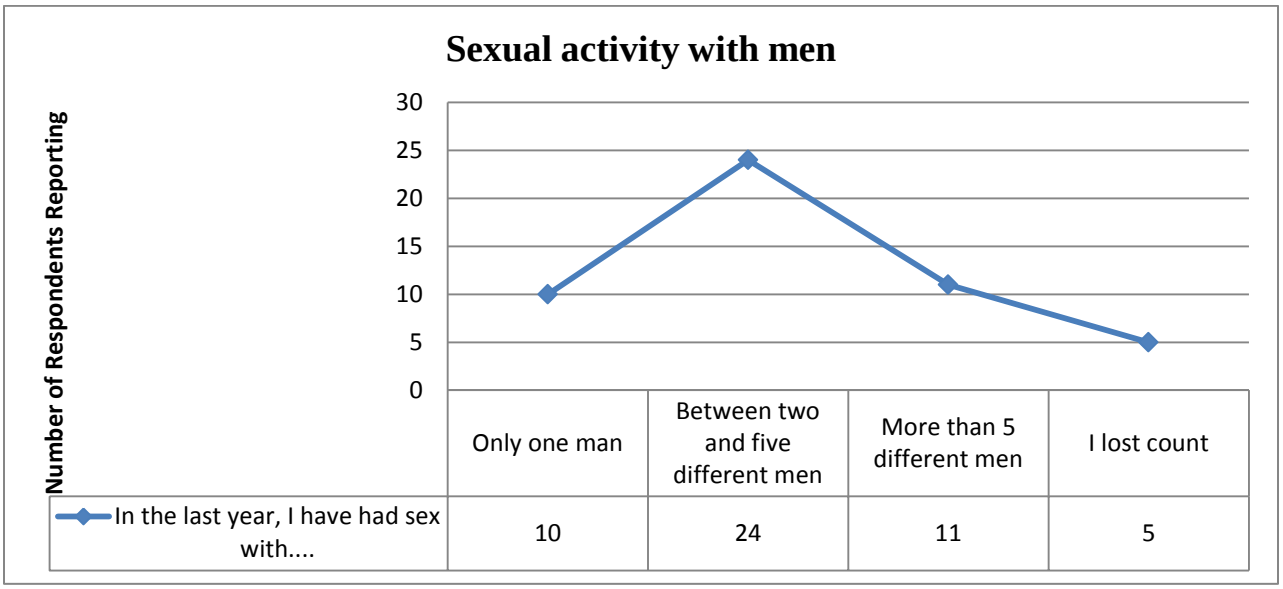


Figure 4:2 Self-Reported Sexual Encounters with Men

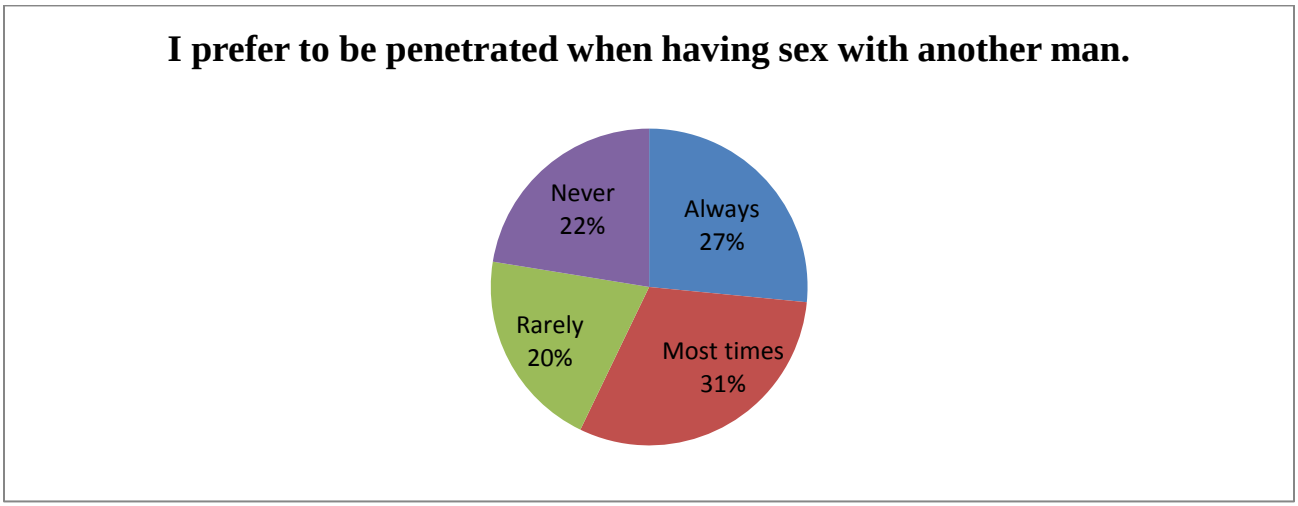


Figure 4:3 Sexual Roles with Men

One common discrepancy identified during the qualitative data collection process pertained to definitions surrounding sexual identity. Some participants drew a distinction between the terms "men who have sex with men" and "gay." Others took the two terms to be synonymous. Several participants used the term MSM to reference bisexuality. All participants seemed to focus on sexual desires to define sexual identity rather than on particular reasons behind sexual activity with men. Another common finding was the commonly held belief that men who identified as gay based on their sexual desires were born that way and could not change their sexuality.

Sexual Activity with Women

One third of all respondents (n=17) indicated they had participated in sexual activity with at least one woman within the last twelve months. (See Figure 4:4) Data triangulation with Question 15 (see Addendum B) indicates that 53% of those responding in the affirmative (having had sex with a woman in the last twelve months) reported sex with only one woman, while 29% and 18% of respondents reported having had sex with between two and five women, and more than five different women, respectively. (See Figure 4:6)

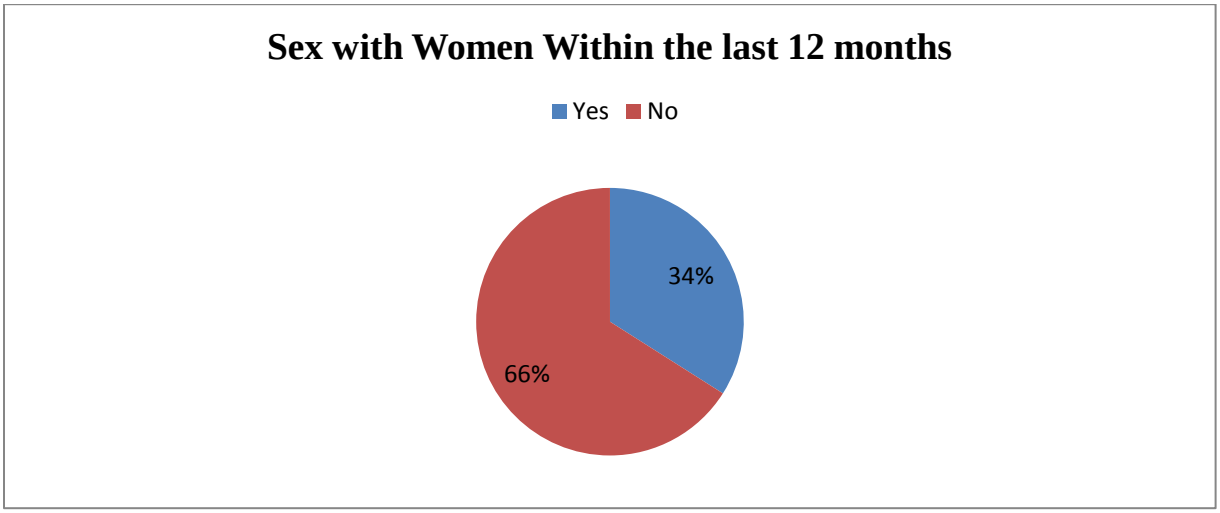


Figure 4:4 Sexual Activity with Women

Further triangulation of data indicates that these 17 men reported having sex with women for enjoyment (n=11), because that is what is expected (n=7), and for other reasons (n=1). (See Figure 4:5) The respondent who reported "other" volunteered that he had had sex with a woman "because I was drunk and she insisted we had sex." (43, 2013)

Echoing this sentiment, several interview participants explained that they have sexual activity with women to meet traditional expectations for manhood. (49, 2013) (40, 2013) (38, 2013) (33, 2013) (32, 2013) (21, 2013) Two men reported that they were currently married to women yet maintained concurrent sexual relationships with men. One of those same participants indicated that he had sex with his wife for the sole purpose of producing a child, not for enjoyment.

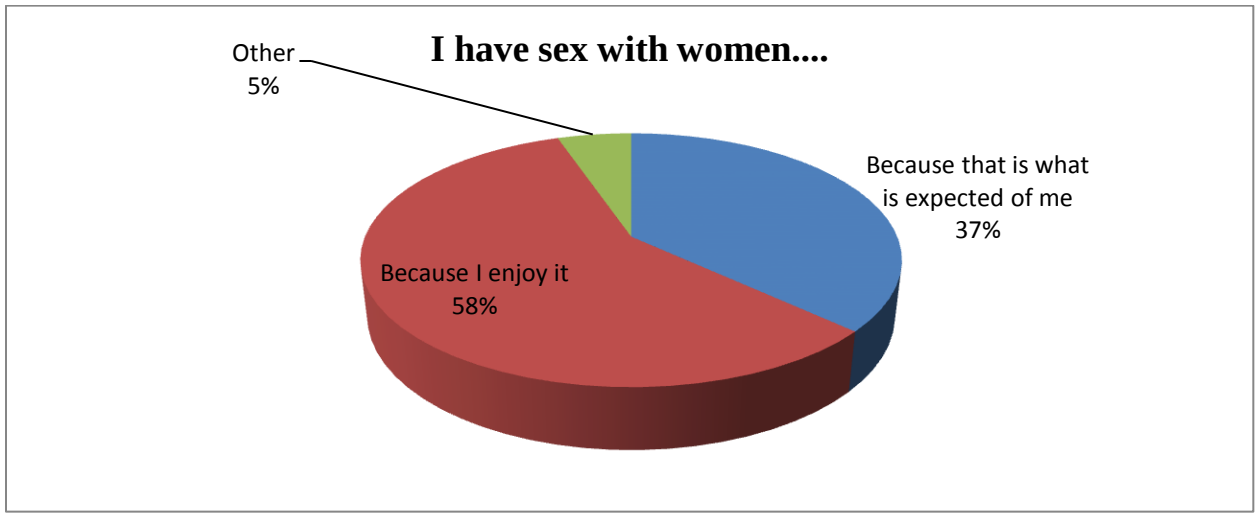


Figure 4:5 Reasons for Sex with Women

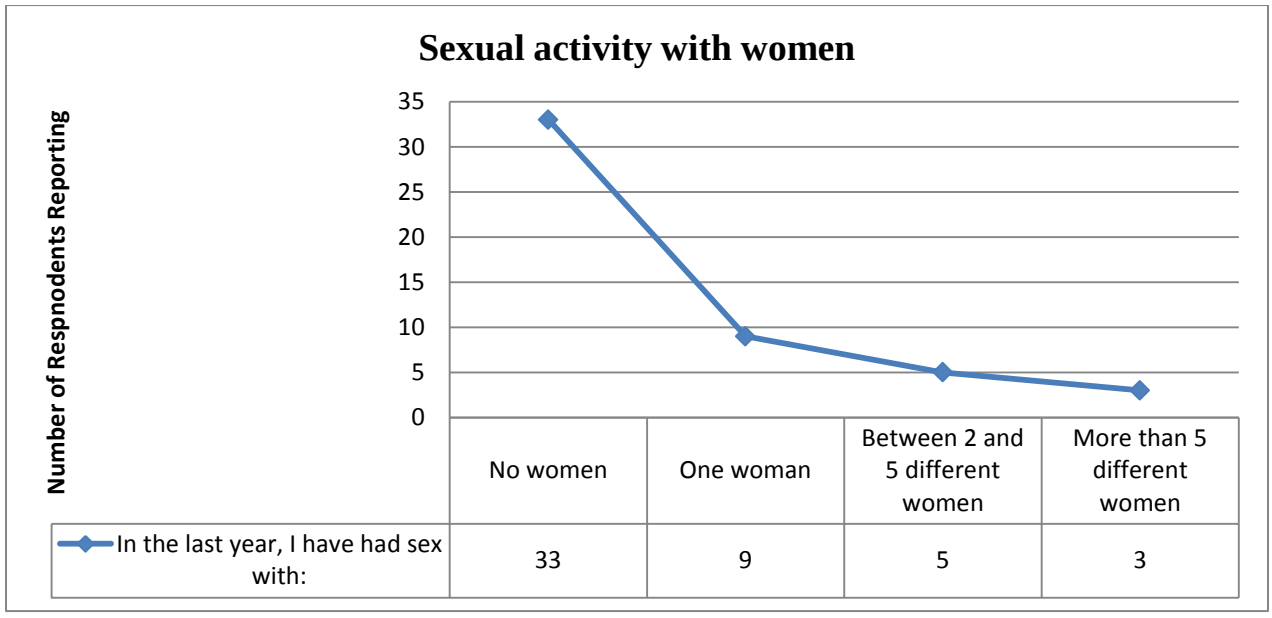


Figure 4:6 Self-Reported Frequency of Sexual Encounters with Women

4.2 Participant Knowledge

Respondents' knowledge was self-reported in the areas of HIV, HIV prevention (condom use), and medical male circumcision.

