



HIV PREVENTION FOR MSM IN CAPE TOWN, SOUTH AFRICA

Context, Dynamics, Recommendations

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Health4Men
a project of Anova Health Institute
24 Napier Street
Green Point
Cape Town 8005
Tel. (021) 421 6127
www.health4men.co.za
www.anovahealth.co.za
geoff@health4men.co.za

Research undertaken by

Health4Men

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Written by

Geoff Jobson

Additional research and input

Glenn de Swardt, Kevin Rebe, Renaldo Adams,
Helen Struthers, James McIntyre

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EXECUTIVE SUMMARY

The HIV prevalence rate among men-who-have-sex-with-men (MSM) in South Africa has been found to be consistently higher than the general population in a number of research studies. The reasons for this increased vulnerability to HIV infection have not been widely researched. This exploratory research offers a broad overview of the various elements that affect HIV risk among MSM in Cape Town, South Africa and offers recommendations for HIV prevention efforts and further research.

The population of MSM living in Cape Town is highly diverse. The spatial and racial segregation imposed under apartheid continues to shape the social and sexual dynamics of MSM communities. While HIV risk behaviours are similar between 'white', 'black', and 'coloured' communities, the contexts in which they occur, and the social dynamics surrounding them differ. A qualitative approach was used to conduct this research. Sampling was purposive and aimed to recruit MSM with differing backgrounds and sexual identities. Key informant interviews and focus group discussions were conducted. Data were analysed thematically, using a grounded theory style approach.

This report focuses on the drivers of HIV risk among MSM in the previously 'black' and 'coloured' residential areas of Cape Town. We found that there are multiple factors driving HIV risk in this population, operating at multiple distances from the individual. We adapt a personal, proximal, distal model as a means of discussing our results, noting the combined effects of stressors at these multiple levels in increasing HIV risk. Important factors at a distal level (cultural and structural issues) included homophobic cultural norms and stigma, HIV-related stigma, and poverty. Proximal factors (interpersonal relationships and the immediate environment) included verbal abuse and violence, lack of safe social and sexual spaces, multiple partnerships, transactional sex, alcohol use, discrimination at health care facilities, and a lack of HIV prevention resources (including condoms and water-based lubricant). Personal factors (within the individual) included self esteem and whether individuals were openly gay or not.

Following the identification of these factors we discuss how the interaction between these multiple levels risk affects the risk environments in which MSM live, and in turn how the risk situations in which HIV is transmitted are directly affected by these risk environments. The structural violence inherent in these risk environments is potentially also linked to the increased risk of HIV infection for MSM living here.

The multiple factors that affect HIV risk for MSM in Cape Town necessitate multi-level, multi-sectoral HIV prevention. This includes standard HIV prevention practices such as condom and water-based lubricant distribution, educational messaging, and workshops on risk-reduction. However, these approaches are likely to have limited effectiveness as they do not address the broader factors that also act to increase HIV risk in this population. It is therefore necessary to broaden the scope of HIV prevention efforts to begin to address the social, cultural, political, and economic factors driving HIV risk.

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1. CAPE TOWN AND MSM

Studies focussing on MSM in Cape Town emphasise the existence of spatially separate, but interconnected communities. Tucker (2009) argues that the arbitrary racial segregation of communities under apartheid has directly affected how MSM in these communities and gay identifying men in particular make themselves 'visible' within and between their communities. In addition to the arbitrary segregations of the apartheid regime, the various communities in and around Cape Town draw on very different cultural backgrounds, and these are also likely to exert an influence on how gay identifying individuals in these communities are able to become visible and the degree to which they are able to exercise agency as gay people. As a result of these various factors, it is possible to identify spatially, and racially, separated gay and MSM identities within the Cape Town metropolitan area (Swarr, 2004, Tucker, 2009).

The interactions between various communities are also, therefore, affected by their historical location, their differing experiences of the process of transition from apartheid to democracy, and the wide economic inequalities that exist between them (Tucker, 2009). In broad terms, there are significant differences between the MSM identities and characteristics within the three major racial groups in Cape Town, i.e. 'white', 'coloured', and 'black' (Tucker, 2009). Additional to the MSM who self-identify as gay, are the men who maintain a heterosexual identity but also have sex with men. Sandfort et al. (2008) note that 12.2% of the MSM in a study covering three provinces in South Africa reported being sexually attracted to both men and women.

1.1. HIV and MSM in South Africa

Men who have sex with men (MSM) are listed as a most at risk population (MARP) in the National Department of Health's National Strategic Plan (NSP) for HIV & AIDS and STI 2007-2011 (Department of Health, 2007). The NSP raises the point that there is very little known about HIV prevalence and incidence among the MSM population while noting that this population is particularly susceptible to HIV infection (Department of Health, 2007). Recent studies appear to confirm the necessity of MSM being listed as being at higher risk, with several studies reporting HIV prevalence rates between 14.1% and 38.3% (Rispel and Metcalf, 2009b, Sandfort et al., 2008, Lane et al., 2009). Beyrer (2007) notes that internationally, HIV prevalence rates are higher among populations of MSM than in the general population.

Given these high HIV prevalence rates, it is likely that the factors underlying HIV risk in the MSM population require a specifically targeted HIV prevention approach. While some risk factors are the same across the entire population, there are specific high risk behaviours that are predominantly performed by MSM, or that are of greater significance in the MSM population.

1.2. Stigma and discrimination in health care settings

One important factor that affects HIV prevention efforts among the MSM population is the stigma experienced by MSM in health care settings. Lane *et al.* (2008a), in a study conducted in Soweto and Mamelodi, report that most participants viewed public clinics '...as places where health care workers constantly threatened MSM's rights to privacy and confidentiality by engaging in gossip and homophobic verbal harassment.' Rispel and Metcalf (2009a) report that MSM may delay seeking

treatment for conditions such as haemorrhoids, rectal bleeding and genital infections due to fear that their sexual orientation would be discovered and that they would subsequently be discriminated against.

