

**AN ASSESSMENT OF HIV AND AIDS KNOWLEDGE, ATTITUDES AND SAFER SEX
PRACTICES AMONG STUDENT MEN WHO HAVE SEX WITH MEN (MSM) AT A
HIGHER EDUCATION INSTITUTION IN THE WESTERN CAPE**

by

Allex Medson Mello Semba

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of Master of Philosophy (HIV/AIDS Management) in the Faculty of
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Supervisor: Mr Burt Davis

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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

The objective of this study was to measure the level of HIV and Aids knowledge, attitudes and safer sex practices among student men who have sex with men (MSM) at a higher education institution in the Western Cape. The study served to recommend guidelines for effective and enhanced targeted intervention response for MSM student community. A total of 36 MSM students aged between 19 and 36 (of which most were South African, black and Xhosa speaking) were recruited to take part in the study. Selection was done via snowball sampling. Respondents completed questionnaires upon consenting to participate in the study.

The study found moderately high levels of basic HIV knowledge among the sampled MSM population. There were, however, lower levels of knowledge reported regarding the associated risk and effective prevention strategies of anal sex when compared to similar information about vaginal sex and oral sex. Findings also show that participants had very positive attitudes towards HIV testing, condom use and a non-discriminating environment. Respondents lacked confidence in both management and student leadership with regards to their responsibility in mitigating homophobia/discrimination against MSM student population. Furthermore, a high number of respondents reported having sex with men and women as well as multiple sexual partnerships. Self-reported alcohol and drug use were found to be very low, with the majority of participants indicating non-use. Participants stated little challenges accessing health care services. However, respondents felt MSM specific information about health care related rights and needs were lacking.

Recommendations from this study include current HIV and Aids policy reform, mainstreaming MSM-friendly health care services, introducing combination HIV prevention programmes such as *Mpowerment* and addressing the human rights needs of MSM.

OPSOMMING

Die doel van hierdie studie was om die vlakke van MIV en Vigs kennis, houdings en veilige seksuele praktyke onder manlike studente wat seks het met mans (MSM) by 'n hoër onderwys instansie in die Wes-Kaap te meet. Die studie het gepoog om riglyne daar te stel vir die bewerkstelling van effektiewe en verbeterde geteikende intervensies vir die MSM studente gemeenskap. Daar was 36 MSM studente tussen die ouderdomme van 19 en 36 (meestal Suid-Afrikaans, swart en Xhosa-sprekend) gewerf vir die studie. Seleksie is gedoen deur middel van die sneeubal steekproef-metode. Deelnemers het 'n vraelys voltooi nadat hulle ingewillig het om deel te neem aan die studie.

Deelnemers het matig tot hoë vlakke van basiese MIV en Vigs kennis getoon. Daar was egter laer vlakke van kennis oor gepaardgaande risiko's en effektiewe voorkoming strategieë ten opsigte van anale seks in vergelyking met dieselfde informasie oor vaginale en orale seks. Die studie het verder bevind dat deelnemers baie positiewe houdings gehad het teenoor MIV-toetsing, die gebruik van kondome en 'n nie-diskriminerende omgewing. Verder het hulle min vertroue getoon in beide die bestuur en studente leierskap se vermoë om sake wat verband hou met homofobie en/of diskriminasie teen die MSM studente bevolking, effektief te hanteer. Daar is gevind dat baie respondenten seks het met mans en vroue en ook verskeie seksuele maats het. Self-gerapporteerde alkohol- en dwelmgebruik was relatief laag onder respondenten met die meerderheid wat aangedui het hulle glad nie alkohol of dwelms gebruik nie. Deelnemers het ook rapporteer dat gesondheidsdienste vir hulle maklik toeganklik is. Respondente het ook gevoel dat MSM spesifieke informasie oor gesondheidsverwante regte en behoeftes tans ontbreek.

Aanbevelings wat voortspruit uit hierdie studie sluit in die hersien van die huidige MIV en Vigs beleid, die skepping van MSM-vriendelike dienste, die implementering van MIV-voorkomingsprogramme soos *Mpowerment* en die bevordering van menseregte wat verband hou met MSM.

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GLOSSARY

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
HEAIDS	Higher Education & Training HIV/AIDS Programme
HEI	Higher Education Institution
HIV-KQ-18	HIV knowledge Questionnaire – 18 Items
HSRC	Human Sciences Research Council
MSM	Men who have sex with men
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nation Programme on HIV/AIDS

CHAPTER ONE

INTRODUCTION

1.1. Introduction

Same sex behaviour is part of the great diversity of human sexuality (Brown, et al., 2011). However, until recently, men who have sex with men (MSM) have generally been disregarded in description, discussions and responses to the HIV epidemic in Africa (Imrie, et al., 2013). Research demonstrates that MSM are not only facing a significantly higher risk of HIV infection than men in the general population but also that MSM behaviour is contributing significantly to sustaining the recorded high number of new infections (Smith, et al., 2009; Imrie, et al., 2013).

Such individuals and/or couples who engage in this behaviour are often hidden, stigmatised and discriminated against. As Caceres, et al. (2008) point out the resultant lower access to adequate prevention and care strategies and the increasing vulnerability to HIV infection underpins the importance of refocusing on targeted prevention intervention packages for MSM populations.

Additionally, correct knowledge on HIV transmission and prevention is important for avoiding infection. At the selected higher education institution, like many other universities, most MSM students come from rural and conservative backgrounds that deny them adequate exposure and access to safer sex knowledge, attitudes and practices. Absence of programmes and services specifically aimed to address health challenges experienced by MSM students does not make access to health care any easier. As such, it is important to assess MSM students' HIV and AIDS knowledge, attitudes, behaviour and practices in order to ensure their rights to adequate health care are met.

1.2 HIV Prevalence among MSM

Murray and Soscoe (2001) indicate that MSM may identify as homosexual, gay or bisexual but may also classify themselves as heterosexual or straight. MSM, in this context, are generally categorised irrespective of whether they also have sexual relationships with females or not.

Understanding worldwide epidemiology among MSM has been a challenge due to the hidden and stigmatised nature of MSM populations and their behaviour across the globe as well as continued criminalisation of homosexuality and other forms of same-sex behaviours in most parts of the world. Beyerer, et al. (2012) asserts that by the end of 2011, only 103 out of 196 countries had reported HIV prevalence among MSM in the previous five years, evidently indicating a difficult environment for MSM populations.

Nevertheless, Scheib, *et al* (2011) point out that HIV prevalence among MSM has been five times higher than among other men in the general population. HIV prevalence among MSM is globally estimated at 6%. Beyerer, *et al.* (2012) bemoan the fact that only one in every 10 MSM is able to access prevention services. Data from most African countries is limited to small cross-sectional studies; however, current data from all parts of Africa shows an HIV prevalence ranging from 6 to 37% (Senior, 2010). This conforms to Scheib, *et al* (2011) asserting that MSM have a higher HIV prevalence than among men in general populations.

In South Africa, HIV prevalence among MSM ranges from 10 to 20% in main urban areas (Scheib, *et al.*, 2011). This is an indication that countrywide generalised prevention strategies have been ineffective in preventing HIV infection among MSM. A similar trend was found in a study commissioned by Higher Education Programme on HIV and AIDS (HEAIDS) in 22 Higher Education Institutions (HEIs). Findings show a general HIV prevalence of 4.1% among MSM populations compared to 1.7% among heterosexual men in HEIs (HEAIDS, 2010).

1.3 Risk factors for HIV among MSM in South Africa.

Most studies have identified structural and societal factors that play a role in driving the epidemic among MSM populations (Smith, *et al.*, 2009; Global Forum on MSM and HIV, 2010). These factors include stigma and discrimination and hetero-normative attitudes (treating all clients as if they were heterosexual) towards MSM by health workers. Fear of stigma and discrimination/homophobia prevents MSM from disclosing their sexuality and discussing risk behaviours. Health workers' own values and beliefs further act as barriers in providing a non-judgemental package of care.

Further factors include human rights abuse, cultural and religious influences, a lack of prevention strategies that include easy access to condoms and water based lubricants as well as little MSM needs recognition by policy makers (Smith, *et al.*, 2009).

Conversely, unprotected receptive anal intercourse remains the primary risk factor for HIV transmission among MSM and carries a higher risk of HIV transmission than other forms of sexual practices (Scheibe, *et al.*, 2011). Individual risk factors identified by Baggaley,*et al.* (2010) and Burrell, *et al.* (2010) include limited knowledge about HIV, high levels of alcohol and drug use and high risk sexual behaviours such as unprotected anal intercourse, multiple concurrent partnerships, sex work, and use of unsafe lubricants such as petroleum jelly.

1.4 HIV Prevention interventions

South African laws and policies offer protection to MSM populations; however, this does not practically translate into ease of access to services. Scheib, *et al.* (2011) recommend that the legal framework needs to be supported by additional institutional policy in order to ease access to intervention service programmes to MSM populations.

Bearing in mind that unprotected anal intercourse is the main driver of the epidemic among MSM, Herbst, *et al.* (2005) point out that there have been global meta-analyses conducted and these have established that behavioural

interventions can decrease the number of sexual partners, decrease the frequency of unprotected anal sex and increase condom use in MSM. Behavioural change programmes, access to condoms and lubricants and HIV counselling and testing (HCT) interventions are effective in response to MSM needs. Coates, *et al.* (2008) assert that Highly Active Antiretroviral Treatment (HAART) demonstrated that multiple interventions that have been proven to work effectively individually can be combined to work synergistically when implemented simultaneously thereby increasing their effectiveness. Similarly, a combination of HIV prevention strategies would follow such a pattern of effectiveness (van Griensven & de Lind van Wijngaarden, 2010). Such prevention packages ensure that this vulnerable group is empowered with the right knowledge to remain HIV negative and also provide MSM specific care and support to students who are HIV positive.

1.5 Research Problem/Question

HIV and AIDS targeted intervention strategies for MSM students are currently absent at the campuses of the selected higher education institution. In addition, negative attitudes often exist towards MSM students resulting in such students failing to access HIV and AIDS and other health-related services within the institution. In this regard, assessment of HIV/AIDS knowledge, attitudes, behaviour, and practices among the MSM student population is essential.

The research question is formulated as follows: “what is the HIV and AIDS Knowledge, attitudes, behaviour and practices among MSM students at this Higher Education Institution?”

1.6. Aims and Objectives

The aim of this study is to identify HIV and AIDS knowledge, attitude, behaviour and practices among MSM students at this HEI in order to develop targeted intervention service packages.

The following are the study objectives:

- To establish the level of HIV and AIDS knowledge among MSM students at the HEI;
- To identify MSM students' attitude towards HIV and AIDS;
- To ascertain self-reported sexual and other risk behaviour and practice of MSM students; and
- To recommend guidelines for effective and enhanced targeted intervention response for MSM students.

1.7. Significance of the study

Information generated from assessing HIV and AIDS knowledge, attitudes and safer sex practices among MSM at the higher education institution's campuses is essential for health professionals at the Student Campus Health Clinics and HIV/AIDS Unit to mount an adequate and targeted intervention response to the epidemic among MSM student population based on the patterns of current risk behaviour. There is a strong need for a specific focus on MSM in all aspects of HIV prevention, care and treatment to curb further HIV infections.

In addition, the results of this study could be helpful for planning and evaluating prevention and care activities and for assessing their impact. Furthermore, the data will inform the review process of the Institutional HIV and AIDS Policy to include the specific needs of the MSM as a key population.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview of Men Who Have Sex with Men (MSM) and HIV

The South African Department of Health National Strategic Plan (NSP) on HIV, STIs and TB (2012-2016) like many other quarters of this calibre categorises men who have sex with men (MSM) as a key population that requires specific focus in terms of HIV prevention, treatment, care and support (DoH, 2011). This NSP affirms that MSM are at a higher risk of HIV infection than their counterparts (heterosexual males) in the national prevalence estimates. This is also noted in a bigger context of MSM populations in sub-Saharan Africa and globally.

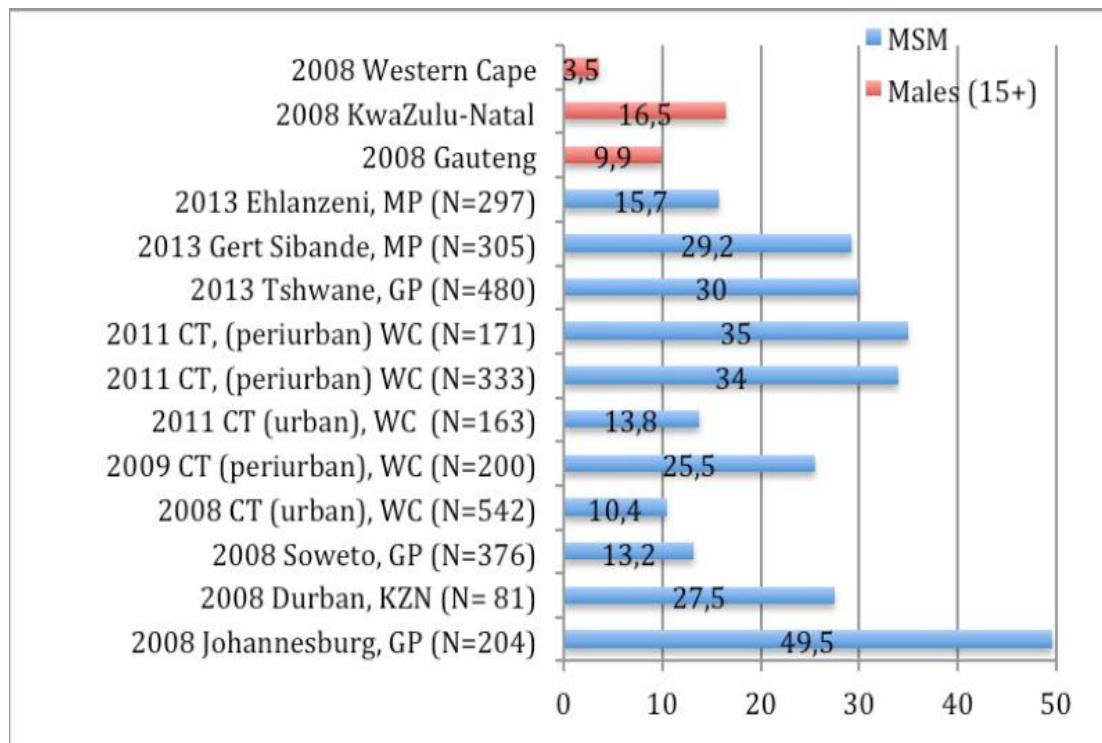
Sub-Saharan studies have reported high rates of MSM unprotected anal intercourse (UAI) that has fuelled the HIV epidemic among MSM (Lane, *et al.*, 2011:626). In a study measuring HIV prevalence, risks for HIV infection, and human rights among MSM in Malawi, Baral, *et al* (2009:e4997) report higher HIV prevalence rates among MSM than those among other men in the general population. Several other studies in Kenya, Senegal and South Africa have reported a similar finding (Wade, *et al.*, 2005: 2133-40; Kajubi, *et al.*, 2008:492-504; Lane, *et al.*, 2008:78-85). In South Africa, the results of the Soweto Men's study further confirm MSM being at higher risk for HIV infection (Lane, *et al.*, 2011:626). Furthermore, Table 2.1 below underpins these assertions by presenting HIV prevalence data for MSM between 2008 and 2013 by region in South Africa.