HIV Knowledge and Prevention

Although 88% of respondents claimed to know three ways of preventing the spread of HIV (see Figure 4:7), only 37% of interview participants (6 out of 16) could explain three ways HIV is transmitted or prevented. Only one participant mentioned breastfeeding and mother-to-child transmission of HIV as possible transmission routes; just 2 participants listed abstinence as a way of preventing the spread of HIV; and only 2 participants (n=16) mentioned faithfulness as a way to minimize HIV transmission. One participant explained that knowing one's status helped to prevent the spread of HIV. Although all participants said that condom use could help prevent the spread of HIV, one participant admitted that he wasn't sure he was using a condom correctly. Several participants articulated the need for further HIV prevention education aimed at the sexual health needs of the MSM community.

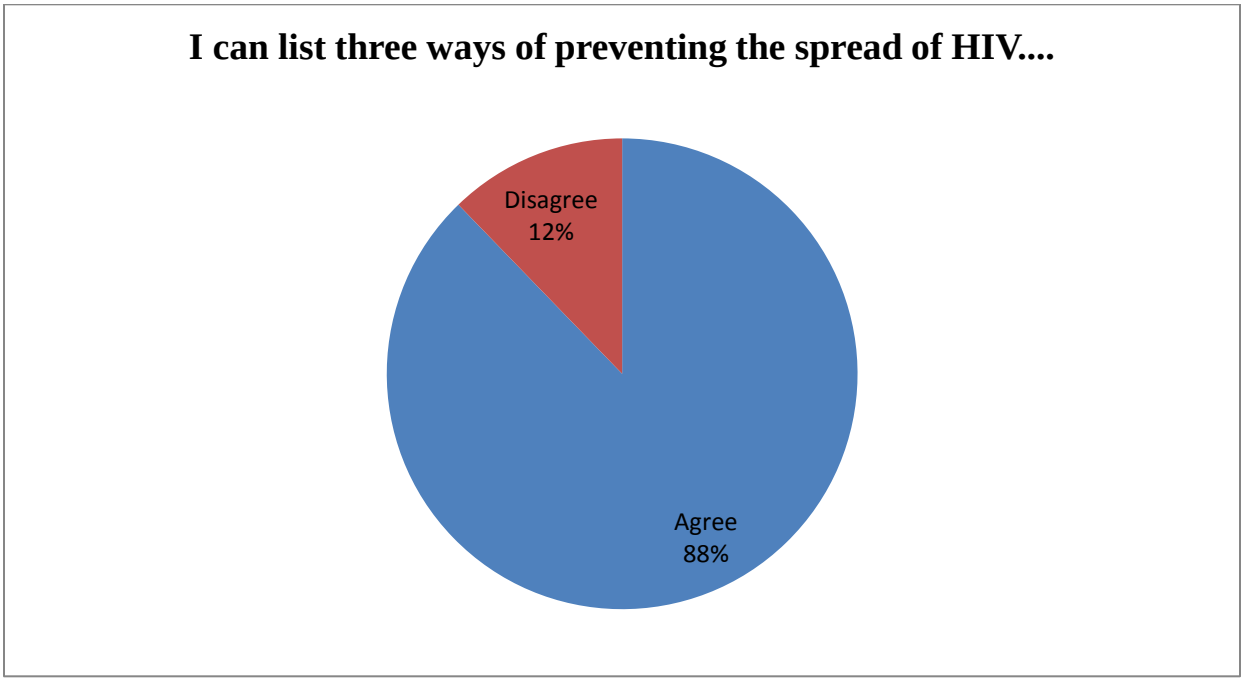


Figure 4:7 Self-Reported Knowledge of HIV Prevention

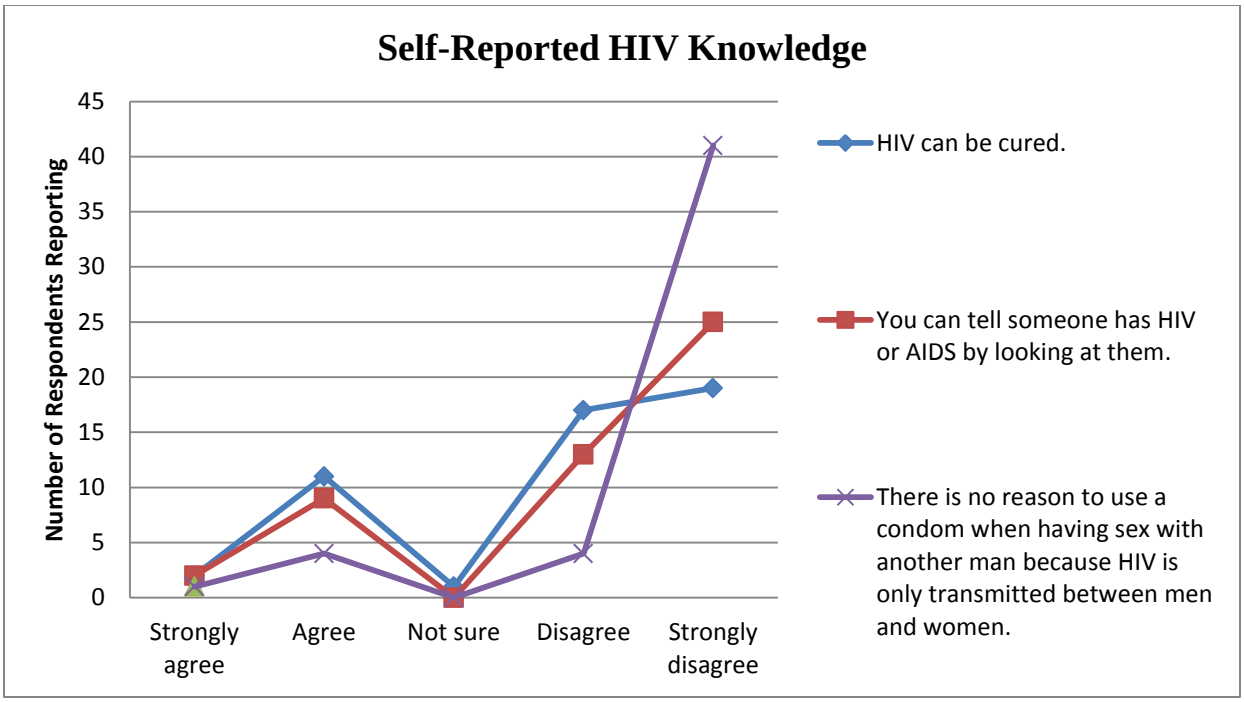


Figure 4:8 Self-Reported HIV Knowledge

Seventy-two percent of respondents disagreed or strongly disagreed with the statement, "HIV can be cured." Additionally, almost 77% of respondents understand that you cannot tell someone has HIV just by looking at them. (See Figure 4:8) Ten percent of respondents believe HIV can only be contracted and/or transmitted during sex between men and women as evidenced in Figure 8.

In spite of decades of HIV prevention education in Lesotho and southern Africa, two respondents strongly disagreed with the fact that condom use helps to prevent the spread of HIV between men and women. It is likely that this number is higher in more rural, less urban areas where HIV knowledge and prevention efforts are not as prevalent. (See Figure 4:9) One respondent sought clarification on the question and stated that condom use did not always prevent the spread of HIV. This line of thinking could account for the two "strongly disagree" responses to this question.

Seventy-eight percent of respondents report having learned the most about sex from their friends. (See Figure 4:10) As Rose-Innes suggests, lack of formal sex education in the home and the classroom has led to the sharing of much misinformation and personal bias. (Rose-Innes, 2006 (updated 2009)) This misinformation may also contribute to the number of respondents who

think that 1) HIV can be cured; 2) you can tell someone has HIV or AIDS by looking at them; or 3) there is no reason to use a condom when having sex with another man because HIV is only transmitted between men and women. (See Figure 4:8)

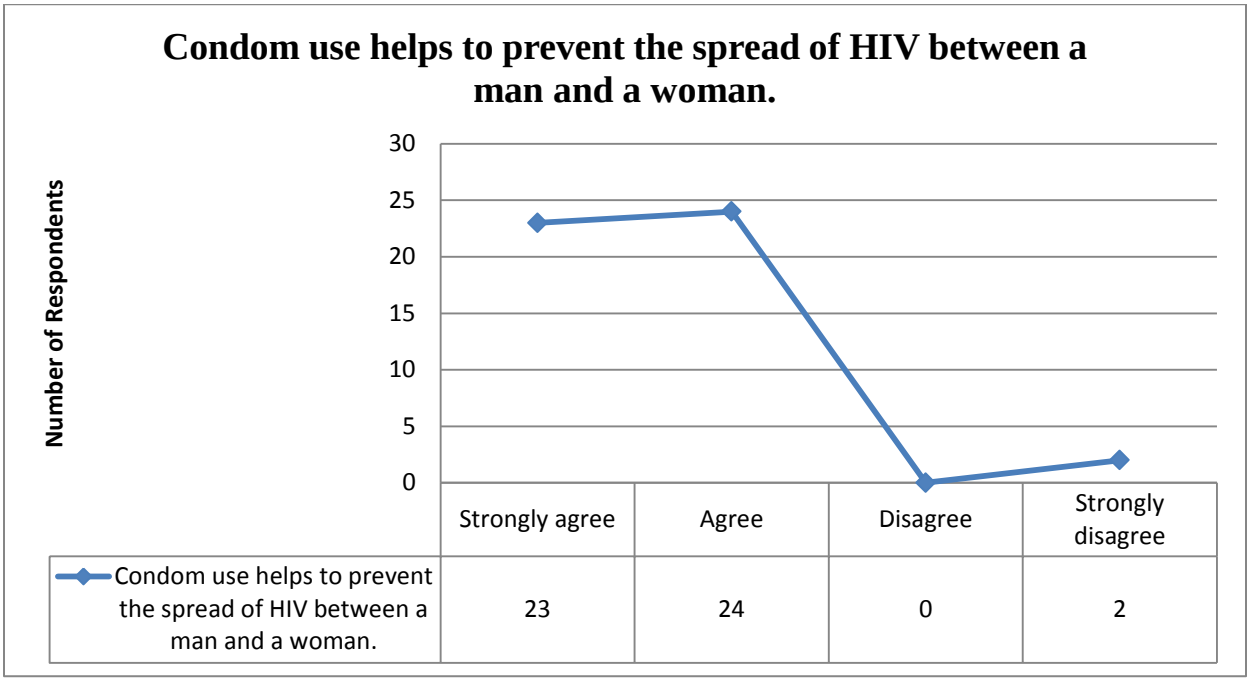


Figure 4:9 Understanding the Importance of Condom Use during Sexual Activities between Men and Women

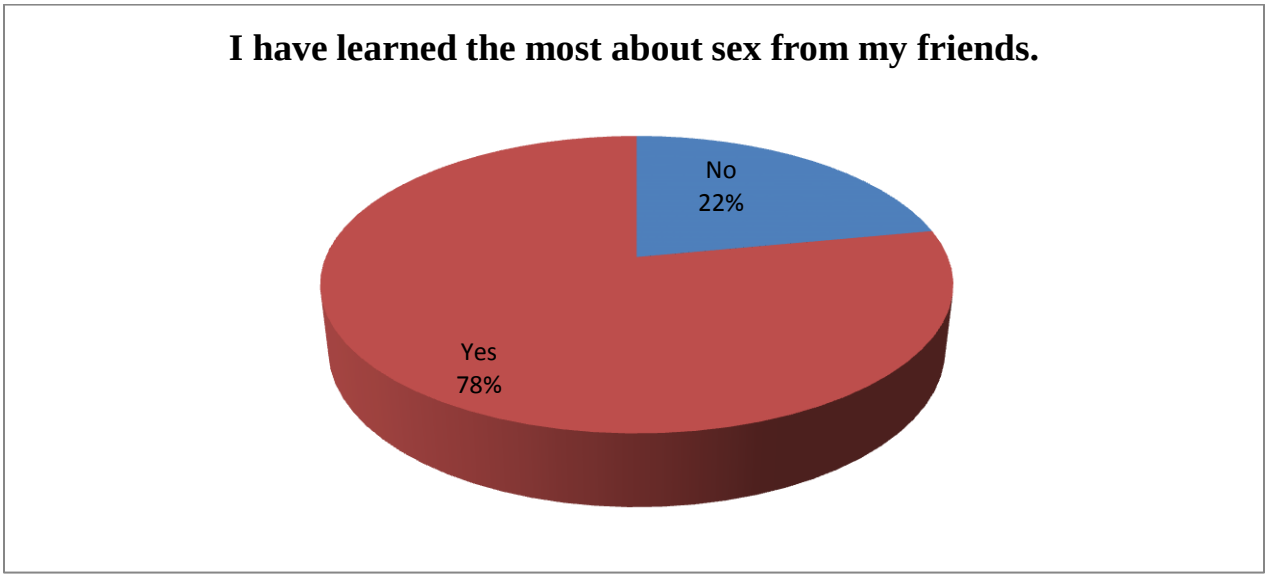


Figure 4:10 Informal Sex Education

Knowledge of HIV Status

As Figure 4:11 shows, 14% of respondents reported not knowing someone who is HIV positive (n=7). Of these, two respondents admit to never having taken an HIV test while two others explained that their last HIV test was more than a year ago. One respondent indicated that he'd had an HIV test within the last year, while the remaining two participants report having taken an HIV test within the last month. (See Figure 4:12)