Delaying seeking medical help may increase the risk of contracting HIV, or of passing on the infection, particularly for individuals with sexually transmitted infection (STIs). Further, lack of access to supportive, MSM friendly VCT services may result in MSM lacking awareness of effective risk reduction strategies specific to the risk behaviours that they engage in.

1.3. HIV and alcohol use

Alcohol use has been identified in a number of studies as playing an important role in HIV transmission in South Africa (Kalichman et al., 2008, Avalos et al., 2009, Luseno and Wechsberg, 2009). Levels of alcohol use in South Africa are high, as are levels of risky alcohol use. Parry *et al.* (2005) for instance found that one third of alcohol users reported risky drinking over weekends based on 1998 Demographic and Health Survey (DHS) data. High risk drinkers are listed as a Most At Risk Population (MARP) in Shisana *et al.*'s (2009) recent national HIV survey. In this survey high risk drinkers reported the highest percentage of multiple sexual partners among MARPs (Shisana et al., 2009).

Alcohol use among MSM is also noted as an important risk factor for HIV transmission in this population both in South Africa and internationally. Irwin *et al.* (2006) argue that, while alcohol use is widely recognised as a risk factor for HIV infection among MSM, it is also important to understand how alcohol use may serve different 'functions' for insertive and receptive partners respectively. These authors found that 'risk associated with receptive anal sex is more susceptible to the effects of alcohol than insertive anal sex...' and note that this suggests that the effects of alcohol on decision making are greatest for the riskiest behaviour (i.e. unprotected receptive anal intercourse) (Irwin et al., 2006). In another recent study, Berg (2008) found that alcohol use in sexual contexts was associated with unprotected anal intercourse (UAI) among MSM who used the internet to meet sexual partners. The association between alcohol and HIV risk is confirmed by Koblin *et al.*'s (2006) longitudinal analysis of data from 4295 HIV-negative MSM, which found that use of alcohol or drugs before sex accounted for 29% of HIV infections in the study.

Data on alcohol use among MSM in South Africa is fairly limited, but in one recent study, Lane *et al.* (2008b) found that unprotected anal intercourse (UAI) was significantly associated with regular alcohol use among a sample of 199 MSM from Gauteng province. Rispel and Metcalf (2009b) note that 73% of MSM participating in their study report having sex after consuming alcohol in the last 12 months.

The social dynamics of alcohol use, centred around the places where people drink and socialise, are of particular importance with regard to the spread of HIV (Kalichman et al., 2008). Kalichman *et al.* (2008) note that meeting sex partners at alcohol-serving establishments is a significant risk factor for HIV in southern Africa. Myer *et al.* (2002) found that alcohol consumption before sex was more common with irregular partners, and that alcohol consumption before sex was negatively associated with condom use. Shebeens¹ are among the most common venues in townships that people access to purchase alcohol (Kalichman et al., 2008). Kalichman *et al.* (2008) found that 28% of participants in their study had met at least one sexual partner at shebeens, participants who met

¹ 'Shebeens' are informal, often unlicensed, drinking establishments.

sex partners at shebeens drank more heavily, had more sex partners, and had higher rates of unprotected sex compared to participants who did not meet sex partners at shebeens. Shebeens may also be used as venues for sex, which may occur in toilets, back rooms, dark corners, or nearby vacant lots (Kalichman et al., 2008).

1.4. 'Black' and 'Coloured' MSM sexualities

The sexual identities of MSM in the parts of Cape Town that were classified as 'Black' and 'Coloured' under apartheid remain significantly different from one another, and the dynamics affecting risk behaviours among this population also differ.

Tucker (2009) documents a historical process of "queer visibility" in the formerly 'Black' areas related both to the cultural backgrounds of these communities and the transition from apartheid to democracy. During the 1980's, gay identified individuals tended to assume a style of dress and behaviour associated with particular types of music (Tucker, 2009). These men were known as 'Ivy's' and were tacitly accepted by the communities, although this may have been due to the fact that these men's sexual preferences were not known by the wider community; and not all Ivy's were gay (Tucker, 2009).

It appears that the transition to democracy, and the ANC's statements around non-discrimination on the basis of sexual orientation encouraged gay identified men to be more open about their sexuality (Tucker, 2009). Exposure to 'coloured' men engaging in drag may also have created an awareness of alternative ways of expressing sexual identity among gay men in the 'black' townships, and cross-dressing became a relatively more common form of homosexual expression in these areas (Tucker, 2009, Swarr, 2004).

Simultaneously, there is a perception among homosexual men in rural areas from where many immigrants to Cape Town originate, of Cape Town as a place where gay men are able to openly express their sexuality (Tucker, 2009). Cross-dressing has, as a result, become viewed as something done by younger men who have newly arrived in Cape Town, and is sometimes looked down upon by older gay men (Tucker, 2009). The relatively recent adoption of cross-dressing as a form of gay expression, in contrast to the 'coloured' communities, combined with the sometimes provocative behaviour of younger gay men means that gay men who choose to cross-dress are not as easily accepted in the 'black' townships, and are quite often subject to verbal and physical attacks (Tucker, 2009). The prevalence of homophobia in these areas has led to the development of what Tucker (2009) terms 'social nodes'. These are groupings of gay men, usually associated with a leader at whose house or shack men meet (Tucker, 2009). The leaders of these groups are generally respected in the wider community, affording a degree of protection to people meeting at their homes (Tucker, 2009).