The data presented in Table 2.1 and the abovementioned studies demonstrate the varied differences in HIV prevalence among MSM as compared to other men in the general population. For instance, Gauteng registered 49.5% HIV prevalence among MSM whereas men in the general population registered 9.9% in the same year (Baral, *et al.*, 2011:766). A further distinction is observed amongst MSM population living in different geographical areas. HIV prevalence amongst MSM living in peri-urban Cape

Town (26%, n=200) was nearly three times that of MSM living in Cape Town city centre (10%, n=539) (Burrel, et al., 2010:149).

Figure 2.1: Estimated HIV prevalence data for MSM, surveys (2008-2013)

Note: CT: Cape Town; GP: Gauteng; KZN: KwaZulu-Natal; MP: Mpumalanga; WC: Western Cape.



Adapted from: *Presentation provided by Prof Tim Lane, South Africa MSM data triangulation meeting, Cape Town – December 2014.*

Unlike many other African countries, South Africa decriminalised homosexuality in 1994 and in many instances the country attempts to include MSM in strategic documents such as the NSP 2007-2011 and 2012-2016. Nonetheless, although the South African Constitution guarantees equal rights to access to health care services and the right to non-discrimination based on one's sexual orientation, Muller (2014:1) contends that MSM population's right to easily accessible health is relentlessly violated and stigma still abounds. As a result, prevention strategies and uptake of health services by MSM are severely compromised.

Considering the high levels of heteronormative assumptions and homophobia within the communities, MSM populations are faced with an array of barriers to appropriate and correct knowledge acquisition, development of the right attitudes and practice of safer sexual behaviour. Muller (2014:1) further affirms that this informs the need to address structural factors, societal factors and individual factors as barriers that perpetuate MSM vulnerability to HIV infection.

2.2. Risk factors for HIV acquisition among MSM in South Africa

Recent local epidemiological studies have identified individual, social and structural factors as contributing to the vulnerability and higher HIV prevalence rates among MSM.

2.2.1 Individual factors

Scheibe, *et al* (2011:27) postulate that limited knowledge about HIV transmission and prevention, high risk behaviours, high levels of alcohol and drug abuse as well as human rights abuses are some of the well observed individual risk factors for HIV infection among MSM.

2.2.1.1 Knowledge levels

A study in Malawi, Botswana and Namibia showed over 90% of its respondents reporting correct knowledge of the link between unprotected anal sex and high HIV infection (Fay, *et al*, 2011:1088-97). Nonetheless, this did not translate into consistent condom use or regular HIV testing.

On the contrary, other studies have indicated low HIV transmission and prevention knowledge among MSM. According to Batist, *et al* (2013:4) an evaluation study of a community based HIV prevention pilot programme for township MSM in Cape Town observed lower knowledge levels around sexual transmission risks among MSM who have no access or are not reached with MSM focused interventions.

A comparative study conducted by Bradley, *et al* (2012:1-7) measuring HIV knowledge among MSM internet users in South Africa and in the United

States of America found considerably high levels of HIV/AIDS knowledge with median knowledge scores of 16/18 correct for both cohorts. The study further reported that among both cohorts, men with less than a high school education had a significantly lower knowledge of HIV and AIDS. Noden, *et al* (2010:1285) posit that these results substantiate the notion in the large body of research across the globe that affirm that an increase general education resultantly increase the HIV and AIDS knowledge. This could also provide insight into the difference observed in the prevalence rates reported between urban and peri-urban areas.

According to Jobson, *et al* (2013:s12), lower levels of safer sex knowledge among MSM in South Africa are associated with high levels of unprotected anal intercourse and incorrect or non-use of lubrication which puts the individual at an increased risk of HIV acquisition.

2.2.1.2 *Multiple sexual partnerships*

Men who have sex with men (MSM) are one of the largest HIV risk group and having multiple sexual partnerships permits the likelihood of acquiring sexually transmitted infections which in turn increases the transmission of HIV. A study conducted in Vietnam measuring multiple and concurrent sexual partnerships among men who have sex with men observed that 69.5% indicated multiple sexual partnerships in the last 6 months to the study (Garcia, 2014:1).

The study further reports that respondents were more likely to engage in multiple sexual partnerships if they consumed alcohol before and/or during sex, used the Internet to meet casual sex partners and had never participated in a behavioural HIV intervention. The study showed a correlation between sexual partnerships and alcohol or drug use and lack of correct information.

The South African Marang Men's Project (2014) in measuring the number of male sex partners among MSM in Cape Town, Durban and Johannesburg within the previous six months to the study reports that 55.6% of Cape Town and Johannesburg MSM reported having had 3 or more sexual partners. Though, not a significant difference, 50.1% of Durban MSM also reported

having had 3 or more sexual partners within the past six months to the study. Jobson, *et al* (2013:s12) observes that although data on multiple sexual partnerships among MSM in South Africa is not widely available, such partnerships are fairly common. Thus, there is a high possibility of exposure to HIV through the expanding sexual network when having multiple sexual partners. It is worth noting that, whilst effective, condom use does not protect from all STIs which underpins the continued call for further interventions around multiple partnerships, alongside the promotion of condoms.

The levels of acceptability of homosexuality in the different regions brings a different dynamic to multiple sexual partnerships as most respondents in an HIV prevention study for MSM in Cape Town reported multiple partnerships in terms of having sexual relations with both males and females due to social pressure and the fear of discrimination especially for men who are not openly gay (Jobson, *et al.* 2013:s12). The heteronormative expectation in society forces most men to have sex with women to maintain their position in society.

Conversely, other MSM indulge in sex work and intergenerational sex as the social hierarchy is linked to wealth (Fox, 2010:16). Fox asserts that transactional sex or intergenerational sex is compounded by the desire for upward social mobility especially in areas where resource inequalities are rampant. This has implications with regards to one's ability to negotiate for safer sex as the partners are at different power levels.

2.2.1.3 Condom use

In addition to the biologic vulnerability linked to anal intercourse and increased prevalence of HIV infection in male sex partners, high levels of unprotected anal intercourse, substance use, and multiple concurrent partnerships are some of the greatest risk factors that call for correct and consistent condom usage (Lane, 2008:79).

In a study which sought to explore how a group of South African MSM from Cape Town and Port Elizabeth make decisions about using condoms with their partners, Siegler, *et al* (2014: 414) observed that condom use was a

function of behaviours, motivational beliefs, partnership characteristics, and interpersonal skills. They indicate that elements obstructing the use of condoms include perceived substantial declines in sexual pleasure/performance, experiences of condom failure, substance abuse, and being in trusted relationships.

Their results further underscore the important components of self-efficacy scales that include condom negotiation skills and the confidence to use condoms consistently as condoms are a key component of HIV prevention programs for MSM whose use decreases HIV transmission by approximately 78% during anal sex between men.

2.2.1.4 Substance abuse

Reports on the existence of high levels of illegal drug use in relation to high risk sexual practices among MSM in South Africa have been documented. Parry, *et al* (2008:45-53) sought to assess drug related HIV risk among MSM in three South African cities. The study observed that the use of drugs such as crack cocaine, cannabis and methamphetamine precisely for the purpose of facilitating sexual encounters was evident. As a result, inconsistent condom use and other high-risk sexual activities were widespread in spite of the further observed high HIV risk knowledge among the respondents.

Scheibe, *et al* (2011:27) posit that substance use is generally accepted amongst the MSM population as it is intended for recreation, facilitation of sexual encounters as well as dealing with crisis situations such as stigma and discrimination. In that regard, it more episodic rather than addiction. However, this may easily become an addition when the intentions becomes chronic rendering severe health implications.

2.2.1.5 Knowledge of one's HIV status and other Sexually Transmitted Infections

HIV testing and screening for STIs is an important aspect of an individual's health and an important component of HIV prevention globally. Data drawn from a study assessing social vulnerability and HIV testing among South

African MSM in Pretoria demonstrated that a high proportion (32.3%, n=300) of the respondents had never tested before and 60% has not tested in the previous 6 months (Knox, *et al*, 2011:709-713).

In another South African study aimed at measuring the perception of not being at risk of HIV infection and fear of being tested for HIV, 27% (n=280) of MSM had never been tested before for HIV (Nel, *et al*, 2013:51-59). In exploring the factors associated with not testing for HIV, most respondent perceived that they were not at risk of infection (57%) and also that they feared being tested (52%). The fear of testing could be attributed to being sexually active or a history of STIs and other previous experiences of discrimination.

Similarly, in a study among MSM in Vietnam referred to earlier, MSM who never tested for HIV before reported a perception on not being at risk and yet their actual risks were much higher as a result of low and inconsistent condom usage and reported multiple and concurrent partnerships (Garcia, *et al*, 2013:7).

On the contrary, Stephenson *et al* (2013:43-50) present the findings of their study that constituted seven focus group discussions and 29 in-depth interviews in Cape Town, South Africa regarding MSM attitudes towards couple based HIV counselling and testing. The results exhibited high acceptance of the model and components of the service as it would allow couples to increase their commitment and to explore methods of effectively reducing risk of HIV transmission.

Correspondingly, a recent study measuring HIV testing practices of South African township MSM in the era of expanded access to ART found that men had used the opportunity of easily accessible testing drives and expanded testing programmes at public clinics in their areas and tested for HIV (Sandfort, *et al*, 2014:1). Even though previous testing experience facilitated routine testing for some, others only sought testing services after engaging in risky behaviour. The anxiety brought by the fear that they might test positive sometimes caused other men to avoid testing until they felt unwell.

Stephenson *et al* (2013:43-50) further suggest integrating HIV prevention programming such as HIV counselling and testing into general health management system in order to achieve effective results. In their study measuring high HIV risk taking behaviour among MSM, Hays, *et al* (1990) observed that young people could not find HIV prevention attractive enough to cultivate a need to take up prevention strategies.

Based on the need to make HIV prevention more exciting for young MSM Kegeles, *et al* (1990) sought to combine HIV prevention with a platform for young MSM to satisfy their other compelling needs. They later established a concept known as *Mpowerment Project* whose central theme is a social focus.

This project is informed by specific guiding principles based on theories of behaviour change and focus group interviews with MSM communities. According to the evaluation by Kahn, *et al* (2001) and Cohen, *et al* (2005), the project is cost-effective and can be tailored to suit the needs of a particular MSM community.

2.2.2 Societal factors

Social, cultural and religious intolerance of sexuality has had a major impact on HIV risk behaviours and prevalence among MSM population. Smit *et al* (2012:405) alludes to the fact that in spite of public education programmes and equal rights legislation, stigma and discrimination as well as sexual violence against MSM population is extensive and wide-ranging and continues to negatively affect their lives

2.2.2.1 Stigma and discrimination

It is evident that in places where prejudice runs deep about homosexuality in among family members, community or health workers, it is fuelled in part by perceived (received) ideas regarding gender, belief systems, stigmatisation and socialisation, and the absence of human rights and the presence of human rights violations (Lane, *et al*, 2008a:431). Conversely, Scheibe, *et al* (2011:27) attributes the levels of external and internalised homophobia and discrimination as well as the ability of MSM to engage with health workers

around sexual behaviour and to access services to emanate from heteronormativity, cultural and religious beliefs within the society.

In a study assessing HIV risk and prevention among MSM in peri-urban townships in Cape Town, Jobson, *et al* (2013:s12-22) caution against health care discrimination as it hinders health care seeking practices which in turn increase consequences and magnitude of ill health. Cloete, *et al* (2013:259) indicate that in such cases, although health care services such as HI testing and other services are publicly available, study findings suggest that MSM are reluctant to access HIV prevention, treatment and support services.

In a further study among MSM in Cape Town, respondents preferred to access health services away from the areas in which they lived due to discrimination tendencies in the area (Jobson, *et al.* 2013:s12). Nonetheless, this presents challenges as individuals need to secure transportation funds in order to do so thereby delaying access to health care.

On the other hand, due to the discrimination faced within one's community HIV infected MSM individuals experience multiple discrimination which in turn affects their psychological wellness and ability to cope (Jobson, *et al.* 2013:s12). As a result, these experiences impede disclosure of HIV status and thus lead to further HIV transmission.

2.2.2.2 Violence

The South African Police Service Report (2013) alludes to the fact that even if violent crime has gone lower than the previous years, its incidence, especially rape, is one of the highest in the world. An array of homophobic violence, including rape, across the country may be contributed enormously to HIV transmission (Scheibe, *et al.* 2011:27).

In a population based cross-sectional study measuring prevalence of consensual male to male sex and sexual violence in relation to HIV transmission, Dunkel, *et al* (2013) observed that the likelihood of being HIV infected for men who had perpetrated a form of sexual violence on another

man was twice that of men who had not perpetrated such violence. This poses a challenge for the country considering the heteronormative prevention and management strategies mostly used in various parts of the country. Information and access to Post-Exposure Prophylaxis (PEP) is vital in these circumstances.

High levels of intimate partner violence within MSM relationships is another area of grave concern. Stephenson, *et al* (2011: 343-7) studied intimate partner violence and sexual risk taking amongst MSM in South Africa and reported substantial levels of physical and sexual intimate partner violence (8% and 4.5% respectively [n=521MSM]). The association of unprotected anal intercourse and intimate partner violence was significant in the study.

2.2.3 Structural factors

In spite of South Africa's progressive legal protection against discrimination or prejudice on grounds of sexual orientation, implementation leaves a lot to be desired. (Scheibe, *et al.* 2011:27) affirm that the legal framework requires major support by additional policy in order to extend the rights of sexual minorities into other government departments such as Education, Justice and Social Development.

2.2.3.1 Policy frameworks

Some developments have been seen within the National Department of Health's inclusion of key population specific interventions to reduce new infection into the NSP 2007-2011 and 2012-2016. Reddy (2011) indicates that prevention needs are shaped by legal framework followed by policy framework and requires leadership support for effective implementation.

2.2.3.2. Access to health care

It is evident from the discussion that MSM face various barriers that either delay or inhibit access to health care ranging from societal attitudes towards MSM, health worker discrimination, as well as internal discrimination by MSM individuals (Jobson, *et al.* 2013:s12). This problem is compounded by

mainstream public health sector's inability to address the health needs of the MSM population.

At present, very few areas in the country include MSM specific interventions in their plans for mitigating the impact of HIV epidemic and very few allocate resources to provide services specifically for MSM. Cape Town is one of those few privileged to have a number of non-governmental organisation and the Department of Health that focus on programmes aimed at reaching and responding to the needs of the MSM community. Beyerer, *et al* (2011:s96-s99) recommend that all health system elements such as governance, time allocation, financing, human resources, medical products, information and service delivery should adequately enable access, coverage, quality and safety of health services for MSM.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The main aim of the study was to identify HIV and AIDS knowledge, attitude, behaviour and practices among MSM students at a Higher Education Institution in Western Cape in order to develop targeted intervention service packages. The targeted respondents were all male students who have sex with men irrespective of whether they identify as gay or bisexual or otherwise.

3.2 Design

This study utilised a Snowball sampling method which is usually ideal for ‘hard to reach’ populations such as men who have sex with men. In that context, snowball sampling employs the presumed social networks that exist among members of a target population to build a sample. Often, the initial step involves a group of individuals who are known members of the population to create a “seed”. For the purpose of this study, a field worker who is openly gay and who has knowledge of MSM activities on campuses was requested to become the ‘seed’ to access this hard to reach population.

3.3 Ethical Clearance and Ethical considerations

Ethical clearance was sought through the Stellenbosch University Research Ethics Committee (REC) at which the Investigator is studying. In addition to the REC approval, the Investigator sought further clearance from the Senate Ethics Committee (SEC) of the HEI involved.