Data suggests there is not necessarily a correlation between knowledge of someone who is HIV positive and HIV testing. When asked if he knew the HIV status of all his sexual partners, male and female, one participant retorted "no, man! I don't even know mine." The same participant said he was always up for the game with men and women although he admitted to not always using condoms correctly or consistently. (33, 2013)

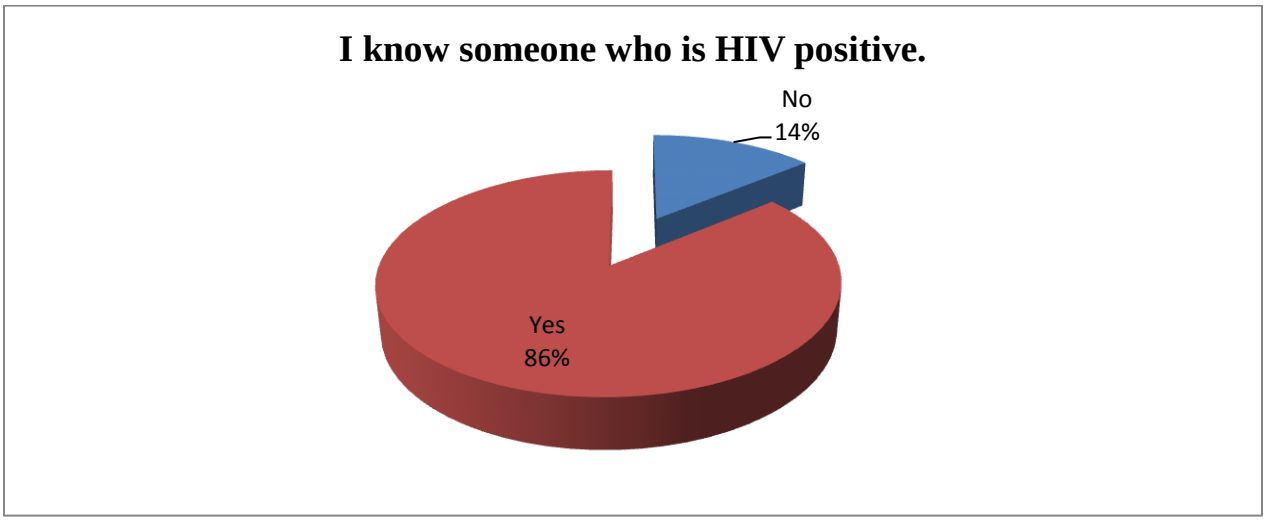


Figure 4:11 Knowledge of Someone who is HIV Positive

Age Group	Never	> 1 year ago	< 1 year ago	Within last month
18 – 25 (**n=29**)	10	3	6	10
26 – 30 (**n=17**)	1	3	6	7
31 – 40 (**n=3**)		1	2	
41 or older (**n=1**)				1

Table 4:2 Frequency of HIV Testing by Age Group

Sixty-four percent of all men in the study report having had an HIV test at a minimum within the last year however, there are as many men in the 18 – 25 age group who reported never having had an HIV test as those who reported their last HIV test was within the last month. Evidence suggests that an HIV testing campaign aimed at all men who have sex with men, especially those in the younger age groups could be beneficial.

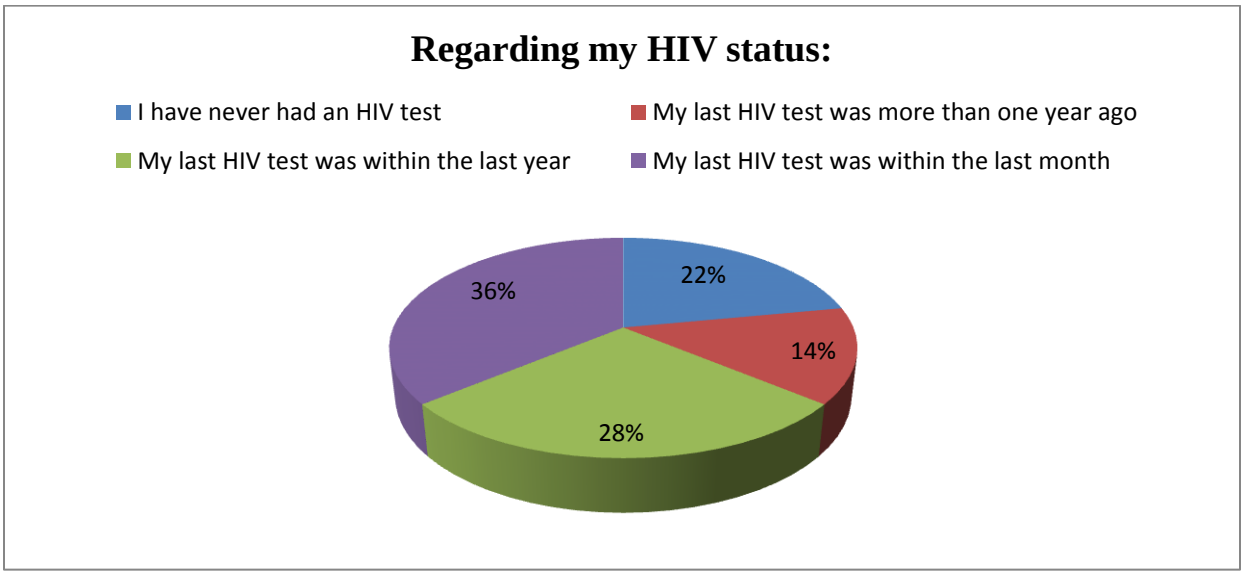


Figure 4:12 Self-Reported Knowledge of HIV Status

Seventy-six percent of respondents report not knowing the HIV status of all of their sexual partners. (See Figure 4:13) As previously mentioned, knowledge does not translate to behavior.

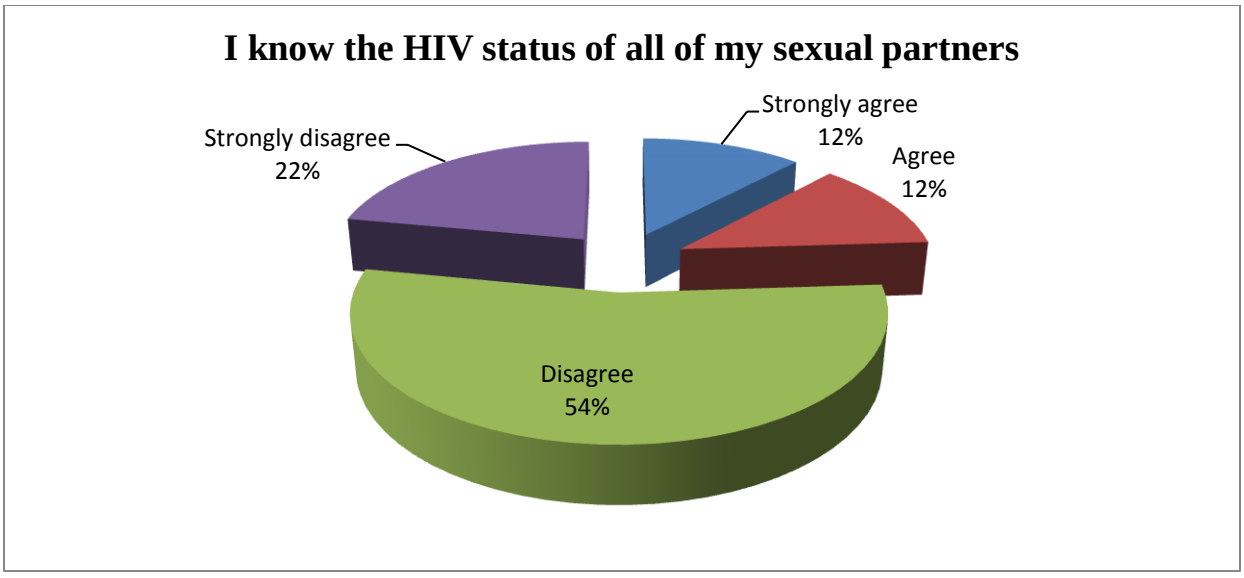


Figure 4:13 Knowledge of HIV Status of Sexual Partners

Almost two-thirds of all respondents reported that they knew HIV-positive men who were having sex with other men. It is not clear how many of those men (known by the respondents) are practicing safe sex or the extent of their sexual partnerships, with men and/or women. (See Figure 4:14)

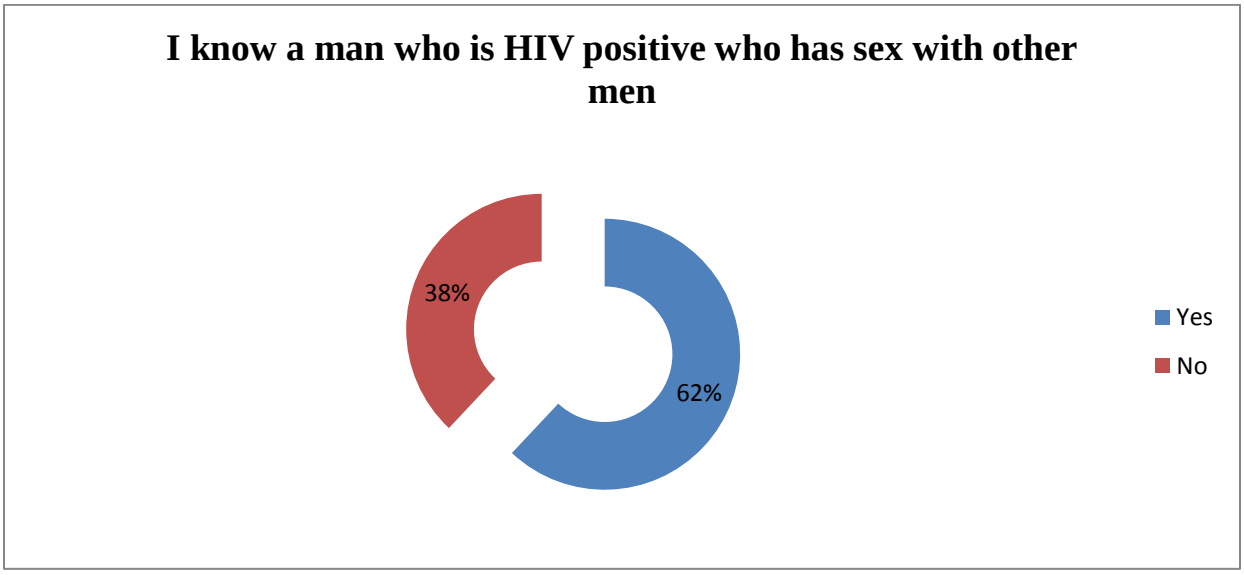


Figure 4:14 Knowledge of HIV Positive Men Having Sex with Other Men

All but one respondent indicated that they know men who are married to women who also have sex with other men. (See Figure 4:15) Further research is needed to better understand this phenomenon and the extent of HIV risk involved for all partners. Data from this research indicates that condom use between men is far from consistent, with 42% reporting that they use condoms only sometimes with other men. For men who reported sexual activities with women, five men reported condom use as sometimes or never. Given Lesotho's HIV-prevalence rate of 23.3%, it would be safe to assume that some of those men who reported having sex with men and/or women in the absence of condom use are HIV-positive.

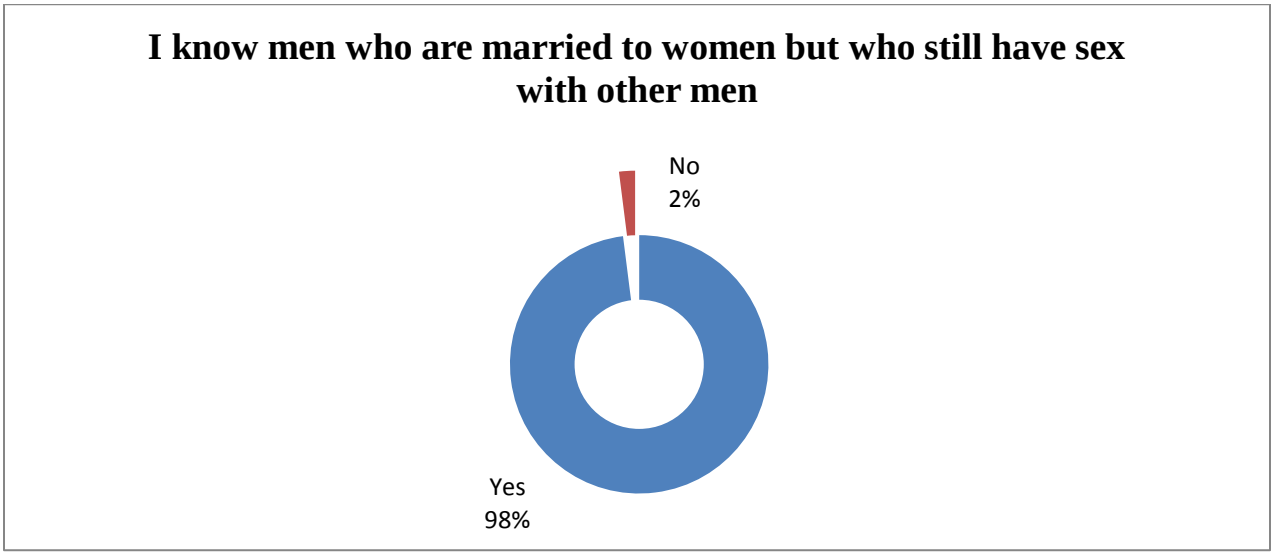


Figure 4:15 MSM Activity among Men Married to Women

Medical Male Circumcision (MMC)

Regarding knowledge around the health benefits of medical male circumcision, 62% of respondents reported that medical male circumcision (MMC) can help prevent the spread of HIV. (See Figure 4:16) This number is likely higher in Maseru District but will presumably rise throughout Lesotho as campaigns for voluntary medical male circumcision (VMMC) become more prominent. Reports of 33,000 men having been circumcised in 18 months will help to increase demand. (Helie, 2013) Currently, VMMC is free of charge at many clinics and service providers. In spite of the growing popularity of the health benefits of medical male circumcision, 38% of respondents are still unsure of the health benefits of VMMC and this number must certainly be higher the farther one gets from the capital.

