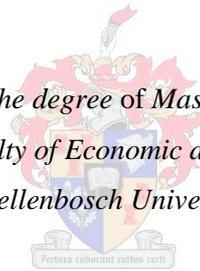


**HIV Prevention Needs for Men who have Sex with Men in Swaziland: A  
Case Study of Manzini City**

by

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Management) in the Faculty of Economic and Management Sciences at  
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## **DECLARATION**

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## ABSTRACT

Since the beginning of the HIV epidemic in the early 1980s, men who have sex with men (MSM) have been disproportionately affected by the virus. Sex between men is the main route of transmission of HIV in some parts of the world. In some other places it is a secondary route of transmission. Worldwide, MSM are classified as most-at-risk populations because of their higher risk of HIV transmission. Although sex between men occurs in most societies, its existence, importance in HIV prevention are frequently denied. Often, these men are neglected in HIV prevention interventions. Sexual acts between men have often been condemned and sometimes criminalized. In some countries, penalties for those accused of sexual acts between men are among the severest available. Elsewhere, even where same-sex behaviour is not illegal, there is frequently unofficial persecution by the authorities or discrimination against or stigmatisation of those men known or thought to be having sexual relations with other men. For these reasons, in many parts of the world, sex between men is hidden or secretive. This makes an assessment of its extent, and of the various types of sexual acts that occur, even more difficult.

As a result of being neglected, there has been generally lack of research and services directed towards MSM. In sub-Saharan Africa, for instance, it was only over 10 years ago, in 2001, when the first behavioural survey among MSM was conducted. However, few countries have conducted such studies and MSM's specific health needs, especially for HIV prevention, are still not being met. In most countries, like Swaziland, the HIV prevalence is still generalized. Although Swaziland bears the burden the highest HIV prevalence in the world at 26% for the age group 15-49 (UNAIDS, 2010), interventions to MSM and other most-at-risk populations are limited.

The study's main aim was to identify the prevention needs of MSM in Swaziland. A total of 50 MSM were interviewed in order to find information. In addition, five key informants who were managers of HIV prevention programmes were also interviewed. It was established that there is a gap between the MSM's needs and the interventions currently available. There were factors that put MSM at risk for HIV infection that were identified by the study. It was established that some of the HIV prevention did not meet the specific needs and expectations of MSM. Knowledge on some HIV risk behaviours and some prevention strategies targeting MSM was limited.

## OPSOMMING

Sedert die begin van die MIV-epidemie in die vroeë 1980's, het die seks tussen mans (MSM) as buite verhouding beïnvloed deur die virus. Seks tussen mans is die belangrikste roete van die oordrag van MIV in sommige dele van die wêreld. In sommige ander plekke is dit 'n sekondêre roete van oordrag. Wêreldwyd, MSM word geklassifiseer as die meeste-at-Risk bevolking as gevolg van hul hoër risiko van MIV-oordrag. Alhoewel seks tussen mans in die meeste samelewings voorkom, word dikwels sy bestaan, belang in MIV-voorkoming geweier. Dikwels word hierdie manne verwaarloos in MIV-voorkoming intervensies. Seksuele daade tussen mans dikwels veroordeel en soms gekriminaliseer. In sommige lande, strawwe vir diegene wat beskuldig word van seksuele daade tussen mans is onder die ergste beskikbaar. Elders, selfs waar van dieselfde geslag gedrag nie onwettig is nie, is daar dikwels nie-amptelike vervolging deur die owerhede of diskriminasie of stigmatisering van daardie manne wat bekend is of gedink word om seksuele verhoudings met ander mans. Vir hierdie redes, seks tussen mans, in baie dele van die wêreld is verborge of geheimsinnig. Dit maak 'n assessering van die omvang, en van die verskillende tipes van seksuele daade wat plaasvind, nog moeiliker.

As 'n gevolg van verwaarloos, is daar gewoonlik gebrek aan navorsing en dienste gerig op MSM. In sub-Sahara Afrika, byvoorbeeld, dit was net meer as 10 jaar gelede, in 2001, toe die eerste gedrags-opname onder MSM is uitgevoer. Egter, het 'n paar lande uitgevoer sodanige studies en MSM se spesifieke gesondheid behoeftes, veral vir MIV-voorkoming, is nog steeds nie bereik word nie. In die meeste lande, soos Swaziland, die voorkoms van MIV is nog steeds algemene. Hoewel Swaziland dra die las om die hoogste voorkoms van MIV in die wêreld op 26% vir die ouderdomsgroep 15-49 (UNAIDS, 2010), intervensies MSM en ander die meeste-op-risiko bevolkings is beperk.

Die studie se hoofdoel was om die voorkoming van MSM te identifiseer in Swaziland. 'N totaal van 50 MSM is ondervra ten einde inligting te vind. Daarbenewens is ook vyf sleutel informante wat bestuurders van die voorkoming van MIV-programme ondervra. Daar is vasgestel dat daar is 'n gaping tussen die MSM se behoeftes en die intervensies wat tans beskikbaar is. Daar is faktore wat sit MSM 'n risiko vir MIV-infeksie wat deur die studie geïdentifiseer is. Daar is vasgestel dat sommige van die MIV-voorkoming het nie voldoen aan die spesifieke behoeftes en verwagtinge van MSM. Kennis op 'n aantal MIV-risiko gedrag en 'n paar voorkoming strategieë fokus MSM is beperk.

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## **CHAPTER 1 INTRODUCTION**

### **1.1 Introduction**

AIDS remains one of the world's most serious health challenges and globally, 34.0 million people were living with HIV at the end of 2011 (UNAIDS, 2012). Although reports indicate a fall in the number of newly infected people (adults and children), the number is still high with 2.5 million people infected in 2011 alone. Sub-Saharan Africa region accounts for 71% of the adults and children newly infected in 2011, and therefore underscoring the importance of continuing and strengthening HIV prevention efforts in the region.

Since the beginning of the HIV epidemic in the early 1980s, men who have sex with men (MSM) have been disproportionately affected by the virus. The risk of infection remains high among them and recently in the 21<sup>st</sup> century, there has been resurgence of HIV infection among MSM, particularly in developed countries. MSM are defined as most-at-risk populations (MARPS) in the HIV interventions because of their higher risk of infection. However, in most developing countries, there is insufficient data on MARPS, including MSM.

The Global HIV Prevention Working Group (2012) states that unless the rate of new HIV infections is sharply lowered, the long-term viability of treatment initiatives stands to be jeopardized. However, too few people at high risk of HIV infection receive the prevention services they need. The populations most at-risk of HIV infection are especially neglected in HIV prevention efforts. In the widespread of the HIV epidemics in sub-Saharan Africa for instance, it is proposed that most at-risk populations, such as MSM, are less targeted because HIV transmission is sustained in the general population with average HIV acquisition and transmission risks. This understanding that MARPS, such as MSM, are less relevant in the epidemics of Africa is based on the surveillance system from which these populations are mostly excluded. Outside of sub-Saharan Africa, the epidemics of HIV are concentrated in the same populations that are excluded from the primary HIV surveillance systems in sub-Saharan Africa (Baral & Mafuya, 2012).

Although surveillance data where conducted has consistently shown extremely elevated HIV prevalence among MSM, prevention efforts routinely neglect these populations. In sub-Saharan Africa, HIV surveillance among MSM began 10 years ago in Senegal. Since then, other surveys conducted in 14 countries have established that HIV prevalence among MSM in these countries are significantly higher

than corresponding general populations, and that MSM engage in sexual risk behaviours that place them and their partners at higher risk and that issues of stigmatisation and discrimination inhibit HIV interventions for them.

Swaziland has the highest HIV prevalence in the world at 26% for the adult population (aged 15-49). The HIV epidemic is highly generalized among the general population. Most institutions have assumed that the modes of HIV transmission in the country are entirely through heterosexual sexual intercourse. As a result, most at-risk populations including MSM have been generally neglected (Modes of Transmission, MOT, 2007). It is recently that Swaziland has identified most at-risk populations, including MSM.

HIV prevention strategies are continuously being developed and improved. These include biomedical, behavioural and structural interventions. The extent of their knowledge, acceptability, utility and relevance of the HIV prevention strategies and technologies among MSM in Swaziland is not known. The factors that contribute to the uptake of the available HIV prevention strategies is not known among the MSM and so are the specific HIV prevention needs of the MSM in Swaziland.

This study was designed to investigate the HIV prevention needs for MSM in Swaziland. Special focus was on identifying the factors that put MSM on risk for HIV infection, the existing HIV prevention strategies for MSM acceptability and perception of some HIV prevention strategies targeting MSM.

## **1.2 Background of the Study**

HIV and AIDS still remain a threat to public health globally with UNAIDS estimating that there were 34.0 million people living with HIV by the end of 2011 worldwide (UNAIDS, 2012). In 2011 alone, there were 2.5 million newly infected with HIV. Sub-Saharan Africa remains most severely affected - while it has 10% of the world's population, it accounts for 69% of the people living with HIV worldwide and 71% of new infections in 2011 (UNAIDS, 2012). Swaziland has one of the highest HIV prevalence in the world at 26% among the adult population aged 15-49 (Central Statistics Office, CSO, 2008).

Since the beginning of the epidemic, MSM have been disproportionately affected by the virus. Although sex between men occurs in every culture and society, its extent and public acknowledgement varies from region to region. UNAIDS (2012) estimates that MSM account for about 5-10% of the global burden of HIV, with considerable differences between countries and regions. MSM are a recognized high risk group for HIV infection in North America, Western Europe and Australia (Muraguri, Temmerman & Geibel, 2012).

Although studies in all regions have consistently indicated extremely elevated HIV prevalence among MSM, prevention efforts routinely neglect these populations (Global HIV Prevention Working Group, 2012). In sub-Saharan Africa, it is only recently that there has been attention to HIV among MSM in some countries, with the first behavioural survey among MSM conducted in Senegal just over 10 years ago in 2001 (Muraguri, Temmerman & Geibel, 2012). Since then, a number of survey activities have been conducted in several African countries, providing basic needed epidemiological data. Muraguri *et al* report since 2001, 14 countries have conducted surveys in sub-Saharan Africa.

Although several countries have conducted some HIV surveys, the extent of the HIV prevalence is not known among MSM in most countries in sub-Saharan Africa. Same-sex behaviours have been neglected by researchers and those that are involved in HIV and AIDS interventions. HIV prevention strategies therefore always target the general population while the specific needs of most-at-risk-behaviour populations, like MSM, are always neglected. As a result, HIV prevalence among the MSM population continues to be hidden in the prevalence of the general population and continues to rise.

In the widespread HIV epidemics of sub-Saharan Africa, it is often proposed that some populations with specific HIV acquisition and transmission risk factors are less relevant because HIV transmission is sustained in the general population with average HIV acquisition and transmission risks (Baral and Mafuya, 2012). In 2000, the World Health Organisation (WHO) convened a collaborative group defined generalized epidemics as being when the HIV prevalence is consistently higher than one percent in antenatal clinics in contrast to concentrated epidemics where HIV prevalence is consistently higher than five percent in at least one of the population sub-group, but less than one percent in antenatal clinics. The collaborative group also defined low-level epidemics where HIV prevalence is less than five percent any population sub-group and less than 1% in antenatal clinics (UNAIDS & WHO, 2010). The continental countries in Southern and Eastern Africa all have generalised epidemics, which is a categorization independent of the burden of disease in the population sub-groups. This is a result of the surveillance systems being used that are less relevant in the epidemics of Africa from which these sub-populations are mostly included (Baral & Mafuya, 2012).

Outside of sub-Saharan Africa, the HIV epidemics are mostly concentrated among the same sub-groups population that are excluded from the primary HIV surveillance systems in SSA. Swaziland had its first HIV prevalence surveillance in 2011 among the MSM population sub-group. The HIV prevalence amongst this group was found to be estimated at 17.7% (Swaziland Ministry of Health, SMOH, 2012).

Among the general population, the HIV prevalence among men in Swaziland is estimated at 20%. The prevalence among the MSM was slightly lower than general population something that is not consistent with other studies elsewhere. However, this might be because of the fact that the HIV prevalence among the men in the general population is concentrated among the age group 30-44 years at 42% and lowest among the age group 15-29 years at 19.5%. In contrast, 90.4% of the MSM that were screened for HIV prevalence surveillance were from the least infected age group of 15-19 years; only 9.6% of the MSM population screened were from the most severe infected age group (SMOH, 2012; CSO, 2008). As a result, the HIV prevalence among the MSM sub-population was lower than that of the men in the general population as the majority of the MSM that were screened were from the age group of men that generally have the lowest HIV prevalence.

Results from studies in most countries indicate high rates of HIV infection, high risk behaviour, and evidence of behavioural links between MSM and heterosexual networks yet most MSM have no safe access to relevant HIV and AIDS information and services. Most African countries have not begun to address the needs of MSM in their HIV and AIDS programmes (UNAIDS, 2012). In most sub-Saharan African countries, the response to HIV related needs for MSM is challenged by social and political hostility which is endemic, especially where same-sex behaviour is illegal.

Despite the strong impact of the HIV epidemic on MSM, to date, only recently, in 2011, there were technical recommendations have been developed to guide the health systems' response to the epidemic among the sub-population. Both the WHO and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), respectively, developed technical recommendations and guidelines to address prevention programmes for MSM. This followed a global consultation held by WHO in 2008 on "Prevention of HIV and other sexually transmitted infections (STI) for MSM and transgender populations", in Geneva, Switzerland (WHO 2011).

### **1.3 Motivation of the Research Project**

The study was motivated by the need of research among the MSM population in the Manzini region of Swaziland. Although MSM have been disproportionately affected by HIV since the beginning of the epidemic, they have been generally ignored by researchers and health care programmes especially in sub-Saharan Africa, including Swaziland, as the epidemic is believed to be generalized. There is general lack of information on MSM and HIV, and this study was the first to investigate the specific HIV prevention needs of MSM in Swaziland.

Firstly, the study was therefore motivated by that it will contribute to the body of scientific information, benefiting the MSM population through services that may be delivered to them as they have been neglected in HIV prevention interventions. The study was also motivated by the fact that national health officials, health workers, managers of HIV and AIDS programmes and non-governmental organisations can benefit from knowledge on the HIV prevention needs of MSM, which may be useful in scaling up HIV prevention programmes.

The study was also motivated by both the recent (2011), PEPFAR and WHO technical guidelines respectively (PEPFAR, 2011; WHO, 2011). Both guidelines are for the prevention of HIV (and STIs) among the MSM (and transgender) population. As these guidelines are recommendations, the study's aim was to provide evidence-based information that can be useful in the implementation of these technical guidelines. These technical recommendations have been made to guide health systems' response to the epidemic among the MSM.

#### **1.4 Research Problem**

Sex between men occurs in every culture since the beginning of the world. However, their acknowledgement of their existence varies from region to region. In most cases, their existence is suppressed by homophobic stigma and punishment. They therefore remain hidden and hardly access health care services. Even when they access health care services their specific needs are always not met as they rarely disclose their true sexual behaviour. MSM are often in the HIV prevention interventions although globally, they are defined as most-at-risk population because of their high risk to HIV infection. The high HIV prevalence among MSM in Sub-Saharan African nations is always hidden in the overwhelming county-specific heterosexual epidemics. There is general lack of studies, information and services targeting MSM. The general lack of HIV studies for MSM in sub-Saharan Africa has led to general lack of interventions targeting MSM sub-population. Even if some of the HIV prevention interventions are offered to the general population, such approach may not meet the specific health needs of MSM, including HIV prevention.

Family Health International (FHI) (2001) states that HIV prevention approach should begin with the most-at-risk behaviour sub-populations, like the MSM; because they have a higher HIV risk infection and then move to the general population. Unfortunately in most parts of Africa, the priority is the general population and the sexual behaviours of the most-at-risk populations, like MSM; remain hidden hence prone to vulnerability and more risk to HIV infection.

Among the factors that cause high risk infection among MSM are poor availability of, or access to and use of, condoms and water based lubrication; poor screening for and treatment of anal sexually transmitted infections (STIs); sexual practices, particularly unprotected receptive anal sex; frequency and higher number of sexual partners. Some of the vulnerabilities that are associated with the high risk infection include cultural, religious and political stigmatisation; discrimination resulting in marginalisation; mental health and psychosocial factors; recreational substances including alcohol and drugs; myths and misconceptions about risks associated with different behaviours and about methods of reducing risk of infection and hetero-normativity and/or homo-prejudice (Anova Health Institute, 2011).

According to Baral and Mafuya (2012), the overall rate of HIV infection among MSM in sub-Saharan Africa is estimated to be four to five times higher than the rate of other heterosexual men. In some countries, this could even be more than 20 times higher. Receptive anal sex is the most risky encounter to HIV infection with about one in 300 encounters. On the other hand, receptive vaginal sex, which is the second risky act, calculates a risk of one in 500 encounters. Receptive anal sex remains the highest risk to HIV infection because of the risk of bruise and cuts that are likely to occur during anal sex.

The problem question was: What are the HIV prevention needs of MSM in Manzini, Swaziland?

## **1.5 Aim and Objectives of the Study**

The aim and objectives of the study were as follows: To determine the HIV prevention needs of MSM in Swaziland in order to provide information that can inform HIV and AIDS policies and programmes on specific HIV prevention strategies that can target MSM.

### **1.5.1 Objectives**

- To distinguish the factors that put MSM in Swaziland at risk for – and vulnerable to – HIV infection.
- To identify the HIV prevention needs of MSM in Swaziland.
- To identify the existing HIV prevention strategies targeting MSM in Swaziland.
- To describe the MSM's knowledge, perceptions and attitudes towards HIV prevention strategies targeting MSM in Swaziland.
- To develop recommendations for HIV prevention strategies for MSM in Swaziland.

## **1.6. Research Methodology**

The data was collected from both MSM (primary population) and managers of HIV and AIDS programmes (key informants) in Manzini city. Mixed methods were used for data collection – Both

qualitative and quantitative data was collected. Qualitative data was collected from both MSM and managers of HIV and AIDS programmes. Quantitative data was collected exclusively from the MSM population. Semi-structured interviews were used to collect qualitative data while the quantitative data was collected through questionnaires.

Two non-random sampling methods were used to collect the data from the two populations, MSM and managers of HIV and AIDS policies and programmes. Snowball sampling was used to collect data from the MSM population and 35 MSM were selected for qualitative interviews and an additional 15 MSM were sampled for the qualitative interviews. Five managers of HIV and AIDS policies and programmes were selected through purposive sampling.

Four of the six managers of HIV and AIDS policies and programmes interviewed were from non-governmental organisations (NGOs) while the remaining two were from the Ministry of Health. The MSM population was men ranging between 18 and 44 years. However, the majority of these men was below the age of 30 and identified their sexual orientation as gay. The MSM participants were all male who were either with different marital status and levels of education and were all having an experience of having anal sex with another man in the past.

### **1.7 Limitations of the Study**

The study had several limitations. One of the limitations was that the sample was from only one city in Swaziland, Manzini. It might be possible that the experiences and HIV prevention needs of the MSM in the city of Manzini are different from other places in the country.

The instrument used for data collection was developed by the researcher and therefore had not been used before in the population that was being studied in Swaziland. Moreover, although the snowball sampling was useful to access the hidden and rare to find MSM population, the participants were likely to invite their peers to participate after participating themselves. So it was likely that one participant will invite his peers with similar characteristics.

The stigma and illegal nature of the same-sex practice in Swaziland also limited participation of the MSM population. Most of the MSM remain hidden. It is therefore those that were willing to volunteer to participate despite the stigma that participated and the study was limited to include MSM that are hidden.

## **1.8 Outline of Chapters**

The research report is divided into five chapters, namely:

- Chapter 1: Introduction
- Chapter 2: Literature Survey
- Chapter 3: Research Methodology
- Chapter 4: Reporting of Results
- Chapter 5: Conclusions and Recommendations

## **1.9 Conclusion**

HIV and AIDS remains a global health challenge since the last three decades. However, in most low - and middle - income countries; the epidemic is much generalized, without considering the specific needs of sub-populations that are most-at-risk for HIV infection. Following the background of the HIV and the prevention strategies in place as well as its status quo among the MSM, especially the lack of data and studies in Swaziland, the following chapter will explore the available literature.

## **CHAPTER 2**

### **LITERATURE SURVEY**

#### **2.1 Introduction**

HIV is different from AIDS, yet related. HIV means Human Immunodeficiency Virus and it is the Virus that causes AIDS. AIDS means Acquired Immunodeficiency Syndrome and it refers to the state when after one is infected with HI virus, the body's immune system cannot protect it from illnesses because of the low CD4+ T helper cells in the body. The HIV, which is a virus that lives only in the human body, attacks the CD4+ cells once entering the body and therefore through different stages, the condition progressively reduces the effectiveness of the immune system and leaves individuals susceptible to opportunistic infections and tumours. AIDS is the last stage of the progression.

HIV is transmitted from human to human through direct contact of a mucous membrane or the bloodstream with a bodily fluid containing HIV, such as blood, semen, vaginal fluid and breast milk. The transmission can be through anal, vaginal or oral sex, blood transfusion, or mother-to-child. Although a majority of infections are accounted to heterosexual sex, anal sex is said to have the highest risk of HIV transmission.

Although the origins of HIV remains a debate, with genetic research indicating that it originated in west-central Africa during the late 19<sup>th</sup> or early 20<sup>th</sup> century, HIV and AIDS has become a pandemic. AIDS was first recognised by the United States Centres for Disease Control and Prevention in 1981 (Epstein, 2007). It was first recognized among MSM but throughout the past three decades, MSM have been neglected in HIV interventions in most low- and middle- income countries. Millions of people have been infected with HIV and million have died since it was first recognised.

#### **2.2 Global HIV Epidemic**

Since the beginning of HIV and AIDS three decades ago, it has remained the world's widespread burden to health. Although the AIDS epidemic is reported to be stabilizing, there are still challenges. Globally, 34 million were living with HIV at the end of 2011. The number of people newly infected by HIV in 2011 alone was estimated to be 2.5 million while 1.7 million people died from AIDS-related causes worldwide. Sub-Saharan Africa is the severely affected region globally, accounting for 69% of people living with HIV in the global epidemic. It is estimated that one in 20 people is living with HIV in sub-Saharan Africa. Sub-Saharan Africa also has the highest number of new infections as it accounts for nearly 70% of the

new infections in 2011. This region also accounted for about 70% of the AIDS-related deaths in 2011 (UNAIDS, 2012).

### **2.3 Swaziland HIV Epidemic**

Swaziland bears a disproportionate burden of the HIV epidemic in the world. Swaziland has a population of 1.2 million and the HIV prevalence is 26% among the adult population aged 15-49. Generally, females have a higher prevalence than males. The prevalence among females is 31%, while the males have 20% prevalence in the adult population age group (CSO, 2008). The prevalence in the country is generalized. The HIV incidence in Swaziland is 2.4% according to a 2011 longitudinal cohort that enrolled 11, 880 (Swaziland HIV Incidence Measurement Survey, SHIMS, 2011). HIV testing counselling and ART are available for free in the country.

### **2.4 HIV Epidemic among MSM**

There is generally insufficient data on the HIV prevalence among MSM. Most of the available data comes from developed countries where the prevalence among the MSM population has been recognized. Surveillances and special surveys in many parts of the world indicate that the prevalence of HIV is high among MSM compared to men in the general population. These men often infect their partners who are men and, in some cases, women as well. A high HIV prevalence among MSM population is being reported from countries that had previously ignored or denied the existence of MSM in their population (USAID, 2010). Despite epidemiological evidence, widespread and the increase of the problem, the rates of essential HIV prevention is extremely low among MSM (WHO, 2008). Decreasing the relative burden of HIV among MSM will require targeted prevention programmes. HIV prevention needs among MSM cannot be fully understood without understanding the specific biological, socio-behavioural, social and cultural factors that put them at greater risk of HIV infection and the vulnerabilities that limit MSM ability to avoid these risks.

Sex among men is a major route of HIV transmission in the developed countries, and the emerging data from low - and middle - income countries indicate that MSM bear a substantial burden of HIV epidemics. A meta-analysis of 83 studies from 38 countries showed that MSM were at 19-times greater risk of infection with HIV than the general population (USAID, 2010). It is estimated that at least five to 10% of all infections worldwide are due to sexual transmission between men, and this figure varies within countries and between regions. In Swaziland, the HIV prevalence among MSM is 17.7% (SMOH, 2012).