Each prospective respondent was read and completed the consent form that detailed the purpose of the study, procedures, potential risks, potential benefits confidentiality and rights of the respondent (refer to Appendix A). This was ensured before the prospective respondent completed the questionnaire.

3.4 The questionnaire

The self-administered questionnaire was developed and adapted to provide responses to the objectives of the study. The questionnaire comprised of five sections as follows:

- Biographical information;
- HIV and AIDS knowledge;
- HIV and AIDS attitudes;
- Sexual practices; and
- Health seeking behaviour.

In total the questionnaire had 85 questions in order to provide in-depth information on students HIV knowledge, attitudes towards HIV and AIDS and sexual practices.

3.5 Study location and sample size

The study was conducted on two campuses of the selected institution. A prevalence study of male to male sex in South Africa (Dunkle, 2011) was used as guide in deciding the sample size. Due to this hidden nature of the MSM population, this study targeted a ratio of 1:40 MSM students to total students on the two campuses.

3.6 Data collection method

A Field worker who is openly gay and who has knowledge of MSM activities on campuses has volunteered to access this hard to reach population. The Field worker collected the questionnaires and consent forms and distributed them to participants in single envelopes. Additional envelopes were made available to the participants for submission of the questionnaire after completion.

The Field worker upon being in the presence of a prospective respondent sent a “please call me” message from his cellphone to the investigator while with the prospective participant. The researcher called and explained the purpose of the research, the consent form and the questionnaire to the prospective participant. This was for the purpose of ensuring confidentiality of the respondents.

When prospective participant consented, he signed the consent form and submitted it to the field worker and continued to complete the questionnaire which was to be submitted in an enclosed envelope to the field worker.

The field worker also provided the participant with contact details of the researcher in case of any further required clarifications. The questionnaire was submitted in an enclosed envelope to the field worker upon completion in order to maintain confidentiality so that it is not linked with the consent forms. These sealed envelopes were submitted as such to the investigator by the Fieldworker for data capturing. All consent forms were submitted in one envelope to prevent linking them to the questionnaires.

3.7 Data analysis

To begin with, all questions on the questionnaire were coded before capturing on an excel spreadsheet and the actual data analysis was done using the latest 2014 Statistical Package for Social Sciences (SPSS). This provided descriptive statistics for the study and were further analysed to make conclusions for the study.

For the seven (7) questions that required respondents to specify, the qualitative analysis was done using ATLAS Ti and thereafter presenting the emerging themes.

Further quality assurance procedures were followed to ensure integrity, correctness and quality of data.

CHAPTER FOUR

STUDY RESULTS

4.1 Introduction

This chapter presents the results of the study for the sampled students who consented to take part in this study at the two campuses of the Institution. The questionnaire had five sections, namely: Respondents' demographic information, MSM knowledge about HIV and AIDS, attitudes towards HIV and AIDS, sexual practices and respondents' health seeking behaviour. Each section was considered separately in the analysis. A total of 36 questionnaires were received and analysed out of the sample size of 40 representing a 90% response rate.

4.2. Section One: Biographical information

This section included personal, academic and employment information.

4.2.1 Personal information

Q1. Respondents' age (n=36)

Table 4.1: Age

Age range	N	(%)
19-24 Yrs	17	47.
25-29 Yrs	15	42
30+ Yes	4	11
		100

Of the respondents, 47% were between 19-24 years of age and 42% were between 25-29 years of age. The median age of the respondents was 26 (age ranging from 19-36).

Q2. Respondents' nationality (n=36)

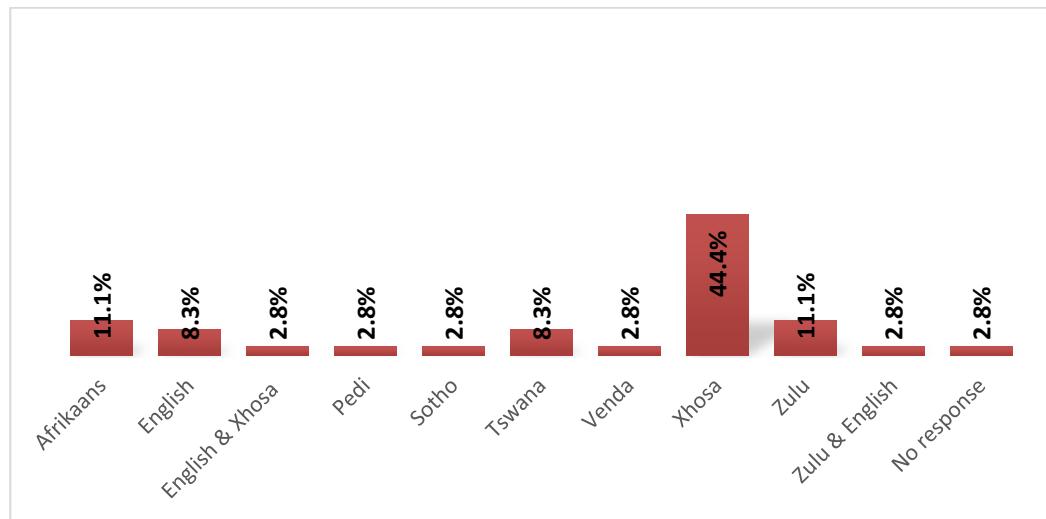
Table 4.2: Nationality

Nationality	N	(%)
South African	35	97.2
No Response	1	2.8
		100

Almost all respondents (n=35) were South Africans.

Q3. Respondents' language spoken at home (n=36)

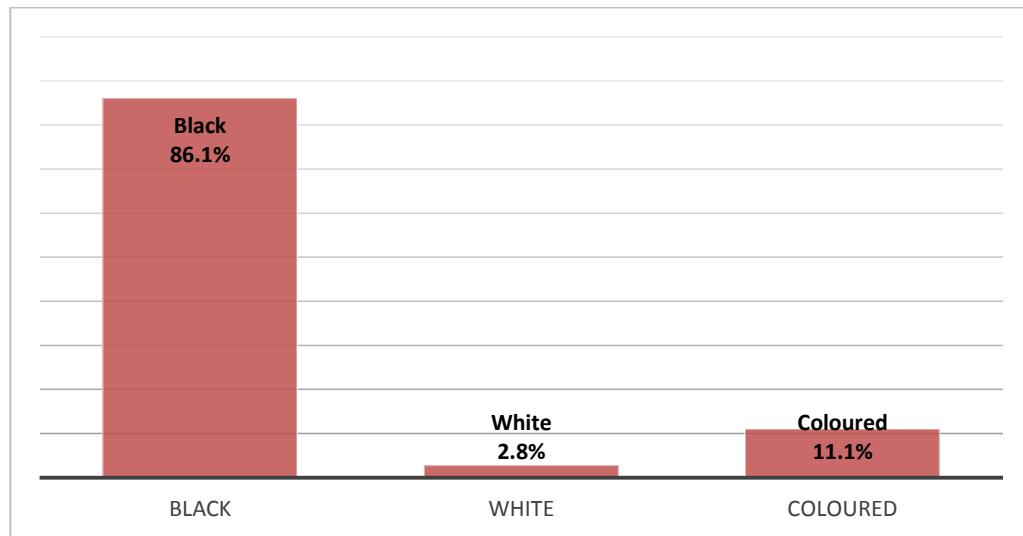
Figure 4.1: Language



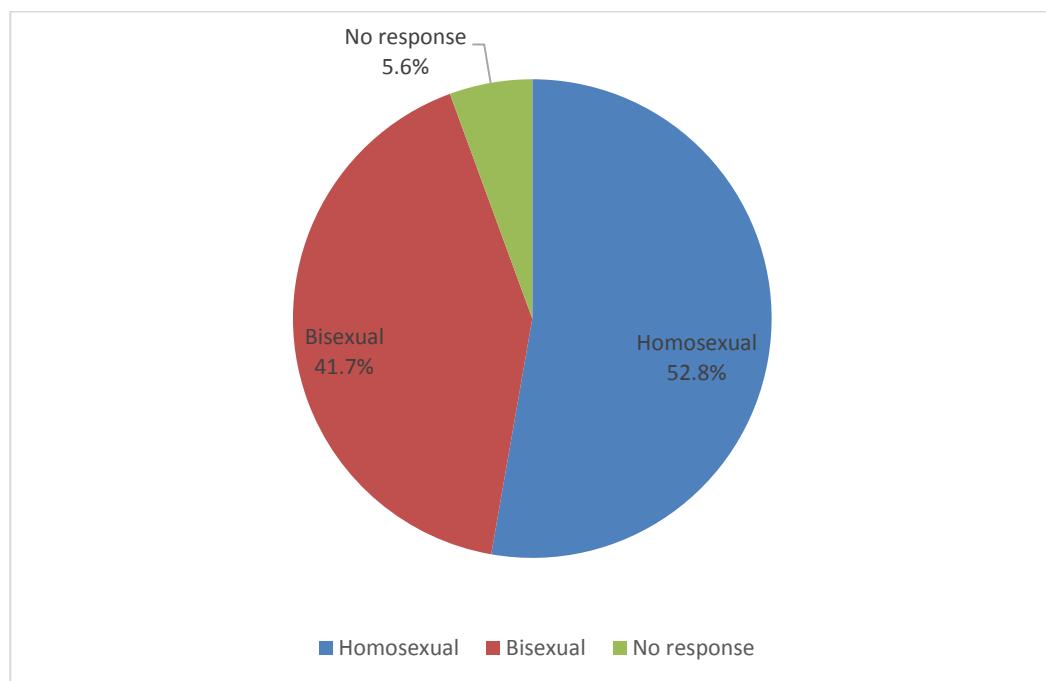
Of the respondents, the majority were Xhosa speaking (44.4%) followed by Afrikaans (11.1%), Zulu (11.1%), English (8.3%) and Tswana (8.3%).

Q4. Respondents' race (n=36)

Figure 4.2: Race



Of the respondents 86.1% (n=31) were black; 11.1% (n=4) were coloured and 2.8% (n=1) was white.

Q5. Respondents' sexual orientation (n=36)*Figure 4.3: Sexual orientation*

Of all the respondents, over half self-identified as gay (52.8%) while 41.7% are bisexual and 5.6% did not complete the question.

Q6. Respondents' use of social media (n=36)*Table 4.3: Social media usage*

Social Media usage	N	(%)
On Social Media	34	94.4
Not on Social media	1	2.8
No Response	1	2.8
		100

Almost all respondents (94.4%) are on social media.

Q7. Respondents' knowledge of people living with HIV/AIDS (n=36)*Table 4.4: PLWHA known by respondents*

PLWHA known	N	(%)
None	1	2.8
One-Two	20	55.6
Three-Five	7	19.4
Six-Ten	3	8.3
11 or More	5	13.9
		100

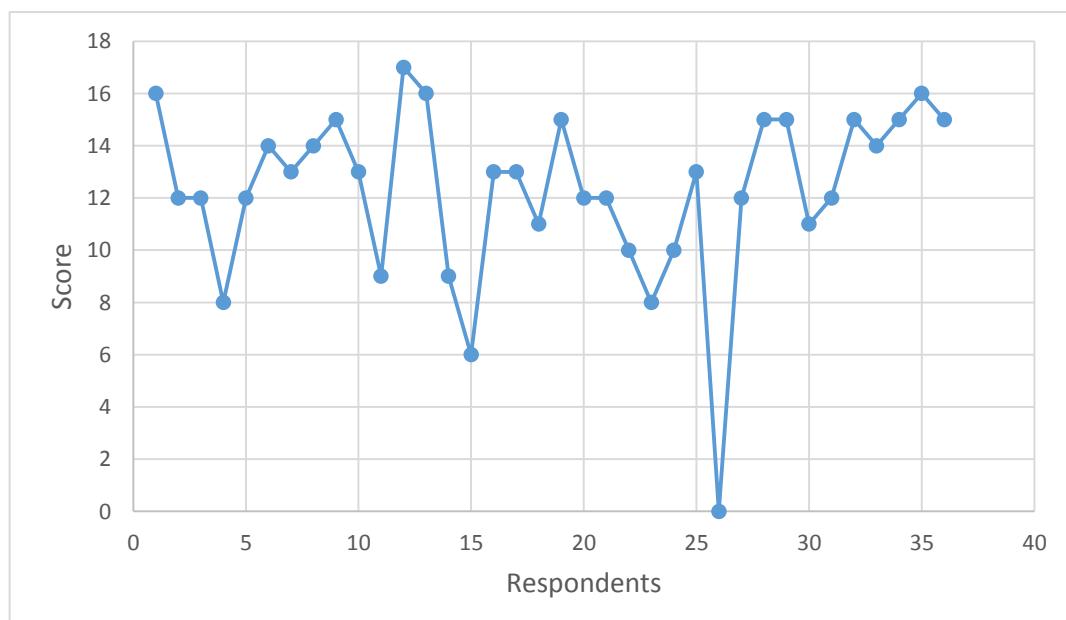
More than half of the respondents (55.6%) knew one to two people living with HIV or AIDS. In total, 19.4% knew three to five people infected with HIV or living with AIDS and 13.9% knew eleven or more people living with HIV/AIDS.

4.3. Section Two: HIV/AIDS Knowledge

This section measures respondents' knowledge of HIV using the standard 18-item HIV Knowledge Questionnaire (HIV-KQ-18). This questionnaire was developed by Carey and Schroeder (2002) adapted from the 45-item questionnaire to measure respondents' basic current knowledge about HIV.

The respondents read the 18 statements about HIV and indicated whether the statements were true or false or perhaps they don't know. For each respondent, a score was calculated by summing up all correct answers. The higher the score, the greater the knowledge. This instrument has a maximum possible score of 18. Figure 4.4 below illustrate the scores per respondent ($n=36$)

Figure 4.4: Respondents' HIV-KQ-18 scores



On average, the sample of MSM respondents scored reasonably high on the questionnaire of HIV knowledge with an average of 70% ($M=13$) from a possible score of 18 ($M=13$; $SD=2.6$).

The results are summarised in Table 4.8, however, the following statements indicating a lack of basic HIV knowledge amongst the respondents are worth noting:

- 50% of respondents did not know that coughing and sneezing CAN NOT spread HIV;
- 52.8% did not know that the chances of getting infected with HIV are higher for anal sex than for vaginal sex;
- 44.4% thought that there is a vaccine that can stop adults from getting HIV;
- 86.1% did not know that a female condom can help decrease a man's chance of getting HIV during anal sex;
- 44.4% thought that a person will NOT get HIV if she or he is taking antibiotics; and
- 55.6% did not know that a person can get HIV from oral sex.