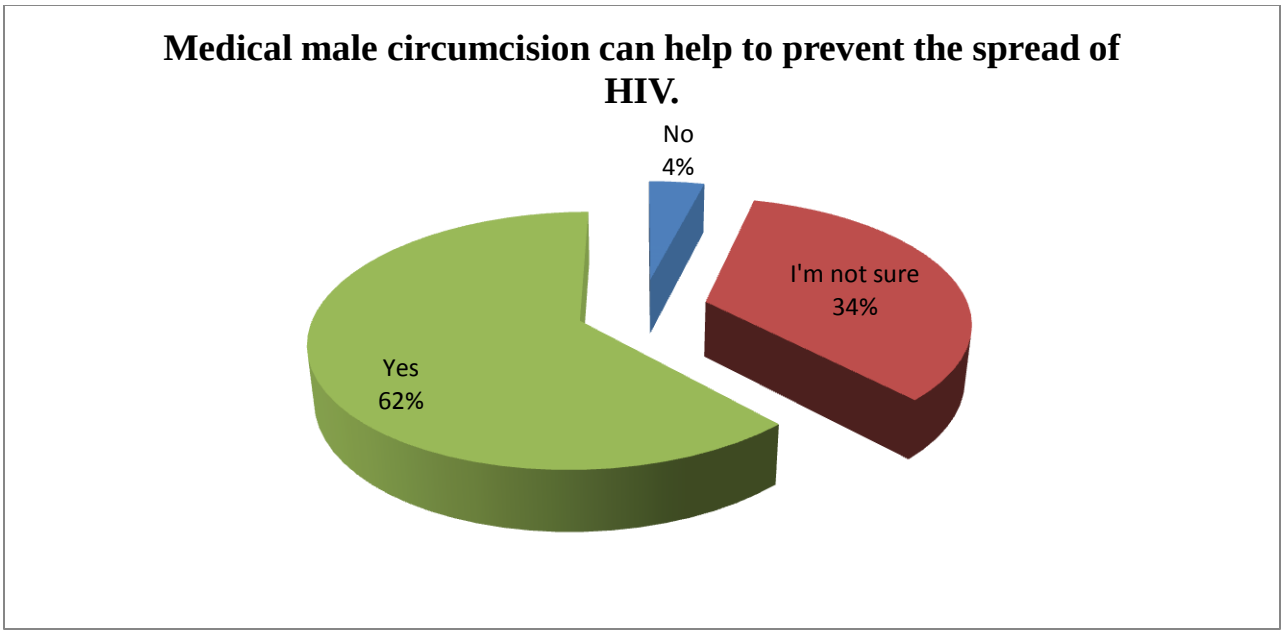


Figure 4:16 Self-Reported Knowledge of Health Benefits of Medical Male Circumcision

4.3 Stigma and Discrimination

As previously mentioned, there was a discrepancy among interview participants as to how they defined sexual relationships between men. Some regarded the terms gay and men who have sex with men to be synonymous while others defined men who have sex with men to more accurately reflect bisexuality. A common theme among respondents was that these words were influenced by one's sexual desire rather than the reasoning behind same sex relationships. One could consider the possibility of these sexual identity definitions the result of internalized stigma in a traditional culture. These terms of reference are similar to archetypes identified and discussed in a similar study in Viet Nam. (Garcia, Mercer, Meyer, & Ward, 2013) Further research into this phenomenon is warranted to better understand these definitions.

Another common finding was the notion that men who truly desired sex with other men were born that way and could not change. Several interview participants indicated that if given the choice to change their sexual orientation they would do so. Two participants shared that they had considered hurting themselves because of the stigma and discrimination they'd experienced.

"If a straight guy doesn't say anything about me or to me I get worried. I'm so used to people saying bad things about me I worry. I get so worried if boys don't talk about me, good or bad. That's what keeps me going." (51, 2013)

"Maparo," "stabana," "faggot," "maotoana," "sissy boy," and "mofi" were all terms that participants reported having been called. Some participants reported using these derogatory names in describing or labeling other, more effeminate men in an effort to divert attention. Two interview participants explained how they'd been chased away from church, one by the pastor himself who, according to the participant, did so out of fear of his own sexuality being revealed. "After-nines" was another term that was shared which highlighted men who only have sex with other men after nine (p.m.) and only then do so in a hurry.

Several participants reported having been the victims of physical violence but revealed that they did not report it to the police for fear of further stigma and discrimination.

Seventy-six percent of respondents disagreed with the belief that Basotho are accepting of men who have sex with men. (See Figure 4:17) This notion was resoundingly supported in interviews with several participants suggestion sensitization campaigns were greatly needed.

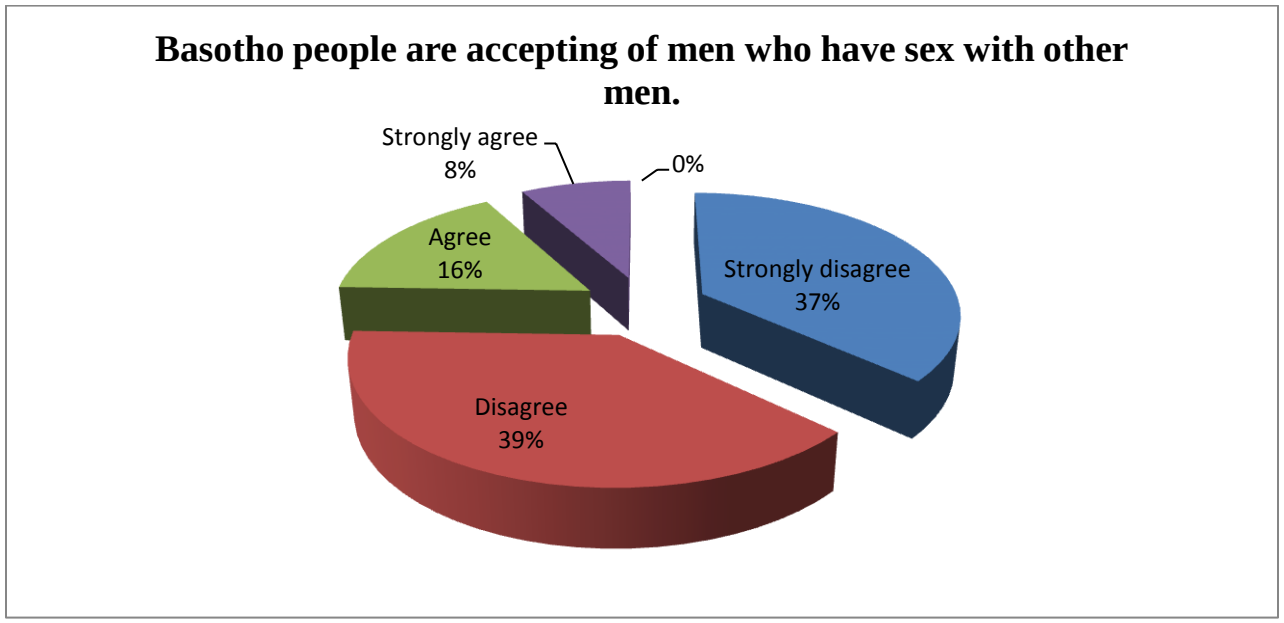


Figure 4:17 Basotho Views of Male-to-Male Sexual Activity

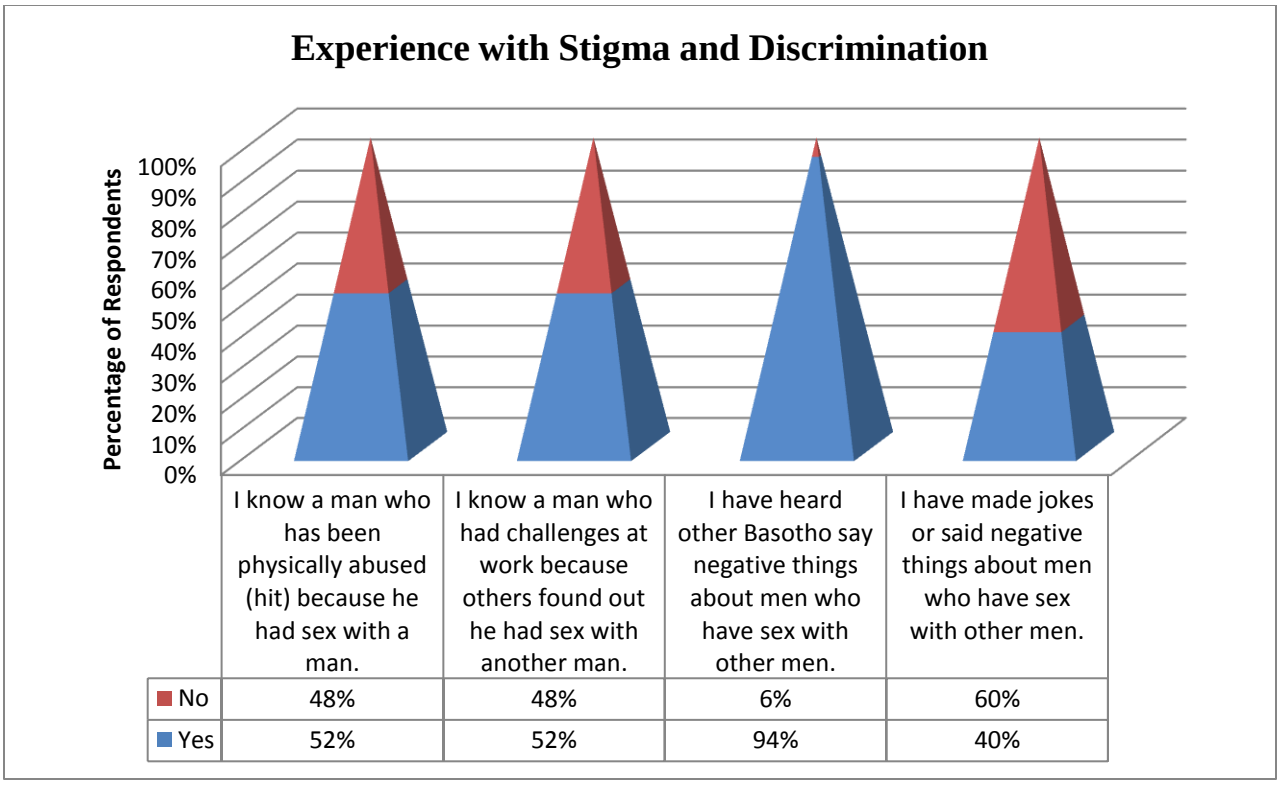


Figure 4:18 Self-Reported Experience with Stigma and Discrimination of Men Who Have Sex with Men

In Figure 4:18, fifteen participants reported "yes" to both questions about physical abuse and work complications due to sexual activity between two men. Twelve participants reported "no" to both of these questions, leaving twenty-two participants who reported knowing someone who had either been the victim of physical violence or who had experienced work challenges because of stigma around sexual identity. In total, more than 75% of respondents reported knowing someone who had experienced some type of discrimination as a result of MSM activity.

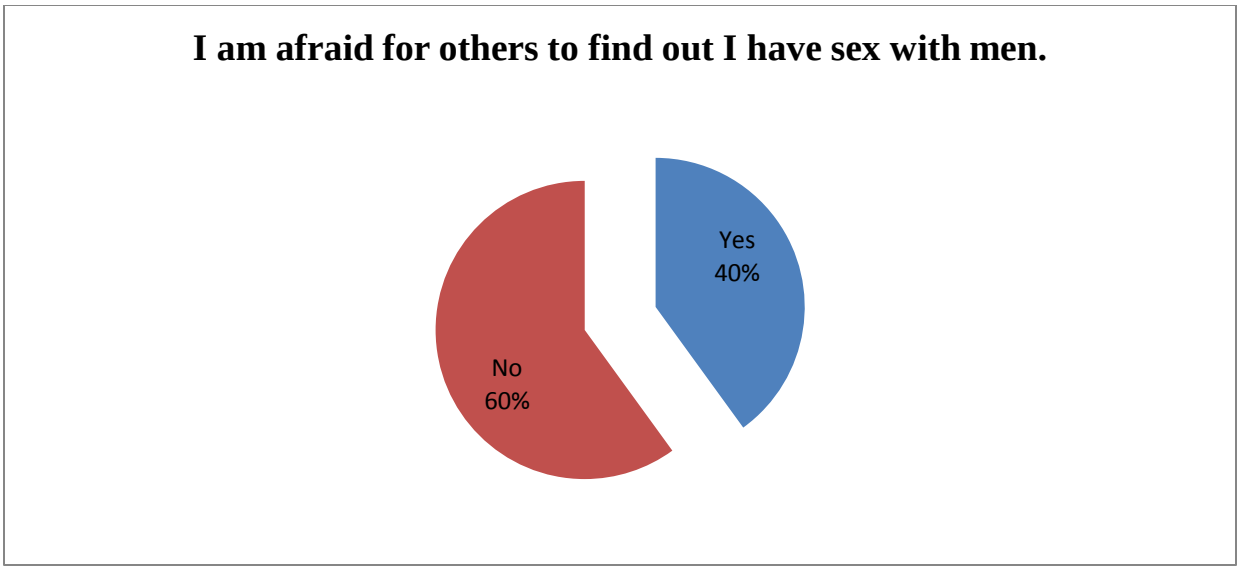


Figure 4:19 Growing Sense of Pride?