1.5. Former 'Coloured' areas

Homosexual identity among the 'coloured' population of Cape Town is often associated with gay men openly cross-dressing in everyday life (Tucker, 2009, Swarr, 2004). This form of gay identity is sometimes historically linked to the residential area, District Six, which was destroyed under the Group Areas Act during apartheid (Tucker, 2009, Swarr, 2004). The relocation of 'coloured' communities to the Cape Flats and areas such as Lavender Hill, Mitchells Plain, Retreat, and Steenburg also 'relocated' the established gay identities within District Six (Tucker, 2009).

The relative social acceptability of cross dressing men in District Six is highlighted by 'coloured' cross dressers as a reason and basis for their own cross dressing. This, in ways, forms a '...continuation of a long legacy and normalisation of "coloured" queer expression' (Tucker, 2009). Cross-dressing also had important political implications during the apartheid period, and was viewed as a means of defying increasingly oppressive and intrusive apartheid legislation (Tucker, 2009).

Swarr (2004) argues that drag in the 'coloured' communities of Cape Town can be most accurately understood through the lens of 'performativity' (after Butler 1993) of gender and race. This understanding of drag is furthered by Tucker (2009), who argues that there may be considerable pressure for homosexual men in 'coloured' communities to adopt feminine characteristics as a means of making them more socially acceptable in the eyes of the wider community. The 'performance' of femininity by these men on a daily basis serves to identify them as feminine. Accordingly, these men often seek relationships and sexual interactions with heterosexual men (Swarr, 2004). In line with this, and in contrast to the white gay community, there are no exclusively gay bars or clubs in these areas (Tucker, 2009).

While cross-dressing may be the most visible expression of 'coloured' gay identity, it is by no means the only one. Tucker (Tucker, 2009) notes that among sections of the 'coloured' gay community, cross-dressing is looked upon as 'a form of social disempowerment and as a culturally regressive act' (Tucker, 2009). Among some non cross-dressing gay men, there is a view of cross-dressers as being 'used' by heterosexual men for sexual gratification, without any intention to form relationships based on mutual respect (Tucker, 2009).

1.6. Apartheid, post-Apartheid, and identity

The dynamics of same-sex sexuality in Cape Town's communities are also affected by the broader dynamics of race and racial identity in these communities. The idea of 'coloured' racial identity is contested, and is, as Adhikari (2004) argues, in a state of flux.

Sonn and Fisher (2003) note that under apartheid 'the institutionalised identity label, 'coloured', and the accompanying racial status in the hierarchy, signified the political construction of the 'coloured' group.' The hierarchy referred to describes the status of the 'coloured' population as being relatively more privileged than 'black' Africans while simultaneously experiencing oppression relative to 'whites' (Sonn and Fisher, 2003, Kometsi, 2007). While 'coloured' is an *imposed* racial identity, the lived realities of 'coloured' communities do reflect a unique *cultural* identity (Adhikari, 2004). Adhikari (2004) argues that this identity was originally founded on 'a claim to higher social status and better treatment than Africans on the basis of being partly descended from European colonists'. Embracing this intermediate status in the racial hierarchy was one of the defining aspects of 'coloured' identity under apartheid (Adhikari, 2004, Kometsi, 2007, Sonn and Fisher, 2003).

The effects of the racial hierarchy effected under apartheid are still felt in the interactions between communities and individuals belonging to different racial groups in South Africa. In 'coloured' communities, Adhikari (2004) argues that this idea is reflected in the idea of not being 'black enough' to benefit from the post-apartheid reform process. This position is captured by Adhikari (2004) as a 'perennial predicament of marginality'. This perceived marginality appears to find expression in racist perceptions of 'black' Africans (Kometsi, 2007, Adhikari, 2004). While racism remains a common feature of South African society, it is perhaps counter-intuitive that racism between previously oppressed groups would exist. This racism, in part, seems to be due to the perceived lack of tangible benefits under the new dispensation (Adhikari, 2004).

These community level racial dynamics have important implications for HIV/AIDS programmes. Importantly, the differences between these communities, in spite of their geographical proximity, demand sensitivity. The fact that the risk situations in which HIV is transmitted are similar across communities does not necessarily imply that the dynamics influencing these situations are similar.

1.7. 'Traditional' culture, gay identity, and HIV

In the 'black', predominantly isiXhosa speaking townships in Cape Town, the expression of gay identity is mediated by a range of social and cultural factors. Henderson and Shefer (2008:2) note that:

'South Africa remains a homophobic, heterosexist society where, across cultures, homosexuality is pathologised, and where cultural discourses such as the notion that "homosexuality is not African" continue to play themselves out.'

While prejudice and discrimination against homosexual individuals occurs across the spectrum of South African culture, the expression of this prejudice may differ between racial, and socio-economic groups. Similarly, the ways that gay men adapt and cope with prejudice and homophobic cultural norms also shapes the ways that they express their identity on a daily basis (Tucker, 2009). Viewed from the perspective of studies on masculinities (cf. Connell, 1995), the central focus should then be on the relationship between constructions of 'queer masculinity' and 'hegemonic masculinity', and how these differ in different contexts. Henderson and Shefer (2008:5) phrase this question as follows: 'To what extent do normative practices of masculinity come to bear on gay male relationships?' Given the very different dynamics in the gay communities across different areas and racial groups in Cape Town (Tucker, 2009), it is likely that these processes also differ.

The masculinity valued by Xhosa men as hegemonic emphasises 'male' traits of 'forbearance, courage, fortitude, and strength' (Vincent, 2008:437). These traits are emphasised as part of the circumcision ritual that young Xhosa men are expected to undergo as part of their initiation into 'manhood' (Vincent, 2008). Vincent (2008) notes that in addition to the emphasis on developing these characteristics, initiates may be given sexual instruction and taught about married life. This process can be viewed as reinforcing a particular construction of masculinity, as valued above others, and may affect how gay Xhosa men conceive their own masculinities.