## **2.5 Factors that make MSM Vulnerable to HIV infection**

MSM, and other MARPS, are often more vulnerable to HIV infection than the general population, yet their vulnerability is often overlooked (USAID, 2010). According to the Desmond Tutu HIV Foundation (2011), there are biological, socio-behavioural, structural and political factors that increase the susceptibility of MSM to HIV infection.

### **2.5.1 Biological Factors**

It is easier for HIV to be transmitted through unprotected anal sex than vaginal sex (Baral, 2008). According to the Desmond Tutu HIV Foundation (2011), penile-anal sex is more susceptible to HIV infection because there are no natural lubricants as the lining of the anus and rectum is thinner than that of the vagina, making it easier for damage and bleeding to occur during sex. The Desmond Tutu HIV Foundation further states that the presence of faecal matter in penile-anal sex is likely to contain bacteria. Sexually Transmitted Infections (STI) can be extra biological factors that increase the risk of becoming infected with HIV. Baral further states that STIs are relatively common among MSM, and rectal STIs are often undiagnosed and untreated. In most cases, the fear of discrimination prevents MSM from accessing testing and treatment services.

### **2.5.2 Socio-Behavioural Factors**

MSM communities in Africa are more vulnerable to HIV infection than most MSM in other settings. This is mostly a result of socio-behavioural factors. These factors may be personal or social and include knowledge of risk; safe sex skills; and testing and knowledge of HIV status (Desmond Tutu HIV Foundation, 2011).

#### **2.5.2.1 Knowledge of Risks of MSM Sexual Practices**

Many MSM have misconceptions about anal sex and as a result, they regard it as a safe alternative to vaginal sex (Desmond Tutu HIV Foundation, 2011). This may be a result of lack of sexual health information and education that highlight the risks of anal sex. The Desmond Tutu HIV Foundation (2011) further adds that some studies have indicated that there are MSM who are not aware of the potential benefit of condom use in protecting themselves during anal sex. Radebe (2011) further states that there is generally poor messaging around HIV prevention for MSM. Radebe (2011) states that many MSM, for instance, are not aware that male circumcision only benefits one partner, that is, the insertive partner during penile-anal sex.

### **2.5.2.2 Safe Sex Skills**

Condom use for HIV prevention during penile-anal sex works effectively when used with water-based lubrication (Rebe, 2011). This protection depends upon skills of the MSM to select and apply condoms properly and their ability to use condoms with water-based lubricants. According to Desmond Tutu HIV Foundation (2011), unfortunately, many African MSM opt for other forms of lubricants that are easily available, especially oil-based lubricants, which may damage latex condoms. Access to water-based lubrication can be difficult for most MSM.

### **2.5.2.3 Testing and Knowledge of HIV Status**

Knowing one's HIV status can benefit MSM as negative HIV status can reinforce existing good prevention practices, while positive HIV status allows the individual to access early HIV treatment as well as adopting practices that reduce the risk of affecting other sexual partners. However, most MSM live unaware of their HIV status due to ignorance of the risks of their own sexual behaviours and/or reluctance to use available testing services (Desmond Tutu HIV Foundation, 2011).

## **2.5.3 Structural and Political Factors that may Increase HIV Vulnerability**

HIV prevention intervention to MARPS, including MSM, is often challenged by structural and political issues. Without considering and tackling such issues, HIV prevention among these populations is a challenge or, in many settings, impossible (Baral & Mafuya, 2012). The following factors may be considered that may challenge HIV prevention intervention to MSM and increase vulnerability to HIV:

### **2.5.3.1 Laws and Politics**

Male same-sex behaviour is illegal in most African countries, including Swaziland. According to The Desmond Tutu HIV Foundation (2011), countries that have decriminalised the MSM behaviour and offered legal protection for MSM see it as a benefit for more MSM coming forward for HIV prevention, as well as testing treatment. Unfortunately, many African countries report harassment from state authorities and/or public in relation to their sexual orientation. The Desmond Tutu HIV Foundation further states that in Southern Africa, studies have shown blackmail to be related to HIV risk. USAID (2010), further states that the United Nations reported in 2008 that in countries without laws to protect MSM, only a fraction of the population have access to HIV prevention. Conversely, in countries with legal protection and the protection of human rights for MSM, many more have access to services and as a result, there are fewer infections.

### **2.5.3.2 Public Opinion**

Public opinion towards MSM in African countries may be extremely hostile, irrespective of the law. The causes of public opinion may include the misconceptions that homosexuality is a behaviour that is foreign in Africa and cultural expectations that men should have sexual partnerships that bear children (Desmond Tutu HIV Foundation, 2011).

### **2.5.3.3 Self-Esteem**

Most MSM experience homophobic stigma in communities where they live. The stigma has a direct impact on an individual's sense of personal worth (Desmond Tutu HIV Foundation, 2011). Caceres (2008) further states that lack of self-esteem arising from stigma has been shown to reduce a person's motivation to protect himself or others from high-risk sexual behaviours.

### **2.5.3.4 Inappropriate Services for MSM**

While many HIV prevention and treatment services may be available to serve the general population, these services are always ill prepared to deal with the specific sexual health needs of MSM, including HIV prevention needs (Desmond Tutu HIV Foundation, 2011). Radebe (2011), states that this may be due to reasons including lack of MSM-appropriate HIV prevention materials, that is, information, water-based lubricants and condoms. Lack of experience and training on MSM related issues among health care workers is also common. Radebe (2011) further states that judgmental or abusive reactions to MSM from health care workers and other users of facilities increase the vulnerability of MSM to HIV infection.

## **2.6. Risks among MSM**

MSM are defined as most at risk populations because of their higher risk to HIV infection than the general population. There are different reasons that put MSM at higher risk for HIV infection than the average population. The following conditions can be considered as being risks:

### **2.6.1 Unprotected Anal Sex**

The main explanation for the higher risks of HIV among MSM is that HIV is very easily transmitted during unprotected anal sex (Desmond Tutu HIV Foundation, 2011). Caceres (2008) further explains that unprotected, receptive anal sex is the strongest risk factor for HIV among MSM and that official figures suggest that African MSM frequently do not use condoms for anal sex, and when they do, they frequently do not use safe water-based lubricants.

## **2.6.2 Drug and Alcohol Use**

Some African MSM, in certain contexts, may also report a higher use of recreational and illegal drugs than other members of the population. Consumption of alcohol commonly takes place where MSM socialise and meet sexual partners. Some research suggests that alcohol use with sex reduces inhibitions and increases MSM risk-taking behaviours (Wade, 2005). Caceres (2005) further states that alcohol use, which is common among MSM, increases the risk of having multiple concurrent sexual partners.

## **2.7 HIV Prevention among MSM**

According to WHO (2009), there is no single existing intervention to prevent the transmission of HIV among MSM or any other population. The WHO suggests that prevention programmes should include: mapping and documenting recent epidemiological trends to identify current and emerging prevention needs among MSM; supporting combination prevention by combining biomedical, behavioural and structural interventions to craft a comprehensive prevention response; and support and evaluate promising and innovative practices to determine effectiveness and impact of prevention interventions at country level.

### **2.7.1 Evidence-Based HIV Prevention with MSM**

WHO (2009) states that there is a critical need for comprehensive HIV prevention programmes for MSM that are scientifically accurate, evidence-based, designed to be responsive to the needs and experiences of local MSM, and that reach MSM in safe and non-judgmental settings. HIV prevention programmes for MSM can be optimized by creating an environment of laws, regulations and policies that support the implementation and scaling-up of evidence-based interventions. UNAIDS (2009) further identifies two main categories of HIV prevention activities, namely community-based outreach and HIV testing, treatment and care.

#### **2.7.1.1 Community-Based Outreach**

In most communities where homophobia, stigma and discrimination is prevalent, MSM cannot fully access health services as they cannot disclose their sexuality to health care workers and others (WHO, 2009). UNAIDS (2009) states that community-based outreach programmes can heavily depend on the use of peers or trusted individuals who can access members of the population and engage them in HIV prevention and care in their own environments. These trained peers can communicate and reinforce HIV prevention messages. UNAIDS further states that outreach programmes can provide a range of services including, but not limited to: dissemination of risk reduction information and targeted media; distribution of condoms and condom-compatible lubricants; training and correct use of condoms; and provision of

referrals and linkage to HIV testing, prevention programmes, drug and alcohol dependency treatment as well as HIV health care and treatment that provide services that are non-discriminatory and responsive to the needs of MSM. Rebe (2011) advises that oil-based lubrications should not be used with condoms and should not be distributed by HIV prevention programmes. On the other hand, strategies should be used to increase the availability of condoms and condom-compatible lubricants and this may include placing them in venues that are frequented by MSM.

WHO (2009) also states that development of information, education and communication (IEC) is important in the prevention of HIV among the MSM population. This may include activities that seek to improve HIV knowledge and awareness; build skills and self-sufficiency; promote beliefs, attitudes and norms that reduce HIV risk; and motivate HIV testing and changes in behaviour. UNAIDS (2009) further states that this could be achieved through evidence-based community, small-group, and individual behavioural interventions, peer education behavioural interventions or social marketing campaigns.

#### **2.7.1.2 HIV Testing Treatment and Care**

According to UNAIDS (2009), HIV testing and counselling is critical among the MSM and their sex partners and in facilitating HIV positive MSM's access to appropriate health care services. High-quality counselling can reduce HIV risk and sexually transmitted infections among MSM. UNAIDS suggests that a variety of models for HIV counselling and testing should be used. Such models can include providing HIV counselling and testing in clinics and community-based organisations that serve the MSM; conducting HIV testing in outreach settings; developing networks of MSM private providers, using of social network to recruit more MSM and their partners for HIV testing, and other prevention strategies. Radebe (2011) further states that couple-based HIV testing has been successful with heterosexual couples and can also be adapted for MSM.

WHO (2009) states that timely access to life-saving health care, antiretroviral treatment and opportunistic infection prophylaxis has powerful effects on the health and well-being of people living with HIV. There should be effort to provide HIV positive MSM access to timely and appropriate HIV medical care and antiretroviral treatment as part of a comprehensive HIV strategy for MSM. This should include appropriate referrals to alcohol and drug treatment for HIV positive MSM.

### **2.7.2. Optimizing HIV Prevention with MSM**

Best practices that can improve the effectiveness of HIV prevention efforts for MSM must be taken into consideration (PEPFAR, 2011). This may include involvement of MSM; ensuring confidentiality; and collecting and using strategic information. WHO states that there should be efforts to build the capacity and ability of local MSM organisations to lead and implement HIV prevention programmes. Strengths and networks of MSM should be developed and they should be involved in planning, implementation and leadership of HIV prevention interventions. UNAIDS (2009) adds that it is essential that participation in the HIV prevention programmes, receipt of HIV care and treatment should not put MSM at-risk for discrimination, arrest or prosecution.

On the other hand, since older effective prevention and treatment technologies have not been up scaled for MSM in many settings, especially for African MSM, questions arise regarding the applicability and feasibility of newer prevention technologies such as pre-exposure prophylaxis (PrEP) and rectal microbicides (Rebe, Semugoma & McIntyre, 2012). Rebe *et al* state that PrEP study provided proof that daily emtricitabine and tenofovir can reduce the risk of HIV negative MSM acquiring the virus by 44%. The study recruited 88 African MSM out of 2499. They also state that studies conducted in the third world have shown that knowledge on PrEP and rectal microbicides (which are under study) is extremely low but many MSM would be prepared to use the intervention if it was available.

## **2.8 Conclusion**

HIV remains a burden among MSM. There are limited HIV prevention strategies targeting this population. Often, they are neglected in HIV programming. This chapter was reviewing literature related to HIV prevention among MSM. There are HIV prevention strategies being developed globally targeting MSM. The next chapter explains the methodology used to collect data on the study.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

The main aim of the study was to identify the HIV prevention needs for MSM in Swaziland, using Manzini city as a case study. The study had raised some issues in order to achieve this aim. These issues include distinguishing the factors that put MSM in Swaziland at risk for – and vulnerable to – HIV infection; identifying the facilitators and barriers for implementing HIV prevention strategies targeting MSM in Swaziland; and describing the MSM's knowledge, perceptions and attitudes towards HIV prevention strategies targeting MSM in Swaziland.

This chapter describes the method used in achieving the aim of the study. It is divided into five sections, namely, problem statement and question; objectives of the study; research approach; sampling and lastly, conclusion.

#### **3.2 Problem Statement and Question**

Sex between men occurs in every society, yet its extent and acknowledgement varies from region to region. It is estimated that MSM account for 5 to 10% of all global HIV infections and that this figure varies from region to region (UNAIDS, 2006). Biologically, unprotected receptive anal sex has much higher risk than unprotected receptive vaginal sex. Men who have sex with men bear a substantial burden of the HIV epidemics. A meta-analysis of 83 countries showed that overall, MSM were 19 times at greater risk of HIV infection than the general population (USAID, 2010).

In many countries, especially developing countries, there is general lack of acknowledgement on the existence of MSM. MSM continues to fall victims of persecution, discrimination, and gross ill-treatment. They are often subject to extreme violence and often criminalised and severe punished. As a result there are few MSM who have access to HIV prevention in those settings (USAID, 2010). There has been general lack of focus on MSM and other most at risk populations by researchers and service providers, especially in sub-Saharan Africa. These populations are often neglected in HIV prevention efforts (Global HIV Prevention Working Group, 2010). There is, therefore, general lack of data on the specific HIV prevention needs for MSM.

In order to identify the HIV prevention needs of MSM in Swaziland, there was a need to collect data as there is not adequate data to contribute to policies and programmes for HIV prevention. The research

question as the data was collected was: What are the HIV prevention needs for MSM in Swaziland? There were objectives developed in answering the research question.

### **3.3 Objectives of the Study**

- To distinguish the factors that put MSM in Swaziland at risk for – and vulnerable to – HIV infection.
- To identify the HIV prevention needs of MSM in Swaziland.
- To identify the existing HIV prevention strategies targeting MSM in Swaziland.
- To describe the MSM's knowledge, perceptions and attitudes towards HIV prevention strategies targeting MSM in Swaziland.
- To develop recommendations for HIV prevention strategies for MSM in Swaziland.

### **3.4 Research Approach**

The study used a case study research approach in data collection. A case study is a kind of study where a particular individual, programme, or event is studied in detail for a defined period of time (Leedy, 2005). It also constituted of a variety of methods for data collection which allows an in-depth focus during a study. The reason for using the case study was that it is important to learn more about the HIV prevention needs for MSM in Swaziland as there is general lack of data on this.

The city of Manzini was selected as a study area because it is the hub city of Swaziland and was reported by gatekeepers of MSM groups to have a large number of MSM living in the city. The MSM population in the city also have existing, informal networks and community groups. The case study of Manzini city was therefore selected on the basis of having possible access to the population under study while the case study was used for the in-depth study of the population as well as its advantages of allowing different data collection techniques.

### **3.5 Data Collection Techniques**

The study used a mixed-method design for data collection using both quantitative and qualitative designs. The quantitative data was collected using structured questionnaires. The questionnaire used closed-ended questions. On the other hand, qualitative data was collected through semi-structured interviews guided by interview guides. Quantitative data was collected from the primary target population, MSM, through questionnaires that were administered by the researcher. The qualitative research, semi-structured interviews, was used to collect data from the key informants, managers of HIV prevention policies and programmes, as well as some other MSM.

A mixed-method design approach for data collection was used to ensure a detailed study of the HIV prevention needs for the MSM in Manzini. As this was an exploratory study, using the mixed-method approach allowed for an in-depth study of the issues raised by the study. Leedy (2005) states that we learn more about the world when we have both quantitative and qualitative methodologies at our disposal than when we are limited to only one approach or the other. The importance of the quantitative research was to seek explanations and predictions that can be generalised to other persons and places. On the other hand, the qualitative research method was used in order to have a detailed study of the HIV prevention needs for MSM in Manzini. Leedy (2005) states that qualitative researchers seek a better understanding of complex situations and their work is exploratory in nature.

### **3.6 Target Population**

The target population was males above the age of 18 years who lived in Manzini city and had experiences of having sex with other males as well as and managers of HIV prevention programmes who were key informants. The MSM were reached in their places of residence and occupation around Manzini while the key informants were reached in institutions where they worked. There are approximately 130 MSM and 10 managers of HIV prevention programmes in Manzini.

### **3.7 Sampling Method**

A non-random sampling was used in the study. Snowball sampling was used to select the MSM because they are a hidden population and could be easily invited by their peers to participate. On the other hand, purposive sampling was used to select the key informants, managers of HIV prevention policies and programmes. The purposive sampling was used because of its convenience to select the key informants as the data was collected from individuals already involved in HIV prevention policies and programmes. The selection criterion is explained below.

#### **3.7.1 Snowball Sampling**

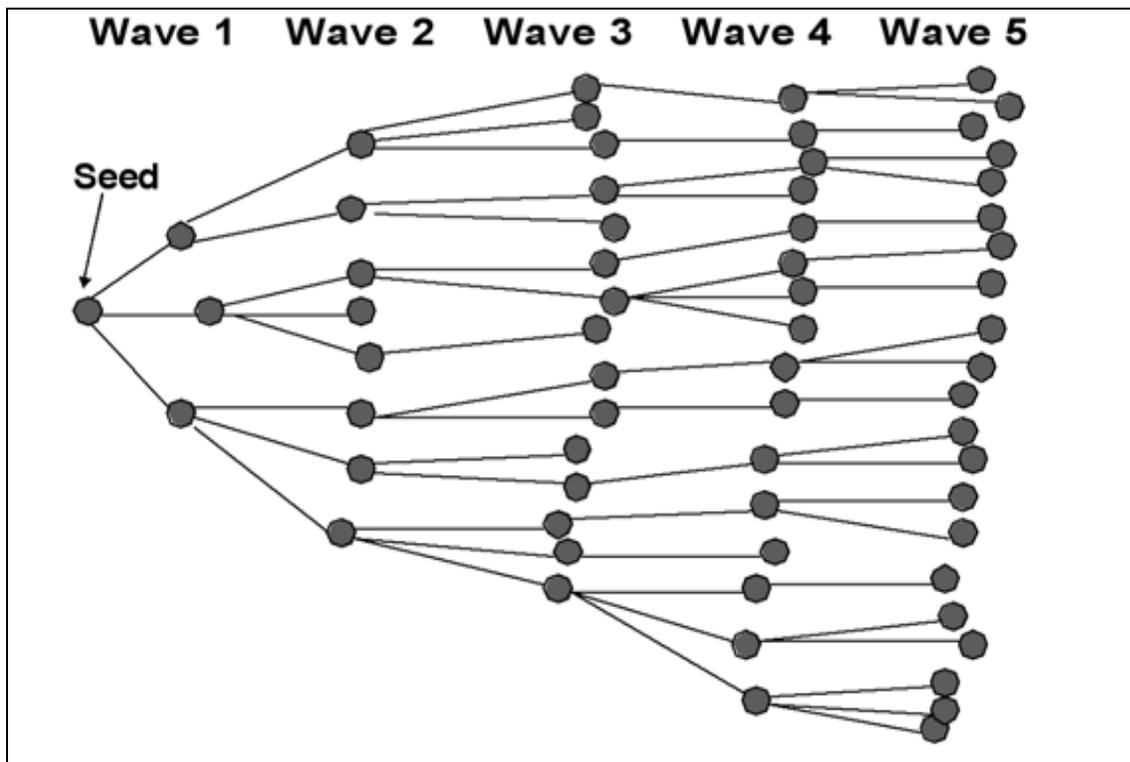
Snowball sampling is typically used with unknown and rare populations. It is ideal for members of populations that are difficult to locate and which obtaining a sample from using traditional random sampling methods would not be easy (Miller, 2010). As a result, snowball sampling employs the presumed social networks that exist among members of a target population to build a sample. Snowball sampling is a multi-step process in which more and more people are added to the sample with each step. Miller further states that the initial step involves a group of individuals who are known members of the population to create a “seed”.

As some of the MSM as well as gatekeepers of MSM groups in Manzini were known to the researcher, the gatekeepers assisted in selecting the seeds. In order to limit bias, the seeds were selected from diverse demographic characteristics as they were likely to invite peers with same demographic characteristics to participate in the study. There were three initial seeds selected to participate through the assistance of the gatekeepers.

After participating, each seed invited other three MSM peers to participate in the study. The seeds who had participated first then produced the first wave of individuals by inviting their peers after participating, who in turn participated and invited other three MSM potential participants that made the second wave. The second wave then produced the third wave, and so on, until the target sample size of 35 MSM was reached. Figure 3.1 shows the inclusion process in the snowball sampling.

**Figure 3.1**

**Snowballing sampling**



Source: Behavioural Surveillance Participant Manual, CDC Global AIDS Program, September, 2007.

The snowball sampling was used in sampling the MSM population that participate in both the quantitative and qualitative research. There were 35 MSM selected for quantitative research and in addition, 15 more

MSM were selected for the qualitative research. In total, 50 MSM were sampled through snowball sampling. When selecting the participants for the qualitative research, the same procedure was used as with the quantitative sample. Three “seeds” were initially identified from the MSM population through gatekeepers. The seeds then invited three other eligible MSM peers to participate which in turn they also invited three peers until the target of 15 MSM was reached. MSM who participated in the quantitative research did not participate in the qualitative research.

### **3.7.2 Purposive Sampling**

Purposive sampling is a form of non-probability sampling in which decisions concerning the individuals to be included in the sample are taken by the researcher based upon a variety of criteria which may include specialist knowledge of the research issue (Miller, 2010). The aim of the purposive sampling was to focus on certain individuals of interest among the population – managers of HIV prevention programmes that specifically may have some contacts with the MSM issues in their occupation. For instance, the sampling method was used to sample only individuals that were HIV and AIDS programmes for most-at-risk behaviour populations in the Ministry of Health. The findings from the key informants were not intended to be generalised to the whole population.

As a result, a kind of purposive sampling known as expert sampling was used. According to (Miller, 2010), expert sampling is a type of purposive sampling technique that is used when the research needs to glean knowledge from individuals that have particular expertise. The purposive sampling was important in the sampling of the key informants as their occupations are of different expertise. There were five managers of HIV prevention programmes sampled through the purposive sampling. This sample participated in a qualitative research and was key informants.

### **3.8 Data Analysis**

The quantitative data was analysed using basic descriptive statistics. These statistics were those describing the point of central tendency and variability. The data from the completed questionnaires was captured into and analysed using the Statistical Package for the Social Sciences (SPSS®) software. The qualitative data was analysed through transcribing data from voice recorders, coding the data and identifying the themes. The data was then grouped according to the identified themes. The data was presented using words and other statistics presentation.

### **3.9 Ethical Consideration**

In order to conduct the study, the permission was requested and granted by the Scientific and Ethics Committee of Swaziland. Furthermore, the research proposal and request for ethical approval was

submitted to the Research Ethics Committee: Human Research (Humanities) in the University of Stellenbosch. An approval was also received from the Committee.

The study was classified to be medium risk to harm as it involved MSM, who are publicly stigmatised, hidden and a sensitive population. However, there was no risk of harm or injury to any of the participants arising from this research. Consent to participate in the study was sought from participants through signed consent forms (Appendix E & E). All information generated during data collection was safeguarded to ensure confidentiality and privacy. Informed written consent was obtained from each participant. There were no identifiers used. Data was only identified by unique serial numbers.

### **3.10 Conclusion**

The chapter has described in detail the process involved in conducting this research. Special focus was given to discussing the problem statement; objective of the study; research approach; sampling procedure, data analysis and the ethical considerations. In the next chapter, the results will be reported.

## **CHAPTER 4**

### **REPORTING OF RESULTS**

#### **4.1 Introduction**

The main aim of the study was to identify the prevention needs for MSM in Swaziland, using Manzini city as a case study. This chapter presents data collected from the study. The data was collected from men who have sex with men and managers of HIV prevention programmes. Structured questionnaires were used to collect quantitative data from MSM. Semi-structured interviews were used to collect qualitative data from managers of HIV prevention policies and programmes as well as other MSM. The quantitative data will be presented first, followed by the qualitative data in this chapter.