Table 4.5: HIV Knowledge items and correct scores

HIV Knowledge Item	N=36	%
2.1. Coughing and sneezing DO NOT spread HIV.	18	50.0%
2.2. A person can get HIV by sharing a glass of water with someone who has HIV.	34	94.4%
2.3. Pulling out the penis before a man climaxes/cums keeps a man from getting HIV during sex.	26	72.2%
2.4. Chances of getting infected with HIV are higher for anal sex than for vaginal sex.	17	47.2%
2.5. Showering, or washing one's genitals/private parts, after sex keeps a person from getting HIV.	29	80.6%
2.6. All pregnant women infected with HIV will have babies born with AIDS.	30	83.3%
2.7. People who have been infected with HIV quickly show serious signs of being infected.	33	91.7%
2.8. There is a vaccine that can stop adults from getting HIV.	20	55.6%
2.9. People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV.	30	83.3%

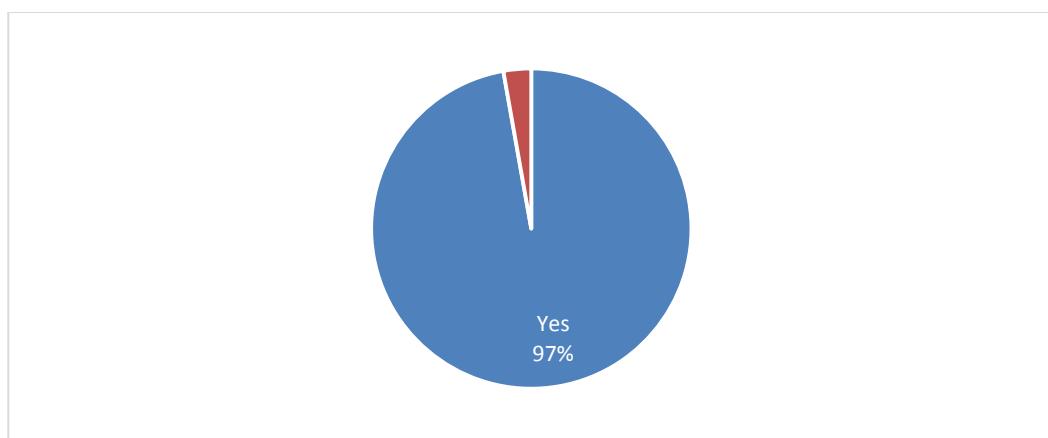
HIV Knowledge Item	N=36	%
2.10. Circumcision prevents HIV transmission.	28	77.8%
2.11. A female condom can help decrease a man's chance of getting HIV during anal sex.	5	13.9%
2.12. A natural skin condom works better against HIV than does a latex condom.	15	41.7%
2.13. A person will NOT get HIV if she or he is taking antibiotics.	20	55.6%
2.14. Having sex with more than one partner can increase a person's chance of being infected with HIV.	34	94.4%
2.15. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.	27	75.0%
2.16. A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.	34	94.4%
2.17. A person can get HIV from oral sex.	16	44.4%
2.18. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.	24	66.7%

4.4. Section Three: MSM attitudes towards HIV and AIDS

This section includes questions measuring a respondent's perception of risk, HIV testing, condoms, and the environment they live in.

Q1. Ever tested for HIV (n=36)

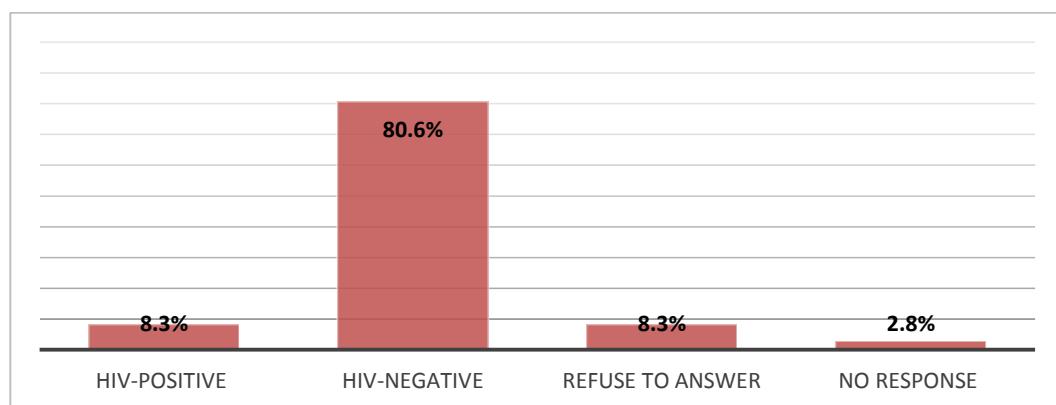
Figure 4.5: HIV testing



Almost all the respondents (97%) have tested for HIV before.

Q2. Result of most recent HIV test (n=36)

Figure 4.6: HIV testing results



Majority of the respondents (80.6%) reported receiving an HIV negative result at their last HIV testing.

Q3. Frequency of HIV testing (n=36)

Table 4.6: HIV testing Frequency

Testing Frequency	N	(%)
Once	10	27.8
Twice	12	33.3
Three times	11	30.6
Four times	0	0
Five times or more	2	5.6
No response	1	2.8
	100	

Most of the respondents have had HIV tests ranging from once up to three times (between 27.8% and 33.3%) with a third (33.3%) having tested twice.

Q4-Q7. Attitudes towards HIV testing on campus

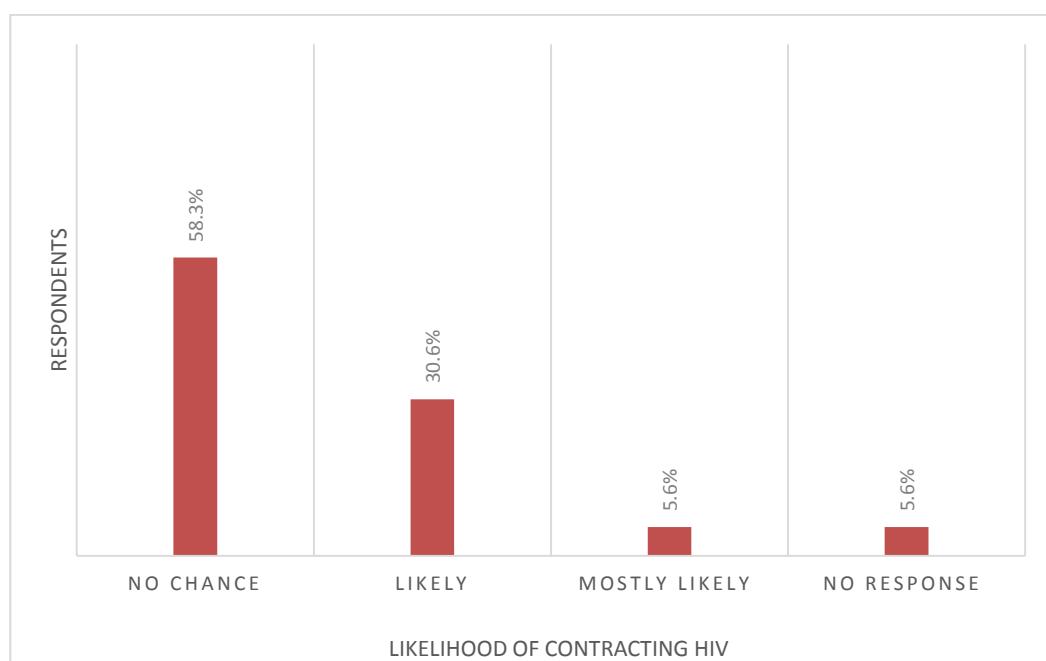
Table 4.7: HIV testing Frequency on campus

Item	Yes (%)	No (%)	No Response
Was your last HIV test less than one year ago?	50.0	47.2	2.8
Are you planning to get tested again?	69.4	27.8	2.8
Have you been tested for HIV on campus?	66.7	25.0	8.3
If NO, would you go for HIV-Testing on campus?	5.6	19.	75.0

Half of the respondents (50%) acknowledge recently going for an HIV test (less than a year). More than half (69.4%) would like a repeat test and another 66.7% report having had their HIV test on campus. Out of the remaining 33.3%, only 5.6% would go for an HIV test on campus.

Q8. The likelihood of the respondent to contract HIV in the near future.

Figure 4.7: Likelihood of contracting HIV

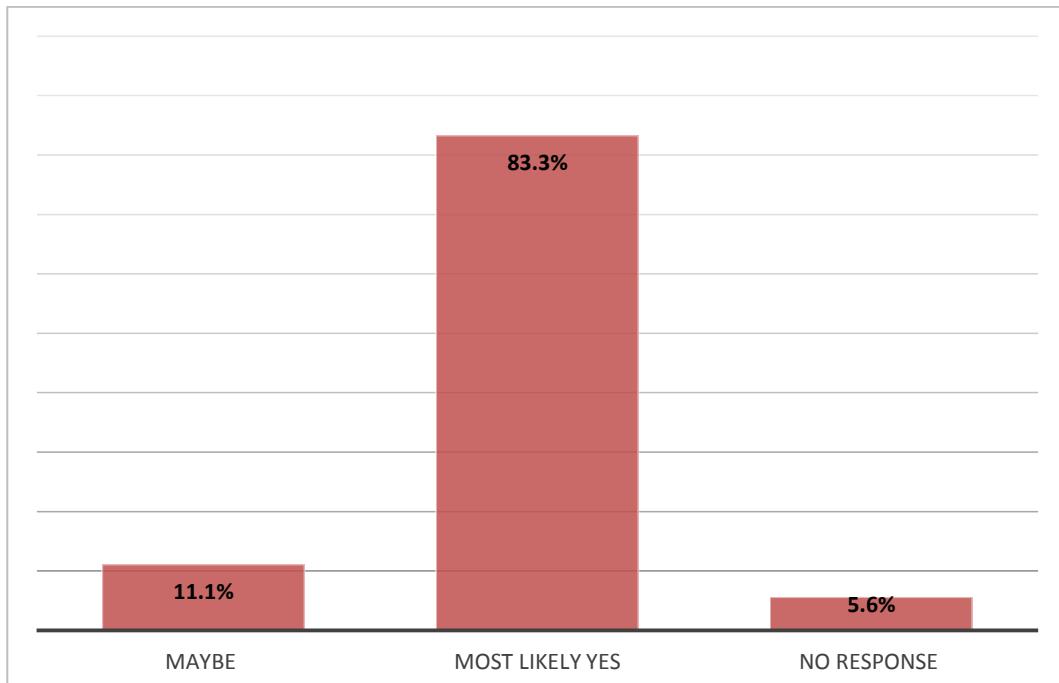


A majority of the respondents (58.3%) do not foresee themselves contracting HIV in the near future while 30.5% think that there is a possibility to contract HIV. A further 2 respondents (5.6%) think that it is most likely that they will be infected.

Q9. Influencing factors for condom use*Table 4.8: Condom use attitudes*

Item	N	(%)
The fear of contracting Sexually Transmitted Infections.	8	22.2
The fear of contracting HIV.	9	25.0
The fear of infecting your partner with HIV/AIDS/STIs.	1	2.8
The fear of contracting Sexually Transmitted Infections & The fear of contracting HIV.	11	30.6
The fear of contracting Sexually Transmitted Infections, The fear of contracting HIV & The fear of infecting you partner with HIV/AIDS/STIs.	4	11
The fear of contracting Sexually Transmitted Infections & The fear of infecting you partner with HIV/AIDS/STIs	2	5.6
The fear of contracting HIV & The fear of infecting you partner with HIV/AIDS/STIs.	1	2.8
		100

Most of the respondents (30.6%) are influenced by a combination fear of contracting STIs and the HIV. Similarly, the fear for contracting HIV and STIs respectively influenced more respondents (25% and 22.2%).

Q10. The likelihood of condom use for fear of contracting HIV.*Figure 4.8: Likelihood of condom use vs contracting HIV*

Evidently, over three-quarters (83.3%) of the respondents believe they would most likely use a condom frequently for fear of contracting HIV.

Four (11.1%) of the respondents were unsure of using condoms for fear of contracting HIV.

Q11-Q14. Condom usage

Table 4.9: Condom use

Item	Agree		Disagree	
	N	(%)	N	(%)
The use of condoms is necessary when having sex with same sex partners.	34	94.4	2	5.6
The chance of contracting HIV is very high when having oral sex without using condoms.	26	72.2	10	27.8
You have a total control in deciding whether to use condoms when having sex with your sex partner.	24	66.6	12	33.4
Among the peers you know, most of them would use condoms during sexual intercourse.	27	75	9	25

Respondents agree with the statements within a range of 66.6% to 94.4%. However, control in deciding whether to use condoms when having sex with your partner received the lowest rating (66.6%).

Q15, 18-20. Attitudes towards the environment

Table 4.10: Safe environment

Item	Yes (%)	No (%)	No Response
Do you consider your campus a safe environment for MSM students?	58.3	38.9	2.8
The management of this institution takes discrimination against MSM students seriously?	66.7	19.4	13.9
The student leaders of this institution take discrimination against MSM students seriously?	41.7	50.0	8.3
I feel safe from physical harm on campus	86.1	11.1	2.8

More than half of the respondents (58.3%) consider their campus a safe environment. Two-thirds (66.7%) believe that management takes discrimination against MSM students seriously and also feel safe from physical harm on campus. However, half of the respondents (50%)

believe that student leaders do not take discriminations against MSM students seriously.

Q16. Reasons MSM students do not consider their campus a safe environment for MSM students

Participants' responses included:

"I am scared of coming out" (23 year old, black, Xhosa, homosexual).

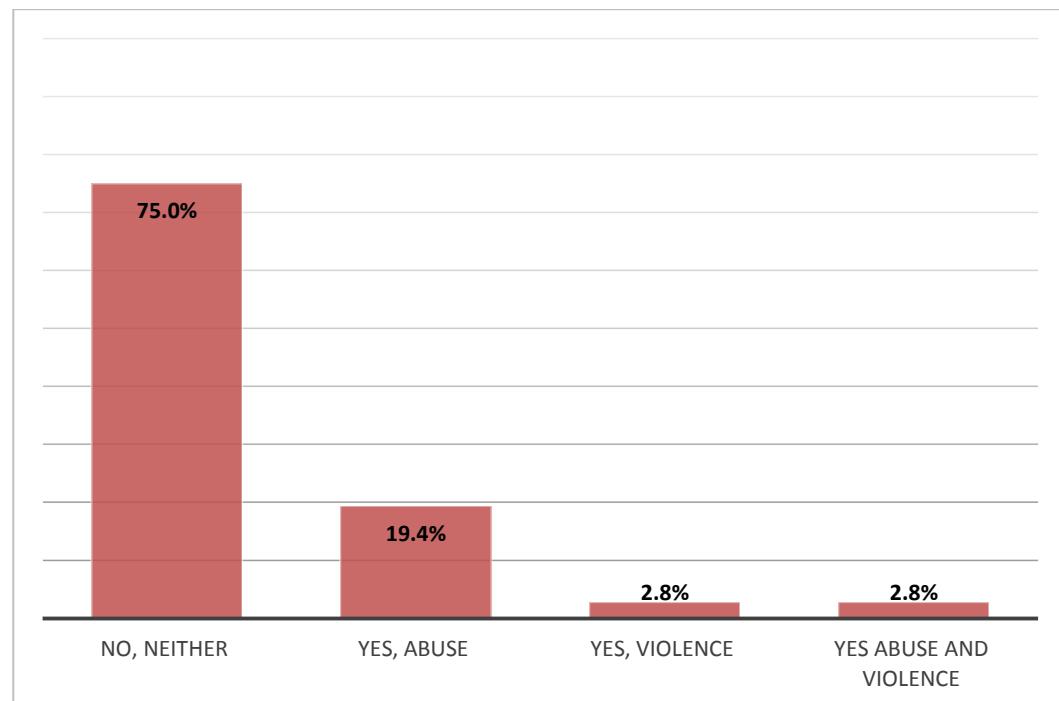
"Discrimination" (21 year old, black, Tswana, homosexual).

"They are ridiculed by other male students and discrimination" (28 year old, black, Xhosa, homosexual).

"Made fun of" (25 year old, black, Xhosa, bisexual).

Q17. Abuse and/or violence on campus due to sexual orientation

Figure 4.9: Likelihood of abuse and/or violence



Three-quarters of the respondents (75%) have neither experienced violence or abuse.

Crosstabs Q10 (4.2.2) and & Q17 (4.2)

Residential location versus experiencing abuse and/or violence

The results indicate that of the 19 students living in residence 16.8% (n=6) have experienced abuse, 2.8% (n=1) has experienced violence and another 2.8% (n=1) has experienced both abuse and violence.