1.8. Socio-economic context

South Africa's high levels of poverty and unemployment affect vast numbers of people in the country and the official unemployment rate was 24% as of the fourth quarter of 2010 (Statistics South Africa, 2011), while the broad unemployment rate stood at 32.5% (The Presidency of the Republic of South Africa, 2009). High levels of poverty and unemployment form important negative aspects of the context in which communities and individuals live, and may play a direct role in affecting certain HIV risk behaviours.

Hunter (2005) for instance, argues that among Zulu men, the decreasing number of employment opportunities since the 1970s has led to a greater emphasis on having multiple sexual partners as markers of 'achieving' masculinity. The importance of having employment and being financially secure as markers of masculinity is also noted by Barker and Ricardo (2005). Not being able to fulfil

these expectations of masculinity may contribute to increased risk behaviours among men, including alcohol and drug use, increased numbers of sexual partners, and transactional sex.

Recent studies suggest that the frequency of multiple concurrent partnerships in Africa provides an important explanatory factor for the very high HIV prevalence rates in many parts of the continent (cf. Halperin and Epstein, 2004).

Beyrer *et al.* (2010), in a study in Malawi, Namibia, and Botswana, found that 53.7% of MSM reported both female and male partners in the past six months, with 16.6% reporting concurrent relationships with a man and a woman. Sexual concurrency has been widely acknowledged as a feature of southern African labour patterns, where men migrate for lengthy periods of time, and both men and women have several sexual partnerships (Beyrer *et al.*, 2010). The meanings attached to multiple concurrent partnerships, and the reasons behind engaging in these partnerships may differ between men and women, and may also be different for MSM.

Hunter (2007), for example, notes that circular *female* migration, and consequent multiple partnerships, has become more frequent in South Africa over the past 40 years and argues that three important dimensions of contemporary political economy need to be considered in thinking about this migration. These are: '(1) rising unemployment and the marginalisation of women, (2) rapidly declining marital rates, (3) the growth in women's movement, often in circular migration patterns that pivot around a rural "home"'. The women migrants in Hunter's study (2007) depended largely on a range of informal sector activities to earn income, with the sexual economy forming an increasingly important means of acquiring income and support. LeClerc-Madlala (2003) documents similar processes in operation among young women in townships near Durban. She emphasises the agency of young women using their sexuality in an *instrumental* way to access 'high profile' consumer goods, such as cell phones or branded clothing. It is possible that similar dynamics affect multiple partnerships among MSM.

There is very little data available on the interaction between MSM sexual behaviour and poverty and unemployment. However, in light of Rispel and Metcalf's (2009b) recent findings on the prevalence of transactional sex among MSM in three South African cities, it is possible that similar dynamics to those noted above are in operation among this population.

2. METHODOLOGY

Ethics approval for this study was obtained from the University of the Witwatersrand's Human Research Ethics Committee (Medical), protocol number M090448.

A qualitative approach was used to conduct this research. Sampling was purposive and aimed to recruit MSM with a range of socio-economic and racial backgrounds. Existing contacts within the communities targeted in this study were asked to refer potential participants for interviews and focus group discussions. Purposive sampling was used due to the 'hidden' nature of much of the MSM community in the townships surrounding Cape Town, making a random sample difficult and costly to implement.

In-depth interviews and focus group discussions formed the basis of the research. Written informed consent was obtained from all participants prior to interviews and focus groups. Ten interviews were conducted. Three focus group discussions were conducted; two with 'black' participants, and one with 'coloured' participants; a total of 21 men participated in FGDs. Total sample size was 31. Interviews were conducted prior to focus group discussions and the initial findings from the interviews were presented and discussed as part of the discussions.

Interviews were recorded and transcribed. Thematic analysis of the transcripts elicited the key issues discussed below.

2.1. BIAS AND LIMITATIONS

This study was exploratory and there are potential sources of bias that need to be acknowledged. The relatively small sample, while including participants from a range of racial, social, and economic backgrounds, precludes the generalisability of these results. The use of purposive sampling through Health4Men's existing community-level contacts, although these men have a range of backgrounds, also means that we may have restricted our analysis to particular social networks of MSM, who shared the same social and sexual contexts as each other. Our sample was also primarily of 'out' gay men whose risk behaviours are likely to be different from MSM who are not openly gay. This could have skewed our results and interpretations of these results.

The primary researcher was a young white man, and given the sensitive nature of the research topics, it is possible that participants did not discuss these issues as openly as they may have in the presence of a researcher who shared their backgrounds.

In spite of these limitations and potential sources of bias, the results of this study reveal important areas requiring further attention in HIV prevention campaigns and social research investigating HIV risk for MSM in South Africa.

3. RESULTS

The daily experiences of gay men in the townships around Cape Town are affected by a complex interplay of factors operating at different levels. Eaton *et al* (2003:149) state that these factors operate at different 'levels', namely the *personal* (within the individual), the *proximal* ('interpersonal relationships and the physical and organisational environment'), and the *distal* (cultural and structural factors). Within each of these levels, however, there are factors that may positively or negatively affect individuals' decision making and risk behaviours.

Individuals' experience of, and exposure to, these factors is spatially and temporally mediated by their daily activities. For example, an individual who is unemployed and spends large amounts of time in shebeens or taverns will be affected by different factors to an individual who is employed.

3.1. DISTAL LEVEL

Several important 'distal' or structural factors were identified by participants in this study as both positively and negatively affecting HIV risk within their communities. The range of factors with negative effects across these communities included 'culture', unemployment and poverty, HIV related stigma, and widespread homophobia.