The data from the quantitative research instrument will be presented according to the order as in the questionnaire that was used to collect it (Appendix A). The Questionnaire was into four sections and the quantitative data results will be represented as follows:

- Section 1 – Demographic and Socio Economic Information
- Section 2 – Risks and Vulnerabilities
- Section 3 – Sexual Behaviour (HIV Prevention Practices)
- Section 4 – Information, Education and Communication

On the other hand, the qualitative research will start with the interview schedule for MSM and be followed by the interview schedule for managers of HIV prevention programmes. The remainder of this chapter will, therefore, be presented as follows:

Qualitative Data Results:

- Interview Schedule for MSM
- Interview schedule for Managers of HIV Prevention Programmes
- Conclusion

#### **4.2 Quantitative Research**

The following four sections present the findings of the quantitative research conducted among the MSM sample:

#### 4.2.1 Section 1 – Demographic and Socio-Economic Information

The first section presents the demographic and socio-economic information of the respondents. This information includes the age and sex; educational level and employment status; sexual orientation and gender as well as marital status and number of children of respondents.

##### 4.2.1.1 Age and Sex

The final sample size for the quantitative research was 35 MSM respondents; therefore, all the respondents were males (Table 4.1). Nearly half of the participants were aged between 20 and 24 years. Overall, the sample was young with 80% of the sample younger than 30 years old.

**Table 4.1**  
**Age Distribution of the MSM Respondents (n=35)**

<b>Age</b>	<b>Respondents (number)</b>	<b>Respondents (%)</b>
15-19 years	4	11
20-24 years	16	46
25-29 years	8	23
30-34 years	5	14
>35 years	2	6
<b>Total</b>	<b>35</b>	<b>100</b>

##### 4.2.1.2 Education Level and Employment Status of Respondents

With regard to education level, nearly half of the participants (n=16) were either college students or had already finished college education (Table 4.2). Very few of the participants (n=3) had not completed secondary schooling. In terms of employment status, a majority of the sample (n=21) was not employed; of these, most (n=12) were students. The remainder of the respondents were either self-employed (n=8) or had a job.

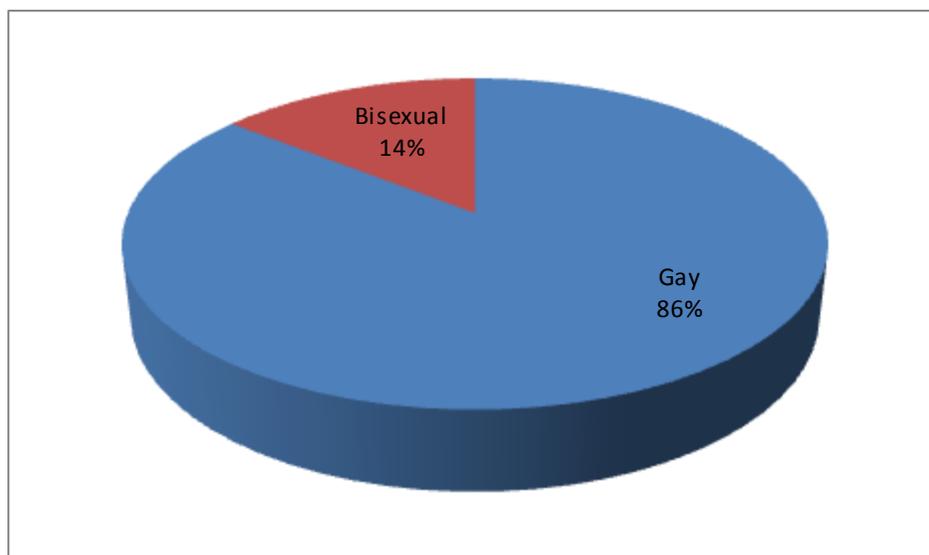
**Table 4.2**  
**Educational Level of MSM Respondents (n=35)**

Education Level	Frequency	Percentage
Never attended school	1	2.9
Some Secondary or high school	2	5.7
Completed secondary or high school	14	40.0
Post HS Vocational Training	2	5.7
Post HS College/University	16	45.7
<b>Total</b>	<b>35</b>	<b>100.0</b>

#### 4.2.1.3 Sexual Orientation and Gender of Respondents

With regard to sexual orientation, most of the respondents (n=30) identified themselves as gay, whereas the rest identified themselves as bisexual (Figure 4.1). Of the 35 respondents, 77% considered their gender as men while 23% regarded themselves as 'women'.

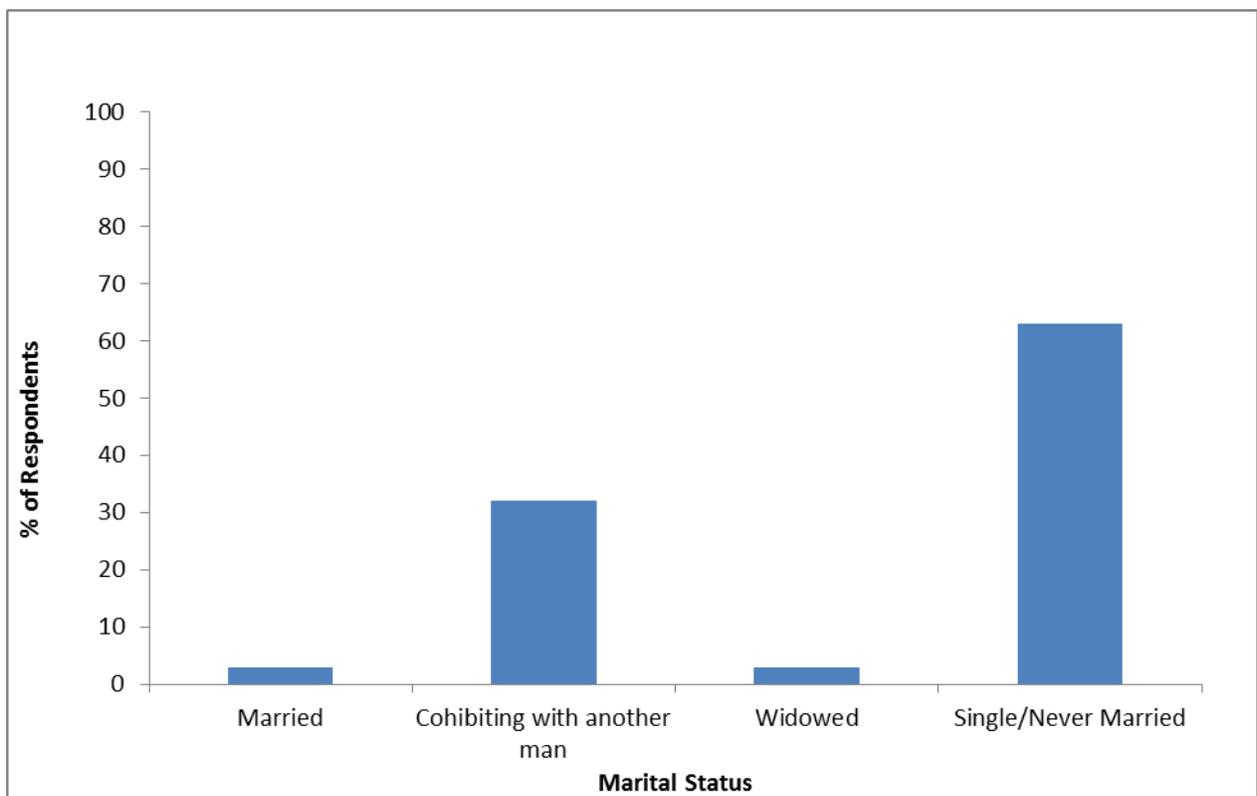
**Figure 4.1**  
**Sexual Orientation of Respondents (n=35)**



#### 4.2.1.4 Marital Status and Number of Children of Participants

A majority of the participants 62% (22, n=35) reported to have never been married and were living without sexual partners. However, 32% of the respondents were cohabitating with another man (Figure 4.2, below). Only one respondent was married and one was widowed after the death of his female partner. A vast majority of the sample (88%) did not have any children while 12% had either two children or more.

**Figure 4.2**  
**Marital Status of MSM Respondents (n = 35)**



#### 4.2.2 Section 2 – Risks and Vulnerabilities

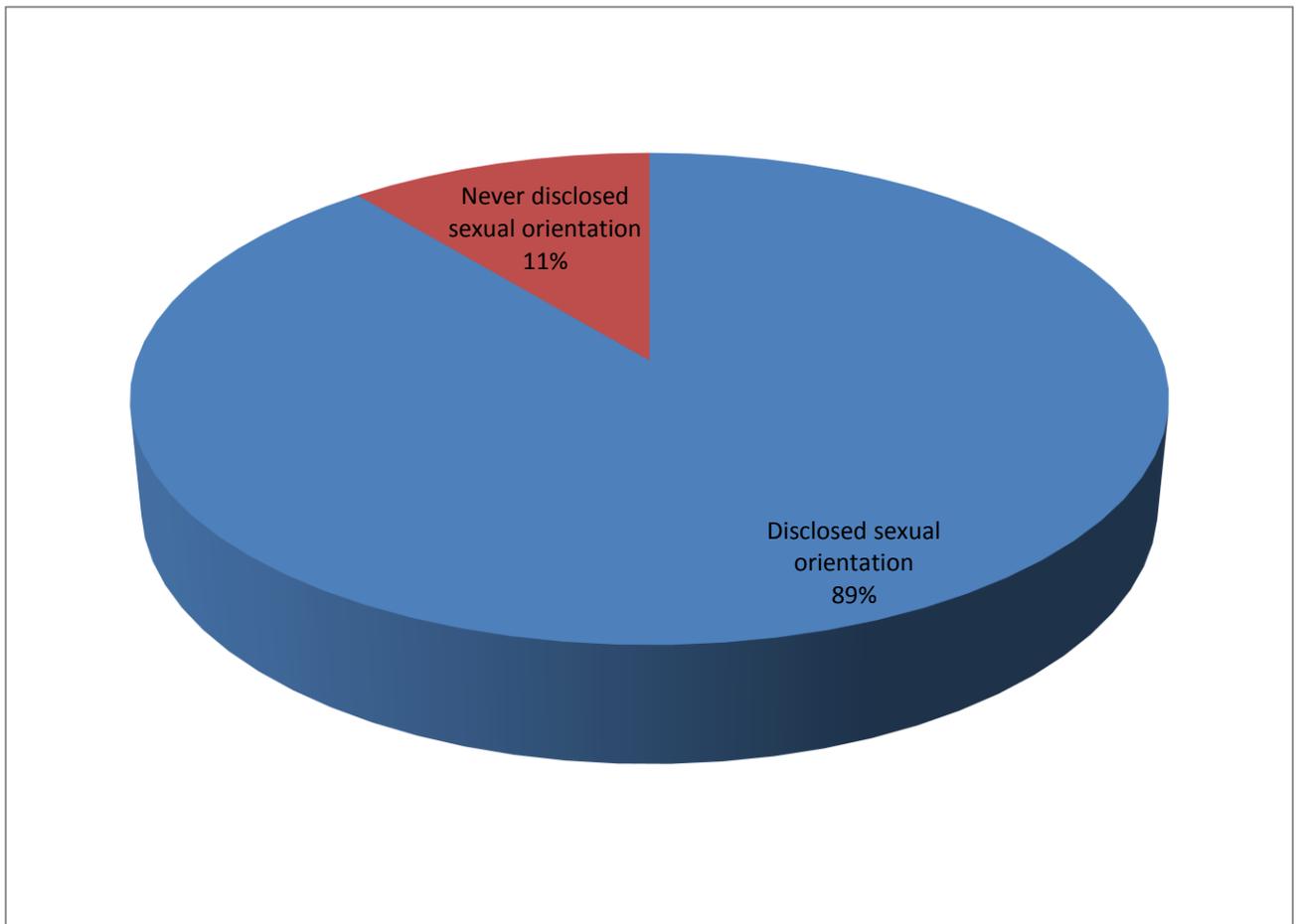
This section presents the findings on the factors that put MSM on risks for – and vulnerabilities to – HIV infection. Findings on disclosure of sexual orientation; experiences of stigma and discrimination; and knowledge of HIV risk are presented:

##### 4.2.2.1 Disclosure of Sexual Orientation

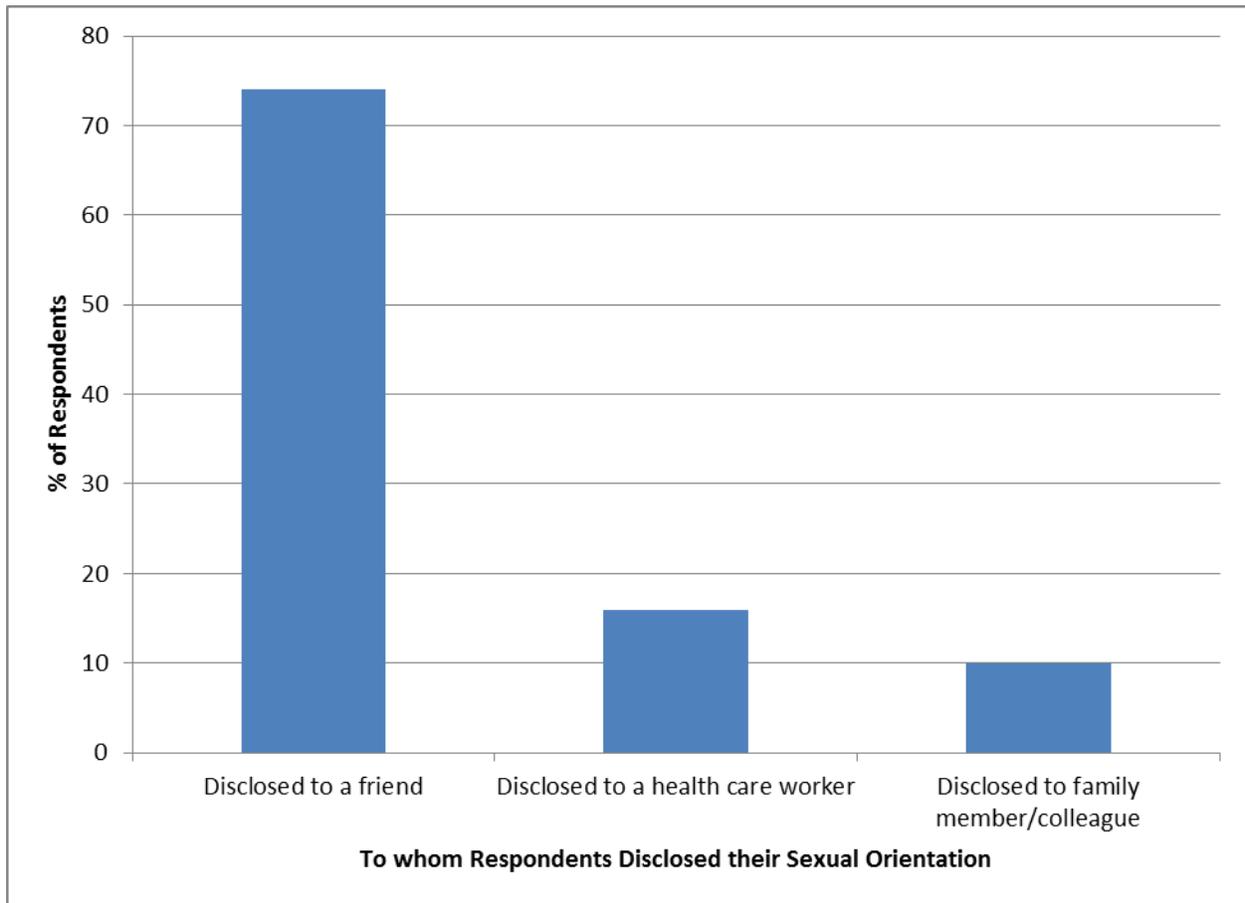
The findings of the study indicated that a vast majority of the sample, 89% (31; n=35), had disclosed their sexual orientation to someone else (Figure 4.3). Most of respondents (74%; n=31) reported that they had

disclosed their sexual orientation to a friend. However, only 16% (5/31) reported to have disclosed their sexual orientation to a health care worker. Only less than 10%, who reported to have disclosed their sexual orientation to colleagues and family. The findings, therefore, indicated that although a majority of the sample had disclosed their sexual orientation, but such disclosure is mostly to friends. Figure 4.4 below illustrate the findings.

**Figure 4.3**  
**Percentage of Disclosure of Sexual Orientation among Respondent (n=35)**

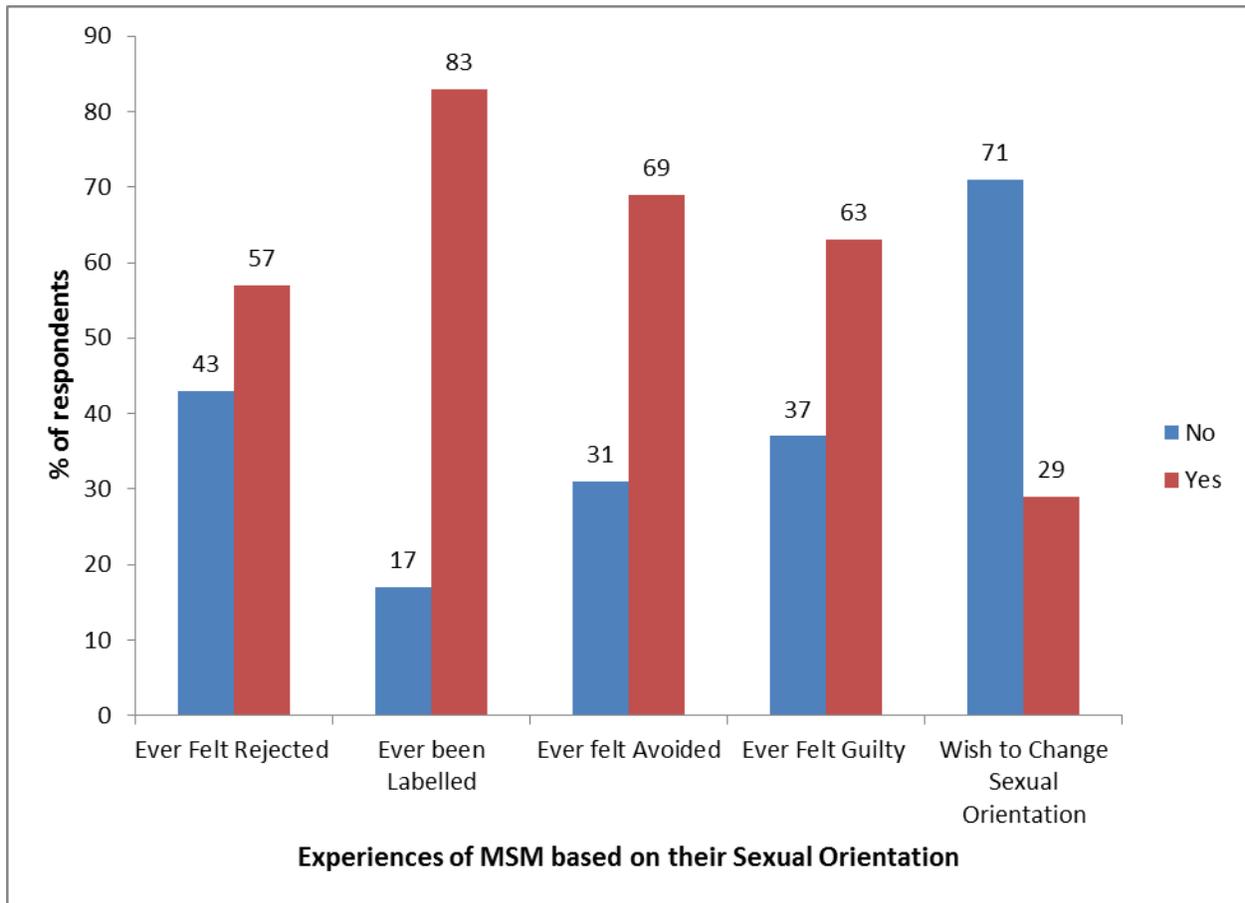


**Figure 4.4**  
**Respondents' Disclosure of Sexual Orientation**



#### **4.2.2.2 Experiences of Stigma and Discrimination**

With regard to experiences of stigma and discrimination directed towards MSM, a majority of the sample, 57%, reported to have felt rejected because of their sexual orientation. Furthermore, a majority of 83% (29/35) of the sample had been *labelled* because of their sexual orientation, while 66% (23/35) reported to have been avoided because of their sexual orientation. Although a majority (77%, n=27/35) of the participants reported they would not wish to change their sexual orientation, a large number of the sample (n=27) reported to be feeling guilty because of their sexual orientation as a result of experiences of stigma and discrimination (Figure 4.5). In addition, 54% (19/35) of the sample reported to be persuaded by their families to get married to a woman. Furthermore, 36% of the participants whose sexual orientation is known to their families reported to be under pressure of being persuaded by their families to change their sexual orientation.

**Figure 4.5****Experiences of MSM because of their Sexual Orientation (n=35)****4.2.2.3 Knowledge of HIV Risk**

Knowledge of HIV and STI risk was limited as 54% (19/35) of the respondents indicating that vaginal and anal sex carry an equal risk of HIV infection. Only 14% of the sample indicated that anal sex has the higher risk of HIV infection than vaginal sex. With regard to STIs, only 6% (2/35) stated that anal sex have a higher risk of STIs. Knowledge about type of anal sex with high risk of HIV infection was also limited as only 20% (7/35) of the participants answered that receptive anal sex carries the highest risk of HIV infection. A majority of the sample (66%; n=23/35) answered that insertive anal sex carries more risk for HIV infection than vaginal sex.

### **4.2.3 Section 3 – Sexual Behaviour (HIV Prevention Practices)**

The third section presents the findings on sexual behaviour of MSM. The section mainly presents findings on the sexual behaviours of participants and practices used MSM for HIV prevention. The findings are presented in the sub-sections:

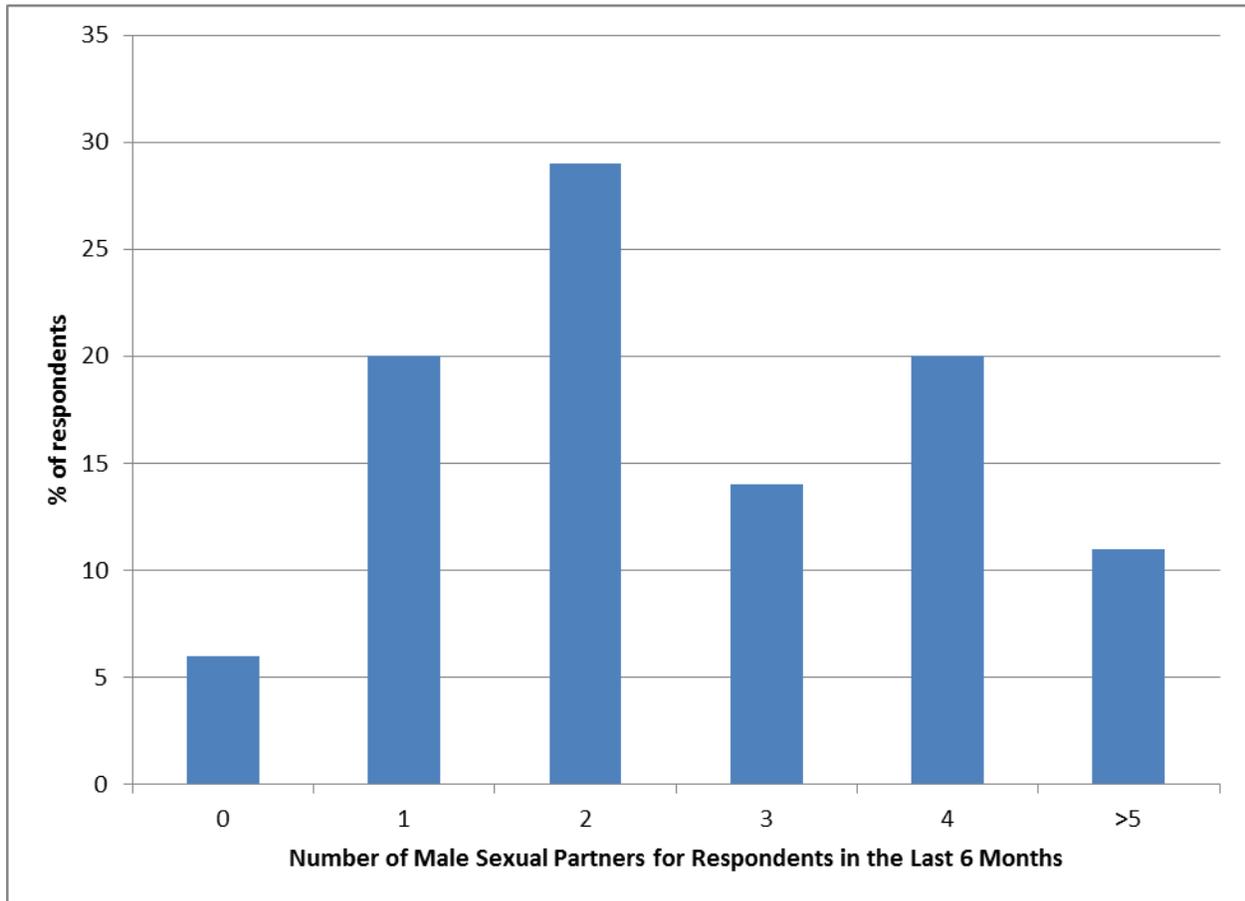
#### **4.2.3.1 Sexual Partners**

A vast majority (86%, n=30/35) of the respondents reported to be in an on-going sexual relationship with another man at the time of the study. Furthermore, 80% (27/35) reported to have been in a sexual relationship before their current sexual relationship. Nearly 80% of the respondents who reported to have been in a sexual relationship prior to the current relationship (79%, 23/30) reported that their sexual relationships have lasted between two and five months. Of the 86% (30/35) respondents who reported to be in a sexual relationship during the time of the study, only 7% (2/30) were in the same sexual relationships for more than 12 months. A vast majority of the respondents (93%, 28/30) had been in their sexual relationships for less than 12 months during the time of the study.