4.5. Section Four: Sexual Practices

This section attempts to measure respondents' risky sexual practices that could render them vulnerable to HIV transmission.

Q1 & Q3. Being openly MSM on campus and sexual activity

Table 4.11: sexual activity

Item	Yes (%)	No (%)	No Response
Are you openly MSM on campus?	83.3	13.9	2.8
Have you ever had sexual intercourse?	97.2	0	2.8

Only five (13.9%) of the respondents were not openly MSM, while the majority (83.3%) were living openly MSM. In the context of sexual activity, almost all the respondents (97.2%) have had sexual intercourse before.

Q2. Reasons for not being openly MSM on campus

Participants' responses included:

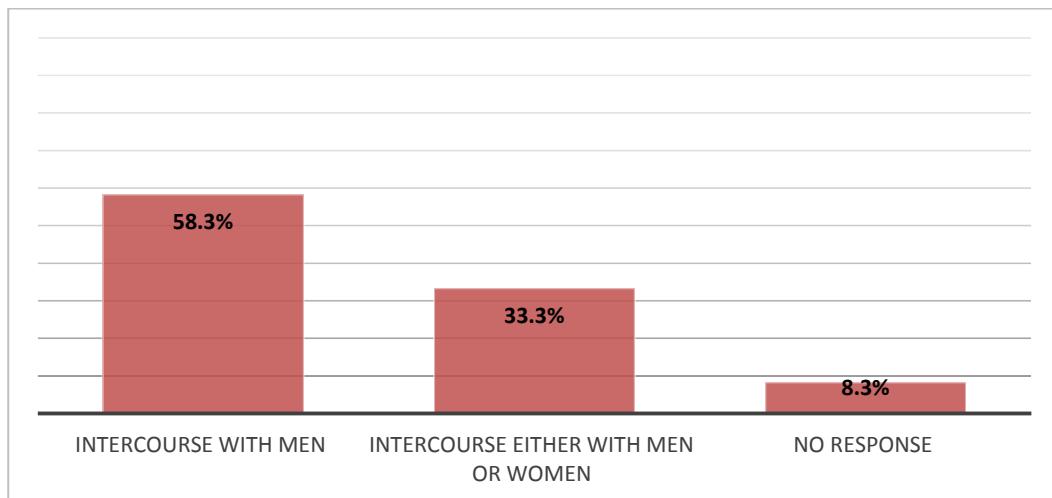
“Closet” 20 year old, black, Xhosa, homosexual).

“I have a girlfriend” (23 year old, black, English & Zulu, did specify sexual preference).

“Not comfortable” (25 year old, black, Xhosa, bisexual).

Q4. Sexual partnerships

Figure 4.10: Sexual partners



Over half (58.3%) of the respondents only have sexual intercourse with other men. Twelve (33.3%) of the respondents reported having sexual intercourse with both men and women while 8.3% ($n=3$) chose not to respond.

Q5. Age at first sexual activity with a man

Table 4.12: Age at first sex with a man

Item	n	(%)
11-15 yrs	6	16.7
16-20 yrs	18	50.0
21-25 yrs	10	27.8
>25 yrs	2	5.6
		100

Half of the respondents (50%) had their first sexual activity with a man between the ages of 16-20 years. In total, 27.8% ($n=10$) were between the ages of 21 and 25 years, while 16.7% ($n=6$) started between the ages of 11-15 years.

Q6. Sexual partners in the past 6 months*Table 4.13: Number of sexual partners in the past 6 months*

Item	n	(%)
0	2	5.6
1-3	20	55.6
4-6	11	30.6
7-9	2	5.6
>9	1	2.8
		100

More than half of the MSM students (55.6%) reported having between one and three sexual partners in the past 6 months. Another, 30.6% (n=11) reported having four to six sexual partners. However, whereas some respondents (n=2) had no sexual partners, 5.6% (n=2) had between seven and nine and 2.8% (n=1) had more than nine (9) sexual partners.

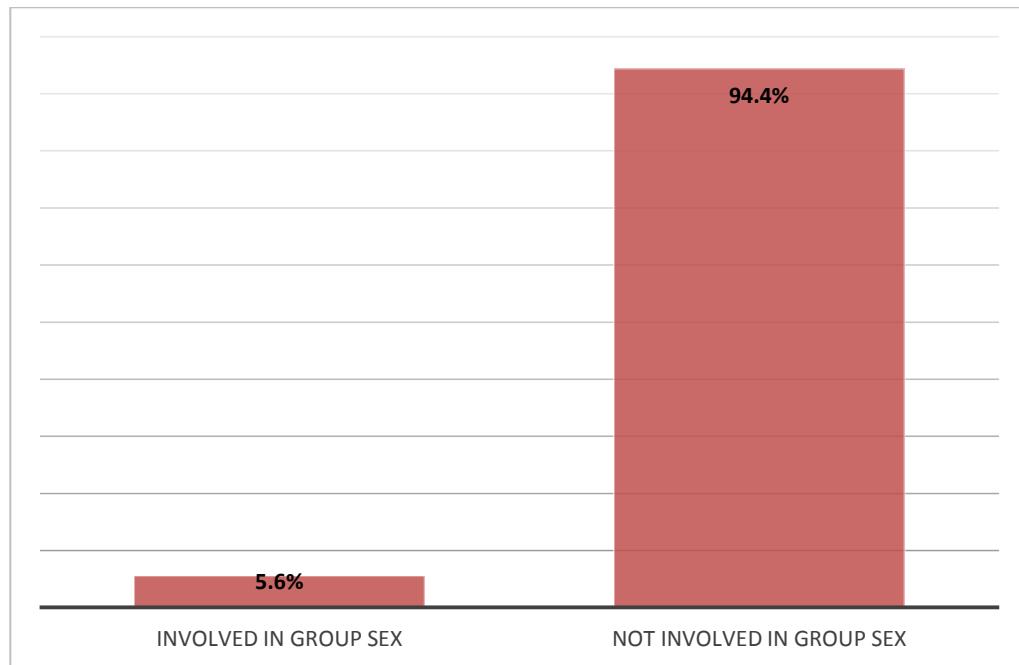
Q7. Place where sexual partner was met*Table 4.14: Where sexual partner was met*

Item	n	(%)
Sex parties on campus	1	2.8
Bars/Clubs	12	33.3
Online/Dating Websites	8	22.2
Bars/Clubs & Online/Dating Websites	7	19.4
Other: community, mall, campus	7	19.5
No response	1	2.8
		100

The majority of the respondents (33.3%) reported having met their sexual partner in a bar or club. In total, 22.2% of the MSM has met their sexual partner online.

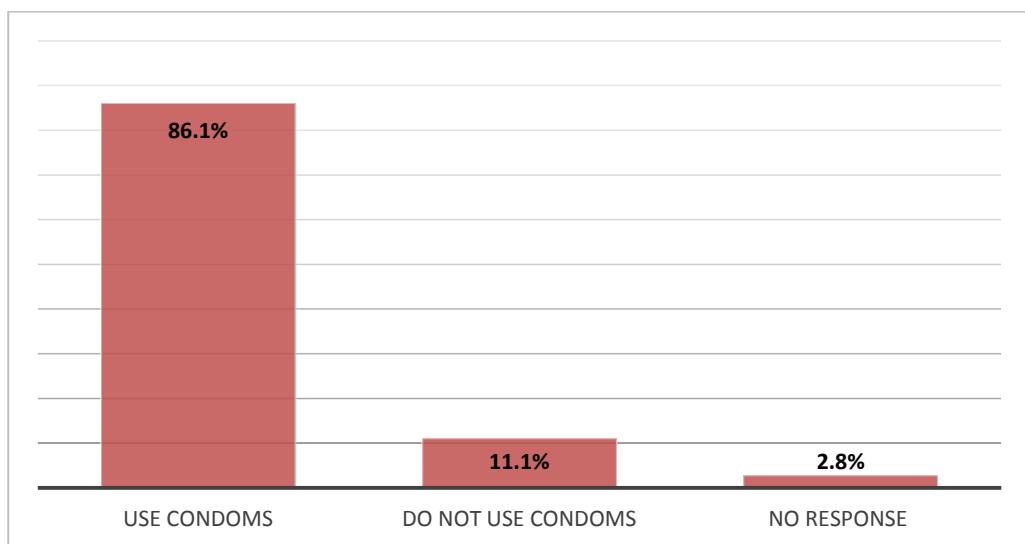
Q8. Involvements in group sex in the past 6 months

Almost all the respondents (94.4%) were not involved in group sex in the past six months. Two of the participants (5.6%) reported being involved in group sex as shown in Figure 4.11.

Figure 4.11: Group sex behaviour**Q9. Sexual practices in the past 6 months***Table 4.15: Types of sexual practices in the past 6 months*

Item	N	(%)
Oral Sex	5	13.9
Mutual Masturbation	2	5.6
Receptive Anal Sex	5	13.9
Insertive Anal Sex	2	5.6
Fisting	0	0
Oral Sex & Mutual Masturbation	1	2.8
Oral Sex, Mutual Masturbation & Receptive Anal Sex	1	2.8
Oral Sex, Mutual Masturbation, Receptive Anal Sex, Insertive Anal Sex	2	5.6
Oral Sex & Receptive Anal Sex	7	19.4
Oral Sex, Receptive Anal Sex & Insertive Anal Sex	1	2.8
Oral Sex, Receptive Anal Sex & Fisting	1	2.8
Receptive Anal Sex & Insertive Anal Sex	6	16.7
Receptive Anal Sex , Insertive Anal Sex & Other	2	5.6
missing		2.5
		100

Most of the MSM students (19.4%) in the study reported practicing both oral and receptive anal sex in the past 6 months. Other most notable sexual practices include a combination of receptive and insertive anal sex (16.7%), receptive anal sex (13.9%) and oral sex (13.9%).

Q10. Condom usage during sexual intercourse*Figure 4.12: condom usage*

The majority of the respondents (86.1%) use condoms during sexual intercourse.

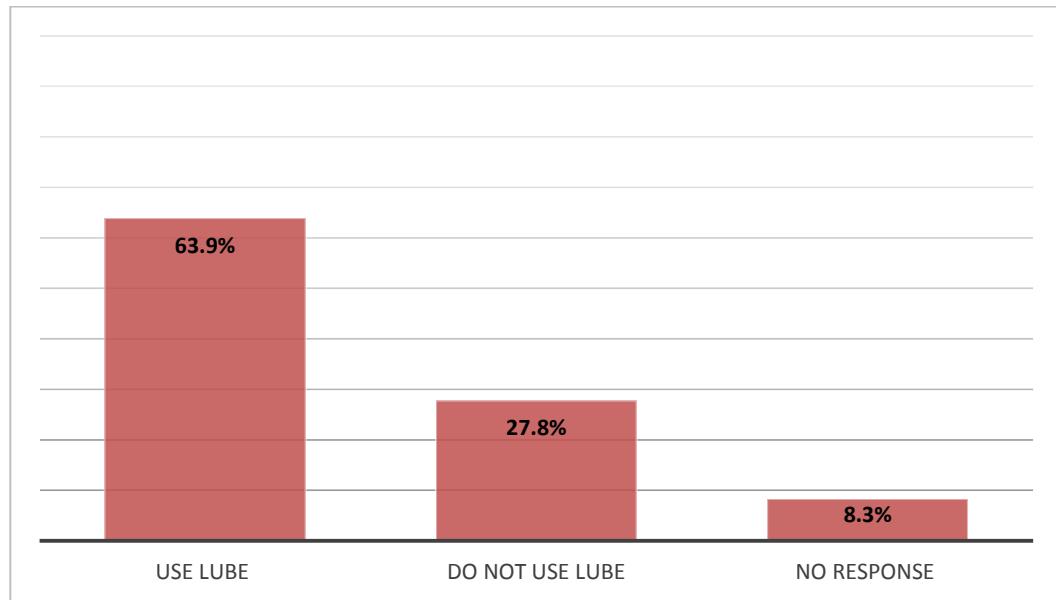
Q11. Places where MSM obtain condoms*Table 4.16: Source of condoms*

Item	n	(%)
Condom dispensers on campus	19	52.8
Campus Clinic	2	5.6
HIV/AIDS Unit	3	8.3
Condom dispensers on campus, Campus Clinic, HIV/AIDS Unit & Health & Wellness Unit	1	2.8
Condom dispensers on campus & HIV/AIDS Unit	2	5.6
Condom dispensers on campus & H&W Unit	3	8.3
Other – Pick & pay, Shoprite retailers	2	5.6
No response	4	11.1
		100

Over half of the respondents (52.8%) access condoms from condom dispensers that are installed at strategic positions on the campuses. Only 8.3% (n=3) of the sampled population accessed condoms through the HIV/AIDS Unit and 5.6% (n=2) through the campus clinic.

Q12. Use of lubricants (lube) with condom during sexual intercourse

Figure 4.13: Lubricant use



Most of the respondents (63.9%) use lubrication with condoms during sexual intercourse. Ten of the respondents (27.8%) reported not using lubricants during sexual intercourse.

Q13. Reported reasons for not using lubricants (lube) with condom during sexual intercourse

The participants' responses included:

"I do not see the need for them" (26 year old black, Xhosa, homosexual).

"My partner does not like to use lube" (21 year old, black, Tswana, homosexual).

"I never saw a need to use lube on vaginal sex" (23 year old, black, Zulu, bisexual).

"I do not know what is it for" (26 year old, black, Xhosa, homosexual).

"I think a condom has enough lubricant" (24 year old, black, Zulu, homosexual).

Q14. Reported reasons for not using condoms

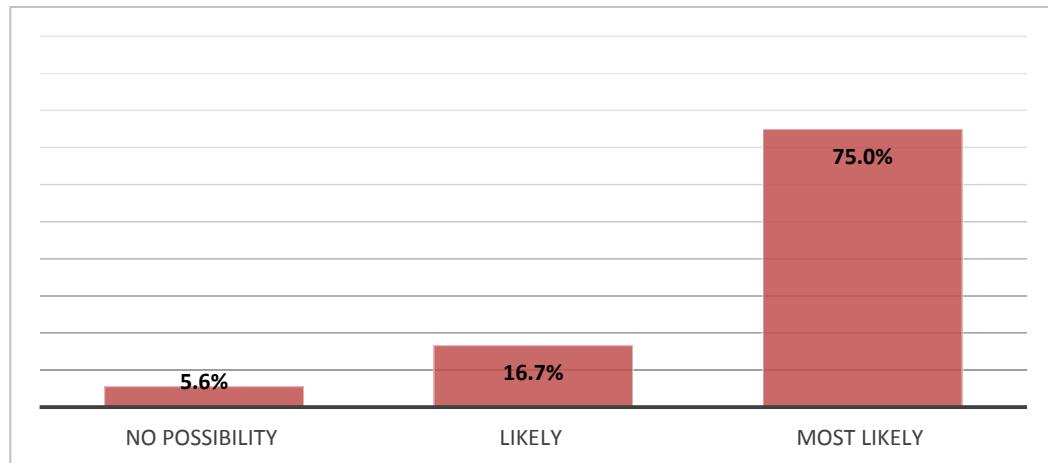
"My partner and I get tested together" (23 year old, black, Xhosa, homosexual).

"Noisy and uncomfortable" (28 year old, black, Xhosa, homosexual).

"I enjoy having sex without a condom" (25 year old, black, Xhosa, bisexual).

Q15. Possibility of using condoms every time when having sexual intercourse in the next six months.