Distal level factors influencing HIV transmission that are specific to 'coloured' communities include factors that are similar across 'black' and 'coloured' communities, but also reflect the unique nature of the 'coloured' communities of Cape Town. High levels of poverty and unemployment are important factors that may influence HIV risk for many communities in Cape Town (table 1). However, the historically privileged position of the 'coloured' communities means that in general these areas have better facilities and services than 'black' townships, and the effects of poverty on HIV risk may be different between 'black' and 'coloured' communities. Adhikari (2004) notes that this position of relative privilege under apartheid actually led to a decline in living standards among 'coloured' communities as apartheid era subsidies were phased out. It is possible that the increasing poverty of 'coloured' communities could have led to an increase in risky sexual behaviours.

Table 1 Unemployment, informal housing and HIV prevalence for Cape Town for 'coloured' and 'black' race groups (Statistics South Africa, 2007, Shisana et al., 2009)

	Unemployment (StatsSA 2007)	Informal housing (StatsSA 2007)	HIV Prevalence (National - HSRC 2009)
Coloured	21.8%	5.6%	1.7%
Black	39.7%	37.6%	13.6%

3.1.1. 'Culture', masculinity, and gay identity

Social and cultural intolerance of sexuality has been shown to have important negative effects on HIV risk behaviours, and HIV prevalence rates among MSM globally (Barker et al., 2010, Folch et al., 2009, O'Leary et al., 2007, White and Carr, 2005). Participants from both 'coloured' and 'black' backgrounds in this study both reported that their social and cultural backgrounds limited their ability to openly express their sexuality.

'Black' Xhosa speaking participants reported that being homosexual in Xhosa culture was difficult, and that Xhosa culture was intolerant of homosexuality. This perception of Xhosa culture as not tolerating homosexuality was put most strongly during a focus group discussion by one man who said:

'...first of all in our culture we not allowed to be gays, that's absolutely Satanism' (FGD 2, 14/10/2009).

The idea of traditional Xhosa culture being linked to intolerance of homosexuality was also associated with 'rural areas', especially the Eastern Cape Province, with some participants associating homophobia with people newly arrived from the 'rural areas'. The Eastern Cape under apartheid included the Xhosa 'homeland', and the association of the rural Eastern Cape with homophobia may also be linked to the idea of Xhosa tradition as being intolerant of homosexuality.

'I can say maybe it's some of them they come from the rural areas...people who always speaking about the culture' (Key Informant 4, 19/08/2009).

More broadly, however, widespread discourses casting homosexuality as un-African, or as a tool used by colonial powers to undermine African culture may contribute to the acceptability of discriminatory practices, beliefs and behaviours .

In addition to intolerance of homosexuality, the need to fulfil cultural ideals of masculinity was noted as a factor that might prevent men from living openly gay lives. Particular emphasis was placed, by one man, on the expectation that men should be married and have children.

'...some will say it's because of the culture that is enforced in you as a black person that I'm a Xhosa, you've got to have a wife, you've got to have children, your sexual status your sexual relationship it's not counted as the thing, it's only that you're a man so you have to behave like a man' (Key Informant 2, 09/07/2009)

The idea of 'being a man' was also seen as incompatible with being gay i.e. being gay negates the possibility of achieving status as a 'real man'. For instance:

'...we even approached this one man, which he was very shy, you know, like "we're you, my God, I think, I still think you are a man, and you are getting fucked!" You know? "*So it means you are not a man*"[my emphasis] (Key Informant 2, 09/07/2009).

It is possible that this participant is using 'man' to indicate the active/penetrative sexual role, rather than as an indication of a hierarchical gender relationship. However, the relationship between ideals of masculinity and homosexuality is an important aspect of the social dynamics around

homosexuality in any culture. This relationship can be framed in terms of the idea of hegemonic masculinity, developed by Carrigan *et al.* (1985). Hegemonic masculinity is understood as the masculinity that occupies a hegemonic position in a given pattern of gender relations; this position is characterised by dominance of the institutions of authority and control in a society (Connell, 1995, Segal, 1990). Connell emphasises the relational nature of gender, arguing that masculinities (and femininities) are constructed in relation to each other and are historically situated (Connell, 1992, Connell, 1995).

In terms of the relationship between homosexual and hegemonic masculinities it seems likely that this understanding of homosexuality as qualitatively different from the masculinity 'required' by Xhosa culture affects these men's beliefs and behaviours in ways that increase their risk of contracting HIV and accessing services for HIV if they do contract the disease. For instance, stigmatising of homosexual relationships may lead MSM to have sex with other men in secret. These encounters, by their nature, are less likely to involve the use of condoms and water-based lubricant (cf. O'Leary *et al.*, 2007). Lane *et al.* (2008a) also note that homophobia has been associated with increased risk behaviour for HIV and other STIs among MSM.

In 'Coloured' communities, in contrast, some authors have reported a relative degree of acceptance of openly gay men who cross dress (Tucker, 2009, Swarr, 2004). Swarr (2004) argues that for these communities 'being gay' means having '...both same-sex desire and feminine gender'. This acceptance of same sex sexuality would seem to be reflected in the openness with which participants expressed their sexuality, and several participants cross dress on a daily basis. In contrast to the 'black' township communities, 'coloured' participants did not appear to experience homophobia as strongly as a daily feature of their lives. Homophobia in 'coloured' communities was reported by participants to be associated with specific areas, or with particular groups of men. Levels of homophobia reported by participants also varied according to the areas that the participants lived. Participants who lived in relatively better-off areas reported lower levels of stigma and homophobia, while those living in areas with higher levels of poverty reported higher levels. This contrast is illustrated in the comments below:

'G: And is there any stigma around being gay? Or homophobia and that kind of thing?