Although 67% (20/30) of the respondents who reported to be in a sexual relationship during the time of the study considered their sexual partners as a main partner, 33% (10/30) did not consider their current sexual partners as main partners. Multiple concurrent sexual partners was common among the respondents with 74% (26/35) of the sample, either in a sexual relationship with a main partner or not, reported to have more than one sexual partner in the last six months. Figure 4.6 below shows the distribution of sexual partners among the sample in the last six months.

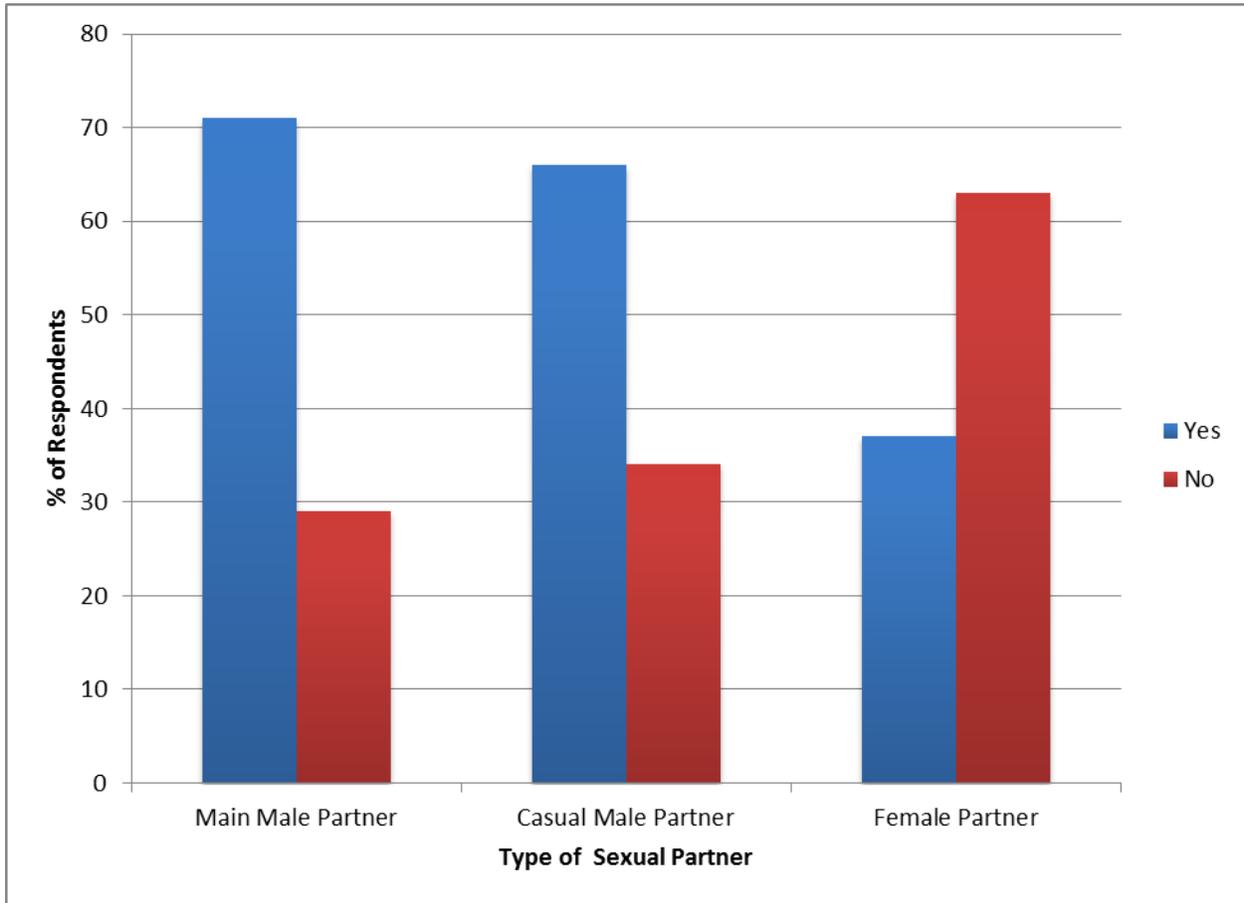
Sex with female partners was also reported among the MSM. 23% (8/35) of the respondents reported to have had vaginal sex with a woman in the last six months. Only one of the eight respondents reported to consider the female sexual partner a main partner.

**Figure 4.6**  
**Male Sexual Partners Respondents had Sex with in the Last Six Months (n=35)**



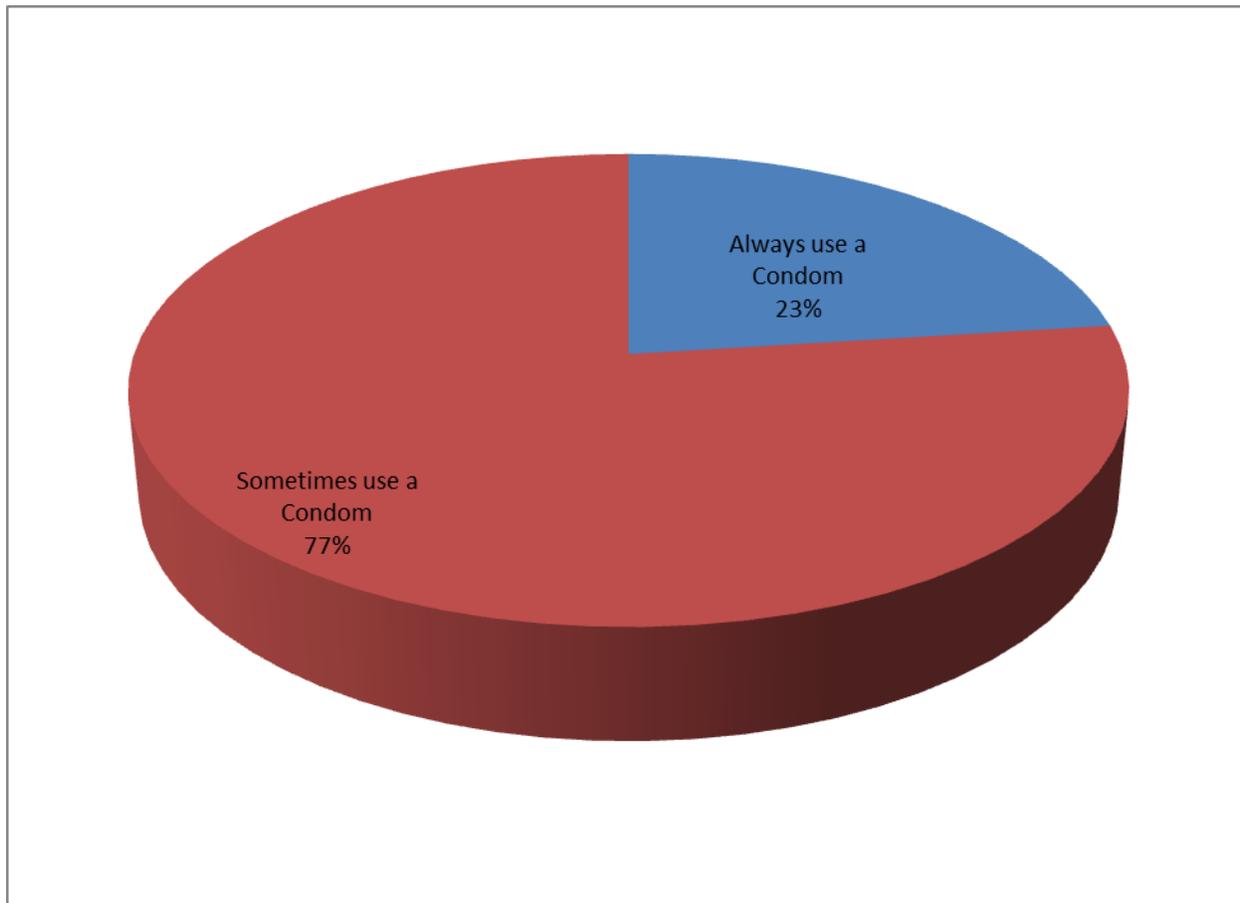
#### 4.2.3.2 Condom Use

Condom use was reported to be high among the sample as 71% (24/35) reported to have used a condom the last time they had sex with a male main partner. However, 29% of the sample reported not to have used a condom the last time they had sex with a male main sexual partner. The number of respondents not using a condom increased with type of relationship as more respondents, 34% (12/35) of respondents reported to not have used a condom the last time they had sex with a casual partner. There was limited use of condoms among MSM who reported to have also had sex with female partners; 63% (5/8) of them reported not to have used a condom the last time they had sex with a female partner (Figure 4.7).

**Figure 4.7****Condom Use with Different Sexual Partners the Last Time Respondents had Sex (n=35)**

Consistency in using a condom was low among the sample. Only 23% (4/35) reported to always using a condom when having sex with male sexual partners. A majority of the sample, 77% (31/35) reported to either use it sometimes or almost always (Figure 4.8). On the other hand, only two of the eight respondents reported to have had sex with female partners reported to have always used a condom with a female partner.

**Figure 4.8**  
**Usage of Condom when having with Other Men (n=35)**



Condom breakage was also reported among the MSM. 37% (13/35) reported to have experienced a tearing condom while having sex with another man. Most of the respondents (44%, n=16/35) normally access condoms through peer educators while others, either buy them or collect them from public places. However, public places were reported to be unpopular as only 14% (5/35) reported to get condom from public places. A majority of the respondents, 80% (28/35) also reported to have a preferred brand of condoms and among them, ‘Trust® Condoms’ were reported to be favourite as 41% preferred it.

Lubricant use was not consistent. While all respondents reported to use lubrication when using a condom during anal sex with another man, 14% (4/35) reported not to use a lubrication when having anal sex with a partner without condom. A majority (97%; n=34/35) of the sample reported to use water-based lubricants for anal sex and 56% (20/35) reported to access the lubricants from a peer-educator. Access to the lubricants was reported to be a challenge amongst the respondents. 56% (20/35) reported either to have difficult or some little access to the lubricant.

Using female condoms for anal sex with male sexual partners was reported to be very low among the sample. Only 17% (6/35) reported to have used a female condom with male sexual partners. Most of those that never used it stated that they were not aware of its usage during anal sex 41% (12/29), while 38% (11/29) reported to not like it.

With regard to decision making on condom use (either male or female), 69% of the respondents reported to made decision equally with their sexual partners, while 27% (10/35) reported that they are the ones making decisions for their partners.

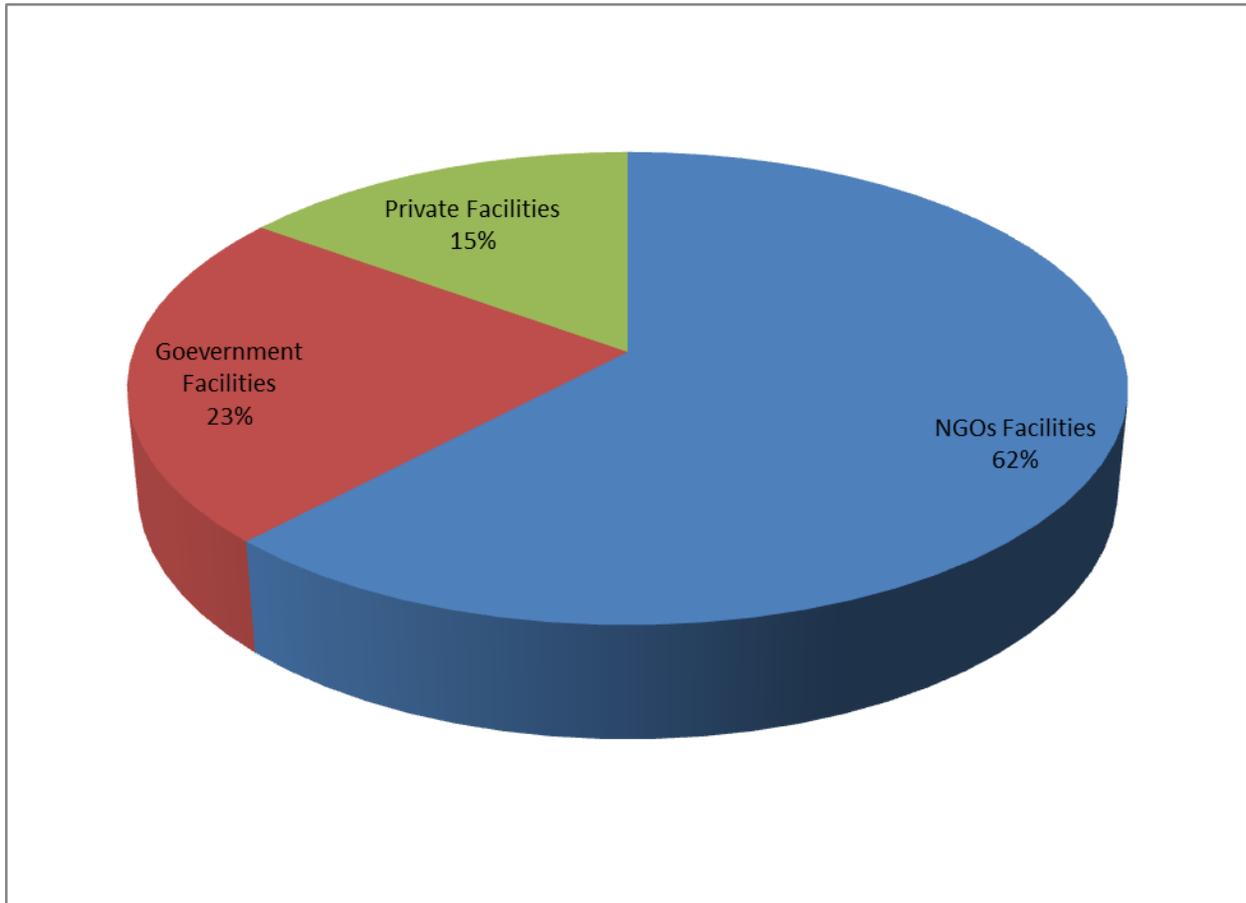
#### **4.2.3.3 Male Circumcision among the MSM**

Overall, 40% (14/35) of the respondents reported to have been circumcised. Of these, 68% (8/14) thought that circumcision benefits them during anal sex by reducing chances of HIV infection. Of the 14 respondents who reported to have been circumcised, 35% (5/14) reported to be receptive partners during anal sex. Although circumcision does not benefit the exclusive receptive partners in the prevention of HIV (Rebe, 2011), these respondents stated that the reason for circumcision was to reduce the risk of HIV infection during anal sex. In terms of circumcision preferences, most of the respondents, 67% (24/35) stated to prefer a circumcised sexual partner over uncircumcised sexual partner.

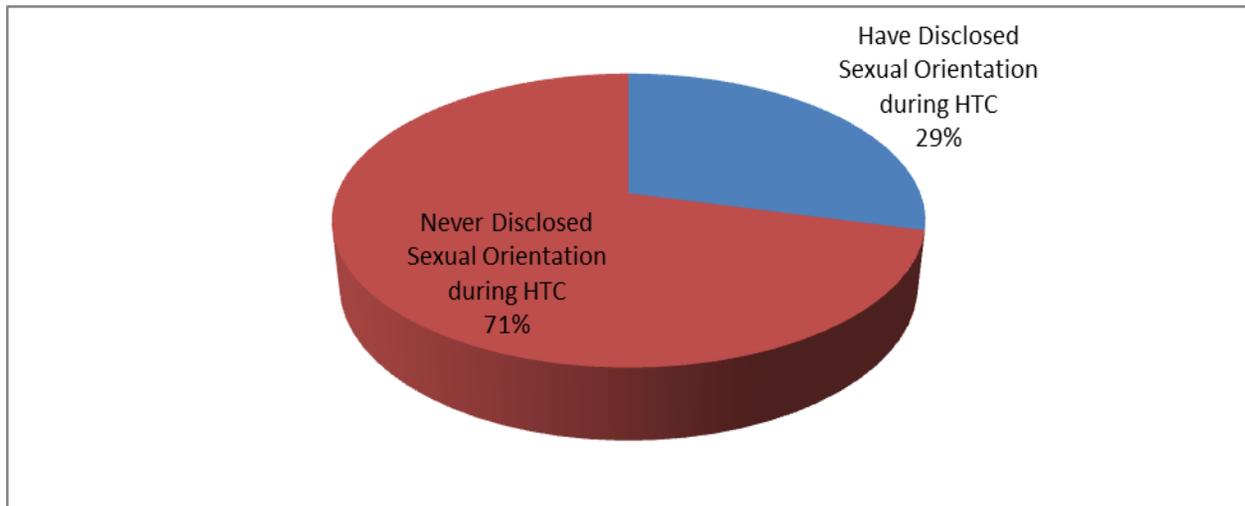
#### **4.2.3.4 HIV Testing and Counselling (HTC)**

Overall, 89% (31/35) of the sample reported to know their HIV sero-status. Non-governmental organisation (NGO) facilities were reported to be popular as 62% (22/35) of the sample reported to have their HTC in those facilities. Other respondents reported to either go to government facilities, 23% (8/35), or private facilities (15%) Figure 4.9 shows the results.

**Figure 4.9**  
**Respondents' Preferred Access Points for HTC Uptake (n=35)**



A majority (77%) of the respondents were comfortable with the procedures where they receive the HTC with only 23% (8/35) reporting to be not comfortable. These were the respondents who also reported to uptake HTC at government facilities. The eight respondents who reported not to be comfortable with the procedures at government facilities where they normally have HTC further stated that they rather prefer NGO's facilities and other private facilities. However, a majority of the respondents (71%; n=25/35) reported never to have revealed their sexual orientation to any service provider during a HTC session. These respondents reported never to have disclosed their true sexual behaviour. Only 29% (10/35) reported to have once told a service provider about their sexual orientation (Figure 4.10).

**Figure 4.10****Disclosure of Sexual Orientation to a Service Provider during HTC (n=35)**

On the other hand, HTC was high as 89% (31/35) of the sample reported to have taken HTC once or more in the last 12 months. However, the HTC was not consistent as most of the participants, 53% (19/35) reported to have only done HTC once to twice in the past 12 months. Eleven percent reported not to have done HTC in the past 12 months prior to the study.

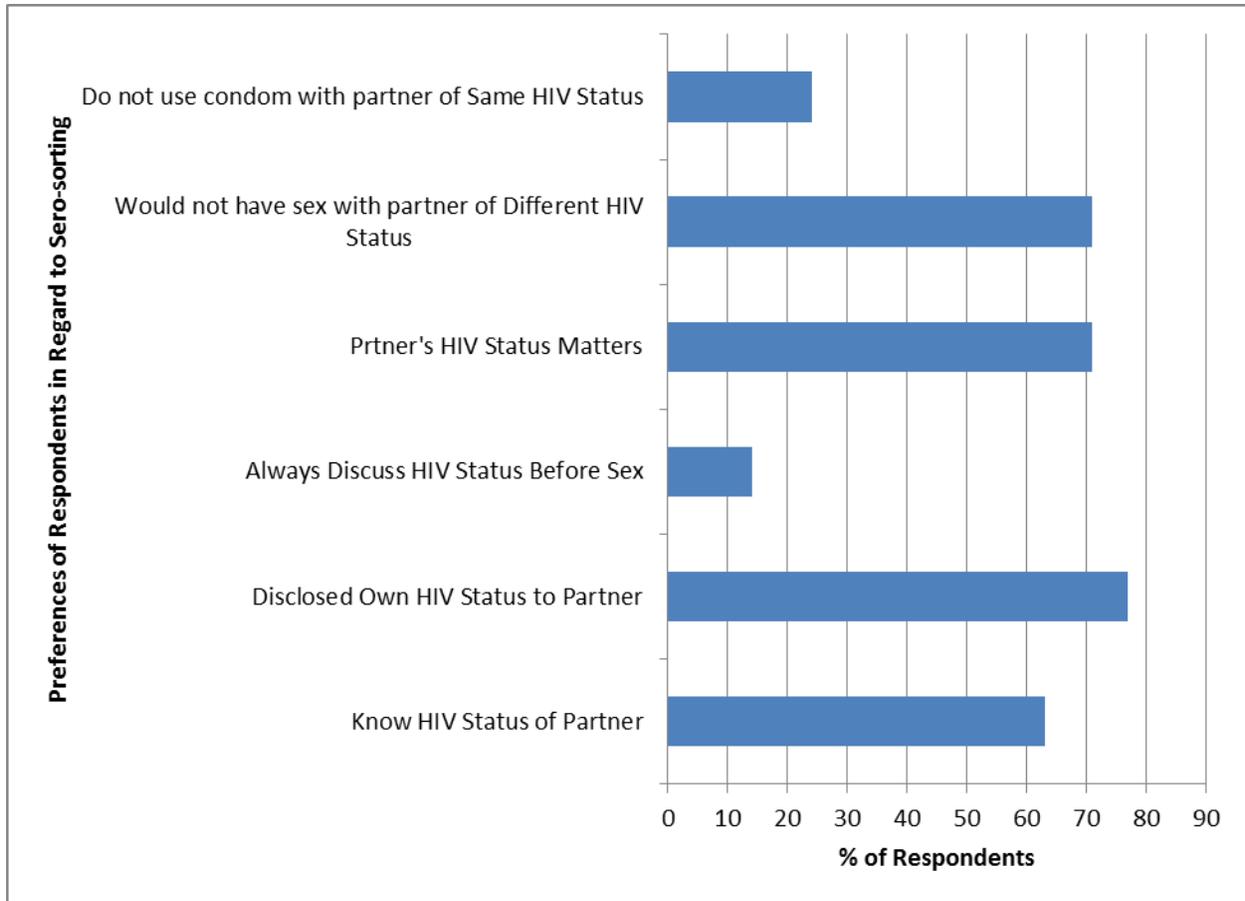
Couple-based HTC was limited among the sample with only 25% (9/35) of the respondents reporting to have done HTC together with their male sex partners while 74% (26/35) reported to have never. Of the 26/35 respondents who reported never to have taken HTC together with male sex partners, 65% (17/26) stated that they consider doing it in the future while 35% (9/35) did not consider having HTC with male sexual partners because of fear of stigma, and/or not being comfortable.