According to Figure 4:19, one could argue that, in spite of the data about experience with, or knowledge of someone who has been the victim of physical violence or work problems because of sexuality, there appears to be a growing sense of pride among some of the respondents. This could be a result of the work that Matrix Support Group has done to establish support services for men who have sex with men. It should be noted however that these numbers are not necessarily a true reflection of the rest of the country. Matrix Support Group, which gained legal recognition in 2010 organized the first gay pride march in Lesotho in May 2013. (Hall, 2013) Events like these not only increase public awareness of the challenges faced by marginalized groups but also go a long way in building a sense of community and pride as people establish support systems where previously there was only misunderstanding and frustration.

Considering the lack of comparable data, it is difficult to ascertain if there is a change in internal attitudes and self-esteem. However, while one could focus on the numbers of respondents who reported that they did not want their families to know, that their families would not support them, or that they would not feel comfortable speaking with a health care worker about same sex sexual activity, there are a number of respondents who report having the support of friends and family, as documented in Figures 4:20, 4:21 and 4:22.

Several interview participants articulated the need for more formalized sex education and sensitization, in- and out-of-school, as a way of breaking down barriers to stigma and discrimination and correcting misinformation about HIV.

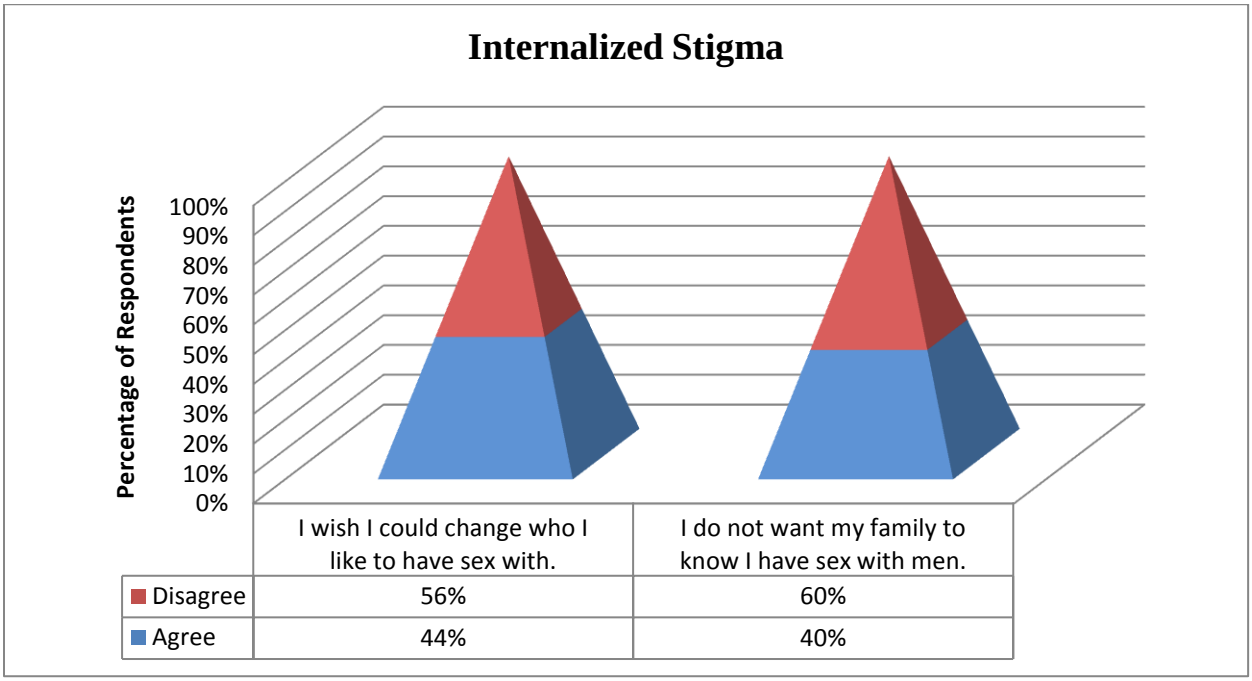


Figure 4:20 Internalized Stigma

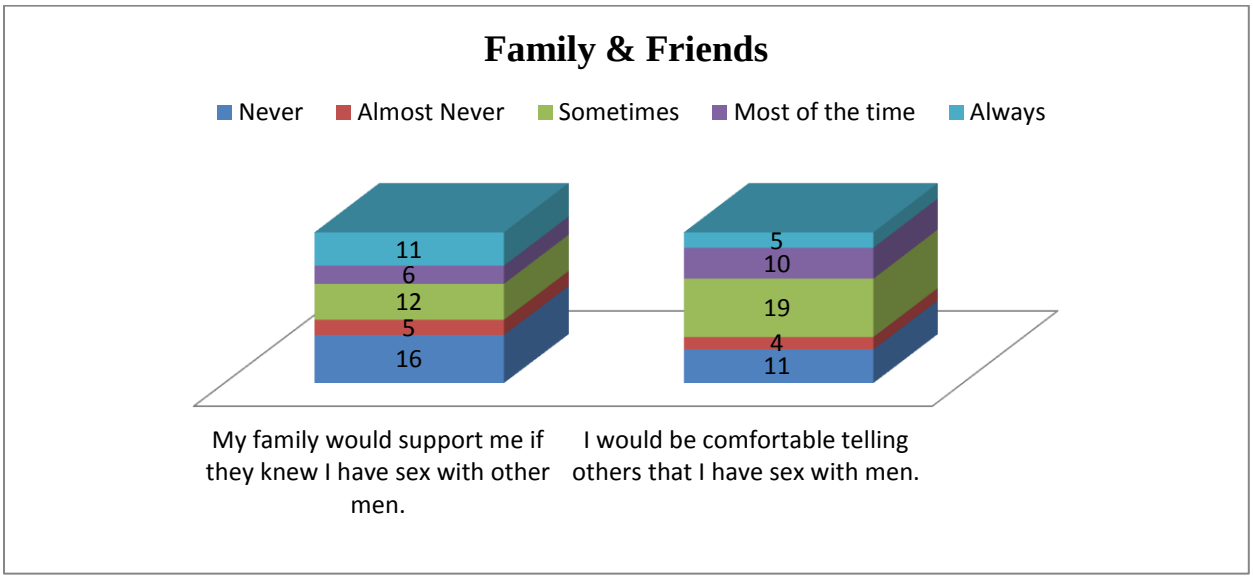


Figure 4:21 Possibility of Support from Family and Friends?

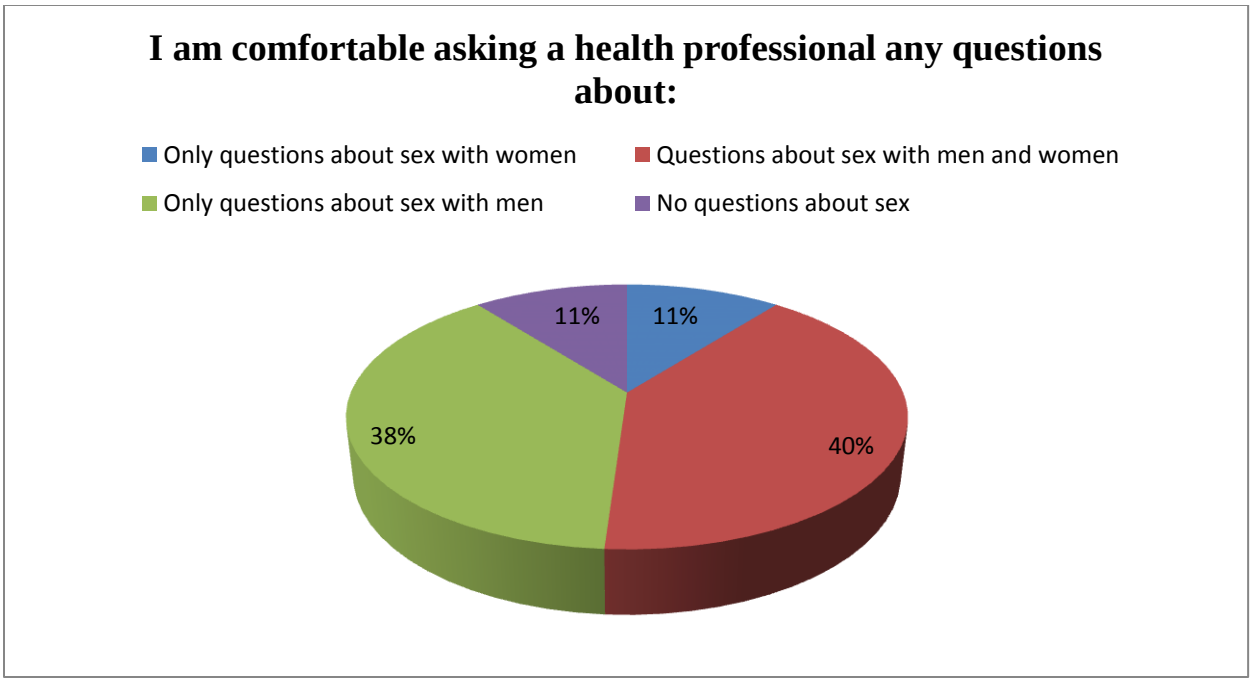


Figure 4:22 Contact with Health Professionals

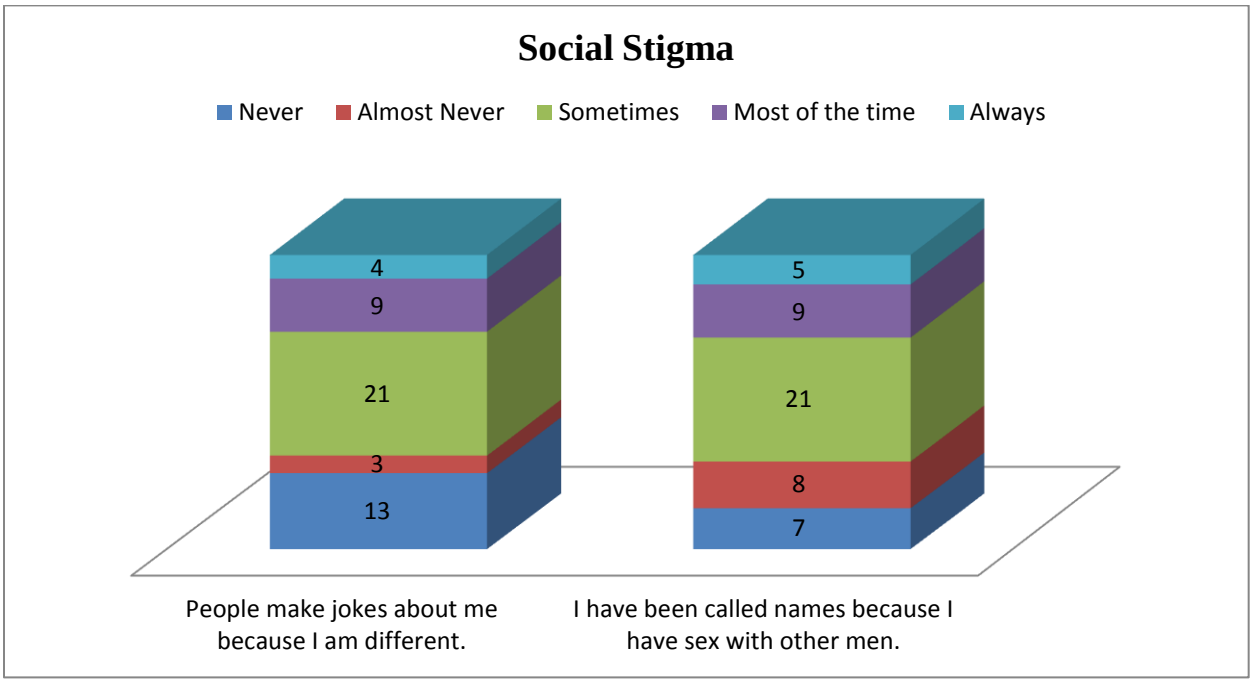


Figure 4:23 Experience with Social Stigma

Regardless of the number of male sexual partners reported within the last 12 months, half of all respondents are considering marriage to a woman in the future. (See Figure 4:24) Using the current HIV prevalence rate of 23.3%, at least six of those are likely to be HIV positive, half of whom are probably not aware of their status, thus the HIV transmission cycle continues.