P: Ja I think it's generally as in most places, it's become more acceptable. It obviously depends on who you come across. With most people it's easily done, but you obviously find the minority, who have their strong views'. (Key informant 10, 27/11/2009)

'...because people are homophobic in our rural areas - like Mannenburg whatever you know, and people in our area they are very much homophobic' (FGD 3, 04/11/2009).

'...because some of the discrimination are so strong out there, especially in Mannenberg, that I want to stand up for my boyfriend' (Key informant 8, 21/10/2009).

The dynamics around MSM and the homophobia experienced by 'coloured' gay men seems to vary significantly between different areas, in contrast to the more uniform reports of homophobia among 'black' respondents.

Another facet of the stigma experienced by these participants was related to their perception that people in their communities made specific assumptions about what 'being gay' means. This was expressed by one participant as follows:

'The reason I ask is because, you know the people, the broader community, when you talk about gay it's almost this stereotype of money and sex. You know, I don't want them by you know talking about that uhh for them to continue to have this image that gay is about just sex' (FGD 3, 04/11/2009).

The idea that people who hold homophobic beliefs do so because they do not understand what 'being gay' means was expressed by several participants. These participants felt that one way to deal with homophobia was to engage people in conversation and to explain to them what 'being gay' actually means.

'Because actually everything it's all about ignorance, people are ignorant...I always take my time to explain, 'homosexuality is this and this and that' I always talk about my own experience, and sometime when they see me calm and cool talking to them, they say 'oh OK we didn't know, oh OK so it's like that', you see, so it's about communication and acknowledge people if I can say' (FGD 3, 04/11/2009).

'It's definitely about how open the gay person also is, because if you going to get defensive, then you also going to get defensive, you know, where if you calm and talk about it, and not feel that- and even in your- in one's response, you know, to not get personal sometimes, people can so easily lose themselves in something that's not really their fight as such, you know, because you can change someone if you say something positive it will change the way they think, then obviously they're going to speak to somebody else' (FGD 3, 04/11/2009).

The fact that these participants report having the opportunity to discuss and explain homosexuality to others in their local communities would seem to imply a more accepting and less threatening atmosphere around homosexuality than that reported by 'black' participants.

Religion is another important factor affecting the social and cultural dynamics around homosexuality. Both 'Coloured' and 'Black' participants noted that religious groups were an important factor affecting community perceptions of homosexuality. The areas in which participants live generally have a strong religious element and Islam and Christianity were reported by participants to be the main religions in their areas. Maughn-Brown (2010) for example, notes that 86% of respondents in a longitudinal study conducted in Cape Town, reported holding religious beliefs. Both Islam and Christianity were noted as sources of discrimination among participants in this study.

'It's taboo to be gay and you're Muslim...You know because they are being stigmatised, or labelled, and they don't feel comfortable in that institution'(Key informant 7, 19/10/2009).

'They are chasing you out of the church if you are gay, they don't let you come easily' (FGD 3, 04/11/2009).

'Sometimes you go to the church, you see the people they're going to look at you "ooh that's a demon", something like that' (Key informant 4, 19/08/2009).

The fact that religious belief was noted as a key source of discrimination by participants is important as it points to specific aspects of community dynamics which can be targeted for change.

At a distal level, the interaction between prevailing homophobic attitudes, religious beliefs, and 'traditional' masculinities has important negative effects on MSM's risk of contracting HIV, on men's health seeking behaviour, and potentially on their physical health.

3.1.2. HIV-related stigma

The stigma associated with HIV in many South African communities has been widely documented . Parker and Aggleton (2003) discuss stigma and stigmatisation as a social process '...that takes place in a specific context of culture and power.' Stigmatising ideas and beliefs about HIV may be particularly harmful due to their association with pre-existing stereotypes and prejudices which results in moralistic interpretations of HIV positive people's lifestyles and behaviours (Visser et al., 2009). In a homophobic social and cultural context it is possible that HIV stigma will be associated with homosexuality in communities' understandings of the HIV epidemic. High levels of stigma around HIV were noted by men in this study. HIV-related stigma was reportedly common both in the communities in which men live and within the gay community itself:

'It's very stressing especially for gay men, because the problem is what we had as a gay people like if you know someone's status, I mean maybe he's HIV, and then we will just make him gossip around this person and we will talk about it in the street and we will laugh it...we will point fingers for people who are HIV. Now people they are feeling scared to know their status, if like all the gay people like, they feel scared to know their status because of that thing of what they were doing to other people, because they were pointing fingers, they were laughing then, making jokes, they were gossiping about people's status now they...it doesn't matter too that people feel stress of knowing their status' (Key Informant 1, 07/07/2009).

'...and in that case even the community we live in like whenever you get sick, you can get any other sickness, not even HIV, but you start losing weight they start calling you 'ah you are HIV positive' (FGD 2, 14/10/2009).

Importantly however, the link between homophobia and HIV-related stigma was emphasised by several participants. Participants felt that if gay men were seen going to a clinic or other health service it would be assumed by anyone who saw them that they were HIV positive, regardless of the reason for their attendance at that service.

'...if like you are sick whatever you had, a headache whatever anything, any disease or any illness that you had, and then people they will know if you went to the clinic or any where and then they see

you in the clinic they will know that maybe you are testing HIV and AIDS, maybe you have HIV and AIDS' (Key Informant 1, 07/07/2009).

'And the same thing at the hospital they say he is having TB, but in the community they say its AIDS' (FGD 2, 14/10/2009).