#### **4.2.3.5 Sero-sorting and Sero-positioning**

Sero-sorting is choosing a sexual partner based on their HIV status (WHO, 2011). Sero-sorting was common among these respondents. There were 63% (22/35) respondents who reported to know the HIV status of their partner while 77% (27/35) reported to have disclosed their HIV status to their partners. However, only 14% (5/35) of the sample always discuss HIV status with partner(s) before engaging in sex. A majority of the respondents, 71% (25/35) stated that it does matter to them if a sexual partner has a different HIV status to them. Furthermore, 71% (25/35) of the sample stated that they would not have sex with a man who has different HIV status from theirs. Some of the respondents (24; n=8/35) further stated that if HIV status of their partner is known to them and is same as theirs, they do not use a condom (Figure 4.11).

On the other hand, sero-positioning is choosing sex roles among MSM and their partners based on known HIV status (WHO, 2011). Sero-positioning was not common among the sample with only one respondent reported choosing sex roles with partner based on their HIV status.

**Figure 4.11**  
**Sero-Sorting Behaviour of MSM (n=35)**

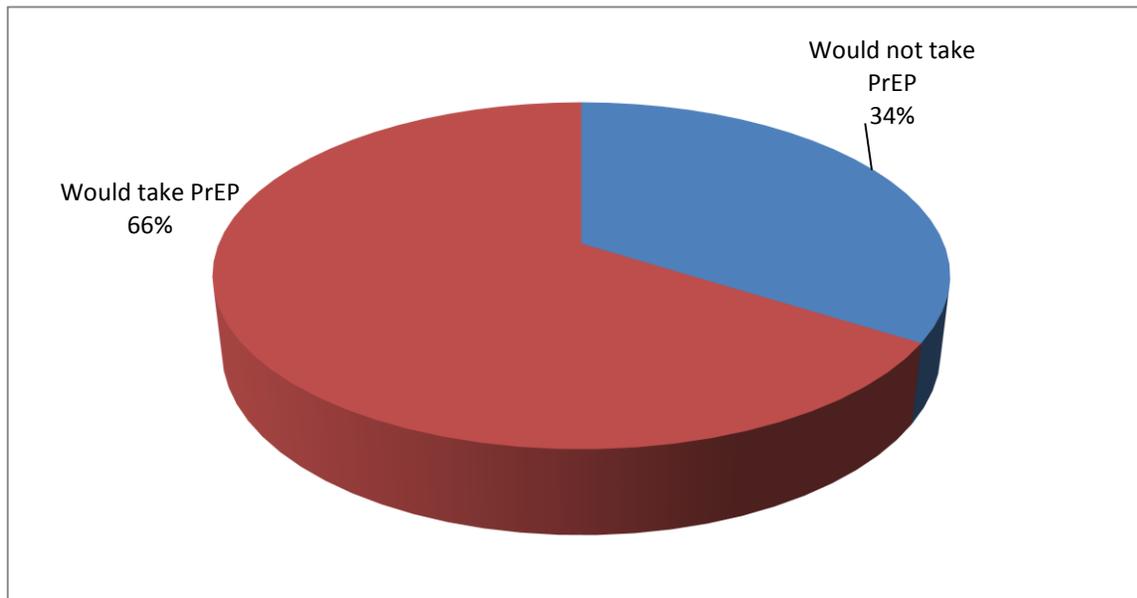


#### 4.2.3.6 Pre-Exposure Prophylaxis (PrEP)

Knowledge about PrEP was limited among the respondents. Only 9% (3/35) had heard about PrEP and they reported to have heard about it from an NGO. None of the respondents had taken PrEP before or at the time of the study. However, 66% (23/35) of the sample were positive to uptake PrEP if it was offered while 34% (12/35) did not think they would uptake it (Figure 4.12, below). Of those that were positive about up-taking PrEP, a majority (70%; n=16/23) stated that they would be able to take PrEP consistently daily. Of the participants thought they would not uptake PrEP, the most common reason was fear of side effects 50% (6/12) while the rest did not have trust on the prevention efficacy of PrEP.

Overall, 51% (18/35) of the respondents thought that taking PrEP would change their sexual behaviour. At least 34% (12/35) of the sample stated that they would not use condoms if they were taking PrEP. Furthermore, 44% (8/18) stated that taking PrEP would increase their number of sex partners. With regard to who should or is preferred to provide PrEP to MSM, 51% (18/35) of the sample preferred to receive PrEP from a peer educator, while 49% (17/35) preferred a health care worker.

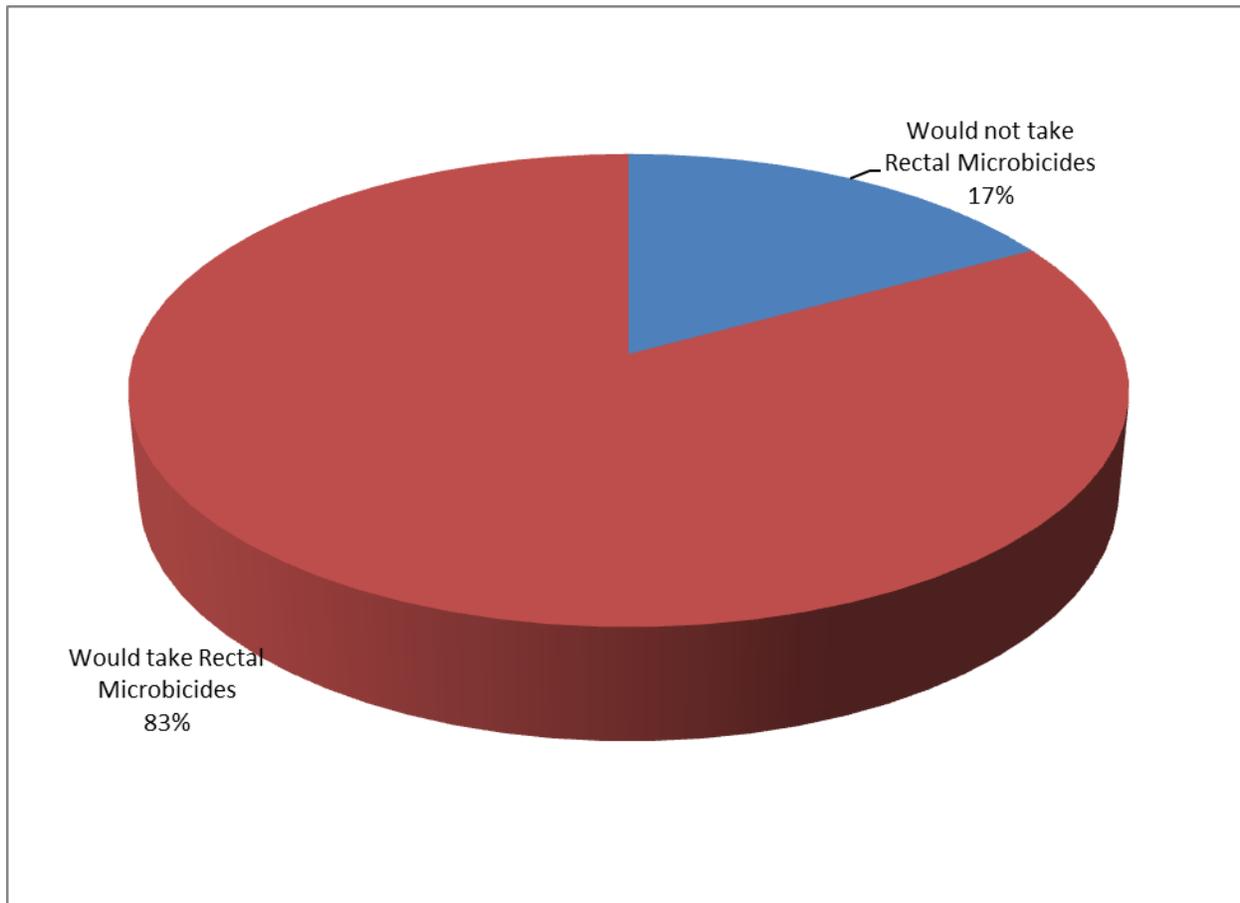
**Figure 4.12**  
**Acceptability of PrEP among the MSM Population (n=35)**



#### 4.2.3.7 Rectal Microbicides

Knowledge about rectal microbicides was none existent. None of the respondents had heard of rectal microbicides nor had used any rectal cream for HIV prevention. However, a majority (83%; n=29/35) reported that they would take rectal microbicides if they were to be offered (Figure 4.13). Moreover, 80% (28/35) of the sample stated that they would be willing to adhere consistently in taking rectal microbicides before having sex or encourage their partners if they are the one taking them. However, 45% (16/35) of the sample thought that using microbicides might change their sexual behaviour by not using a condom with them (63%; =10/16) and by increasing the number of sexual partners (37%; n=6/16). About 50% of the sample (49%; 17/35) preferred to receive the rectal microbicides through a peer educator while 43% (15/35) preferred a health care worker.

**Figure 4.13**  
**Acceptability of Rectal Microbicides among MSM (n=35)**



#### **4.2.4 Section 4 – Information, Education and Communication on HIV Prevention among MSM**

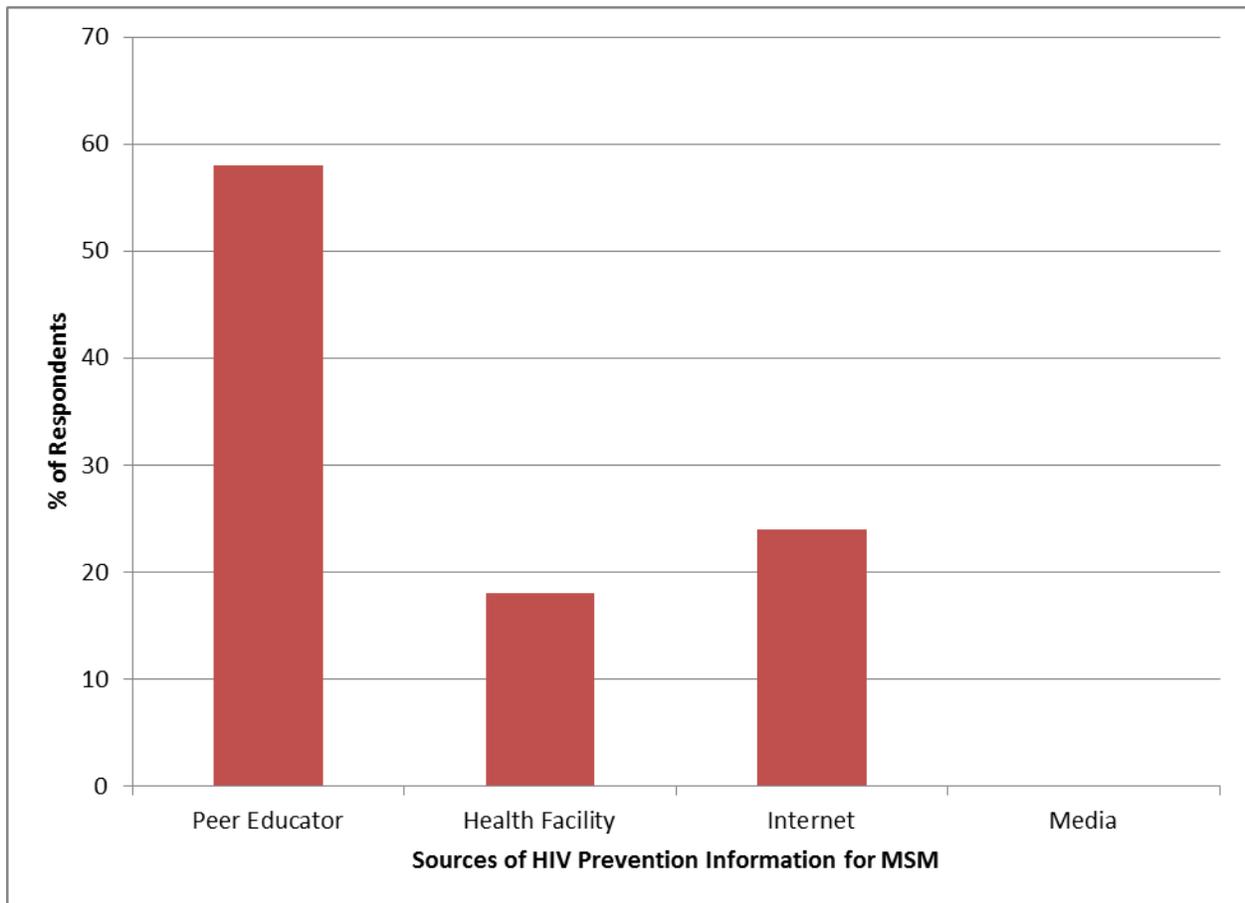
Access to HIV prevention information was a challenge for some respondents. More than half of the respondents, 51% (18/35) did not receive any HIV prevention information on MSM in the last three months while only 49% (17/35) reported to have received it. Most of those that had received HIV prevention information reported to have received it from a peer educator 58% (10/17) while 24% (4/17) received it from the Internet and the remainder had received it from a health facility (Figure 4.14).

A majority of the respondents 83% (29) preferred to access HIV prevention messages for MSM through the Internet in the future. Most of them (45%; n=13/29) preferred the Internet because of easy access to it and the privacy it provides (31%; n= 9/29). All respondents reported to have access to the Internet. Most respondents, 57% (20/35), reported to visit the Internet several times a day.

Public restrooms, parties, and backrooms of clubs were cited as common and known sex venues by a majority of respondents (83%; n=29/35). Most of the respondents (80%; n=28/35) thought that the sex venues should be used for HIV prevention messaging spots for MSM.

**Figure 4.14**

**Sources of MSM HIV Prevention Information for Respondent in the Last Three Months (n=35)**



### 4.3 Qualitative Research

In addition to quantitative research, qualitative research was conducted with MSM (n=15) as participants and managers of HIV Prevention programmes (n=5) as key informants. The aim of conducting the qualitative research was to supplement the data collected through the quantitative research. The qualitative interview was guided by semi-structured interview guide. Each interview conducted took an average of 45 minutes. The findings from the qualitative research are presented below according to the themes abstracted using the interview guides. The findings from the MSM participants will be reported first and then followed by the findings from the managers of HIV Prevention programmes as key informants.

### **4.3.1 Findings from MSM Participants**

The findings from the MSM participants are reported according to the topics from the interview guide (Appendix B). These topics are as follows: Interview Participants; Risks for – and vulnerabilities to – HIV Infection for MSM; HIV Prevention Strategies for MSM; and Information Communication and Education among MSM.

#### **4.3.1.1 Interview Participants**

The interview participants (n=15) were recruited in the Manzini city. Most of the interview participants (n=13) were below the age of 30. All participants were identified as men who have sex with men and they've had sex with another man in the past. In terms of sexual orientation, most of the participants (n=12) identified themselves as gay while the remainder identified as bisexual.

#### **4.3.1.2 Risks for – and Vulnerabilities to – HIV Infection among MSM**

The participants provided a unique perspective on the risks for – and vulnerabilities to – HIV infection for MSM. The information provided by participants was what they knew, what they have heard as well as sharing their personal experiences. The themes are grouped into personal factors and societal factors.

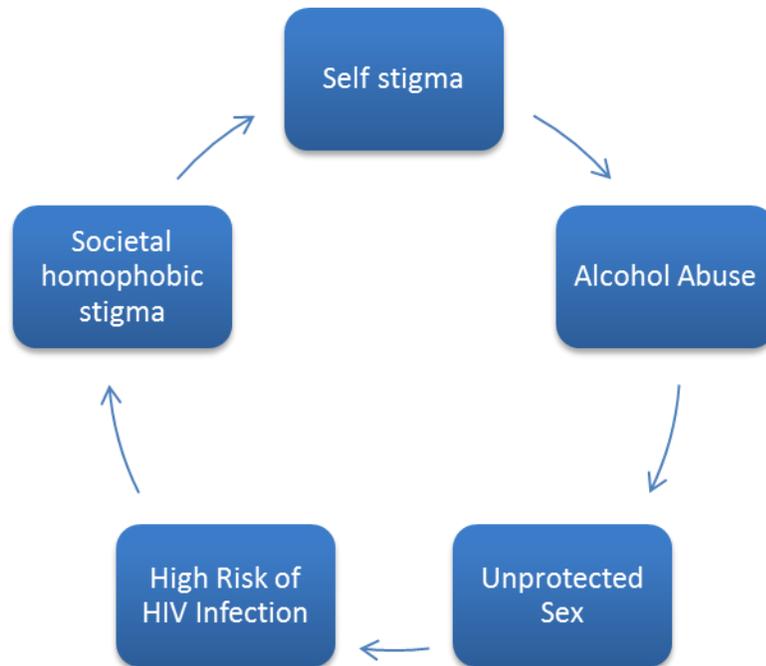
##### ***Personal Factors***

The participants stated that there were personal factors that put MSM at risk for – and vulnerable to HIV infection. These factors were stated to include self-stigma; multiple concurrent partnerships and short-term relationships; decision on condom use and misconception about anal sex.

##### **Self-Stigma**

Fear of being stigmatised was mentioned to be common among the MSM participants. This perceived stigma, or self-stigma, leads to alcohol abuse among other things. Participants stated that such self-stigma emanates from the societal homophobic stigma (Figure 4.15). The MSM participants further stated that most MSM end up abusing alcohol to gain confidence. Additionally, the participants blamed alcohol abuse for 'unplanned' sex with other men which often occur without the use of condom. Participants stated that because of alcohol abuse, sometimes they are "carried away" and therefore do not use a condom. They further explained that often, the HIV sero-status is not discussed among MSM when under the influence of alcohol.

**Figure 4.15**  
**The Cycle of Homophobic Stigma among MSM Participants**



#### **Multiple Concurrent Partnerships and Short-term Relationships**

Multiple concurrent partners and short-term relationships were cited by the participants to be some of the factors perceived to put MSM at risk of HIV infection. The participants explained that multiple concurrent partnerships are common among the MSM population. They further stated that normally, sexual relationships among MSM are often short-term and there is general lack of long-term, monogamous relationships. One of the respondents explained:

*I think most gay people don't have steady partners. They frequently have new sexual partners. I think the ratio between 'top guys' (insertive partners) and 'bottom guys' (receptive partners) has a huge difference. There are few 'top guys' and therefore the 'bottoms guys' always share the 'top guys'. Most gay people end up dating straight guys.*

### **Decision on Condom Use**

Because of an imbalance in power between insertive and receptive sexual partners, some of the receptive participants reported that decision-making on condom use is sometimes made by the insertive partner ‘top guy’. The respondents explained that there is sometimes power imbalance within MSM sex partners and the insertive partner having the status of a decision maker. One respondent further explained:

*As a receptive partner, you don't want to miss a chance of having fun with an insertive partner. So when he approaches you and decides against a condom, you are likely to go on having sex with him without using the condom.*

### **Misconceptions about Anal Sex**

Some of the participants felt there is general lack of knowledge about the risk of sex between men. They quoted that there are a lot of myths and misconceptions about anal sex. They thought that some MSM consider anal sex as being safer than vaginal sex. They also stated that some men state that anal sex more pleasurable without using a condom.

### ***Societal Factors***

In addition to the personal factors that put MSM at risk for – and vulnerable to – HIV infection, there were also societal factors according to the participants. Among the societal factors, the MSM participants mentioned perceived and experienced stigma at health care facilities; size of the country; social gatherings and lack of social support. The societal factors findings were further presented as follows:

### **Stigma at Health Care Facilities**

Participants reported perceived and experienced stigma at health care facilities from health care workers. They stated that health care facilities always have hetero-normative settings and it is not easy for a man who has sex with other men to talk about same-sex issues, especially anal health. As a result, most MSM do not disclose their true sexual behaviour to health care workers. Participants added that most MSM fear, and therefore, avoid seeking health care because of the perceived stigma. One of the participants made an example:

*Most of us end up trying other remedies in private if we have health problems, especially if they are anal related. It is not easy to go and tell a health care worker that I have an illness from having sex with other men. I really don't know how they can think of me. The problem is that these people come*

*from the same societies where we come from. They come from our churches and other institutions where we live and they are possibly our relatives or friends to our relatives sometimes.*

### **Size of the Country**

Swaziland is a small country and respondents felt that one is likely to meet some people he knows whenever seeking health care. The MSM respondents quoted as saying that in Swaziland, everyone knows who you are because of the size of the country. There is a great chance to meet someone known to MSM when seeking health care services. One MSM further explained:

*Even buying water-based lubricant from a shop is a problem. People look at you and you can see they are questioning. The big problem is that you never know when you will meet someone you know while buying as Swaziland is a small country. You may bump into your fellow member of the church in the queue and you never know what happens to you next.*

### **Social Gatherings**

Social gatherings were also cited to be common and popular among MSM, especially younger MSM. Some of the respondents defined this as 'gay social life'. Respondents that these social gatherings are normally going out, partying and drinking, especially on weekends. They stated that this occurs almost every weekend. However, they perceived risk to HIV infection in these social gatherings as they stated that these gatherings are always accompanied by what they termed as 'one night stands' where people would have sex just for one night. These one night stands are often happen with an absence of condoms and lubricant in venues where they could not be accessible at that moment.

### **Lack of Social Support**

There is lack of support from family members and society at large. Participants stated that such lack of social support results in poor decisions and choices. The participants reported having no one who supports them in decision making from families to the entire society. In most cases, they hide their true sexual identity. They stated that most MSM normally disclose their sexual orientation only to other MSM friends who are unlikely to advise them about safe sex.

#### **4.3.1.3 HIV Prevention Strategies among MSM**

There were two main themes that emerged from HIV prevention strategies perceived by the participants and they were short-term and long term HIV prevention strategies. The findings are presented according to these two major themes as follows:

### **Expanding Peer Educators**

Participants explained that most MSM are comfortable receiving information and some services from their peers. They stated that they do not feel judged by their peers and it is easy for them to talk freely about many things. They, therefore, suggested that peer education should be strengthened by adding more peer educators and capacitate them. Participants stated they would prefer to access condoms and lubricants from peer educators.

### **Safe Space**

In addition to accessing services from peer educators, some participants suggested having a safe space where they can meet without fear and have access to information and services. They suggested having regional centres (country-wide) exclusively for MSM needs where they can meet and mentor each other; share their experiences; access health information, condoms and lubricants; get professional counselling, as well as relationships counselling to reduce short term relationships and multiple partners.

### **HIV Prevention Messaging**

Participants explained the most common HIV prevention message towards MSM is encouragement of condom use. Behavioural change messages are rare. Some suggested that there is a need for messaging that encourages faithfulness and abstinence among MSM. They stated that faithfulness and abstinence are often not spoken about as HIV prevention strategies among MSM. One respondent elaborated:

*I think there is the general perception that gay people are promiscuous and therefore they just need condoms as they go around having sex with other men. The truth is, we are also human beings. We also like to have long term relationships like any other people and therefore we need to be advised and encouraged on how to behave sexually and maintain our relationships while preventing ourselves from HIV infection.*

### **Increase Public Awareness**

With the lack of social support, participants suggested that there is a need to increase public awareness on the existence of MSM and the issues around them in order to leverage support families and society at large. They suggested that the Ministry of Health and other civil societies can increase such awareness through public health education. One of the respondents emphasised:

*The Ministry of Health and other organisations should start including topics like 'anal sex' and 'bisexuality' in public health education. These practices do not occur only within the MSM population*

*but also in the general population. People would start to listen because these practices also happen to their sexuality. This can raise awareness about MSM behaviour while acting as a link between MSM sexual behaviour and that of heterosexuals.*

### **Target Appropriate Venues**

Participants suggested that venues frequented by MSM should be targeted with condoms and lubricants. Night clubs were reported to be the most frequented venue. Respondents stated that these are venues where most “unplanned” sex occurs. It was suggested that the condoms and lubricants should be packed together in the same packages, most preferable in the same ratio. This means that if there are 3 condoms in the package, there should be also 3 lubricants. The respondents explained that this can be a reminder to and encourage MSM to use both condoms and lubricants at the same time. They further suggested that such packages should be made available even at health care centres. A middle-aged respondent elaborated:

*Condoms and lubricants should be made available to everyone despite sexual orientation as the extent of their need varies. There are so many heterosexual couples that engage in anal sex and they also need lubricants.*

### **Improve the Public Health Facilities**

Participants thought that the health care system is generally hetero-normative and does not accommodate the needs of MSM. They felt that health care workers are not trained on the specific needs of MSM and therefore suggested that health care workers should be sensitised on the existence of MSM and further trained on interacting with them and attending to their health needs. They also stated that even the health care settings should be inclusive of MSM sex education. This should be visible even from the information, education and communication material available in these centres. Participants stated that this can reduce stigma, inform the general public about MSM as well as make MSM feel accommodated in the health care centres. A 21-year respondent stated:

*I wish health care centres were providing for the health needs of MSM such that I am able to go to a gynaecologist for anal health and find that there are instruments available that are appropriate for that.*

### **Inclusive Sex Education**

Participants further suggested that in order to increase public awareness about MSM issues, there is a need to have inclusive sex education starting from schools, colleges and other institutions. They felt that, often the sex education provided is always hetero-normative and therefore make MSM become sensitive

of their sexuality and remain hidden. This results in them having a fear of seeking health care as well HIV prevention information.