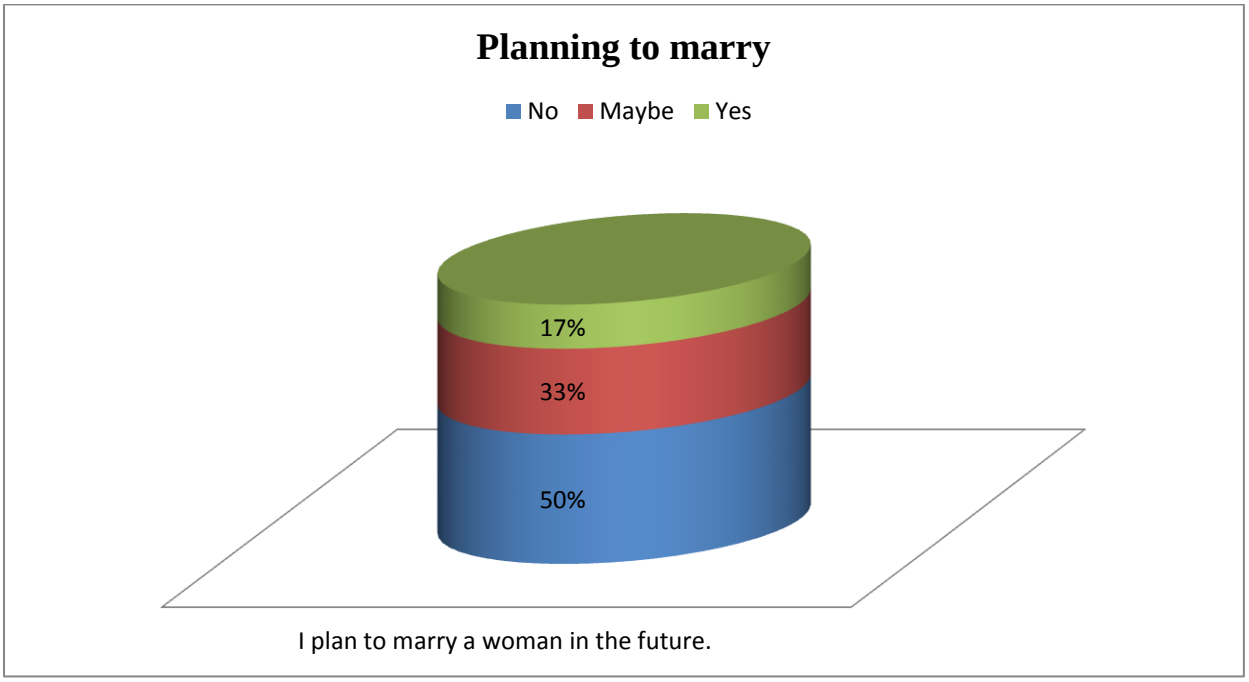


Figure 4:24 Planning to Marry a Woman

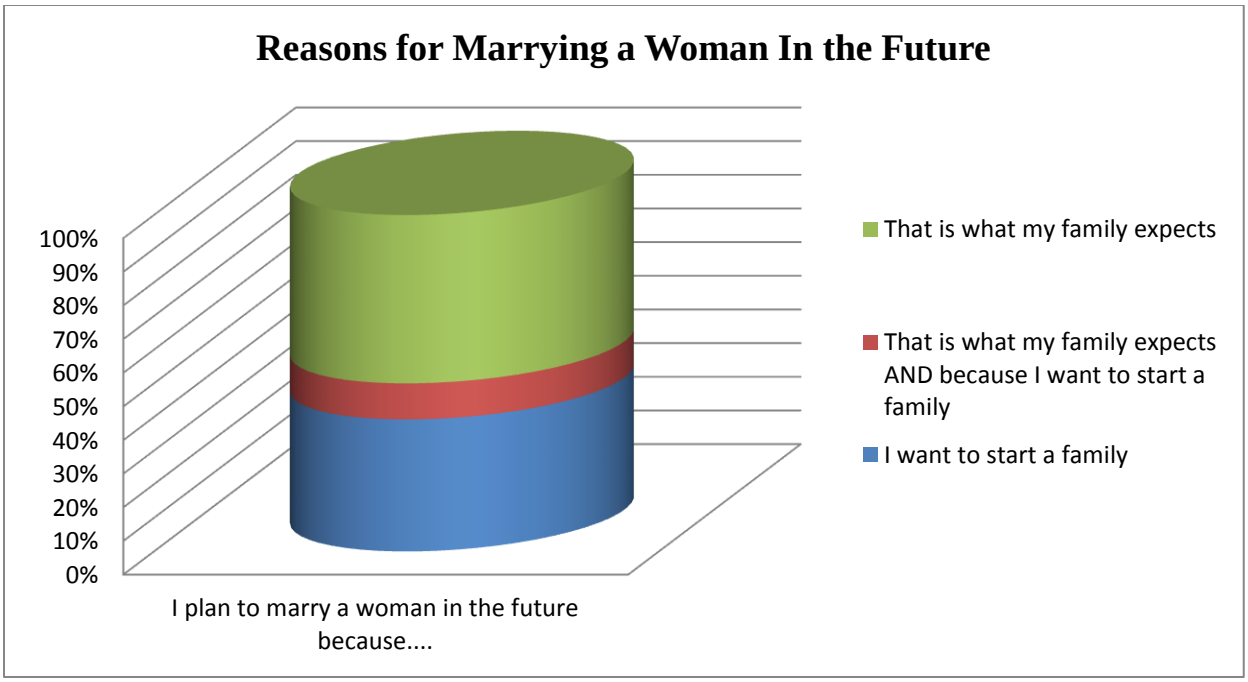


Figure 4:25 Reasons for Planning to Marry a Woman

Sixty-four percent of participants (n=14) who reported that they planned to marry indicated they were doing so solely or in part to meet familial expectations for doing so. One participant self-reported that he was already married and was not included in the total. (See Figure 4:25)

4.4 HIV Risk

Condom Use

In spite of the realization of 76% of respondents not knowing the HIV status of all of their sexual partners, (See Figure 4:13) correct and consistent condom use leaves much to be desired. Forty-two percent of respondents reported only using condoms sporadically when having sex with men, while 28% of respondents reported the same when having sex with women. (See Figure 4:28)

One participant indicated that he did not even know his own HIV status also admitted that he was not sure he knew how to use a condom correctly. The same respondent also confessed that he was "always up to the game," and that he and his sexual partners usually went with the flow, which usually equated to sex without a condom, despite knowing that condom use could help to prevent the spread of HIV. This respondent said he wasn't sure if HIV could be transmitted from

one man to another. Finally, this respondent also indicated that he used lubricant inconsistently and when he did, it was usually Vaseline or body lotion. (33, 2013)

As reported in Figure 8, some Basotho men believe there is no risk of HIV transmission during sexual activity between two men, as evidenced by one interview respondent. "Some of my friends only think they can get HIV when having sex with women so they don't use condoms when having sex with men. They believe since the man does not have natural fluids [vaginal fluids] like the woman has, there is no risk [of HIV transmission]." (3, 2013)

Another interview participant reported not always using condoms when having sex with men or women because, "For you to be a man, you have to not use condoms." This participant went on to explain that health clinics sometimes do not have free condoms and to buy them is expensive – "30 or 40 bucks" [~ $3.00 – 4.00] for a box of condoms. He said it also feels good to not use condoms. "Sometimes you have to go with the flow and when this happens you do not use condoms." He went on to explain that alcohol and drugs are always involved, he usually meets men at the pubs, and he confessed to also having sex with women. (33, 2013)

Evidence from this research study suggests that knowledge of HIV risk seems to have little impact on attitude among some men who have sex with men. Three of the five respondents who reportedly "lost count" of the number of male sexual partners they had within the last year also reported sporadic use of condoms. (See Figures 4:2 and 4:28) Although all three men report they do not have sex with women, all men strongly disagreed with the statement "there is no reason to use a condom when having sex with another man because HIV is only transmitted between men and women," which confirms that they understand there is a risk of HIV transmission during MSM activities. (See Figures 4:4, 4:6 and 4:8) The same three men self-report they prefer to be the passive partner, which puts each of them at greater risk of contracting HIV. (See Figure 4:3) Regarding HIV testing, one had tested within the last month, one within the last year, and one more than one year ago. (See Figure 4:12)

Among those reporting five or more male sexual partners within the last twelve months, the responses are just as worrisome. Six out of 11 respondents who reported five or more sexual partners within the last year report using condoms only sometimes. (See Figure 4:2 and 4:28) Three of these also report having had sex with women in the last year. (See Figures 4:4 and 4:6)

Fortunately all report always using condoms when having sex with women. (See Figure 4:28) Four of the six expressed a preference for being penetrated by another man and three of the six reported using oil, lotion, saliva or no lubricant at all. (See Figures 4:3 and 4:29, respectively)

Use of Lubricants

Two respondents who reported more than five male sexual partners in the last year reported they always use condoms however, their responses to the question about lubricant-use signaled non-water based lubricants were used all or part of the time. (See Figures 4:2, 4:28 and 4:29, respectively) One of these respondents reported the same practice with when he had sex with between 2 and 5 different women in the last year. (See Figures 4:6, 4:28 and 4:29, respectively)

Some participants reported using a variety of lubricants, including lotion, oil, spit (saliva), and water-based lubricants. Other participants reported not using lubricants due to lack or availability or for a different reason. A fifth possible response, "do not use lubricant because it is too expensive" was not indicated as an obstacle by any of the respondents. This is likely due to the "play-kits" provided by PSI, which includes two condoms and two individual packets of water-based lubricant. This approach to HIV-prevention seems to have an impact as a higher number of MSMs than originally thought (of those who participated in the study) were using water-based lubricants at least some of the time.

One interview participant indicated that he uses Vaseline as lubricant when he uses condoms, as well as in the absence of condoms. He says it depends on "how fit my partner is." He went on to explain that he doesn't know the HIV status of his partners and he admitted to never having taken an HIV test himself. (33, 2013)

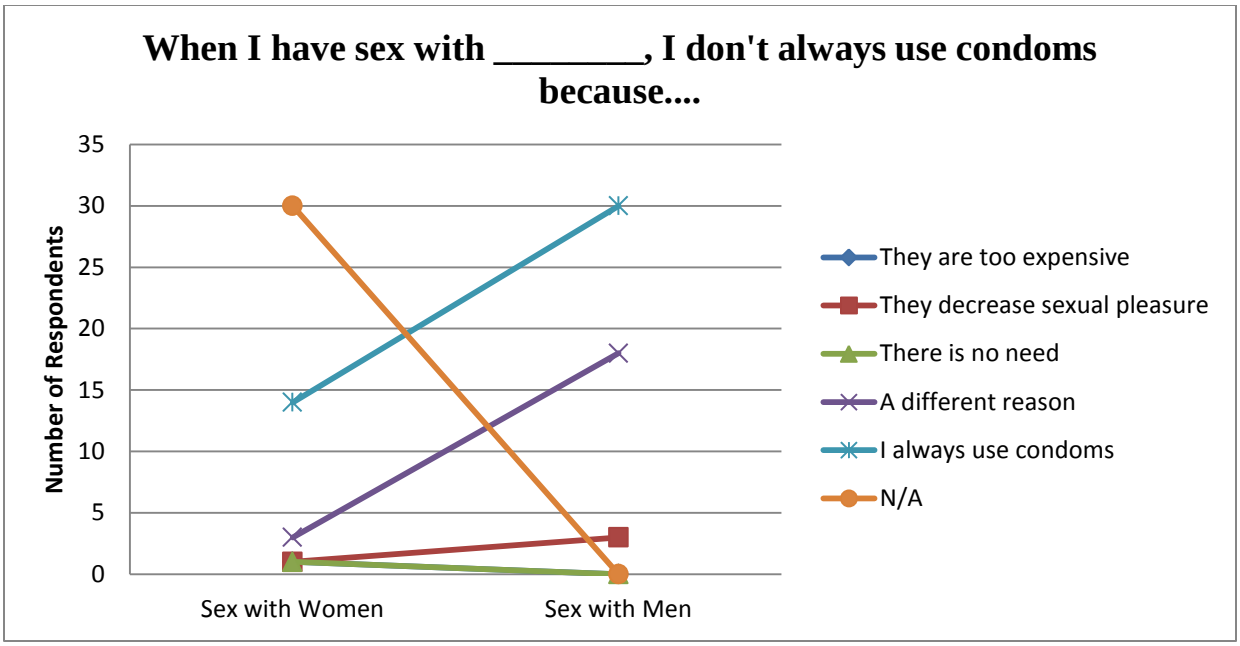


Figure 4:26 Self-Reported Reasons for Non-Use of Condoms

Alcohol and Drug Use

Sixty-four percent of respondents reported drinking alcohol sometimes or more frequently (most of the time or always) before having sex with men. (See Figure 4:27) A number of interview participants also indicated that many men meet their sexual partners at local pubs and clubs. One participant reported knowing some of his friends who put themselves at risk for contracting HIV because they have unprotected anal sex when they are drunk. (9, 2013)

Twenty-eight percent of respondents indicated they used drugs sometimes or more frequently (most of the time or always) before having sex with men. (See Figure 4:27) It is not clear if the same could be said for the number of these men who do the same before having sex with women.