Figure 4.14: Possibility of using condoms consistently

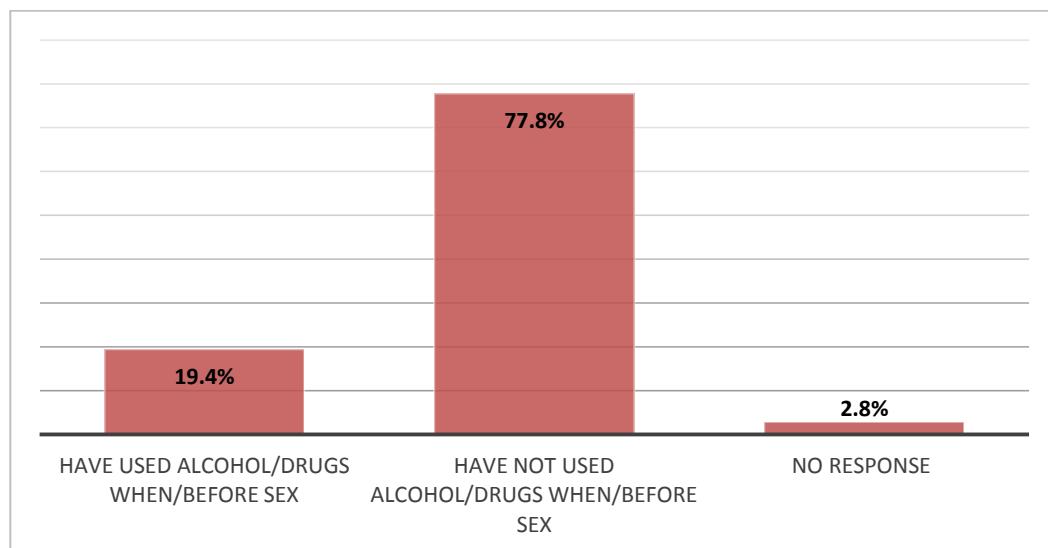


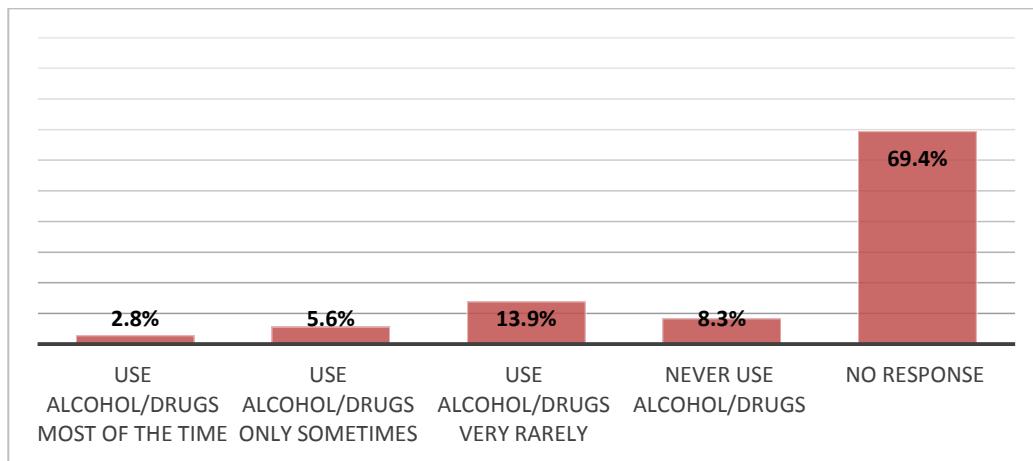
Three-quarters of the MSM population respondents (75%) will most likely use condoms consistently in the next six months.

Q16. Use of alcohol and/or drugs when/before sex

Figure 4.16 illustrates the results of the respondents' responses in which the majority (77.8%) reported having not used alcohol/drugs during or before sexual intercourse.

Figure 4.15 Alcohol/drug use during/before sex



Q17. Frequency of alcohol and/or drugs when/before sex (n=36)*Figure 4.16: Alcohol/drug use frequency*

In total, 69.4% of the sample did not respond considering that they indicated in Q16 that they do not use alcohol/drugs. For those that responded, a total of 8.3% reported never using alcohol or drugs before or during sex. Only 2.8% (n=1) reported using them most of the times while 5.6% (n=2) uses only sometimes. Those that reported rarely using alcohol or drugs were 13.9% (n=5)

Q18. Respondents' likelihood to do something they would normally not do (e.g. break rules/the law, sell things that are important to them, or have unprotected sex with someone)*Table 4.17: Respondents likelihood to break normal routines*

Item	n	(%)
Likely	3	8.3
Unlikely	7	19.4
No response	26	72.2%
		100

Twenty six (72.2%) participants did not respond for the reason that they indicated not using alcohol. Nonetheless, it is unlikely for the 19.4% (n=7) respondents that reported using alcohol/drugs to do something they would normally not do. Only three (8.3%) respondents would likely do something that they normally would not do.

Q19 & Q20. Frequency, amount of use and its effects*Table 4.18: Frequency of substance use and its effects*

Item	All the time (%)	Often (%)	Occasionally (%)	Never (%)	No response (%)
Frequency one got high or had a few drinks immediately before or during sex	0	2.8	16.7	8.3	72.2
Frequency alcohol and drug use made it more difficult for you to have safer sex.	2.8	5.6	8.3	11.1	72.2

In terms of substance use before or during sex, only 2.8% (n=1) reported often having a few drinks or got high and 16.7 (n=6) did that only occasionally. As a result, 8.3% (n=3) occasionally had difficulty in having safer sex; 5.6% (n=2), often and 2.8% (n=1), all the time.

4.6. Section Five: MSM health seeking behaviour

This section measures MSM students' health seeking behaviour.

Q1. Easy access to health care (HIV Counselling & Testing, STI & TB screening, etc.)

Almost all (97.2%) reported having easy access to health care such HIV Counselling and testing, STI and TB screening, etc. Only one (2.8%) indicated difficulty to access health care.

Q2 Barriers to accessing health care services on campus

The respondent (2.8%) who reported difficulty in Q1 above, indicated the geographical location of health care facilities on their campus as barrier.

Q3. Solutions for making it easier for MSM to go to the health care facilities on campus

Recommendations ranged from availability of male health care workers (2.8%); availability of health care services for an extended period of time to include part-time students and reduced waiting times.

Q4. Experience of any specific sexual health needs, which are not addressed by the campus clinic or the HIV/AIDS Unit on campus.

Majority of the respondents (91.7%) stated that they have never experienced any specific sexual health needs, which are not addressed by the clinic or the HIV/AIDS Unit. However, 5.6% (n=2) indicated having had their needs not addressed while 2.8% (n=1) did not respond.

Q5. The respondents did not specify any health care needs that need to be addressed by the clinic or campus health clinic.

Q6 & Q7. Easy access to condoms on campus

Table 4.19: Condom access

Item	n	(%)
Do you have easy access to condoms on your campus?	36	100
		100

All respondents (100%) reported no difficulties with accessing condoms on campus and in this context, no responses were provided for Q7.

Q8. Easy access to water-based lubricants on campus

Table 4.20: Access to water-based lubricants

Item	n	Yes (%)	n	No (%)
Do you have easy access to water-based lubricants (lube) on your campus/work place?	14	38.9	22	61.1

Over half (61.1%) of the respondents reported not having easy access to water-based lubricants while 38.9% (n=14) of the respondents did not have any difficulty accessing the water-based lubricants.

Q9. Reasons for not having easy access to water-based lubricants (lube) on campus

“HIV unit does not supply the lubes in campus and they are unavailable at the cafes” (21 year old, black, Tswana, homosexual man).

“There are no dispensers for lubrication in public toilets, only get lubrication in HIV unit” ((28 year old, Black, Xhosa, homosexual man).

“Not distributed” (26 year old, black, Xhosa, homosexual man).

“Because I do not use them” (24 year old, black, Zulu, bisexual man).

Q10-15. Access to MSM specific information and groups

Table 4.21: Access to MSM Information

Item	n	Yes (%)	n	No (%)	n	No Resp (%)
Have you ever received any information about MSM health on campus?	12	33.3	22	61.1	2	5.6
Have you ever received information about HIV and AIDS on campus?	31	86.1	4	11.1	1	2.8
Have you attended a meeting or function about MSM issues on campus?	5	13.9	30	83.3	1	2.8
I have attended a meeting about HIV and AIDS on campus	25	69.4	10	27.8	1	2.8
I am a member of an HIV/AIDS group on campus	5	13.9	30	83.3	1	2.8
I am a member of an MSM group on campus	1	2.8	34	94.4	1	2.8

Table 4.24 provides insight into the access to MSM related information on HIV prevention and associations on campus. Notably, a majority of the MSM students (61.1% of the sample) have never received any information on MSM health on campus and 83.3% (n=30) have never attended any meeting on campus that was addressing MSM health issues.

On the contrary, In addition, 86.1% have received information on HIV prevention in general and 69.1% have attended a meeting about HIV and AIDS on campus.

In terms of participation in various groups on campus, an overwhelming 94% are not members of any MSM related groups and 83% are not members of an HIV and AIDS group on campus.

CHAPTER FIVE

RESULTS INTERPRETATION AND DISCUSSION

5.1 Introduction

This chapter provides an interpretation and discusses the findings presented in Chapter Four. The content will include a discussion on the HIV and AIDS knowledge levels among the sampled MSM students, their attitudes towards HIV prevention and sexual practices and also their behaviour in relation to seeking health services.

As discussed in Chapter One, the main aim of the study was to identify HIV and AIDS knowledge, attitude, behaviour and practices among MSM students at the selected HEI campuses in order to develop targeted intervention service packages for the institution. Specifically, this chapter provides a discussion based on the students' responses to achieve the following study objectives:

- Establish the level of HIV and AIDS knowledge among MSM students at the HEI selected campuses;
- Identify MSM students' attitudes towards HIV prevention strategies;
- Ascertain self-reported sexual, other risk practices and health seeking behaviours of MSM students; and
- To recommend guidelines for effective and enhanced targeted intervention response for MSM students.

5.2 Biographical information

Majority of the respondents were young MSM ranging from 19 to 29 years old (19-24 years: 47% and 25-29years: 42%). A large percentage (86.1%) were Black and South African (97.2%) Xhosa (44.4%) speaking young men. A total of 52.8% respondents identify themselves as homosexual while 41.7% were bisexual. This is consistent with the findings from the South African Marang Men's Project (2014) conducted by HSRC that also reported 34% homosexual and 11.7% bisexual men in Cape Town, 47.7% homosexual and 41% bisexual in Johannesburg as well as 43.7% homosexual and 17.9% bisexual men in Durban in their study of 925 MSM participants across the three cities. This

points to sexual activity overlapping that can fuel more incidence as most bisexual men are still in the ‘closet’ (hidden).

In this study, almost all respondents (94.4%) is on social media making it a necessary platform for communicating sexual health messages and HIV prevention. It is evident from the responses that almost all (97.2%) respondents know or knew someone living with HIV or AIDS which provides an ideal position to foster HIV prevention or treatment, care and support messages.

The data on campus of registration is divided almost equally with 52.8% registered at Campus 1 and 47.25 registered at campus 2 and most of them (33.3%) are in year two of study and stay in university residence (75%). Almost all (97.2%) respondents are not employed and therefore are dependent on public health services rather than paid private health care, a strong indication of the need for the university to provide targeted interventions.

5.3. HIV and AIDS knowledge

Knowledge was measured through the 18-item HIV Knowledge Questionnaire (HIV-KQ-18) and the expectation was that after more than 30 years of the global epidemic, correct responses should be in the majority. Overall knowledge of HIV transmission was high among the respondents scoring a mean of 13 (mean=70%) from a possible 18 score. However, knowledge was inadequate on a number of statements. Basic knowledge on HIV transmission through coughing and sneezing was low amongst the sample. Half of the respondents provided incorrect answer to this statement.

Results also show that respondents attained inadequate correct responses to the HIV transmission through anal sex as compared to vaginal sex with more than half (52.8%) of the respondents unaware of the high susceptibility to HIV infection through unprotected anal sex compared to unprotected vaginal sex.

Knowledge of unavailability of a vaccine to prevent HIV transmission was inadequate with only 55.6% providing a correct response. Similarly, the same number of respondents believe that an individual would not get infected if taking antibiotics.

Surprisingly, in relation to condom usage, over three-quarters (86.1%) lacked the basic knowledge that a female condom can be inserted in the anus and help decrease chances of HIV transmission for men during anal sex. For communities that focus on heteronormative prevention messaging, this lack of basic essential knowledge among MSM could negatively impact prevention efforts.

A further statement on HIV transmission through oral sex was answered incorrectly with over half of respondents (55.6%) believing there is no risk of transmission. This may be an indication that an extensive education strategy is needed as most of the respondents partake in oral sex.

These findings are similar to results from the South African National HIV survey in which Shisana, *et al* (2014:95) compared analyses of data across 2008 and 2012 surveys and concluded that there was a statistically significant drop in levels of knowledge among males in the recent study. National knowledge levels amongst key populations (22.7% in 2012 compared to 31.8% in 2008) are reported to have declined in comparison to 2008.

On the contrary, Brink (2012:66) in his investigation of risky behaviour, basic HIV knowledge and intention to use condoms among a sample of men who have sex with men in a student community found high knowledge levels (mean=80.94%) consistent with results of an earlier study within higher education institutions (HEAIDS, 2010).

Of possible concern in this current study is the lack of knowledge especially regarding the risk of HIV transmission through anal sex and oral sex as Jobson, *et al* (2013:s12) observed that lower levels of HIV knowledge among MSM in South Africa are associated with high levels of unprotected anal sex

and non-use of lubrication. As a key population, MSM are already at an elevated risk of HIV exposure (Shisana, *et al*, 2014:97). In this context, strategies should be put into place for targeted education to reduce their chances of becoming infected with HIV

5.4. MSM attitudes towards HIV prevention strategies

HIV counselling and testing plays a pivotal role in one's health as it becomes an entry point for further prevention, treatment, care and support which are essential elements for a healthy long and productive life. The study results indicate a large percentage of respondents (97%) have taken an HIV test before with a reported 80.6% receiving an HIV negative result and having tested more than twice (72.3%) on campus (66.7%). A majority of them plan to test again (69.4%).

The results of this study pertaining to HIV testing are consistent with the South African Marang Men's Project (2014) findings that indicate an 82% HIV testing rate amongst studied MSM participants. Similarly, Shisana, *et al* (2014:95) report a 59% HIV testing services uptake among men nationally. A recent study on student sexual health (NACOSA, 2014) further confirm the tendency to regularly test for HIV. The study found 73% of students had been tested before and 60% had tested in less than a year ago. In addition, 85% were planning to retest. Seemingly, young people are heeding the call to take responsibility of their health and future. Of possible concern, nonetheless, are the rising STI figures among young people which counters the sole purpose of getting tested for HIV as it is an indication that they are not using condoms.

Although some studies have reported low rates of people seeking HIV testing services (Knox, *et al*, 2011; Nel, *et al*, 2013), it therefore seems that most people have, at this point, overcome their fears for testing for HIV as it now is regarded a norm for one to know their HIV status.

Most respondents reported understanding the need for condom use (94.4%) and yet 33.3% did not feel fully empowered to take total control in deciding

whether to use a condom when having sex with their sexual partner. The fear of contracting STIs and HIV is reportedly behind the driving force of condom use in this study.