### **Political Support**

Most participants felt that there is a need for political support. Although they felt that having laws that supports the right of MSM may take some time, they said that there is a need for politicians to recognise the existence of MSM and encourage services that will improve their living conditions. They stated that using the findings from the study that was once conducted to measure HIV sero-prevalence among MSM, the public health officials could develop can evidence for the need to improve health services for MSM.

#### **4.3.1.4 Information, Education and Communication on HIV Prevention**

Participants suggested that meetings and trainings should be designed for education and communication with MSM. These meetings and trainings should be specifically targeted at them. Most respondent stated that they have found trainings with their peers effective. At the same time, the respondents expressed the need to build the capacity of peer educators in effectively communicating of HIV prevention information.

Respondents further stated that general public health information, education and communication (IEC) material should also include education on same-sex health issues. They suggested that there should be sections within the IEC material that deals with men who have sex with men health. This was perceived as a form of hetero-normative stigma reduction as well as increasing awareness about MSM.

Respondents also stated that both social and traditional media should be used for education and communication. They stated that the Internet is the technology of the era and can play a major role in communicating HIV prevention messages. They also stated that the traditional media needs to be sensitised on reporting about MSM issues and could be used as means of social change.

#### **4.3.2 Findings from Managers of HIV Prevention Programmes Key Informants**

The findings from the key informants will be reported according to the order of the interview guide used to collect the data under the topics; HIV Prevention Policies and Programmes; Specific HIV Prevention Policies and Programmes for MSM; Collaborating with other Stakeholders in HIV Prevention for MSM (Appendix C).

#### **4.3.2.1 Interview Key Informants**

The key informants (n=5) were managers of HIV prevention programmes. They were from non-governmental organisation (n=3) or from the Ministry of Health (n=2). On average, the key informants have been working as managers of HIV prevention programmes for over 5 years.

#### **4.3.2.2 Existing HIV Prevention Policies and Programmes for MSM**

Key informants stated that until recently, there had been no HIV prevention interventions targeting MSM. They stated that it was the National Strategic Framework (NSF) of 2009-2014 that started to mention MSM population in the HIV intervention. They further explained that the scale of the intervention was limited as the NSF outlines nothing more than an intervention of providing condoms and lubricants to MSM. The key informants stated that it is only from 2011 that some guidelines have been developed that focus on Most at Risk Populations (MARPS), including MSM. They stated that none of these guidelines are printed or available in the public domain. These documents are: “An Operational Framework for Addressing HIV among MARPS” and “MARPS HIV Guidelines”. The key informants reported that some other documents are being developed. The documents were named; Training Manual for MARPS; National Strategic Framework on MARPS, and National HIV Testing and Counselling Strategy. None of all the documents were finalized according to key informants.

#### **4.3.2.3 Existing HIV Interventions Targeting MSM**

There is a MARPS Technical Working Group (TWG) which was established in 2011 under the Ministry of Health. Key informants stated that organisations that provide limited interventions to MARPS, including MSM are represented in this TWG. They pointed out that there were three non-governmental organisations that had HIV prevention interventions targeting MSM. However, they mentioned that these interventions are not adequate; they are limited to providing condoms and sometimes lubricants. On the other hand, the Ministry of Health is coordinating the HIV programmes that are targeting MARPS, including MSM. Overall, the HIV prevention intervention targeting MSM is providing condoms and water-based lubricants. One of the key informants, from the Ministry of Health stated some of the challenges:

*There is general lack of funding for HIV prevention interventions for MARPS, including MSM. This is because of the lack of political will. Our intervention approach is from the public health perspective. We emphasise that there should be no discrimination based on sexual orientation when accessing health care services. We are trying to develop guidelines with stakeholders, NGOs, but none of them are working.*

#### **4.4 Conclusion**

This chapter has presented all the results gathered through the mixed research methods. The results were presented according to the different instruments used to collect them, namely, interview questionnaire and semi-structured interview guides. Both from MSM sample and key informants were presented. In the next chapter, these results will be discussed according to the objectives and conclusions will be reached. Furthermore, recommendations will be made based on the results.

## **CHAPTER 5**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 Introduction**

The main aim of the study was to identify the HIV Prevention needs of MSM in Swaziland, using Manzini as a case study. This chapter discusses the results in relation to the objectives of the study and conclusions are reached. Recommendations are made based on the findings and conclusions. Conclusions will be discussed in the order of the following objectives:

- To distinguish the factors that put MSM in Swaziland at risk for – and vulnerable to – HIV infection.
- To identify the HIV prevention needs of MSM in Swaziland.
- To identify the existing HIV prevention strategies targeting MSM in Swaziland.
- To describe the MSM's knowledge, perceptions and attitudes towards HIV prevention strategies targeting MSM in Swaziland.
- To develop recommendations for HIV prevention strategies for MSM in Swaziland.

#### **5.2 Discussions and Conclusions**

The discussion and conclusions were made according to the objectives of the study. There are four objectives that are discussed in this chapter from which conclusions are made. The last objective is the recommendations that are made from the findings.

##### **5.2.1 Objective 1: To distinguish the factors that put MSM in Swaziland at risk for – and vulnerable to – HIV infection.**

Swaziland has been long recognized as a country with one of the highest relative HIV burden in the world. Because there is sustained transmission in the general population with average acquisition and transmission risks, the role of-at risk populations with specific acquisition, transmissions risks and prevention needs such as MSM has been assumed to be insignificant. MSM are at high risk for HIV infection because of several personal and societal issues.

##### **Sexual Orientation Disclosure and Social Support**

Most MSM still live in the closet; they are not free to disclose their sexual orientation to other people that can support them. Although a vast majority, 89% (31/35) of the MSM respondents had disclosed their

sexual orientation, most of them 90% (28/31) would only disclose their sexual orientation to a friend, who in most cases is also MSM. MSM generally did not disclose their sexual orientation to a health care provider or a family member. The findings further confirmed that there is generally fear of disclosure of sexual orientation in a hetero-normative society. Although MSM expressed the need of being supported by family members and health care providers in their sexual choices and decisions, they also stated that there is fear of being stigmatised and rejected. Lack of support may increase the risk of HIV infection. According to Caceres (2008), lack of support and stigma has direct impact on an individual's sense of worth and has been shown to reduce a person's motivation to protect himself or others from high-risk sexual behaviour.

### **Stigma and Discrimination**

Beside the fear of disclosure to people and institutions that are supposed to support them, the findings also show that most MSM have experienced some form of stigma and discrimination in their lifetime. On average, 70% of the respondents had felt rejected, labelled and avoided because of their sexual orientation. Experiences of stigma and discrimination have made some MSM (63%) to feel guilty about their sexual orientation. Although the experiences of stigma and discrimination were high, most MSM were comfortable of who they are and therefore did not want to change. Only 29% of the MSM expressed that they would want to change their sexual orientation. The experiences of homophobic stigma and discrimination in societies can affect an individual's self-esteem and reduce his motivation to protect himself and others (Caceres, 2008). This was also confirmed as some MSM stated that the fear of homophobic stigma increases their alcohol intake and therefore leads into lack of protection during sex.

### **Societal Pressure**

Beside the lack of support and stigma experienced by MSM, a majority of them (54%) were being persuaded by their family members to get married to a woman. This was especially common with MSM who had disclosed their sexual orientation to family members. One of the factors that contribute to high HIV risk among MSM, especially in developing countries is "sexual mixing" (Epstein, 2007). This, according to Epstein, refers to a specific sub-group that transmit HIV infection to another sub-groups. In this case, it refers to men who have sex with men as well as women; such men are often married. The persuasion of MSM to marry by family members may also account for the young population sample in this study as older MSM might already be married and living in the closet with their families and therefore could not come out and participate in the study.

### **Knowledge of HIV Transmission**

The findings also indicated limited knowledge and misconceptions about anal sex and the risk of HIV. Research has shown that biologically, HIV transmission through unprotected anal sex is higher than vaginal sex, whether that sex occurs between men or in heterosexual sex (UNAIDS, 2010). UNAIDS further states that studies have indicated that men who have anal sex with other men are 19 times at greater risk of HIV infection than the general population. However, such knowledge was limited among the respondents, as indicated by the findings of this study. Only 14% of the sample reported that anal sex has higher HIV infection risk than vaginal sex and 6% reporting that anal sex has high risk of HIV infection. Moreover, the limited knowledge of risk of transmission was observed as 66% (23/35) of the respondents reported that insertive anal sex carries a higher risk of HIV infection than receptive anal sex. Desmond Tutu Foundation (2011) states that research has shown that receptive anal sex has the highest risk of HIV transmission because of the biological and physiological make-up of the rectum. In addition, MSM participants in the qualitative interviews also stated that there are myths and misconceptions about anal sex; it is perceived as safer, and/or more pleasurable without using a condom.

The knowledge concerning the benefits of male circumcision was also limited. Of the respondents that reported to have been circumcised (40%, n=14/35), 35% (5/14) were exclusively receptive partners during anal sex, yet their reason for circumcision was to reduce the risk of HIV infection during anal sex. Radebe (2011) clarifies that the general poor messaging on specific HIV prevention among MSM, is misleading. Radebe states that some MSM are not aware that male circumcision does not benefit the exclusive receptive partner during anal sex.

### **Multiple Concurrent Sexual Relationships**

Multiple concurrent sexual relationships and short term frequent relationships were among the behaviours which were common among the MSM. MSM participants explained that it is common among their peers to have multiple sexual partners or frequent short term relationships. The ratio between insertive and receptive partner, lack of family support and substance abuse were named to be factors exacerbating this behaviour. MSM participants explained that some individuals have multiple partners because there are few insertive partners in their community hence they tend to share partners. They further stated that most of their sexual relationships are kept a secret and are often between the pair that is in the relationship. There is no family support to counsel when met with challenges.

These findings were supported by the findings from the quantitative research. A majority of the MSM sample who reported to have been in a sexual relationship before the current relationship, during the

study, reported to have their relationships only lasting between two to five months while 74% (26/35) had more than one partner at the same time in the past six months. Wade (2005) states that alcohol consumption commonly takes place where MSM socialise and meet sexual partners. Caceres (2005) further states that alcohol abuse, which is common among MSM, increases their risk of having multiple concurrent sexual partners.

### **Condom Use**

The main explanation for the higher risks of HIV among MSM is that HIV is easily transmitted during unprotected anal sex (Desmond Tutu Foundation, 2011). The findings indicated that condom use among the MSM sample was not consistent as 77% (31/35) reported to either sometimes use a condom or almost always. Inconsistent condom use is an HIV risk factor. The findings also indicated that more respondents were not using a condom when having sex with a casual partner (34%) than a main partner (29%). This can be associated with Wade's (2005) report that alcohol consumption is common among MSM and it commonly takes place where MSM socialise and meet sexual partners and condoms would not be available. Findings from the qualitative research elaborates that there is culture of social gathering among MSM, especially younger MSM and it is characterised by drinking, going out, partying and often sex without the availability of condoms.

It has been found that MSM in low and middle income countries frequently do not use condoms for anal sex, and where they do, they do not use safe water-based lubricants (Caceres, 2008). Contrary to Caceres' (2008) findings a vast majority (97%, n=34/35) of the respondents reported to be using water-based lubrications for anal sex. Access to the lubrication was reported to be difficult by a majority (56%, 20/35) of the MSM respondents who also indicated that they obtain these from their peer educators in the community. Indeed participants of the qualitative interviews stated that there is fear of perceived stigma in buying water-based lubrications from local retailers. So, although a vast majority of MSM reported to be using water-based lubrications, there is a challenge in accessing them and MSM preferred to access them through their peer-educators to avoid the stigma of buying them.

Female condoms are known to be beneficial during anal sex if properly used (Desmond Tutu Foundation, 2011). However, the knowledge of its usefulness usage was limited among the respondents. Only 17% (6/35) of the MSM respondents reported to have used a female condom. Some MSM reported that the reason for not using a female condom was that they did not like it. On the other hand, with regard to decision-making on condom use, there was contradicting information between the respondents of the qualitative interviews and the participants in the qualitative interviews. A majority, 69% of the

respondents reported to equally make decision on condom use with their sexual partners while the participants stated receptive partners are always not part of decision making when it comes to condom use.

### **5.2.2 Objective 2: To describe the MSM's knowledge, perceptions and attitudes towards HIV prevention strategies targeting MSM in Swaziland**

The findings on the MSM's knowledge, perceptions, and attitudes towards HIV prevention strategies are discussed under this objective. In addition, conclusions are being made. The discussion and conclusions are follows:

#### **PrEP and Rectal Microbicides**

The findings indicate that knowledge on PrEP and Rectal Microbicides was limited among the sample. Only less than 10% of the respondents had heard about PrEP and none knew about rectal microbicides. PrEP and rectal microbicides pre-exposure prophylaxis under study that are developed for HIV prevention (Nutan & Gupta, 2010). Although there was limited knowledge of these HIV prevention interventions, their acceptability was high with acceptability of rectal microbicides higher than PrEP. More than 80% of the MSM sample stated they would accept use microbicides if they were available while 66% indicating that they would accept and use PrEP.

Although the acceptability of PrEP and rectal microbicides were high, there were concerns about them. MSM respondents had fear of side effects, fear of adherence failure, had some doubt on the strength of prevention of PrEP hence the lower acceptability. On the other hand, rectal microbicides was much trusted by respondents and was perceived as easier to use than PrEP. There were also concerns about sexual behaviour change from some respondents as they thought using PrEP and rectal microbicides was likely to increase their sexual partners and/or decrease condom use. For instance, nearly 40% of respondents reported that PrEP was likely to increase their sexual partners while over 60% stated that they did not think they would use a condom if they were using rectal microbicides.

Accessibility of these HIV prevention strategies, PrEP and rectal microbicides was mostly preferred to be through peer educators. Approximately 50% of the MSM sample stated that they would prefer to access microbicides and rectal microbicides through peer educators because of perceived stigma from other institutions.

### **Sero-sorting and sero-positioning**

Sero-sorting, the choosing of a partner based on their HIV status (WHO, 2011), was a common idea among most respondents though they did not know that they value it and sometimes practises it. Over 70% of the MSM respondents were concerned about the HIV status of their sexual partners and stated that they would not have sex with sexual partners whose HIV status is known to them and is different to theirs. The MSM, 24%, also stated that as a result of sorting their partners according to HIV sero-status, they do not use a condom with a sexual partner whose HIV sero-status is known to them and it is the same as theirs. The practice of choosing a partner with the same HIV sero-status is often to engage unprotected sex in order to reduce acquiring HIV transmission and it depends on the disclosure of sero-status among both partners (WHO). On average, approximately 70% of the MSM sample reported to know the HIV status of their current partners as well as disclosed their HIV status to their partners. Overall, approximately 70% of the MSM sample had behaviours of sero-sorting practices – disclosing sero-status to partners and preferences of partners with same HIV sero-status – while 24% were actual practicing sero-status, that is, having sex without a condom with partners of the same HIV sero-status.

On the other hand, sero-positioning is choosing sex roles among MSM and their partners based on known HIV sero-status to reduce HIV reduce HIV transmission, while engaging in unprotected sex (WHO, 2011). Sero-positioning was not common among the sample with only one respondent reported choosing sex roles with partner based on their HIV status.

### **HIV Testing and Counselling (HTC)**

Approximately 90% of the MSM were aware of their HIV status with more than half reporting to go for HTC in NGOs. Nearly 80% of the MSM respondents were comfortable with the procedures where they uptake their HTC. However, MSM that reported to go to government public facilities reported not to be comfortable with the HTC procedures and stated that they would like to change to NGOs. NGOs' HTC facilities were preferable over government facilities. Some respondents participating in the qualitative interviews added that NGOs were most preferable to most MSM because there is less perceived stigma. MSM stated that the attitudes of health care workers from NGOs to MSM are different from that of health care workers from government facilities. Participants were wondering if NGOs health care workers receive any training on interacting with MSM. Findings from key informants answered that question by pointing out that most NGOs that involve MSM and other MARPS in their work sensitise their staff on interacting with the populations.

Although a vast majority of the participants reported to have been aware of their HIV status, the findings shown that there were not consistent in retesting as over half of the sample reported to have tested only once or twice in the last 12 months. HTC has been considered a key intervention for HIV prevention and current WHO guidance recommends that individuals should be recommended to retest after three months (WHO, 2011).

With a vast majority of the participants reported to be aware of their HIV status, only 29% reported to have disclosed their sexual orientation and true sexual behaviour to a service provide during HTC (Figure 4.10). Most MSM do not disclose the true sexual behaviour. Respondents stated that there is fear of being stigmatised especially because HTC settings are hetero-normative and HTC service providers always assume that every man seeking HTC is heterosexual. Knowing one's HIV sero-status through testing is important in HIV prevention and treatment. Individual can protect themselves and others from HIV infection when knowing their sero-status (UNAIDS, 2010).

### **5.2.3 Objective 3: Identify the HIV Prevention Needs for MSM in Swaziland Providing Services to MSM**

The findings indicated that the MSM sample accesses some of the services from their peers. For instance, over half the sample reported to access water-based lubricants from peer educators. MSM explained that it is easier for them to access service and information from their peers than from institutions and people where there is perceived homophobic stigma. The MSM expressed the need to capacitate and strengthen existing peer educators. They stated that they are comfortable to access the basic services, like condoms and lubricants as well as HIV prevention information from a trained peer educator. Strengthening existing community networks for MSM is important for HIV prevention as especially where MSM are highly stigmatised (UNAIDS 2012).

On the other hand, MSM participants also expressed a need for safe space where they can access HIV related information and services without any fear of being stigmatised. They state that there is a need for centres, exclusively for MSM where they can meet, share their experiences, access health information and receive professional counselling.

The findings also indicate that sometimes sex among MSM occurs in venues where condoms and lubricants are not available. MSM respondents stated that, MSM social gatherings, which are normally accompanied by alcohol, “unplanned” sex occurs. Participants stated that there is a need for condoms and lubricants to be made available to places that are frequented by MSM. Condom availability should be

always made possible as consistent condom use has been vital to HIV prevention efforts since the early days of the epidemic (WHO, 2011).

The findings indicate MSM's need for couple-based HTC. Couple-based has been successful with heterosexual couples and can also be adapted for MSM. It can be beneficially for most partners as they can support each other during HTC (Radebe, 2011). Couple-based HTC was not common among the MSM although nearly two-thirds stated that they consider doing it in the future. Only a quarter, 25%, of the MSM sample had gone for HTC with their male sexual partners before because of perceived stigma. Three-thirds of the sample indicated that they consider testing with their male sexual partners.

### **Reducing Homophobic Stigma and Discrimination**

The MSM participants stated the need to increase public awareness about MSM health needs and therefore decreasing homophobic related stigma and discrimination. The participants stated that if awareness increases about MSM, the stigma and discrimination is likely to decline. For instance, homophobic stigma and discrimination was perceived at health care facilities and other institutions by most MSM participants. They stated that often, health care facilities are hetero-normative settings and they always fear to disclose their sexual behaviour to health care workers. As a result, MSM participants reported to even engage in trying other remedies, especially for sexual health related issues because of the perceives stigma at health care facilities.

The MSM participants therefore suggested the that health care hetero-normative settings should incorporate the health needs of MSM by sensitising health care workers, and having IEC material that will be inclusive of MSM health. They further suggested public health education that is not hetero-normative. MSM participants also suggested that sex education from schools and colleges should also include MSM behaviour. It was pointed out that this can only not increase public awareness about the existence and needs of MSM, but can also reduce stigma and discrimination directed to MSM. Participants explained that this, in turn, can increase health-care seeking behaviour among MSM. Stigma and discrimination affects a person's self-esteem and therefore reduces a person's motivation to project him or others from high risk sexual behaviours (Caceres, 2008).

### **Communication with MSM**

MSM suggested different methods to reach them with information, education and communication. Participants suggested that meetings and trainings specifically for MSM are beneficially in educating

them in HIV prevention. They further stated that trained peer educators are key for reaching MSM with information.

Internet-based information was indicated as a need for communication by the MSM sample. Nearly 80% of the respondents preferred to access HIV prevention information for MSM through the Internet as they stated that it was easy to access and it there was privacy. All respondents had access to the Internet but only nearly 20% had accessed HIV prevention information for MSM through the Internet. The needs for Internet-based HIV prevention information qualifies WHO's (2011) report that Internet-based HIV prevention interventions makes it easier for MSM with Internet access to obtain relevant HIV prevention messages in an anonymous fashion, at a convenient time and in private, especially in setting where there is a lot of homophobic stigma.

#### **5.2.4 Objective 4: To Identify the Existing HIV Prevention Strategies Targeting MSM in Swaziland**

Findings from key informants indicated that the Ministry of Health and other three NGOs have some initiatives on MSM HIV prevention though they explained those initiatives were not adequate. Key informants from the Ministry of Health explained that the ministry's role is to coordinate the HIV prevention programmes targeting MARPS, including MSM. They explained that there were guidelines being developed on HIV programming on MARPS, including MSM, but none of them were functional. Initiatives by the ministry have only started in 2011. The key informants also stated that there is no budget towards interventions targeting MSM from politicians. Populations at high risk for HIV transmission are generally neglected in HIV programming and there is always lack of budget directed towards them when they are supposed to be priority (Global HIV Prevention Working Group, 2010).

On the other hand, key informants from NGOs explained that there were already initiatives on HIV prevention targeting MSM even before the Ministry of Health initiated. However, they stated that accessing the populations was scare. Their interventions were providing condoms and only one NGO provides lubrications periodically.

Most of the MSM participants were aware of the condoms and lubricants interventions supplied by the NGOs but were not aware of the Ministry of Health's initiative, for instance the development of HIV programming guidelines. MSM participants perceived the Ministry of Health as one obliged to make change of reducing homophobic stigma by increase public awareness on the health needs of MSM. They stated that the Ministry of Health has a chance to influence change through public health education.

Participants stated that public health education should include both the HIV prevention needs on heterosexual and MSM sexual behaviour. They stated that this can also inform politicians.

### **5.3 Recommendations**

Overall, the findings indicated the need to meet the HIV prevention needs of MSM in Swaziland. The findings indicated a gap between the needs of MSM for HIV prevention and the current interventions provided. The following recommendations were made based on the findings:

- Experiences and perceptions of homophobic stigma and discrimination were common among the MSM. Stigma and discrimination prevents MSM from accessing health care services. Efforts to eliminate homophobic stigma and discrimination should be integrated into programmes by all stakeholders working with MSM. The MSM participants recommended that the Ministry of Health aim to eliminate stigma and increase public awareness on MSM health issues through public health education that is not hetero-normative.
- Peer educators played an important role in providing services and information to MSM. The findings indicated that most MSM were comfortable to access HIV prevention services and information through their peer educators. Capacity building and strengthening of MSM peer educators should be provided to increase the efficacy of peer educators and expanding interventions to MSM through channels with which they are comfortable.
- The findings from the study indicated limited knowledge on HIV transmission among MSM. There were myths and misconceptions on some risk behaviours. There is a need to educate MSM on the risk of HIV transmission through sex between men, especially anal sex practices.
- Although there was great acceptability of PrEP and rectal microbicides as new technologies for HIV prevention, their introduction should be accompanied by education. It is concerning that most MSM participants indicated that they would be likely to eliminate condom use or increase the number of sexual partners if they began taking PrEP or utilising rectal microbicides.