This link seems to play an important role in affecting the health-seeking behaviour of gay men in these areas. Generally participants noted that they preferred to access health services away from the areas in which they live. For instance,

'They say for confidentiality purposes, they'd much rather go into other areas outside of the area where they live in' (Key Informant 1, 07/07/2009).

Similarly, some participants felt that people in 'Coloured' communities still thought of HIV as a 'gay disease'. The association of HIV with gay men was also found to be a factor affecting HIV positive MSM in a study by Cloete *et al.* (2008), who argue that HIV positive MSM experience multiple discrimination which in turn affects their psychological well-being and ability to cope. In this study respondents felt that HIV related stigma was a barrier to accessing care.

'...there is some doctors that I know, maybe sisters that I know, and no matter they test me - whatever, but they will all ways make a mock of me- just like she will tell the other sister, no matter it is confidential, but she don't have the right to speak to her to her colleague or so, that's why I prefer to go somewhere else' (FGD 3, 04/11/2009).

'So I mean there are voluntary counselling and testing centres now, you know, and but people don't, because again the stigma attached to it: if they see me going in there- 'why did you go there, oh God', you know, even with TB- if you have TB automatically 'ooh you must have AIDS because you're losing weight', and things like that' (Key informant 9, 20/11/2009).

The stigma attached to being gay and having HIV was also noted as a factor affecting individuals' access to treatment and general well-being.

'You know it's like people in Mannenburg - it's just like in Mannenburg - wherever, Delft whatever- they just like thinking that HIV comes from gays' (FGD 3, 04/11/2009).

One participant described the very process of going to government clinics as having a negative effect on one's well being.

'...as a gay person if you go into the government clinics, you going right inside, but you coming out very sick, very sick, you are totally sick...you are worse, your CD4 count just drop immediately' (FGD 3, 04/11/2009).

This perception of government health facilities as homophobic is an important barrier to accessing care, and may result in men delaying seeking treatment. Several 'coloured' participants reported

that they already used services offered by Health4Men and Triangle Project, or alternatively saw private doctors rather than accessing government facilities.

3.1.3. Policy, poverty, unemployment

In terms of the direct relationship between poverty and HIV risk, Kalichman *et al.* (2005, 2006) found that poverty-related stressors were associated with HIV risk behaviours in surveys conducted in various communities in Cape Town. In contrast, Avalos *et al.* (2009) did not find a significant relationship between lacking basic needs and HIV risk, however they note that their fairly uniformly lower socio-economic status sample may have contributed to this finding.

The men in this study reported lack of money as problematic, primarily in terms of accessing the 'gay friendly' health services in central Cape Town.

'...they are making themselves late because now time to visit the doctors, some of the other gays are not working, they are sick and they haven't got money to come to triangle to come to town or wherever' (FGD 2, 14/10/2009).

'...but sometimes it's so difficult from P--- to come from the township to town, because sometimes money problems' (FGD 2, 14/10/2009).

'...those gay guys, those gays, have to open a clinic and then people...if people they see I'm sick now, I don't have money to go to come here' (Key Informant 3, 13/08/2009).

Kalichman *et al.* (2006) note that lack of access to health care is one of the ways in which poverty is associated with HIV infection. Other important links between poverty and HIV risk include 'greater social density, social isolation leading to closed sexual networks, alcohol and drug abuse, and engaging in sex in exchange for survival resources' (Kalichman *et al.*, 2006:1641). These various aspects of poverty, inequality, and disempowerment represent the effects of the structural violence (Parker, 2001) that affects much of the South African populations' vulnerability to HIV infection. Schoepf (2001:336) points out that 'disease epidemics are social processes: spread of infectious agents is shaped by political economy, social relations, and culture'. For MSM in a poor South African context, the risk of contracting HIV is affected by a combination of poverty, inequality, social exclusion, and widespread homophobia and stigmatisation.

These negative aspects of the distal context have important effects on how HIV affects gay men in these areas. It is, however, also important to understand the positive aspects of the distal context that may facilitate access to care and risk reduction practices among gay men.

3.1.4. Positive distal factors

Factors with a positive influence on HIV prevention among gay 'black' men in Cape Town include the constitutional recognition of the rights of the LGBTI community, and the existence of several gay rights and service organisations.

Tucker (2009:118) for instance argues that the constitutional recognition of same-sex sexuality empowered gay Xhosa men who then felt '...more able to visibly express to the wider community that they were sexually attracted to other men – and hence they took on some form of public gay

identity.’ Changing the political (distal level) context of sexual orientation thus seems to have had the effect of affirming these men’s sexual identities.

The existence of gay rights and service organisations in Cape Town over the last twenty years has also played a role in supporting these men in being able to publicly express their identity. One of the participants in this study noted that Triangle Project, an organisation which provides social support services to the LGBTI community, had helped him to come to terms with his sexuality:

‘The time they were there with the Triangle Project. But I get counselling but after that I feel so...I get a hope...So I decide to attend the clinic there in Mowbray and then they told me everything, no just do this, and this, and this and this, and then going to get comfortable life’ (Key informant 4, 19/08/2009).

As aspects of the broader, distal, context, these organisations play an important role as a resource for gay men in the township areas. The existence of organisations that share an identity as serving the LGBTI community may also facilitate a sense of ‘belonging’ to a larger movement or collective experience. This, in turn, may contribute to what Wexler *et al.* (2009) describe as a process through which individuals contribute to ‘collective betterment’, and that this ‘intersection of personal and collective well-being’ may play an important role for individuals in finding a sense of purpose.