This study observed that 58.5% of respondents believe that they are not at risk of HIV infection. These findings are consistent with the national perception of susceptibility to HIV infection reported by Shisana, *et al* (2014). In their study report, 77% of the respondents believe that they are not at risk of HIV infection. Furthermore, the provincial data indicated that the Western Cape ranked highest in proportion of people who believe that they are not at risk of infection (55.6%), which was also the province in which this study was done.

It is concerning to observe that over half of respondents perceive a minimum level of susceptibility noting the lack of knowledge of the respondents reported in this study especially regarding the high risk of unprotected anal sex. Although many studies have indicated a false sense of security due to a perceived lower risk of HIV infection leading to less uptake of HIV testing and other health care services (Kibombo, *et al*, 2007; Shisana, *et al*, 2009), this study reported 83.3% likelihood of condom use of the respondents due to the fear of contracting STIs and HIV is one common reason for believing they are not at risk of HIV infection and 97% knowledge of one's HIV status. Nonetheless, no one prevention strategy is full proof against HIV infection, therefore, this perception remains a challenge for HIV program planning and implementation.

The study further finds low levels of confidence among university management and student leadership in dealing with discrimination against MSM students. Previous research concurs with this lack of confidence in leadership at various institutions due to leadership's predominantly limited engagement with the issues raised by students. In the HEAIDS (2010) prevalence study in South African higher education institutions, majority of both staff and students felt that there should have been more effort by leadership in supporting the health and wellness needs and activities at the institutions. Only 50% and 66.7% of respondents believed that student and

staff leadership, respectively, took discrimination seriously in their campuses. This perception requires serious engagement as it borders on an important student leadership core mandate of representing and responding to the needs of all students regardless of their sexual orientation, gender or race. With lack of confidence in leadership, emanates an inclination to not reporting cases which in turn increases the vulnerability of the MSM population.

Although a majority (86.1%) of the sample feel safe from physical harm on campus, general safety from other forms of abuse is believed to be insufficient by 40% of the respondents. This is evident from some of the respondents' fear of disclosure of their sexual orientation due to frequent ridicule and discrimination by other male students. The data indicates that out of the nineteen (19) students living in residence, 16.8% (n=6) have experienced abuse which is evidence of vulnerability in comparison to other male students in the general campus community in spite of the general feeling of tolerance towards MSM on campuses. This has implications for increasing uptake of health care services as most MSM would prefer to stay 'hidden'. Improving sensitization campaigns especially in residences to the general student population would help reduce discrimination and abuse towards the MSM population.

5.5. HIV related sexual behaviours and practices

The picture emerging from this study is that most young men are already sexually active as they enter tertiary education. According to HEAIDS (2010), most students are sexually active in high school. As reported in this current study, 97% of respondents were sexually active and 16.7% had sex with a man before the age of 15 years. Shisana, *et al* (2014) defines sex before the age of 15 years as early sexual debut which increases one's susceptibility to HIV exposure, according to UNAIDS (2013).

Based on the findings of the sexual behaviour of the sampled MSM population, there is evidence of 'crossover' sexual networks that poses a challenge to heteronormative HIV prevention strategies. In this study, 33.3% of the respondents reported having sex with both men and women consistent

with the HSRC Marang Men's study (2014) that reported a Cape Town 28.4% MSM population that indulged in vaginal sex in the past six months of the study and a 41.4% of the participants that have sex with both men and women on a regular basis. The NACOSA (2014) study also found that one fifth of its MSM respondents reported also having sex with women.

This expanded sexual network raises serious implications of HIV spreading between the concentrated and the general populations. The findings of this study point to many MSM hiding their sexual orientation and appearing to lead a heterosexual lifestyle with a woman. As one respondent stated, not being able to disclose his orientation on campus because he has a girlfriend. This further puts the population at a higher risk of HIV acquisition.

A further concern is the reported number of sexual partners that the study respondents have had in the past six months. As it is reported multiple sexual partners increase one's risk of HIV infection (UNAIDS, 2013; Shisana, *et al*, 2014). In this study, there is a strong indication of multiple sexual partnership relationships, with over half of the respondents having more than one partner in the past six months (over 90%). As Shisana, *et al* (2014) report, one of the reasons for sexual partnerships is to acquire the status being desirable as most of the MSM population are not desired and discriminated by most of the general population. Since most of the respondents are sexually active, it is important to note the need for up-scaling safer sex practice education that could include reducing partner turnover and overall number of sexual partners, and ensure steady provision of condoms and water-based lubricants.

With a reported 19.4% of the respondents having both oral and receptive anal sex, the risk is high for HIV transmission especially considering the lower knowledge levels regarding the risk and effective prevention of HIV transmission through oral sex and anal sex. Even though 86.1% report consistent condom use, 27.8% do not use lubrication with condom during anal sexual intercourse. There is a seemingly higher level of willingness to prevent HIV infection through condom use; however, the non-use of water based

lubricants with anal sex continues to put an individual at risk of infection if the condom breaks.

Common reasons for not using lubricants range from involvement with a female sexual partner, a lack of knowledge about the need for the lubricant, to mere disregard between partners. Nearly all of the respondents reported likelihood of condom use in the next six months, nonetheless, condoms are only effective if used correctly and consistently with all sexual partners and this needs to be promoted vigorously among MSM population. This advocacy should also include correct use of female condom for anal sex as this study observed a considerably higher lack of knowledge in that regard.

Alcohol and drug abuse is another notable risk factor associated with increased risk of HIV acquisition. Based on the findings of this study, 77.8% of the respondents reported not using alcohol or drugs before or during sex. This finding is inconsistent with many findings among young MSM populations who binge drink to escape the daily pressures of stigma and discrimination and resulting into indulgence into unprotected anal sex. For example, in a study by Parry, *et al* (2008), it was reported that MSM population indulged in the use of alcohol and drugs to facilitate sexual encounters. The NACOSA (2014) study focusing on MSM further confirms moderate to high levels of substance abuse among surveyed MSM students. Conversely, this study finds generally occasional use of alcohol/drugs although respondents earlier reported meeting most of their partners at a bar or club.

With respect to finding sexual partners online, this study did not explore further to measure the risks involved and pattern of behaviours involved. Nonetheless, it is encouraging to note the self-efficacy for condom use.

5.6. MSM health-seeking behaviour

Amongst the sampled respondents, 97.2% reported easy access to health care services such as HIV testing and condoms and their related comfort in using health care facilities on campus. The one that found a challenge in this

regard, recommended that the health and wellness departments should appoint more male health professionals in order to further increase access.

Of concern in this study was the unavailability of water-based lubricants on campus which are not accessed by over half of the sampled (61.1%) MSM population due to a lack of supply. Considering the high risk of acquiring HIV through unprotected anal sex and the possibility of condoms breaking, water-based lubricants are an urgent need and form an essential part of condom programming.

In addition to the lack of water-based lubricants, this study also observed that many MSM students (61.1%) have never received any information on MSM specific health care issues where as 86.1% have at least received information on general HIV and AIDS information. Similarly, a large proportion (83.3%) have never attended any gathering focusing on MSM health needs on campus but 69.4% have attended a meeting on general HIV and AIDS information. It therefore seems that, in this context, MSM health care needs are not a priority within the institution. This points to the need for evidence based HIV prevention packages specifically focused on MSM population based on the finding that most of the MSM population also have sexual relations with women and have shown not to have sufficient knowledge of the risks involved and prevention strategies for anal sex.

5.7. Limitations of the study and recommendations for future research

This study provides baseline findings on the levels of HIV and AIDS knowledge, attitudes and sexual and health seeking practices and behaviour among the selected institution's student MSM population. Nonetheless, the following are some of the limitations and recommendations for future research:

- Despite the South African constitution embodying the rights of sexual minorities, MSM remain a hard-to-reach population. Due to this characteristic, their recruitment into a study presents challenges thereby also presenting challenges in terms of generalisation of the study findings. In addition, although the study achieved to recruit a

representative sample of the targeted population ($n=40$), there is a possibility that due to nature of the sampling, the field worker recruited MSM friends within the campus who may possess similar characteristics and experiences.

In this context, this paper recommends increasing the population and geographical locations to include other campuses in order to obtain a more representative sample and findings in future research.

- Self-reported information, in spite of the confidentiality clause, might provide skewed findings due to under- or over-reporting especially for sensitive topics that include sexual behaviour such as condom usage. In this regard, future research may need to include qualitative methods.
- The lack of qualitative data in this study has left a gap in its findings in that more in-depth understanding of the findings has been insufficient. This points to the need to include key informants or focus group interviews in order to provide an opportunity to obtain more data to substantiate the quantitative data findings.

CHAPTER SIX

RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

This chapter provides recommendations based on the findings of this study and conclusions thereof.

6.2 Recommendations of the study

Based on the findings of the study, this paper makes the following recommendations to improve the HIV and AIDS knowledge levels, maintain the right attitudes and safer sex practices and general health seeking behaviour of student MSM population:

6.2.1 HIV Knowledge

Basic HIV knowledge amongst the sampled student MSM population was observed to be relatively high; however, certain basic and critical knowledge in the context of HIV transmission and prevention specifically for anal sex and oral sex was lacking. In this regard, this study recommends that the Institution, through the departments such as the HIV/AIDS Unit and Campus health clinic, should devise educational programmes that are aimed at increasing knowledge levels amongst the MSM population to ensure effective prevention amongst this key population. These educational programmes may include targeted trainings and workshops or discussion groups.

The emphasis of the programmes would be eradication of myths and misconceptions such as those wrongly responded to by the majority MSM respondents in this study. The statements of the 18-item HIV Knowledge Questionnaire (HIV-KQ-18), especially those failed to be correctly responded to can be used as Pre- and Post-Test monitoring tool for the educational interventions. This will allow an opportunity to further monitor the effectiveness of the intervention by measuring increase in HIV knowledge after the intervention on the specified topics as shown in this study.

These study results form a baseline to inform where improvements are required in terms of the MSM community in the institution. This will lead MSM community to further adopt effective HIV prevention strategies and appropriate health seeking behaviour.

6.2.2 MSM attitudes towards HIV prevention and community attitudes

The study has established that there are positive attitudes regarding HIV prevention, care and support amongst the student MSM population. The study observed the high levels of individual knowledge of HIV status and the willingness to partake in HIV testing in future and the high level of condom usage albeit the attitudes towards lubricants. On the contrary, discrimination against MSM populations still remains.

In this context, this study recommends mainstreaming of MSM-friendly health care services into the institutional health care system. This would need to begin with policy review and ensure inclusion of legal guidelines pertaining to provision of health care services, counselling, care and support without prejudice against MSM.

Upon review of relevant policies, there is much in the sensitisation of health care workers, HIV/AIDS practitioners, health promoters, etc in order to address attitudes towards MSM community thereby fostering an enabling environment for easy and effective health care access.

Other quarters that require sensitisation are student leaders at all levels beginning from institutional Students Representative Council (SRC) members to class representatives. In addition, student residence personnel including residence student leaders are an important group that require sensitisation programmes. The general student population should also be sensitised during registration or student orientation programmes. This could effectively assist in creating the much needed enabling environment.

A further recommendation would be to focus on the human rights needs of the MSM community thereby addressing the persistent discrimination that

compounds failure to report discrimination/homophobia cases due to a lack of confidence in the authorities. Protection services and Judicial Affairs employees should be able to effectively address the issues of stigma and discrimination/homophobia.

From the study findings, there is a great need to introduce a comprehensive combination HIV prevention programme for the MSM community. An example of interventions for preventing HIV infection among MSM has been outlined by De Swardt and Rebe (2010) in Annexure B. In Cape Town, ANOVA Health Institute's Health4Men, Triangle Project and Desmond Tutu Foundation are some of the organisations that offer MSM focused interventions at specialist clinics which could be cascaded to serve the needs of the student MSM population through service level agreement. Since some of the services such as HIV testing, STIs and TB screening are currently readily available for all students, specialist care, support and mental health services specific to MSM could be sought from Health4Men.

6.2.3 Sexual practices and health seeking behaviour

Regarding the sexual practices, the study has observed a largely similar trend to other studies' findings (Shisana, *et al*, 2014; HEAIDS, 2010). Some of the findings are as follows:

- Most MSM students are sexually active and some have sex with both men and women;
- There seems to be evidence of multiple sexual partnerships;
- Indulgence in risky oral and receptive anal sex, with a reportedly high condom use albeit without water-based lubricants due to lack of supply;
- MSM students have so far been able to access health care services and are comfortable with campus services, however access to MSM specific information and/or groups is lacking.

In this context, this study recommends engagement with the MSM community members in the design and dissemination of HIV prevention strategies in order to reduce HIV risk. Adopting the evidence based Mpowerment Project

that has been evaluated several times and demonstrated to have the potential to prevent the greatest number of new infections amongst MSM populations and is also cost effective could go a long way in preventing infections among MSM in the institution.

Formation of MSM Peer-to-Peer group based on the Mpowerment Project Model can be used to increase the visibility and availability of safer sex information, condoms, and water-based lubricant among MSM is key to achieving effective psycho-social intervention and advocacy for uptake of biomedical interventions. This could also promote safer platforms for discussion of matters affecting the community especially in attempts to address vulnerability due to multiple sexual partnerships, alcohol and drug use/abuse, non-use of condoms and lubricants, and many others.

6.3 Conclusion

This study set out to assess the level of HIV and AIDS Knowledge, attitudes and sexual practices amongst MSM student population at a higher education institution in Western Cape. To this end, the study results have been presented in response to the research questions and objectives.

The study supports other studies' findings in relation to relatively high levels of basic HIV knowledge among the student MSM community even though some basic HIV knowledge is lacking and needs addressing by the institutional departments concerned.

In addition, the study has found positive attitudes of student MSM regarding HIV testing, condom usage and some underlying discrimination against MSM community. Furthermore, interest in access to health care services is evident from the study, however, there is need for continuous commitment by the institution in order to optimise prevention services.

The study findings advocate for policy health and wellness policy (including HIV and AIDS policy) review in order to build in MSM health care needs. The study notes that in order to address HIV amongst MSM the student

community, there is need for continued and larger scale research; ensure leadership commitment; structural reform, strategic planning and implementation; community engagement and effective monitoring and evaluation.