### **5.4 Limitations of the study**

There were several limitations of the study. The MSM sample was recruited from only one city in Swaziland: Manzini. It might be possible that the experiences and HIV prevention needs of the MSM in the city of Manzini are different from other locales in the country. Future research should encompass different geographic locations in order to detect regional differences.

The instrument used for data collection was developed by the researcher and therefore had not been administered in the population that was being studied in Swaziland. There is a need to have adequate pre-testing of research tools before a subsequent study, especially when studying the knowledge and attitudes concerning hidden and stigmatised behaviours like sex among MSM.

Although the snowball sampling strategy was useful to access the hidden and rare to find MSM population, the study participant was likely to invite his peers who may have had similar characteristics and attitudes. When using snowball sampling, the researcher should strive to select initial ‘seeds’ with different demographic characteristics so that the resulting sample would have optimal diversity.

The stigma and illegal nature of the same-sex sexual practices in Swaziland may also have limited the participation by some MSM. Most of the MSM remain hidden, afraid to disclose their sexual orientation. Recruiting a sample of MSM is a challenge. The researcher needs to collaborate with gatekeepers that may have access to MSM in the communities in order to understand their social networks.

## **5.5 Conclusion**

The main aim of the study was to identify the HIV prevention needs of MSM in Swaziland through some specific objectives. Special focus was on To distinguish the factors that put MSM in Swaziland at risk for – and vulnerable to – HIV infection; identifying the HIV prevention needs of MSM in Swaziland; identifying the existing HIV prevention targeting MSM in Swaziland; describing the MSM’s knowledge, perceptions and attitudes towards HIV prevention strategies targeting MSM in Swaziland. The findings of the study met the objectives as discussed and concluded in this chapter. Lastly, study also made recommendation on HIV prevention programming for MSM in Swaziland.

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**APPENDIX A**

**Survey Instrument: Research Questionnaire**

**HIV Prevention Needs for MSM in Swaziland**

**In Partial Fulfilment of a Master of Philosophy in HIV and AIDS Management from the Africa  
Centre for HIV and AIDS Management at Stellenbosch University**

**June 2012**

**Section 1 – Demographic and Socio Economic Information**

“This first set of questions are about your background”

“*Lemibuto lesitocala ngayo ibuta ngelimuva lakho*”

No .	Question	Coding	Response
1.00	How old are you? <i>Uneminyakalemingakhi?</i>	Age in Years 99= Don't Know	
1.02	What was your nationality at birth? <i>Buyini buve bakho ekutalweni?</i>	01= Swazi 02= Mozambique 02= South African 03=Other African 04=Other → _____ 88= No response 99= Don't know	
1.03	What is the highest level of your education? <i>Ufundze wagcinaphi?</i>	01= Never attended school 02= Some Primary School 03= Completed Primary 04= Some secondary or high School 05= Completed secondary or high school 06=post HS Vocational Training 07= post HS College/University 88= No response 99= Don't know	
1.04	What is your current employment status? <i>Usebenta musebenti muni nyalo?</i>	01= Unemployed 02=Self-Employed 03= Employed by other 04=Student	

		88= No response 99= Don't know	
<b>1.05</b>	What was your income last month (in SZL) <i>Ube ngumalini umholo wakho enyangeni lephelile?</i>	Record number in box 88= No Response 99= Don't know	_ _   _ _
<b>1.07</b>	How long have you lived in Swaziland? <i>Uhleli sikhatsi lesinganani kangwane?</i>	All Numbers (write response in years and months) 88= No response 99= Don't know	_ _  -  _ _  mm          yy
<b>1.08</b>	Where did you grow up? <i>Ukhulelephi?</i>	01= Urban 02= Rural 03=Foreign Country 88= No response 99= Don't know	_ _
<b>1.09</b>	What do you consider your sexual orientation to be? <i>Ucabanga kutsi utsandza bulili buni?</i>	01= Gay or homosexual 02= Bisexual 03= Heterosexual or straight 04= Transgender 05= Other: (specify) 88= No Response 99= Don't know	_ _
<b>1.10</b>	What do you consider your gender to be? <i>Ngubuphi bulili bakho?</i>	01= Man 02= Woman 03=Other → _____ 88= No Response 99= Don't know	_ _
<b>1.11</b>	What is your marital status?	01= Married	_ _

	<i>Umephi kutekutsatsana?</i> <b>(More than one once is acceptable)</b>	02=Cohabiting (with a man) 03=Cohabiting (with a woman) 04= Divorced/Separated 05= Widowed 06= Single/Never Married 07= Other (specify) 88= No Response 99= Don't Know	
<b>1.12</b>	How many children do you have? <i>Unabangaphi bantfwana?</i>	All numbers (write 00 if no children) 88= No Response 99= Don't Know	

**Section 2 – Risks and Vulnerabilities**

“Now we are going to ask about things that make you at risk and vulnerable for HIV infection. Some of the question that will be asked may be personal or make you emotional. Please feel free to answer because everything will be confidential.”

*“Nyalo sesitokhuluma ngetintfo letikubeka engotini yekutfofa i-HIV. Leminye imibuto ingahle ikwente kutsi ungakhululeki. Sicela ukhululeke ngoba konkhe kutoba yimfihlo.”*

	<b>Question</b>	<b>Coding</b>	<b>Response</b>
	<b>Personal Perception</b>		
<b>2.00</b>	Have you ever disclosed you sexual orientation (MSM) to anyone? <i>Wake wantjela yini lomunye umuntfu kutsi utsandzana nebulili lobufanako?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>2.01</b>	If yes, to whom? <i>Nangabe wake, ngubani?</i>	00= Friend 01= Colleague 02= Family	

	<b>(More than one once is acceptable)</b>	member 03= Health care worker 04= Other (specify) 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>2.02</b>	Have you ever felt rejected because of your sexual orientation? <i>Wake wativela ubandlulekile ngenca yebulili lotsandzana nabo?</i>	00= No 01= Yes 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>2.03</b>	Have you ever felt avoided because of your sexual orientation? <i>Wake wativela yini bantfu bakubalekela ngenca yebulili litsandzana nabo?</i>	00= No 01= Yes 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>2.04</b>	Have you ever been labeled because of your sexual orientation? <i>Bake bakusho yini emagama tsite ngenca yebulili lotsandzana nabo?</i>	00= No 01= Yes 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>2.05</b>	Have you ever felt guilty because of your sexual orientation? <i>Wake wativela yini unekutisola noma kutenyanya ngenca yebulili lotsandzana nabo?</i>	00= No 01= Yes 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>2.06</b>	Are you feeling guilty because of your sexual orientation? <i>Utivela utisola/utenyanya yini nyalo ngenca yebulili lotsandzana nabo?</i>	00= No 01= Yes 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>2.07</b>	Would you wish to change your sexual orientation?	00= No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	<i>Ungafisa yini kugucula indlela longiyo ngebulili lotsandzana nabo?</i>	01= Yes 88= No Response 99= Don't know	
<b>2.08</b>	If unmarried, are you planning to get married to a woman in the future? <i>Nangabe usengakashadi, uyafisa yini kushada esikhatsini lesitako?</i> <b>NB: Don't answer question if married</b>	00= No 01= Yes 88= No Response 99= Don't know	
<b>2.09</b>	If sexual orientation is known to family, do they try to persuade you to change? <i>Nangabe umndeni wakho uyati ngawe, bake betama yini kutsi bakugucule?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>2.10</b>	Do family members try to persuade you to have your own family (marry a woman)? <i>Ingabe umndeni wakini uyakuphokelela yini kutsi ushade (newesifazane)?</i>	00= No 01= Yes 88= No Response 99= Don't know	
	<b>Knowledge of HIV Risk</b> <i>Lwati ngebungoti be-HIV</i>		
<b>2.11</b>	What type of sex do you think is more risky for HIV infection? <i>Nguluphi luhlobo lwekulala lolubekana engotini lenkhulu yekutfolela i-HAIV?</i>	01= Vaginal 02= Anal 03= Oral 04= All carry equal risk 88= No Response 99=Don't Know	
<b>2.12</b>	What type of sex do you think carries less risk for HIV infection? <i>Nguluphi luhlobo lwekulala lolunengoti lencane yekutfolela i-HIV?</i>	01= Vaginal 02= Anal 03= Oral 04= All carry	

		equal risk 88= No Response 99=Don't Know	
2.13	Which type of sex is safer between vaginal and anal sex? <i>Nguluphi luhlobo lwekulalana loluphephile (ngemuva noma ngembili)?</i>	01= Vaginal 02=Anal 03= All carry equal risk 88= No Response 99=Don't Know	
2.14	What type of sex puts you at risk for STI? <i>Nguluphi luhlobo lwekulalana lolunengoti lenkhulu yekutfole bogcunsula?</i>	01= Vaginal 02= Anal 03= Oral 04= All carry equal risk 88= No Response 99=Don't Know	
2.15	What type of anal sex do you think carries more risk of HIV infection? <i>Nguluphi luhlobo lwekulalana ngemuva lolunengoti lenkhulu yekutfole i-HIV?</i>	01= Insertive 01= Receptive 88= No Response 99= Don't know	

### **Section 3 - Sexual Behavior (HIV Prevention Practices)**

“Now we are going to talk about your sexual behavior. This will include your past and/or current sexual partners. It will also include HIV prevention strategies you practice and your perception on HIV prevention strategies in general. Please do not be afraid because everything will be confidential.”

*“Nyalo-ke sitawukhuluma ngendlela lotiphatsa ngayo kutekulala. Loku kutofaka ekhatsi bantfu lotsandzene nabo nalotsandzana nabo nyalo. Kutawufaka ekhatsi tindlela tekuvikela i-HIV lotisebentisako nalobuka ngayo tindlela tekuvikela i-HIV. Sicela ungesabi ngoba konkhe kutawugcinwa kuyinfihlo.”*

No.	Question <i>Umbuto</i>	Coding	Response
	<b>Sexual Partners</b> <i>Bantfu lolele nabo</i>		
3.00	Are you currently involved in a sexual relationship with another man? <i>Kukhona yini umuntfu lotsandzana naye nome loke ulale naye nyalo?</i>	00= No <b>(if 00, go to 3.02)</b> 01= Yes 88= No Response 99= Don't Know	_ _
3.01	If yes, how long has it been going? <i>Nangabe kunjalo, seninesikhatsi lesinganani?</i>	00= Less than 2 months 01= 2-5 months 02= 6-12 months 03= 13 months or more 88= No response 99= Don't know	_ _
3.02	Were you in a sexual relationship with another man before the current relationship? <i>Kukhona yini lebewutsandzana naye ngephambi kwalona lokhona nyalo?</i>	00= No <b>(if 00, go to 3.04)</b> 01= Yes 88= No Response 99= Don't Know	_ _
3.03	If yes, how long did it last? <i>Nangabe kunjalo, kwatsatsa sikhatsi lesinganani?</i>	00= Less than 2 months 01= 2-5 months 02= 6 -12 months 03= 13 months or more 88= No response 99= Don't know	_ _
3.04	Would you consider the man you are in a sexual relationship with a main partner?	00= No	_ _

	<i>Ungasho yini kutsi lona lonaye nyalo singani mbamba?</i>	01= Yes 88= No Response 99= Don't know	
<b>3.05</b>	In the last 6 months, how many men you had either anal or oral sex with? <i>Kuletinyanga letingu 6 letendlulile, bangakhi besilisa lolele nabo ngemuva noma ngemlomo?</i>	Record number in box 88= No Response 99= Don't know	
<b>3.06</b>	In the last 6 months, how many female partners did you have virginal sex with? <i>Kuletinyanga letingu 6 letendlulile, bangakhi besilisa lolele nabo ngembali?</i>	Record number in box 88= No Response 99= Don't know	
	<b>3.06.a.</b> In the last 6 months, how many female partners did you have anal sex with? <i>Kuletinyanga letingu 6 letendlulile, bangakhi besilisa lolele nabo ngemuva?</i>	Record number in box 88= No Response 99= Don't know	
<b>3.07</b>	If any, would you consider any of them a main partner? <i>Nangabe bakhona, ungasho yini kutsi bekusingani/tingani mbamba?</i>	00= No 01= Yes 88= No Response 99= Don't know	
	<b>Condom Use</b> <i>Kusebentisa ikhondomu</i>		
<b>3.08</b>	Did you use a condom the last time you had sex with your male main partner? <i>Uyisebentisile yini ikhondomu nawugcina kulala nalomunye wesilisa losingani sakhol lesingisona sona?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>3.09</b>	Did you use a condom the last time you had sex with a male casual partner?	00= No	

	<i>Uyisebentisile yini ikhondomu nawugcina kulala nalomunye wesilisa longasiso singani mbamba?</i>	01= Yes 88= No Response 99= Don't know	
<b>3.10</b>	Did you use a condom the last time you had sex with a female partner? <i>Uyisebentisile yini ikhondomu nawugcina kulala newesifazane?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>3.11</b>	How often do you use condoms with male sexual partners? <i>Uvame kuwasebentisa kanganani emakhondomu nawulala nalomunye wesilisa?</i>	00= Never 01= Almost never 02= Sometimes 03= Almost always 04= Always 88= No Response 99= Don't know	
<b>3.12</b>	How often do you use condoms with female sexual partners? <i>Uvame kuwasebentisa kanganani emakhondomu nawulala newesifazane?</i>	00= Never 01= Almost never 02= Sometimes 03= Almost always 04= Always 88= No Response 99= Don't know	
<b>3.13</b>	If not always, either 3.11 or 3.12, is there any other preferred method of HIV prevention used? <i>Nangabe utsi awuwasebentisi ngaso sonkhe sikhatsi ku 3.11 noma ku 3.12, kukhona yini luhlobo lwekuvumela i-HIV lolusebentisako?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>3.14</b>	Did a condom ever tear while having sex with another man? <i>Kwake kwenteka yini kutsi kudzabuke ikhondomu nawulala nalomunye</i>	00= No 01= Yes	

	<i>wesilisa?</i>	88= No Response 99= Don't know	
<b>3.15</b>	Where do you normally get condoms from? <i>Uvame kuwatfolo kuphi emakhondomu?</i>	00= Buy them 01= Public places (for free) 02= Peer Educator 03= Other: _____ 88= No Response 99= Don't know	_ _
<b>3.16</b>	Do you have a preferred brand of condom? <i>Kukhona yini luhlobo lwemakhondomu lolutsandzako/lolunconotako?</i>	00= No 01= Yes 88= No Response 99= Don't know	_ _
<b>3.16</b> <b>.1</b>	If yes, what brand and why? <i>Nangabe lukhona, nguluphi?</i>	Write response on coding space	
<b>3.17</b>	Do you use any lubrication with the condoms if you have sex with another man? <i>Kukhona yini kwekugcobisa lokusebentisa nalamakhondomu nangabe ulala nalomunye wesilisa?</i>	00= No 01= Yes 88= No Response 99= Don't know	_ _
<b>3.18</b>	Do you use any lubrication if you are having sex with another man without a condom? <i>Kukhona yini kwekugcobisa lokusebentisa nangabe ulala ngaphandle kwenhondomu nalomunye wesilisa?</i>	00= No 01= Yes 88= No Response 99= Don't know	_ _
<b>3.19</b>	What lubrication do you normally use for anal sex? <i>Nguluphi luhlobo lwekugcobisa lovame kulusebentisa nangabe ulala nalomunye wesilisa ngemuva?</i>	01=Petroleum jelly or Vaseline 02=Body creams/fatty creams 03=Water-based	_ _

		lubricant 04=Saliva 05=No lubricant use 88= No Response 99=Don't know	
<b>3.20</b>	Where do you get lubrication from? <i>Ukutfolaphi lokwekugcobisa?</i>	00= Buy 01= Public places (for free) 02= Peer Educator 03= Other (Specify near coding box) 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>3.21</b>	What kind of access to the lubricants do you have when you need them? <i>Kulula kanganani kutfola lokwekugcibisa ngesikhatsi ukudzinga?</i>	00= No Access 01= Difficult or little access 02= Some access 04= Very easy access 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>3.22</b>	Have you or your male sexual partner(s) used a female condom when having anal sex? <i>Ingabe wena noma wesilisa lowake walala naye nake nayisebentisa yini ikhondomu yebesifazane?</i>	00= No 01= Yes 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>3.23</b>	If yes, would you suggest it to other male who have sex with male partners? <i>Nangabe wake wayisebentisa, ungayincoma yini kulabanye besilisa labatsandzana nalabanye besilisa?</i>	00= No 01= Yes 88= No Response 99= Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<p><b>3.24</b></p>	<p>If no to <b>3.22</b>, why have you not used it before?</p> <p><i>Nangabe utsi cha ku 3.22, ingabe kwentiwa yini kutsi awukase uwasebentisa phambilini?</i></p>	<p>01= Not aware of its use for MSM</p> <p>02= Do not like it</p> <p>03= Do not have access to it</p> <p>04= Do not know how to use it</p> <p>05= Other (specify)</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<p><b>3.25</b></p>	<p>Do you consider using it in the future?</p> <p><i>Kepha ingabe uyafisa yini kuwasebentisa esikhatsini lesitako?</i></p>	<p>00= No</p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<p><b>3.25</b> <b>/1</b></p>	<p>Who is responsible for decision making on condom use between you and your male partner(s)?</p> <p><i>Ngubani lowenta sincumo sekusebentisa i-condom kuwe newesilisa lolala naye?</i></p>	<p>00=Him/them</p> <p>01=Me</p> <p>02=Both of us</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
	<p><b>Male Circumcision</b></p> <p><i>Kusoka Kwebesilisa</i></p>		
<p><b>3.26</b></p>	<p>Are you circumcised?</p> <p><i>Ingabe usokile yini?</i></p>	<p>00= No</p> <p><b>(if 00, go to 3.38)</b></p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>

3.37	<p><b>If yes, what was the reason to circumcise?</b></p> <p><i>Nangabe usokile, kwaba yini sizatfu?</i></p>	<p>00= HIV prevention</p> <p>01= STI Prevention</p> <p>02= Personal Hygiene</p> <p>03= Culture</p> <p>04= Other (Specify next to box)</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
3.38	<p>Do you think circumcision benefits you during anal sex?</p> <p><i>Ingabe ngekwati kwakho, kuyasita yini kusoka nawulala nalabanye besilisa ngemuva?</i></p>	<p>00= No</p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
3.39	<p>If yes, state how?</p> <p><i>Nangabe kuyasita, kusita kanjani?</i></p>	<p>Write answer in coding column on the right</p>	
3.40	<p>What role do you normally prefer during anal sex?</p> <p><i>Utsandza kudlala yiphi indzima nakulalwa ngemuva?</i></p>	<p>00= Insertive partner</p> <p>01= Receptive Partner</p> <p>02= Versatile</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
3.41	<p>What kind of sexual partner would you prefer in terms of circumcision status?</p> <p><i>Utsandza kulala nemuntfu lonjani mayelana netekusoka?</i></p>	<p>01= Circumcised</p> <p>02= Non-circumcised</p> <p>03= No preference</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>

	<p><b>HIV Testing and Counseling (HTC)</b>  <i>Kuhlola i-HIV nekweleleka</i></p>		
3.42	<p>Are you aware of your HIV status?  <i>Uyasati simo sakho sengati?</i></p>	<p>00= No  01= Yes  88= No Response  99= Don't know</p>	<p>   </p>
3.43	<p>Where do you normally have your HTC?  <i>Uvame kusihlolaphi simo sengati mayelana ne-HIV?</i></p>	<p>00= Government Facilities  01= NGOs  02= Private Facilities  88= No Response  99= Don't know</p>	<p>   </p>
3.44	<p>Are you comfortable with the procedures where you uptake HTC?  <i>Ingabe uyenetiseka yini ngendlela labachuba ngayo lapho uhlola khona?</i></p>	<p>00= No  01= Yes  88= No Response  99= Don't know</p>	<p>   </p>
3.45	<p>If no, would you prefer any other facility?  <i>Nangabe awenetiseki, kukhona yini indzawo longayincoma?</i></p>	<p>00= Government Facilities  01= NGOs  02= Private Facilities  03= Other (specify under coding box)  88= No Response</p>	<p>   </p>

		99= Don't know	
3.46	When last did you go for an HIV test? <i>Wagcina nini kuyohlola simo sakho sengati?</i>	00= 0-3 months 01=4-6 months 02=7-9 months 03=10+ months 88= No Response 99= Don't know	
3.47	When last was it before the last time? <i>Bewugcine nini ngaphambi kwekutsi uye kulokwekugcina?</i>	00= 0-3 months 01=4-6 months 02=7-9 months 03=10+ months 88= No Response 99= Don't know	
3.48	How many times did you have HTC in the last 12 months? <i>Uhlole kangakhi i-HIV engatini kuletinyanga letingu 12 letendlulile?</i>	00= Never 01= 1-2 02= 3 or more 88= No Response 99= Don't know	
3.49	Have you ever revealed that you have sex with other men to a service provider during a HTC session? <i>Wake waveta yini kutsi utsandzana/ulala nalabanye bebulili lobufanako ngesikhatsi kuloyo lebekakuhlola ingati?</i>	00= No 01= Yes 88= No Response 99= Don't know	
3.50	Have you ever done HTC together with a male sex partner? <i>Wake wahlola yini ingati naloyo lovana naye webulili lobufanako?</i> <b>NB: If yes, go to 3.53</b>	00= No 01= Yes 88= No Response 99= Don't know	
3.51	If no, do you consider doing it? <i>Nangabe awuzange, uyafisa yini kukwenta?</i>	00= No 01= Yes	

		88= No Response 99= Don't know	
3.52	If no, what are the reasons? <i>Nangabe awuzange, ingabe yini tizatfu taloko?</i>	00= Fear of stigma 01= Not comfortable 88= Partner not comfortable 03= Other (specify) 99= Don't know	
	<b>Serosorting and Seropositioning</b>  <i>Kukhetsa singani ngenca yekwati simo se-HIV kanye nekukhetsa luhlobo lwekulala nesingani ngenca yesimo se-HIV</i>		
3.53	Have you disclosed your HIV status to your current partner(s)? <i>Ingabe loyo lotsandzana naye/nabo nyalo wake wantjela yini ngesimo sakho se-HIV?</i>	00= No 01= Yes 88= No Response 99= Don't know	
3.54	Do you know the HIV status of your current partner(s)? <i>Ingabe uyasati yini simo sengati saloyo lovana naye/nabo manje?</i>	00= No 01= Yes 88= No Response 99= Don't know	
3.55	How often do you talk about HIV prevention with your current partner(s)? <i>Niye nikhulume kangani nge-HIV naloyo lenivana naye/nabo manje?</i>	00= Never 01= Almost never 02= Sometimes 03= Almost always 04= Always	

		88= No Response 99= Don't know	
<b>3.56</b>	How often do you discuss HIV status with partner(s) before engaging in sex? <i>Uye ukhulume kanganani naloyo/labo lovana naye/nabo ngaphambi kwekutsi nicale kulala?</i>	00= Never 01= Almost never 02= Sometimes 03= Almost always 04= Always 88= No Response 99= Don't know	
<b>3.57</b>	Does it matter to you if a sexual partner has same HIV status as yours? <i>Unenzaba yini kutsi simo saloyo lovana naye siyafana nesakho?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>3.58</b>	Does it matter to you if a partner has different HIV status from yours? <i>Unenzaba yini kutsi simo saloyo lovana naye sehlukile nome nesakho?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>3.59</b>	Would you have sex with a partner who has different HIV status from yours? <i>Ungalala yini nalovana naye lonesimo lesehlukile kusakho?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>3.60</b>	Do you often use a condom with a sexual partner whose status is known to you and is the same as yours? <i>Uyayisebentisa yini ikhondomu nawulala nalonesimo se-HIV losatiko kutsi sifanana nesakho?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>3.61</b>	Do you choose sex roles (insertive and receptive) with partner based on HIV status?	00= No	