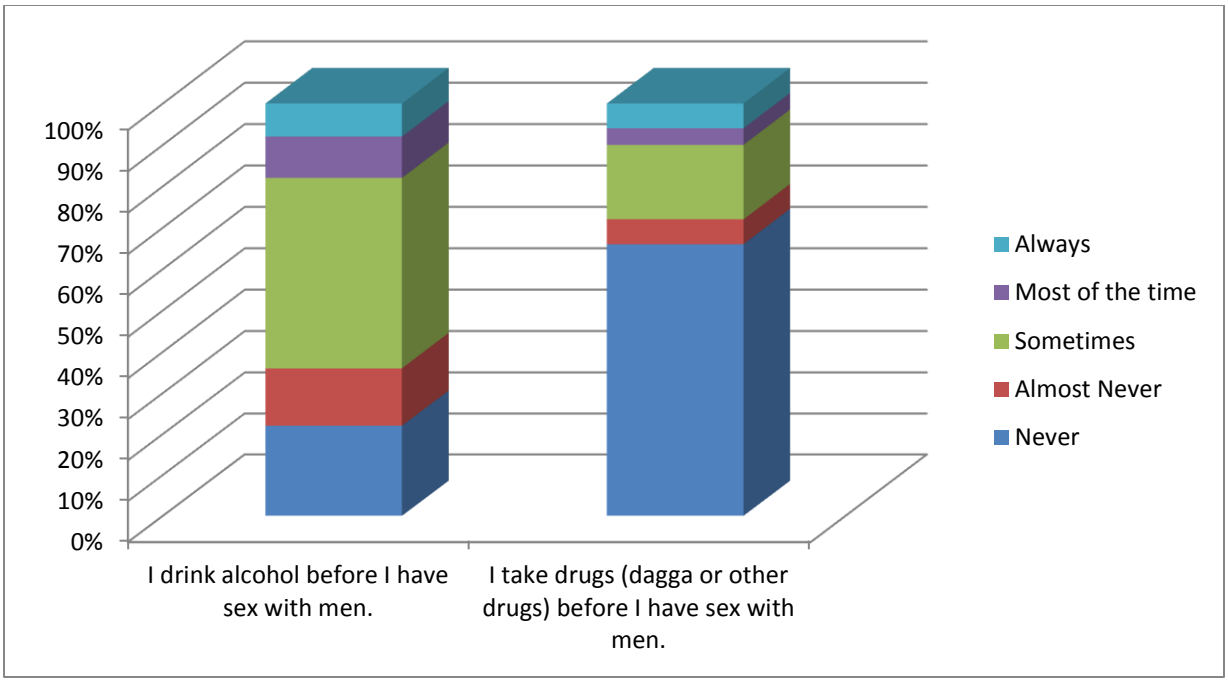


Figure 4:27 Alcohol and Drug Use before Sexual Activity

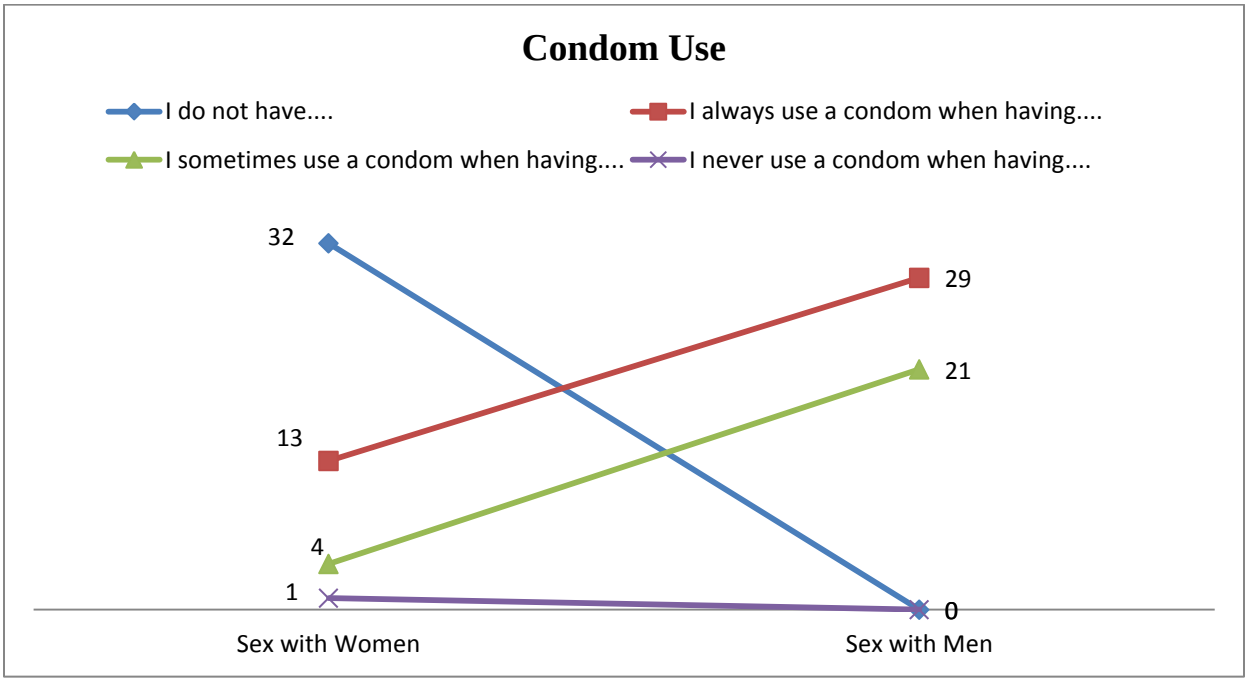
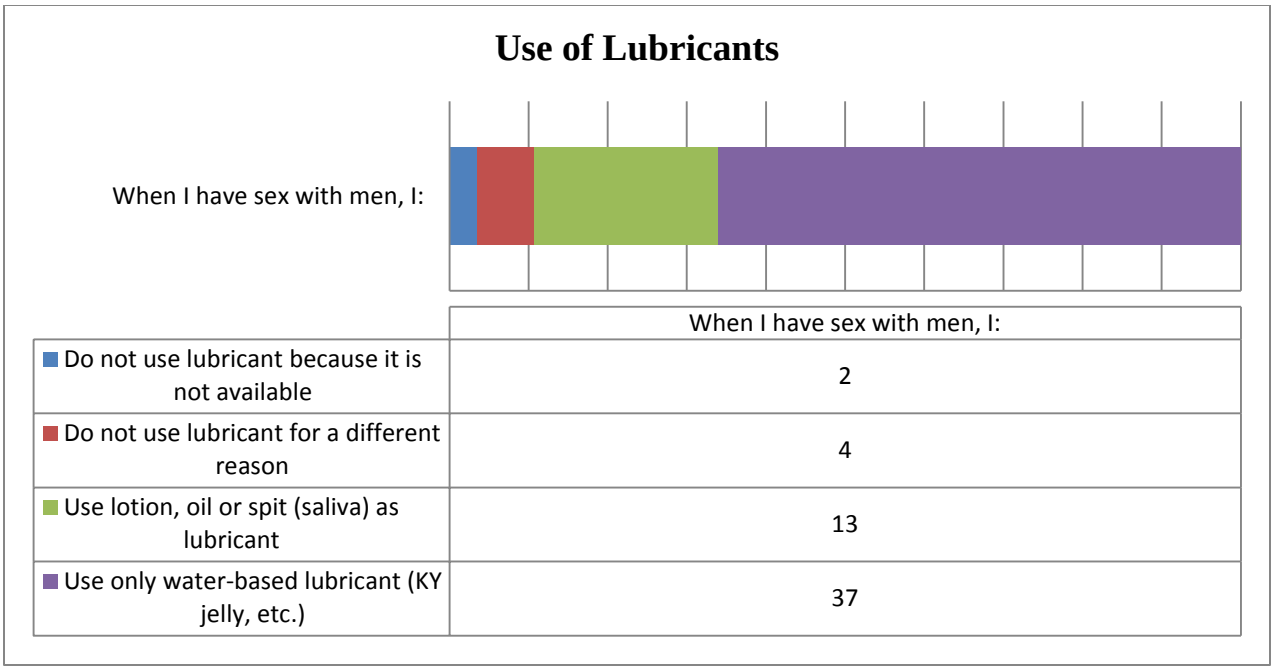


Figure 4:28 Condom Use during Sexual Activity with Women and Men



	When I have sex with men, I:
Do not use lubricant because it is not available	2
Do not use lubricant for a different reason	4
Use lotion, oil or spit (saliva) as lubricant	13
Use only water-based lubricant (KY jelly, etc.)	37

Figure 4:29 Self-Reported Use of Lubricants during Sexual Activity

Medical Male Circumcision

Sixty-two percent of participants reported that they understood the health benefits of circumcision, however knowledge doesn't equate to practice as only 44% of participants indicate they have been medically circumcised. (See Figures 4:16 and 4:30) An equal percentage of respondents expressed intent to get circumcised in the future. Since the research focused on the capital district of Maseru, it is likely that the MSM population in more rural/less urban areas are less aware of the health benefits of medical male circumcision.

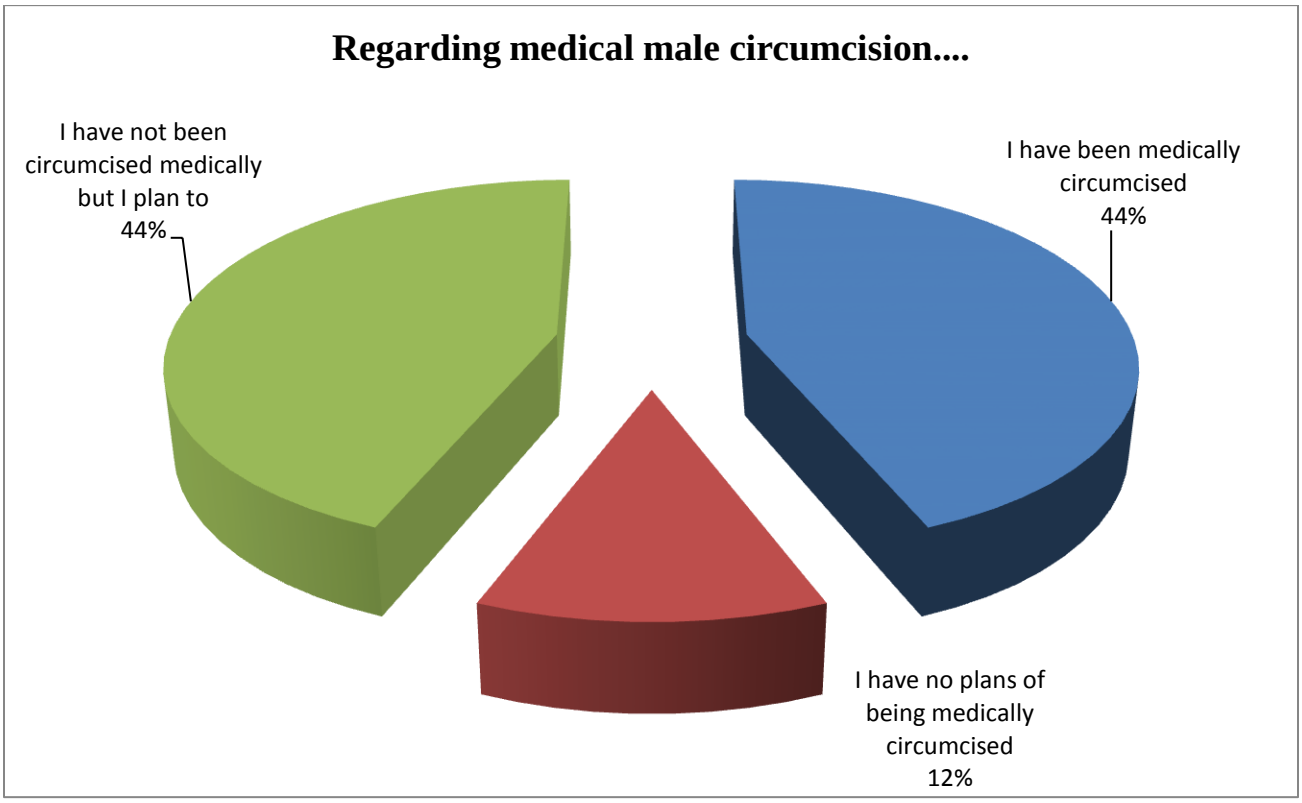


Figure 4:30 Self-Reported Status of Medical Male Circumcision

CHAPTER 5: Limitations and Recommendations

5.1 Limitations with Questionnaire

Question 2

As was previously mentioned under Demographic of Participants (see Table 4:1), seven participants interpreted Question 2 to mean they had only had sex with one other man and were confused by the term "with at least one man." Future studies might clarify this question by asking the following: "During the last twelve months I have had sex with one or more men."

Question 15 and 16

Some participants also interpreted "in the last year" to mean "last year." Clarification was provided to participants on this question. A recommendation for future studies is to use the same terms throughout, such as "within the last twelve months," rather than alternating by also using "within the last year." Participants seemed to understand more clearly the meaning of "within the last twelve months."

Understanding the Needs of MSM Population outside Maseru

The implementation of this study would have been near impossible were it not for the efforts of Matrix Support Group. Due to time constraints and the limitations regarding language translation, the study focused solely on English-speaking men in Maseru District, specifically the urban and peri-urban areas within and around Maseru. Research participants were identified using a snowball sampling approach initiated by Matrix Staff and members, many who are more sensitized to the importance of using condoms and condom-compatible lubricants. Additionally, a large majority of respondents expressed comfort with their sexuality, most likely as a result of recent gay, lesbian and transgender pride marches held within Maseru. It is anticipated, however, that the findings from this study are not necessarily of the knowledge, practices and attitudes of men who have sex with men residing in more rural areas and outside the reach of Matrix Support Group, thus a broader study is recommended to better understand the sexual health needs and HIV knowledge and risk of the MSM community outside Maseru.