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Annexure A: HIV Knowledge Questionnaire Answers

HIV Knowledge Item		
2.1.	Coughing and sneezing DO NOT spread HIV.	TRUE
2.2.	A person can get HIV by sharing a glass of water with someone who has HIV.	FALSE
2.3.	Pulling out the penis before a man climaxes/cums keeps a man from getting HIV during sex.	FALSE
2.4.	Chances of getting infected with HIV are higher for anal sex than for vaginal sex.	TRUE
2.5.	Showering, or washing one's genitals/private parts, after sex keeps a person from getting HIV.	FALSE
2.6.	All pregnant women infected with HIV will have babies born with AIDS.	FALSE
2.7.	People who have been infected with HIV quickly show serious signs of being infected.	FALSE
2.8.	There is a vaccine that can stop adults from getting HIV.	FALSE
2.9.	People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV.	FALSE
2.10	Circumcision prevents HIV transmission.	FALSE
2.11	A female condom can help decrease a man's chance of getting HIV during anal sex.	TRUE
2.12	A natural skin condom works better against HIV than does a latex condom.	FALSE
2.13	A person will NOT get HIV if she or he is taking antibiotics.	FALSE
2.14	Having sex with more than one partner can increase a person's chance of being infected with HIV.	TRUE
2.15	Taking a test for HIV one week after having sex will tell a person if she or he has HIV.	FALSE
2.16	A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.	FALSE
2.17	A person can get HIV from oral sex.	TRUE
2.18	Using Vaseline or baby oil with condoms lowers the chance of getting HIV.	FALSE

Annexure B: Examples of interventions for Preventing HIV among MSM

Psychosocial	Biomedical
Reducing number of sex partners	Increased HCT and early detection of positives
Reducing alcohol and recreational drug use	Male and female condoms
Increasing condom use for risky sexual behaviours	Condom-compatible sexual lubricant
Increasing the use of condom-compatible lubricant	Early ART
Sero-sorting	PEP
Sero-positioning	STI screening and treatment
Motivational counselling	PrEP (refer to SA guidelines)
Couples' services including targeted counselling	Microbicides (undergoing research)
Combating societal homoprejudice and increasing access to non-judgemental healthcare services	HIV vaccines (undergoing research)
Screening and management of depression and other mental health disorders	Harm-reduction programmes for drug users includes safe injection technique, clean injecting equipment (needles), treatment of soft-tissue abscesses, IEC materials, education about overdoses and linkage to rehabilitation programmes for those who want to stop drug use
Development and dissemination of appropriate healthcare and risk-reduction messages that address the specific sexual health needs of MSM	Medical male circumcision; does not provide the same risk reduction as for heterosexual men but might protect bisexual men and those who exclusively adopt the penetrative role in anal sex

MSM = men who have sex with men; HCT = HIV counselling and testing; ART = antiretroviral therapy; PEP = post-exposure prophylaxis; SA = South Africa; STI = sexually transmitted infection; PrEP = pre-exposure prophylactic; IEC = information, education and communication.

Adapted from: De Swardt & Rebe (2010)



UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

An assessment of HIV and AIDS knowledge, attitudes and safer sex practices among student men who have sex with men (MSM) at a Higher Education Institution in the Western Cape.

You are asked to participate in a research study conducted by Mr. Alex Semba, from the Africa Centre for HIV and AIDS Management at Stellenbosch University. The results of research study will contribute toward the researcher's Master's level thesis as part of a requirement for the completion of the Mphil in HIV/AIDS Management programme. You were selected as a possible participant in this study because you are a registered student at the selected Higher Education Institution (HEI) who considers himself part of the MSM community.

1. PURPOSE OF THE STUDY

The overall purpose of the research study is to identify HIV and AIDS knowledge, attitudes, and safer sex practices among MSM students at this HEI campuses in order to develop targeted and easily accessible intervention service packages within the campuses.

2. PROCEDURES

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

- Take some time to read and understand the information presented in this form;
- The Field worker will send a 'please call' to the researcher on 0739632191 for explanation and further clarification of instructions for the questionnaire;
- If you consent to participate in this study, you are expected to sign this form;
- Submit this form to the Field Worker and collect the questionnaire with an envelope which you will use to submit your questionnaire.
- Anonymously complete the questionnaire provided to you
- Completing the questionnaire should not take you more than 10 minutes;
- Submit the questionnaire to the Field Worker in a sealed envelope.
- Confidentiality, anonymity and privacy of data will be maintained at all times.

3. POTENTIAL RISKS AND DISCOMFORTS

Although there are no foreseeable risks, you may stop your participation at any time if you experience any discomfort in expressing your opinions regarding your HIV and AIDS knowledge, attitudes and sexual practices. In the event that you become emotionally distressed during the course of completing the questionnaire please contact student counseling services.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The findings of this proposed research study will provide a clear understanding of the levels of HIV and AIDS knowledge, attitudes and sexual practices among MSM students within campuses. This information is vital in the development of adapted and tailored prevention packages for the MSM community that has generally been sidelined for a long time. In this regard, participants and the entire MSM community will benefit from the resultant available and easily accessible services and programmes.

5. PAYMENT FOR PARTICIPATION

Please understand that no remuneration will unfortunately be offered for your participation in this research study.

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:

- ensuring questionnaires and consent form submission will be done in a way that the two forms cannot be linked thereby ensuring that your responses are not linked to you
- all questionnaires will be stored in a locked cabinet at the researcher's home and will only be accessed by the researcher or his supervisor. Upon completion of the study, the records will be destroyed
- results of the study will be reported in a way that does not enable you to be identified and/or your views be stigmatized
- the data collected will only be used for the completion of the Mphil in HIV and AIDS Management. Please note that it is a requirement that the data collected, analysed and interpreted be reported and published. Be assured that in writing the thesis report, confidentiality anonymity and privacy of participants will remain the highest priority of the researcher.

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.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact the researcher, Mr. Alex Semba at 012 481 28102 during office hours or 0739632191/0783897995 during and after office hours. If you prefer email, you may wish to contact me on alexsemba@yahoo.co.uk/alex@hesa.org.za

If you may have any questions or concerns raised to the researcher's supervisor, please feel free to contact Mr. Burt Davis on email (burt@sun.ac.za) or telephone at 0218083006 during office hours.

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 Mr. Alex Semba in English and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

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

Name of Subject/Participant

Signature of Subject/Participant

Date

SIGNATURE OF INVESTIGATOR

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

Signature of Investigator

Date

An assessment of HIV and AIDS knowledge, attitudes and safer sex practices among student men who have sex with men (MSM) at a Higher Education Institution in the Western Cape

by
Alex MM Sembra

**Thank you for your willingness to participate in this KAB Survey. Your time is appreciated.
Please note that it will not take you more than 10 minutes to complete this questionnaire.**

Your information will be kept strictly confidential by the researcher.

SECTION ONE: BIOGRAPHICAL INFORMATION

Please select your answer to each question below by completing as required or marking with an X.

Personal Information:

1. How old are you? _____
2. Indicate your nationality: _____
3. Indicate the languages spoken at home: _____
4. Which best describes you?

Black	White	Coloured	Indian	Other.....
-------	-------	----------	--------	------------

5. Choose which best describes you.

Homosexual	Bisexual	Other.....
------------	----------	------------

6. Do you use social media (Facebook, Twitter, Google+, etc.) on a weekly basis?

YES	NO
-----	----

7. How many people living with HIV/AIDS do you know/have you known?

None	1-2	3-5	6-10	11 or more
------	-----	-----	------	------------

Academic Information:

8. Which campus are you registered at?

Bellville	Cape Town
-----------	-----------

9. In which year of study are you academically?

1 st	2 nd	3 rd	4 th	5 th or higher
-----------------	-----------------	-----------------	-----------------	---------------------------

10. Where do you live while at university?

University Residence
With family
Other Accommodation-Please specify _____

Work Information:

11. Are you currently employed?

If answered NO, please go to SECTION TWO.

YES	NO
-----	----

12. If yes, are you employed

Full-time?	Part-time?
------------	------------

SECTION TWO: HIV/AIDS KNOWLEDGE

Please select by crossing either TRUE, FALSE, or I DON'T KNOW to indicate your answers to the following.

1.	Coughing and sneezing DO NOT spread HIV.	TRUE	FALSE	I DON'T KNOW
2.	A person can get HIV by sharing a glass of water with someone who has HIV.	TRUE	FALSE	I DON'T KNOW
3.	Pulling out the penis before a man climaxes/cums keeps a man from getting HIV during sex.	TRUE	FALSE	I DON'T KNOW
4.	Chances of getting infected with HIV are higher for anal sex than for vaginal sex.	TRUE	FALSE	I DON'T KNOW
5.	Showering, or washing one's genitals/private parts, after sex keeps a person from getting HIV.	TRUE	FALSE	I DON'T KNOW
6.	All pregnant women infected with HIV will have babies born with AIDS.	TRUE	FALSE	I DON'T KNOW
7.	People who have been infected with HIV quickly show serious signs of being infected.	TRUE	FALSE	I DON'T KNOW
8.	There is a vaccine that can stop adults from getting HIV.	TRUE	FALSE	I DON'T KNOW
9.	People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV.	TRUE	FALSE	I DON'T KNOW
10.	Circumcision prevents HIV transmission.	TRUE	FALSE	I DON'T KNOW
11.	A female condom can help decrease a man's chance of getting HIV during anal sex.	TRUE	FALSE	I DON'T KNOW
12.	A natural skin condom works better against HIV than does a latex condom.	TRUE	FALSE	I DON'T KNOW
13.	A person will NOT get HIV if she or he is taking antibiotics.	TRUE	FALSE	I DON'T KNOW
14.	Having sex with more than one partner can increase a person's chance of being infected with HIV.	TRUE	FALSE	I DON'T KNOW
15.	Taking a test for HIV one week after having sex will tell a person if she or he has HIV.	TRUE	FALSE	I DON'T KNOW
16.	A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.	TRUE	FALSE	I DON'T KNOW
17.	A person can get HIV from oral sex.	TRUE	FALSE	I DON'T KNOW
18.	Using Vaseline or baby oil with condoms lowers the chance of getting HIV.	TRUE	FALSE	I DON'T KNOW

SECTION THREE: HIV/AIDS ATTITUDES

Please select your answer to each question below.

1. Have you ever been tested for HIV?

YES	NO
-----	----

If answered NO, please go to Question 8.

2. What was the result of your most recent HIV Test?

HIV-Positive	HIV-Negative	Refuse to answer
--------------	--------------	------------------

3. How many times have you been tested for HIV?

1	2	3	4	5 or more
---	---	---	---	-----------

4. Was your last HIV test less than one year ago?

YES	NO
-----	----

5. Are you planning to get tested again?

YES	NO
-----	----

6. Have you been tested for HIV on campus?

YES	NO
-----	----

If answered YES, please go to Question 8.

7. If NO, would you go for HIV-Testing on campus?

YES	NO
-----	----

8. In your opinion, what is the chance of contracting HIV in the future?

No chance	Likely	Most likely
-----------	--------	-------------

9. What is the most influential factor for motivating you to use condoms with your partner?

The fear of contracting Sexually Transmitted Infections.
The fear of contracting HIV.
The fear of infecting your partner with HIV/AIDS/STIs.
Other (please specify):

10. Would you use a condom more frequently because of the fear of contracting HIV?

Most likely not	Maybe	Most likely yes
-----------------	-------	-----------------

11. The use of condoms is necessary when having sex with same sex partners.

Strongly agree	Agree	Disagree	Strongly disagree
----------------	-------	----------	-------------------

12. The chance of contracting HIV is very high when having oral sex without using condoms.

Strongly agree	Agree	Disagree	Strongly disagree
----------------	-------	----------	-------------------

13. You have a total control in deciding whether to use condoms when having sex with your sex partner.

Strongly agree	Agree	Disagree	Strongly disagree
----------------	-------	----------	-------------------

14. Among the peers you know, most of them would use condoms during sexual intercourse.

Strongly agree	Agree	Disagree	Strongly disagree
----------------	-------	----------	-------------------

15. Do you consider your campus a safe environment for MSM students?

YES	NO
-----	----

16. If NO, why not?

17. Have you ever experienced abuse and/or violence on campus due to your sexual orientation?

No, Neither
Yes, Abuse
Yes, Violence
Yes Abuse and violence

18. The management of this institution takes discrimination against MSM students seriously?

YES	NO
-----	----

19. The student leaders of this institution take discrimination against MSM students seriously?

YES	NO
-----	----

20. I feel safe from physical harm on campus

YES	NO
-----	----

SECTION FOUR: SEXUAL PRACTICES

The questions following are about your sexual practices, use of alcohol and other drugs. Your answers will be kept private. Please select the response that best fits for you.

By "sex" we mean anal intercourse, vaginal intercourse or oral sex.

By "sexual intercourse" we mean sex when the penis is put into the vagina or the anus (rectum).

1. Are you openly MSM on campus/at your workplace?

YES	NO
-----	----

If answered YES, please go to Question 3.

2. If NO, please specify why.

3. Have you ever had sexual intercourse?

YES	NO
-----	----

If answered NO, please go to SECTION 5.

4. Which of these is true for you?

I have sexual intercourse only with men.
I have sexual intercourse with either men or women.

5. What was your age at first sex with a man?

<10	11-15	16-20	21-25	>25
-----	-------	-------	-------	-----

6. How many sexual partners did you have in the past 6 months?

0	1-3	4-6	7-9	>9
---	-----	-----	-----	----

7. Indicate where you met your sexual partner?

Sex parties on campus
Bars/Clubs
Online/Dating Websites
Other (please specify):

8. Have you been involved in group sex in the last 6 months?

YES	NO
-----	----

9. Indicate which sexual practices you have involved in the last 6 months?

Oral Sex
Mutual Masturbation
Receptive Anal Sex
Insertive Anal Sex
Fisting
Other (please specify):

10. Do you use condoms during sexual intercourse?

YES	NO
-----	----

If answered NO, please go to Question 14.

11. If YES, where do you obtain condoms?

Condom dispensers on campus/at the work place
Campus Clinic
HIV/AIDS Unit
Mobile Wellness Unit
Other (please specify):

12. Do you use lubricants (lube) with condom during sexual intercourse?

YES	NO
-----	----

If answered YES, please go to Question 15.

13. If NO, please indicate your reasons.

14. If you do not use condoms, please evaluate why.

15. In the next 6 months, what is the chance of using condoms every time when having sex?

No possibility	Likely	Most likely
----------------	--------	-------------

16. Have you ever used alcohol and/or drugs when/before you had sex?

YES	NO
-----	----

If answered NO, please go to SECTION 5.

17. How often do you use alcohol and/or drugs when/before having sex?

All of the time	Most of the time	Sometimes	Rarely	Never
-----------------	------------------	-----------	--------	-------

If answered NEVER, please go to SECTION 5.

18. When drinking and/or using drugs, were you more likely to do something you would normally not do (e.g. break rules/the law, sell things that are important to you, or have unprotected sex with someone)?

YES	NO
-----	----

19. How often did you get high or had a few drinks immediately before or during sex?

All the time	Often	Occasionally	Never
--------------	-------	--------------	-------

20. How often would you say that alcohol and drug use made it more difficult for you to have safer sex?

All the time	Often	Occasionally	Never
--------------	-------	--------------	-------

SECTION FIVE: HEALTH SEEKING BEHAVIOUR

Please select your answer to each question below.

1. Do you have easy access to health care (HIV Counselling & Testing, STI & TB screening, etc.)?

If answered YES, please go to Question 4.

YES	NO
-----	----

2. If NO, what are barriers to accessing health care services at your campus/work place?

Geographical location of health care facilities
Bad experiences with health care workers
Fear of stigma and discrimination
Laise-fair attitude
Other (please specify):

3. What would make it easier for you to go to the health care facilities on your campus/work place?

Male health care workers
Special days for MSM
8 hour availability of health care services
Reduced waiting times.
Other (please specify):

4. Have you experienced any specific sexual health needs, which are not addressed by the clinic or the HIV/AIDS Unit on your campus/work place?

If answered NO, please go to Question 6.

YES	NO
-----	----

5. If YES, please specify, which health care needs need to be addressed.

6. Do you have easy access to condoms on your campus/work place?

If answered YES, please go to Question 8.

YES	NO
-----	----

7. If NO, please evaluate on the reasons.

8. Do you have easy access to water-based lubricants (lube) on your campus/work place?

YES	NO
-----	----

9. If NO, please evaluate on the reasons.

10. Have you ever received any information about MSM health on campus?

YES	NO
-----	----

11. Have you ever received information about HIV and AIDS on campus?

YES	NO
-----	----

12. Have you attended a meeting or function about MSM issues on campus?

YES	NO
-----	----

13. I have attended a meeting about HIV and AIDS on campus

YES	NO
-----	----

14. I am a member of an HIV/AIDS group on campus

YES	NO
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15. I am a member of an MSM group on campus

YES	NO
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Thank you very much for your participation!