	<p><i>Ingabe kuyenteka yini ukhetse tindlela tekulala (ngetulu noma ngephansi) naloyo lovana naye ngenca ngesimo senu sengati?</i></p> <p><b>NB: If no, go to 3.63</b></p>	<p>01= Yes 88= No Response 99= Don't know</p>	
3.62	<p>If yes, what are the roles? <i>Nangabe kuyenteka, ngutiphi leto tindlela tekulala lenivame kutikhetsa?</i></p>	<p>00= HIV negative-receptive 01= HIV positive-insertive 02=HIV negative-insertive 88= No Response 99= Don't know</p>	<p>   </p>
	<p><b>Pre-Exposure Prophylaxis (PrEP)</b> <i>Kunatsa Emaphilisi ekuvikela i-HIV ngaphambi kwekube ulale</i></p>		
3.63	<p>Have you heard of PrEP? <i>Wake weva yini ngekunatsa emaphilisi ekuvikela kutfola i-HIV ngaphambi kwekulala?</i></p> <p><b>NB: If no, go to 3.65</b></p>	<p>00= No 01= Yes 88= No Response 99= Don't know</p>	<p>   </p>
3.64	<p>If yes, where have you heard of it? <i>Nangabe wake weva, wakuvaphi?</i></p>	<p>00= NGO 01= Health Facility 02= Peer Educator/workshop 03= School 04= Internet 05= Friends 06= Media 88= No Response 99= Don't know</p>	<p>   </p>

<p><b>3.65</b></p>	<p>Have you taken antiretroviral medication that is taken by HIV negative individuals for HIV prevention before? <i>Wake wawanatsa yini emaphilisi ekuvikela kutfolo i-HIV lanatfwa ngulabete i-HIV ngaphambi kwekube balale nalomunye?</i></p>	<p>00= No 01= Yes 88= No Response 99= Don't know</p>	<p>   </p>
<p><b>3.66</b></p>	<p>Are you taking antiretroviral medication <b>for HIV prevention</b> now? <i>Ingabe kukhona yini emaphilisi lanjalo ekuvikela lowanatsako nyalo ngaphambi kwekube ulale nalomunye?</i></p>	<p>00= No 01= Yes 88= No Response 99= Don't know</p>	<p>   </p>
<p><b>3.67</b></p>	<p>If no, would you take antiretroviral medication for treatment if it was offered? <i>Nangabe awuzange, ungawanatsa yini emaphilisi lanjalo ekuvikela i-HIV ngaphambi kwekube ulale nalomunye?</i></p>	<p>00= No 01= Yes 88= No Response 99= Don't know</p>	<p>   </p>
<p><b>3.68</b></p>	<p>If yes, would you be able to take it consistently on daily basis? <i>Nangabe ungawanatsa, ungakhona yini kubelesela uwanatse onkhe malanga ngekwetsembeka nome wati kutsi ute ligciwane?</i></p>	<p>00= No 01= Yes 88= No Response 99= Don't know</p>	<p>   </p>
<p><b>3.69</b></p>	<p>If no to <b>3.67</b>, why would you not take antiretroviral treatment for prevention daily? <i>Nangabe utsite cha ku 3.67 ngenhla, yini lokungakubangela kutsi ungawatsatsi ungawatsatsi emaphilisi onkhe malanga kuvikela i-HIV?</i></p>	<p>01= Fear of stigma 02= Poor adherence 03= Side effects 04= Do not trust its protection 05= Other (specify) 88= No Response 99= Don't know</p>	<p>   </p>
<p><b>3.70</b></p>	<p>Would you use condoms if you were on PrEP? <i>Nangabe bewungawanatsa emaphilisi kuvikela ligciwane le-HIV, ungayisebentisa yini nekhondomu?</i></p>	<p>00= No 01= Yes 88= No Response</p>	<p>   </p>

		99= Don't know	
<b>3.71</b>	<p>Do you think taking PrEP would change your sexual behavior if you were to take it?</p> <p><i>Ucabanga kutsi ingashintja yini indlela lotiphatsa ngayo kutekulala nawungake-nje uwatfole lamaphilisi ekuvikela i-HIV?</i></p> <p><b>NB: If no, please go to 3.73</b></p>	<p>00= No</p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<b>3.72</b>	<p>If Yes, how?</p> <p><i>Nangabe kunjalo, ucabanga kutsi ungashintja kanjani?</i></p>	<p>00= Increase number of sex partners</p> <p>01= Decrease number of sex partners</p> <p>02= Eliminate other prevention strategies</p> <p>03= Other (specify)</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<b>3.73</b>	<p>Would you be able to encourage your sexual partner to uptake PrEP if you were taking it?</p> <p><i>Ungamkhutsata yini loyo lovana naye kutsi awatsatse naye lamaphilisi ekuvikela i-HIV nawungake ucale uwanatse wena?</i></p>	<p>00= No</p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<b>3.74</b>	<p>What kind of MSM do you think they need to take PrEP?</p> <p><i>Ucabanga kutsi ngulabanjani ngesimo se-HIV kubantfu labatsandzana nebulili lobufanako lebafanele kunatsa lamaphilisi ekuvikela i-HIV?</i></p>	<p>00= Young/old</p> <p>01= HIV negative</p> <p>02= HIV positive</p> <p>03= With multiple sexual partners</p> <p>04= Other (Specify)</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<b>3.75</b>	<p>How do you think PrEP can benefit MSM?</p>	<p>00= Prevention</p>	<p>   </p>

	<p><i>Ucabanga kutsi emaphilisi ekuvikela i-HIV angabasita kanjani besilisa labatsandzana nebulili lobufanako?</i></p>	<p>HIV infection</p> <p>01= Prevention of STI</p> <p>02= Other (Specify)</p> <p>88= No Response</p> <p>99= Don't know</p>	
<p><b>3.76</b></p>	<p>Who do you think should provide PrEP to MSM?</p> <p><i>Bobani-ke locabanga kutsi bangafanelwa ngumsebenta wekuniketa lamaphilisi kubesilisa labatsandzana nebulili lobufanako?</i></p>	<p>00= Health care worker</p> <p>01= Peer Educator</p> <p>02= Friend</p> <p>03= Other (specify)</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
	<p><b>Rectal Microbicides</b></p> <p><i>Emafutsa ekugcobisa ngemuva kuvikela i-HIV</i></p>		
<p><b>3.77</b></p>	<p>Have you heard of rectal microbicides?</p> <p><i>Ingabe wake weva yini ngemafutsa ekugcobila ngemuva kuvikela i-HIV?</i></p> <p><b>NB: If no, go to 3.79</b></p>	<p>00= No</p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<p><b>3.78</b></p>	<p>If yes, where have you heard about it?</p> <p><i>Nangabe wake weva, wevaphi?</i></p>	<p>00= No information</p> <p>01= Health Facility</p> <p>02= Peer Educator/workshop</p> <p>03= School</p> <p>04= Internet</p> <p>05= Friends</p>	<p>   </p>

		06= Media 88= No Response 99= Don't know	
3.79	Have you ever used any rectum cream/lubricant for HIV prevention? <i>Wake wawasebentisa yini emafutsa ekugcobisa ngemuva kuvikela i-HIV?</i>	00= No 01= Yes 88= No Response 99= Don't know	
3.80	If rectal microbicides, which is under development, was to be offered, would you take it for HIV prevention or suggest it to your male sexual partner? <i>Nangabe lamafutsa angaba khona, ungawagcobisa yini kuvikela i-HIV nome uncome kutsi loyo lolala naye awasebentise?</i>	00= No 01= Yes 88= No Response 99= Don't know	
3.81	If yes, would you be able to take it (or encourage your partner, if he's the one taking) consistently every time before having sex? <i>Nangabe utsi yebo, ungakhona yini kuwagcobisa (noma ukhutsate lovana naye, nangabe kunguye logcobisako) njalonzalo ngaphambi kwekutsi nilale?</i> <b>NB: If yes, please go to 3.84</b>	00= No 01= Yes 88= No Response 99= Don't know	
3.82	If no to 3.80, why would you not take microbicides cream for HIV prevention daily? <i>Nangabe utsi chake 3.80 ngenhla, kungabangelwa yini kutsi ungawavumi lamafutsa ekuvikela i-HIV?</i>	01= Fear of stigma 02= Poor adherence 03= Side effects 04= Do not trust its protection 05= Other (specify) 88= No Response 99= Don't know	
3.84	Would you consider using condoms with partner if you were using microbicides?	00= No	

	<i>Nawucabanga ungayisebentisa yini ikhondomu nangabe socale kusebentisa lamafutsa?</i>	01= Yes 88= No Response 99= Don't know	
<b>3.85</b>	Do you think using microbicides would change your sexual behavior if you were to take it? <i>Ingabe ucabanga kutsi kusebentisa lamafutsa kungakwenta yini wena bese ushintja indlela lotiphatsa ngayo kutekulala?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>3.86</b>	If Yes, how? <i>Nangabe uyavuma, kungayishintja kanjani?</i>	00= Increase number of sex partners 01= Decrease number of sex partners 02= Eliminate other prevention strategies 03= Other (specify) 88= No Response 99= Don't know	
<b>3.87</b>	Would you be able to encourage your sexual partner to use microbicides, if you were not using it? <i>Kepha ingabe ungamkhutsata yini loyo lovana naye kutsi awasebentise lamafutsa nangabe awuwasebentisi wena?</i>	00= No 01= Yes 88= No Response 99= Don't know	
<b>3.88</b>	What kind of MSM do you think they need to uptake microbicides? <i>Kubantfu besilisa labatsandzana nebulili lobufanako, ngulabkanjani locabanga kutsi kufanele basebentise lamafutsa?</i>	00= Young/old 01= HIV negative 02= HIV positive 03= With multiple sexual partners 04= Other (specify) 88= No Response	

		99= Don't know	
<b>3.89</b>	<p>How do you think microbicides can benefit MSM?</p> <p><i>Ucabanga kutsi lamafutsa ekugcobisa ngemuva angabasita kanjani besilisa labatsandzana nebulili lobufanako?</i></p>	<p>00= Prevention HIV infection</p> <p>01= Prevention of STIs</p> <p>02= Act as lubricants</p> <p>03= Other (specify)</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<b>3.90</b>	<p>Who do you think should provide microbicides to MSM?</p> <p><i>Nawucabanga, bobana labafanele nanikwe lelilungelo lekwemukelisa/kunika lamafutsa kubesilisa labatsandzana nebulili lobufanako?</i></p>	<p>00= Health care worker</p> <p>01= Peer Educator</p> <p>02= Friend</p> <p>03= Other (specify)</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>

#### Section 4 – Information, Education and Communication

<b>4.00</b>	<p>In the last 3 months, have you received information on prevention of HIV infection between men?</p> <p><i>Etinyangeni letintsatfu letendlulile, uke walutfolo yini lwati noma kufundziseka ngekuvikela i-HIV emkhatsini webesilisa labatsandzana bodvwana?</i></p>	<p>00= No</p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<b>4.01</b>	<p>If Yes, where did you get this information?</p> <p><i>Nangabe uke walutfolo lwati, walutfolo kuphi?</i></p>	<p>00= No information</p> <p>01= Health Facility</p>	<p>   </p>

		02= Peer Educator/workshop 03= School 04= Internet 05= Friends 06= Media 88= No Response 99= Don't Know	
<b>4.02</b>	How often do you use the Internet in a week? <i>Uvame kuyisebentisa kangaphi i-Internet ngeliviki?</i>	00=about once a week 01=Several times a week 02= About once a day 03= Several times a day 88= No Response 99= Don't Know	__ __
<b>4.03</b>	Would you prefer to access HIV prevention messages for MSM through the Internet? <i>Ungakutfokotela yini kutfola lwati ngekuvikela i-HIV nge-Internet?</i>	00= No 01= Yes 88= No Response 99= Don't know	__ __
<b>4.04</b>	If yes, why? <i>Nangabe uyavuma, yini sizatfu?</i>	00= Easy to access 01= Anonymous 02= Private 03= Convenient with time 04= Other (specify) 88= No Response	__ __

		99= Don't know	
<b>4.05</b>	<p>What sex venues do you know?</p> <p><i>Ngutiphi tinzawo tekulala (tesive) lotatiko?</i></p>	<p>01= bathhouses</p> <p>02= saunas</p> <p>03= sex clubs</p> <p>04= health clubs</p> <p>05= parks</p> <p>06= public restrooms</p> <p>07= backrooms of bars</p> <p>7.1= Other (specify)</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>
<b>4.06</b>	<p>Do you think sex venues can be used for HIV prevention messaging among MSM?</p> <p><i>Ucabanga kutsi tinzawo tekulala tingasentjetiswa yini kufundzisa besilisa labatsanzana nebulili lobufanako ngekuvikela i-HIV?</i></p>	<p>00= No</p> <p>01= Yes</p> <p>88= No Response</p> <p>99= Don't know</p>	<p>   </p>

*End of interview. Thank you.*

## APPENDIX B

### Interview Guide for Men who have Sex with Men (MSM)

In partial fulfilment of a study to explore the HIV prevention needs of MSM in Manzini, Swaziland, I shall arrange to interview some men who identified to have had sex with other men in the past. During the interview, I would like to ask some questions on the participant's knowledge on MSM's risks and vulnerabilities for HIV infection; his knowledge on HIV prevention strategies for MSM and his perception and attitude towards some HIV prevention strategies.

*Ngenjongo yekutfola lwati ngetidzingo tekuvikela i-HIV tebesilisa labatsandzana nebulili lobufanako kaManzini, ngitawubuta imibuti kulaba besilisa labake balala nebulili lobufanako phambilini. Kulolucwaningo, ngitawubuta ngelwati ngetintfo letibeka besilisa labatsandzana nebulili lobufanako engotini yekutfola i-HIV; lwati ngetindlela tekuvikela tebesilisa labatsandzana bodywana; nendlela lotsatsa ngayo leto tindlela tekuvikela.*

The interview should take about 30 to 45 minutes.

*Lolucwaningo kungenteka lutsatse sikhatsi lesinganga 30-40 wemizuzu.*

The interview will be semi-structured, guided by the following kind of questions:

#### A. Understanding of Risks and Vulnerabilities

1. What are the things do you think put MSM at risk for HIV infection? (Tell me about personal, societal and political/structural issues) How do they put MSM at risk for HIV?  
*Yini tintfo locabanga kutsi tibeka besilisa labatsandzana bodywa engotini ye-HIV? (Ngitjele ngetintfo leticondzene nemuntfu, naleto letisho lokwenteka eveni nje bese kuba nguleto letifaka ekhatsi tekuphatsa kubosopolitiki noma labanye labaphetse emimangweni) Kubaka kanjani engotini letintfo lotibalile?*
2. How do you think those issues can be addressed?  
Ucabanga kutsi loku lokubale langenhla kungacatululeka kanjani?
  - 2.1 Personal issues? Can you tell me more?  
Lokucondzene nemuntfu? Ngichazele kabanti?
  - 2.2 Societal issues? Can you tell me more?  
Lokwenteka eveni nje? Ngichazele kabanti?
  - 2.3 Structural/political issues? Can you tell me more?  
Tekuphatsa nome ipolitiki? Ngichazele kabanti?

#### B. HIV Prevention Strategies for MSM

1. What HIV prevention strategies available for MSM do you know? Can you describe them for me?  
Ngutiphi tindlela tekuvikela ligciwane lotatiko kubantfu labatsandzana nebulili bunye?
2. How well do you think these strategies meet the HIV prevention needs of MSM? Why?  
Ucabanga kutsi letindlela lotibalile tiyahlangabeta yini tidzingo tebesilisa bebulili bunye? Leni?
3. What would you prefer to be provided as HIV prevention strategies for MSM? Why?

Ungancoma ini wena kutsi kuniketwe kuhlangubeta tidzingo tebesilisa labatsandzana bodwa kuvikela i-HIV? Leni?

**C. Information, Education and Communication**

1. What channels of information, education and communication would you recommend to MSM for HIV prevention? Why?  
Ngutiphi tindlela tekuchumana nekufundzisa nge-HIV letingasebentiswa kubesilisa labatsandzana nebulili lobufanako?

## APPENDIX C

### Interview Guide for Managers of HIV Prevention Programmes

In partial fulfilment of a study to explore the HIV prevention needs of MSM in Manzini, Swaziland, I shall arrange to interview some individuals who are involved in developing and implementation of HIV prevention policies and programs in the country. During the interview, I would like to ask some questions on participant's background on the work currently involved in; HIV policies and programs in general; specific policies and programs focusing on MSM; HIV prevention strategies provided to MSM and collaboration with other stakeholders in tackling HIV prevention among MSM.

The interview should take about 30 to 45 minutes.

The interview will be semi-structured, guided by the following kind of questions:

#### **D. General Career Background**

3. How long have you been working in this job?
4. What organization are you working for?
5. What exactly are you doing in the HIV and AIDS career?

#### **E. Existing HIV Prevention Policies and Programmes for MSM**

1. Do you know any specific prevention programs for MSM in the country? Can you describe them for me? What is working well with these programs? How could these programs be improved?
2. Are there any specific policies and programs for MSM in the work you are doing? Can you describe these policies and programs? What is working well with these programs? How could these programs be improved?
3. If not, are there any specifications for MSM prevention in the policies and programs of your work?
4. If not, are you planning to include MSM HIV prevention in the work you are doing?

#### **F. Existing HIV Prevention Interventions for MSM**

1. Is your organization collaborating with other stakeholders in HIV prevention? If so, how? Does that include programming for MSM HIV prevention? Can you describe what this collaboration is like?
2. Who are your stakeholders?
3. Does your HIV prevention programming involve collaboration with legislators and public leaders? If yes, does it specifically involve HIV prevention for MSM?
4. Do you have any programs that involve interventions for MSM?
5. If you have HIV prevention interventions for MSM, do you involve MSM as participants in your HIV and AIDS policies and programs? How are they involved? How do you reach these participants?

## APPENDIX D



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### STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

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#### HIV Prevention Needs for MSM in Swaziland

##### Men who have Sex with Men

You are asked to participate in a research study conducted by Bhekizitha Sithole, from the Department of Economics and Management Sciences at Stellenbosch University. The results will contribute to a thesis. You were selected as a possible participant in this study because you have shared information to your peer that you have had sex with another man before and you voluntarily agreed to participate when your peer invited you to participate in the study.

#### 1. PURPOSE OF THE STUDY

The purpose of the study is to learn about the HIV prevention needs of men who reported to having had sex (oral, anal) with other men in the past. The study focuses on the risks and vulnerabilities of the MSM, their perception of HIV prevention strategies and the HIV prevention strategies they currently utilize.

#### 2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

We will conduct one face-to-face survey with you. The survey will take place in a private place where there would be no disturbances. The survey is expected to take approximately 30 minutes of your time.

In the survey we will ask you question about your background, things that puts you at risk for HIV, things that can make you vulnerable to HIV infection, your knowledge and perception on HIV prevention strategies and the things you consider as needs for HIV prevention with your male sexual partner(s).

After participating in the survey, you will be asked to talk to three of your peers that you know, who are MSM, and invite them to participate in the study. After they have voluntarily agreed to participate, after you have spoken to them and told them that their participation will be confidential and anonymous, you or they can contact the investigator in the number to be given below. Your peers are not forced to participate but can only contact you or the investigator if they voluntarily agree to participate. Your contacts or your peers' contacts will remain confidential to the investigator after contacting him they will be deleted immediately after participating.

### **3. POTENTIAL RISKS AND DISCOMFORTS**

We do not think there will be significant risks for you that can be possibly created by being part of this study. The survey will be asking you about your day-to-day experience. Some of the question may be emotional or difficult to answer. You do not have to answer any questions that you will prefer not to answer. If you would like to talk with a counselor after participating, that would be arranged for you at any time.

There is a risk that if someone finds out that you are participating in this survey that they will discover that you once had sex with other men. We will do everything we can to protect this information. Your name will not be collected or published at any point during this study.

Whether or not you decide to participate in the study will not affect your involvement in any other research study or any of the services you currently receive. You can stop the study at any time without penalty.

### **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

There are no direct benefits to you from participating in this study. However, we hope that the findings will help to increase HIV prevention knowledge on MSM and improve HIV prevention services targeting the MSM population.

### **5. PAYMENT FOR PARTICIPATION**

There is no payment received for participating in the study. Participating is voluntary.

### **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of identifying data only by using a unique ID number. Your name will not be published anywhere in the study. The data that will be collected will be stored in a computer which is going to be safeguarded with a password. Only the investigator will have access to the data. After the analysis of the results and publication, that is after four months, the data will be destroyed so that no one can have access to it. The results of the study will be published without any identifiers of sources of information.

### **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. Such circumstances may include your emotional state or physical state that can make it impossible to continue with the survey.

## 8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact the Principal Investigator, Bhekizitha Sithole at cell: (+268)76137084 or email: [bhekie.sithole@gmail.com](mailto:bhekie.sithole@gmail.com), or contact the supervisor, Prof. Elza Thomson at cell: (+27) 082 494 6920 or email at [elzathomson@gmail.com](mailto:elzathomson@gmail.com) or the Ministry of Health at 2404-2431.

## 9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [[mfouche@sun.ac.za](mailto:mfouche@sun.ac.za); 021 808 4622] at the Division for Research Development.

### SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by \_\_\_\_\_ in English/Siswati and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

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

\_\_\_\_\_  
Signature of Subject/Participant or Legal Representative

\_\_\_\_\_  
Date

### SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to the participant. He was encouraged and given ample time to ask me any questions. This conversation was conducted in English/Siswati and no translator was used.

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

## APPENDIX E



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### STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

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#### **HIV Prevention Needs for Men who have Sex with Men (MSM) in Swaziland**

#### **Managers of HIV Programmes in Swaziland**

You are asked to participate in a research study conducted by Bhekizitha Sithole, from the Department of Economics and Management Sciences at Stellenbosch University. The results will contribute to a thesis. You were selected as a possible participant in this study because your work is related to policies and programs of HIV in the country.

#### **1. PURPOSE OF THE STUDY**

The purpose of the study is to learn about the HIV prevention needs of MSM in Swaziland. The study focuses on the risks and vulnerabilities of the MSM, their perception of HIV prevention strategies and the HIV prevention strategies they currently utilize. The study further established the current HIV prevention strategies available for MSM in the country in relation to what they need.

#### **2. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things: we will conduct one face-to-face semi-structured interview with you. The survey will take place in a private place where there would be no disturbances. The survey is expected to take approximately 30 to 45 minutes of your time.

In the survey, we will be asked about your HIV carrier background, HIV policies and programs in general; specific policies and programs focusing on MSM; HIV prevention strategies provided to MSM and collaboration with other stakeholders in tackling HIV prevention among MSM.

#### **3. POTENTIAL RISKS AND DISCOMFORTS**

We do not think there will be significant risks for you that can be possibly created by being part of this study. The survey will be asking you about your day-to-day work and experience. Some of the question may be emotional or difficult to answer. You do not have to answer any questions that you will prefer not to answer. If you would like to talk with a counselor after participating, that would be arranged for you at any time.

There is a risk that if someone finds out that you are participating in this survey that they will know that you have contributed information to the study. We will do everything we can to protect this information. Your name will not be collected or published at any point during this study.

Whether or not you decide to participate in the study will not affect your involvement in any other research study. You can stop the study at any time without penalty.

#### **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

There are no direct benefits to you from participating in this study. However, we hope that the findings will help to increase HIV prevention knowledge on MSM and improve HIV prevention services targeting the MSM population.

#### **5. PAYMENT FOR PARTICIPATION**

There is no payment received for participating in the study. Participating is voluntary.

#### **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. The data that will be collected will be stored in a computer which is going to be safeguarded with a password. Only the investigator will have access to the data. After the analysis of the results and publication, that is after four months, the data will be destroyed so that no one can have access to it. The results of the study will be published without any identifiers of sources of information.

#### **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. Such circumstances may include your emotional state or physical state that can make it impossible to continue with the survey.

#### **8. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact the Principal Investigator, Bhekizitha Sithole at cell (+268) 76137084 or email: [bhekie.sithole@gmail.com](mailto:bhekie.sithole@gmail.com) or the supervisor, Prof. Elza Thomson at (+268) 082 494 6920 or email at [elzathomson@gmail.com](mailto:elzathomson@gmail.com) or the Ministry of Health at 2404-2431.

#### **9. RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you

have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to me by \_\_\_\_\_ in English/Siswati and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

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

\_\_\_\_\_  
**Signature of Subject/Participant or Legal Representative**

\_\_\_\_\_  
**Date**

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to the participant. He was encouraged and given ample time to ask me any questions. This conversation was conducted in English/Siswati and no translator was used.

\_\_\_\_\_  
**Signature of Investigator**

\_\_\_\_\_  
**Date**