5.2 Recommendations

Attitudes around Consistent Condom Use among MSM

In spite of the knowledge of the risks of HIV transmission involved and the resources poured into Lesotho to increase knowledge and prevention of HIV, and with 88% of respondents

reporting not knowing the HIV status of all of their sexual partners, (See Figure 4:13), the uptake of correct and consistent condom use is paltry. Forty-two percent of respondents reported only using condoms sporadically when having sex with men, while 28% of respondents reported the same when having sex with women. (See Figure 4:28) While this evidence might suggest a pattern similar to that discussed in a study conducted in the U.S.A. regarding an increase in new HIV infections among minority men who have sex with men (Mustanski, Newcomb, & Clerkin, 2011), further research is needed to better understand the knowledge, attitudes and practices around correct and consistent condom use among men who have sex with men in Lesotho. Unlike the aforementioned study that suggests dwindling condom use as a result of committed, trusting relationships, the sexual relationships of Basotho men who have sex with men seem to be of a more casual nature.

Knowledge of the Importance of using Water-Based Lubricants

During the data collection process, Matrix Support Group staff and members shared that PSI Lesotho has made available "play kits" for the MSM population which consists of two condoms and two small packets of water-based lubricant. (The number of lubricants provided in the kits was increased from one to two per kit after concerns were raised by the target group that one small packet of lubricant was not sufficient.) This programme seems to be having an impact as a number of research participants seemed to understand the importance of water-based lubricant and indicated that they are currently using the kits and helping to ensure their friends had access to them. (See Figure 29) Information about the play kits and men who have sex with men as a target group was absent on the PSI Lesotho website and the sustainability of this programme is not clear, as is always the case with donor-funded programmes.

Medical Male Circumcision

While much progress is being made with respect to voluntary medical male circumcision, it is imperative that health messaging on medical male circumcision be targeted specifically to the needs of men who have sex with men.

The Maternal and Child Health Integrated Program (MCHIP) reported that 33,000 men in Lesotho have been medically circumcised within 18 months. Keys to the success of this programme include culturally sensitive approaches to medical male circumcision in light of Basotho traditions of initiation schools. (Helie, 2013) Due to increasing demand for voluntary

medical male circumcision (VMMC), MCHIP touts on its website that VMMC services have expanded to 13 new sites in eight of ten districts in Lesotho, due to addition of partners including the Christian Health Alliance of Lesotho (CHAL) and private health facilities. In addition to providing medical male circumcision, the project also provides messages and education on HIV and other sexual health topics, condoms, and referrals for care and treatment. (Helie, 2013)

It is unclear whether this project or these partner facilities cater to the needs of men who have sex with men in an environment free of stigma, given the traditional lack of support for same-sex activity by religious groups or the fact that culture and tradition in Lesotho are devoid of any notions of male-to-male sexual activity.

Addressing Social and Internalized Stigma

Of all the recommendations to consider, addressing social and internalized stigma of and among sexual minorities is perhaps the most difficult and time-consuming, yet the one with potentially the greatest payoff.

It is evident that Matrix Support Group has a key role to play in this regard. In fact, Matrix has already made a difference in the lives of many sexual minorities in Lesotho through the hard work, bravery and commitment of its staff and members. The staff of Matrix is well-poised to carry the organization and its members into a new era in Lesotho, however for this to happen, a strategy and support is needed for the first human rights organization of its kind in Lesotho.

In collaboration with PSI, Matrix is also starting to make a difference in the lives of the MSM community through the provision and distribution of the safe-sex play kits. Many of the interview participants also view the staff of the Lesotho Planned Parenthood Association (LPPA) as allies, as well as a customer-friendly health service provider. An expansion of essential sexual services provided by LPPA includes free medical male circumcision, a service that could benefit many of the interview participants, as well as their sexual partners.

Sensitization Campaign for Shop Owners and Attendants

In order to strengthen access to health products such as condoms and water-based lubricants, sensitivity training should be provided to shopkeepers and counter attendants for shops selling condoms and lubricants in Maseru and throughout Lesotho. Insensitivities by shop owners and

counter attendants, as experienced and described by a number interview participants can lead to risky behavior among men who have sex with men.

A brief review of shops selling water-based lubricants in Maseru at the two largest shopping malls in Maseru revealed that water-based lubricants (KY Jelly) were available behind a counter with an attendant. Only one shop provided a variety of water-based lubricants accessible to the shopper. Several interview participants indicated growing animosity from counter attendants to anyone purchasing water-based lubricants. One interview revealed that he was asked by a counter attendant why he needed to buy lubricant because women have normal fluids that aide with penetration. The participant said he hadn't gone back to that shop. Another interview participant said that he was ashamed to purchase condoms at a counter after the attendant told him he was too young and since he was not married and shouldn't be having sex.

Promotion of Play Kits at Clubs and Pubs

Considering that many of the respondents indicated that alcohol and drugs are involved in sexual decision-making, and the common understanding that many men meet sexual partners (men and women) in clubs and local pubs, it is recommended that partnerships be explored with local pubs and clubs to promote the use of play kits and to sensitize owners and staff to the importance of helping to protect their customer base and their business.

CHAPTER 6: Conclusion

Pride marches, like the one organized for the lesbian, gay, bisexual, transgender and intersex community in Lesotho by Matrix Support Group in May 2013 seems to be having an impact on the MSM community and how it deals with stigma and discrimination. This march, to celebrate International Anti-Homophobia and Transphobia Day was the first gay pride march in Lesotho. (Hall, 2013)

Findings from this study support evidence from an earlier study by Niang, Et al. (Niang, et al., 2003). Evidence of the impact of derogatory terms used to describe sexual minorities signaled lower levels of self-esteem and higher-risk sexual practices. While his evidence seems to suggest a growing sense of pride among the Basotho, violence against members of the LGBTI community exist, as illustrated in Hall's article, and reiterated by several interview participants who reported personal experiences with violence. (Hall, 2013) Nevertheless, attitudes seem to be changing. Matrix staff shared that getting a permit to hold the gay pride march was easy, likely due to much of the groundwork already laid by Matrix.

As promising as the pride marches may be, findings from this study signify there is much work to be done with respect to the sexual health of the vulnerable group of men who have sex with men in Lesotho. As the study revealed, internalized stigma is real, and many men in Lesotho engage in sexual activities with women to meet traditional expectations while also keeping male sexual relationships under cover. Multiple concurrent partnerships are already the biggest drivers of the HIV epidemic in Lesotho and if a comprehensive HIV education and prevention campaign doesn't address all vulnerable groups, regardless of traditional values and norms, Lesotho will continue to struggle with the HIV pandemic.

This study was only the second known study of its kind focusing on the sexual health needs of men who have sex with men in Lesotho. (Baral, 2010) We are just beginning to scratch the surface to better understand the needs of a vulnerable community so delicately poised to erase gains made in HIV prevention, however thanks to Matrix and its committed staff and the courageous sexual minority community in Lesotho, anything is possible.

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Addenda

Addendum A: Semi-Structured Interview Template

Interview # _____

(day – interview for that day, i.e. 3 – 3, third interview conducted on day three)

1. Please tell me some of the ways that HIV is transmitted? How can HIV transmission be prevented?

2. Have you or someone you know ever put yourself/himself/herself at risk for contracting HIV? If so, in what way? What did you/he/she do about it (HIV test, change behaviour)?

3. Where do men get condoms? How available is lubricant? How comfortable are you asking for or purchasing condoms? How comfortable are you asking someone else to use a condom during sex?

4. How supportive is Basotho society of gay men? Who do gay men speak with if they have questions about sex or sexuality? In your experience, do you know very many of your male Basotho friends who follow-up with a trained health care professional about any issues related to sexual health?

5. Have you ever been stigmatized or discriminated against? If so, what were the reasons behind the discrimination?

Addendum B: Questionnaire

A Questionnaire about Relationships, Stigma and HIV						
For each of the following statements below, choose one of the responses to the right by filling in that circle.						
1	I am a male and my age is between:	Under 18 O	18 - 25 O	26 - 30 O	31 - 40 O	41 or older O
2	During the last 12 months, I have had sex with at least one man.		YES O		NO O	
3	I have sex with men….(Check all that apply.)	Because that is what is expected of me O	Because women aren't available O	For money O	For practice O	Because I enjoy it O
4	During the last 12 months, I have had sex with at least one woman.		YES O		NO O	
5	I have sex with women….		Because that is what is expected of me O		Because I enjoy it O	
6	I am accepting of people who are different than me.	Strongly Agree O	Agree O		Disagree O	Strongly Disagree O
7	Basotho people are accepting of men who have sex with other men.	Strongly Agree O	Agree O		Disagree O	Strongly Disagree O
8	I can list three ways of preventing the spread of HIV from one person to another.		Agree O		Disagree O	

9	HIV can be cured.	Strongly Agree O	Agree O		Disagree O	Strongly Disagree O
10	You can tell someone has HIV or AIDS by looking at them.	Strongly Agree O	Agree O		Disagree O	Strongly Disagree O
11	I know someone who is HIV positive.		YesO		NoO	
12	Condom use helps to prevent the spread of HIV between a man and a woman.	Strongly Agree O	Agree O		Disagree O	Strongly Disagree O
13	There is no reason to use a condom when having sex with another man because HIV is only transmitted between men and women.	Strongly Agree O	Agree O		Disagree O	Strongly Disagree O
14	I have learned the most about sex from my friends.		Yes O		No O	
15	In the last year, I have had sex with:	No women O	One woman O		Between 2 and 5 different women O	More than five different women O
16	In the last year, I have had sex with:	Only one man O	Between 2 and 5 different men O		More than 5 men O	I lost count O
17	When I have sex with men I use a condom….	I do not have sex with men O	Always O	Sometimes O	Never O	

18	When I have sex with a woman, I use a condom….	I do not have sex with women O	Always O	Sometimes O	Never O	
19	When I am having sex with a man, I don't always use condoms because:	They are too expensive O	They decrease sexual pleasure O	There is no need O	A different reason O	I always use condoms O
20	When I am having sex with a woman, I don't always use condoms because:	They are too expensiveO	They decrease sexual pleasureO	There is no needO	A different reasonO	I always use condomsO
21	I know the HIV status of all my sexual partners.	Strongly Agree O	Agree O		Disagree O	Strongly Disagree O
22	I prefer to be penetrated when I am having sex with another man…..	Always O	Most times O		Rarely O	Never O
23	The following people know that I have sex with other men:	No one O	Only my closest friends O	Some friends and family O	Only my closest family O	Everyone O
24	I would be comfortable telling others that I have sex with men.	Always O	Most of the time O	Sometimes O	Almost never O	Never O
25	People make jokes about me because I am different than other Basotho men.	Always O	Most of the time O	Sometimes O	Almost never O	Never O

26	I have been called names because I have sex with other men.	Always O	Most of the time O	Sometimes O	Almost never O	Never O
27	My family would support me if they knew I have sex with other men.	Always O	Most of the time O	Sometimes O	Almost never O	Never O
28	I am comfortable asking a health professional any questions about:	Only questions about sex with women O	Questions about sex with men and women O		No questions about sex O	Only questions about sex with men O
29	I am afraid for others to find out that I have sex with men.		YES O		NO O	
30	I know a man who has been phsyically abused (hit) because he had sex with a man.		YESO		NOO	
31	I know a man who had challenges at work because others found out he had sex with another man.		YES O		NO O	
32	I have sex with women….		Because that is what is expected of me O	I do not have sex with women O	Because I enjoy it O	
33	I have heard other Basotho say negative things about men who have sex with other men.		YES O		NO O	
34	I have made jokes or said negative things about men who have sex with other men.		YES O		NO O	
35	I wish I could change who I like to have sex with.		AGREE O		DISAGREE O	

36	I do not want my family to know that I have sex with men.		AGREE O		DISAGREE O	
37	I plan to marry a woman in the future.	Yes O		Maybe O		No O
38	I plan to marry a woman in the future because….	That is what my family expects O		Because I want to start a family O		I am not getting married to a woman in the future O
39	I do not always use condoms when I have sex with men because….	Condoms are too expensive O	Condoms decrease sexual pleasure O	Condoms are not available O	There is no need O	A different reason O
40	When I have sex with men, I:	Use lotion, oil or spit as lubricantO	Use only water-based lubricant (KY Jelly, etc.)O	Do not use lubricant because it is not availableO	Do not use lubricant because it is too expensiveO	Do not use lubricant for a different reasonO
41	I drink alcohol before I have sex with men.	Always O	Most of the time O	Sometimes O	Almost never O	Never O
42	I take drugs (dagga or other drugs) before I have sex with men.	Always O	Most of the time O	Sometimes O	Almost never O	Never O
43	I know men who are married to women but who still have sex with other men.		YES O		NO O	

44	I know a man who has sex with other men who is HIV positive.		YES O		NO O	
45	Medical male circumcision can help to prevent the spread of HIV.		YES O	I'm not sure. O	NO O	
46	Regarding medical male circumcision:	I have no plans of being medically circumcised O		I have been medically circumcised O		I have not been circumcised medically but I plan to O
47	Regarding my HIV status:	I have never had an HIV test O	My last HIV test was more than one year ago O		My last HIV test was within the last year O	My last HIV test was within the last month O