3.2.PROXIMAL LEVEL

The proximal level, according to Eaton *et al.* (2003) relates to the ‘interpersonal relationships and the physical or organisational environment’. The interpersonal interactions that occur on a daily basis between gay men and their communities play an important role in shaping their beliefs and behaviours, and may affect their risk of contracting HIV. Campbell (1997:274) argues in this vein that ‘explanations of why people engage in high risk behaviours involve an understanding of their social identities and of the social conditions in which such identities are constructed’. In order to create successful HIV prevention programmes, it is therefore necessary to understand both the risk behaviours undertaken by gay men in these areas, and how they interpret these behaviours. It is also necessary to understand other factors and interactions that may indirectly increase the likelihood of these men engaging in high risk behaviour.

3.2.1. Discrimination and stigma—individual and collective experiences

While discrimination, stigma, and homophobia form important aspects of the distal context, where the constant awareness of discrimination affects gay men’s perceptions of their environment and the possibilities for expressing their sexuality, the experience of verbal and physical abuse that results from these socially accepted norms directly affects these men’s daily lives. Consequently, the spaces available to gay men in Cape Town’s townships in which they are able to socialise, and access services and opportunities freely are limited. Verbal abuse was reportedly common:

‘...in the township when they start calling you by names you start feeling bad about yourself, as if what you doing is something else that’s what make like most of gay people hide themselves you know’ (FGD 2, 14/10/2009).

'...they call us moffies, stabane. The bad word they will use, maybe everybody will laugh if they talk about this word, bayalalang, amadoda' [men who sleep together] (FGD 2, 14/10/2009).

'Sometimes you go to the church, you see the people they're going to look at you 'ooh that's a demon', something like that' (Key Informant 4, 19/08/2009).

Physical violence, and the threat of physical violence were also reported:

'Sometimes you get beaten, sometimes you're shouted something like that...We don't go to every place, because people are not the same some of them they are rude, some of them they like to murder' (Key Informant 4, 19/08/2009).

'It actually you risk life, because sometimes you can get a man from the shebeen and he act as he loves you then you go out with him maybe to his house, he stab you, and you dead. He rip you off or whatever, or you take him to your house, he clean your house out. He kill you' (FGD 2, 14/10/2009).

Discrimination in taverns and shebeens was linked by some participants to alcohol use.

'P1: And where I'm going to say, where it happen often, those kind of stuff, when we meet you know in those tavern or social club, you know with straight people sometimes they just wait the occasion to come and... just assault you or...

P4: Especially when they're drunk' (FGD 3, 04/11/2009).

Tucker (2009) argues that the lack of safety combined with the intolerance of their local communities has made it very important for these men to belong to wider social groupings of gay men, what he terms 'social nodes'. He argues that these social groupings are important both in terms of providing safe spaces for gay men to meet and socialise and in terms of affirming their identities as gay Xhosa men (Tucker, 2009). These 'nodes' could therefore be argued to play an important role in supporting the resilience² of gay men in Cape Town's 'black' townships. Wexler *et al.* (2009) note that in their broader conception of resilience, as 'a dynamic process based on people's interpretations and social affiliations', the focus on understanding what it means to be marginalised may lead individuals to 'understand themselves and their experiences within a larger context'. This understanding, in turn, may promote efforts to change the structures of inequality (Wexler *et al.*, 2009).

'Coloured' participants also reported that homophobia was widespread in their communities. However, specific instances of homophobic behaviour appeared to be associated with particular places and particular situations. The two most frequently mentioned included health centres and clinics, and taverns or shebeens.

² We use the term 'resilience' following Wexler *et al.* (2009) who argue that '...resilience – rebounding after experience of hardship – is a process involving personal and collective meaning-making and negotiation, which should not be assumed to be a steady state'.

Health centres and clinics were the most frequently mentioned as specific sites where discrimination was experienced.

'In my experience with clinics it's quite awkward because of the little comments and, well not little comments, the comments that the nurses and those sort of people sometimes make, it's- you want to punch them, but you can't because you are dependent now on their service, you know and they would call in other sisters, and or speak behind curtains, you know it's quite degrading, you know, and you don't feel comfortable' (FGD 3, 04/11/2009).

'...especially if you have to sit for tablets, people they mock you, you know people they all people like 'moffie' all these things, and it it's come really it's not nice' (FGD 3, 04/11/2009).

The experience of discrimination based on sexual orientation at clinics and health facilities was also reported by 'black' participants, and was an important deterrent to seeking medical care and going for HIV tests.

'And one thing I've noticed is that most of gay people they can't reach those facilities because they are afraid they will be discriminated, you know' (FGD 2, 14/10/2009).

'...it's very difficult, sometime you stay you know because even if you feeling sick you don't feel like going because they ask those different questions, because if you got STI, the nurse will ask with whom did you sleep' (FGD 2, 14/10/2009).

'They said 'are you a man, a real man? What you want here?', they said 'ooh wait I'm going to help you', those people they stay there for a long time, they wont get help they just laugh, laugh... ' (Key Informant 3, 13/08/2009).

'But in some instances you will find that gay people feel scared to go there, because when they do your test, or you visit, or your STI questions will arise that who do you sleep with' (Key Informant 2, 09/07/2009).

The men reported that clinic staff were not supportive, and that rather than providing counselling they sometimes criticised them for having sex with men. Lane *et al.* (2008a) found that MSM in Gauteng reported similar experiences. These experiences then must be viewed in the context of homophobia as the 'norm' in South Africa in general.

Another important issue that participants reported worrying about was the perceived lack of confidentiality around HIV, and the fear that if they tested HIV positive, this would be a source of gossip in the community. Participants noted that this was also related to the way that clinics are managed, and several men described the difficulty associated with having to stand in the 'HIV section' or being told by nurses to go to specific areas for HIV while other people were present.

'...the problem here is every condition has it's own section, pregnancy here, TB that side, HIV that side. So if you go stand in the HIV queue then everyone will know that you were there and they will tell the rest

of the people "oh I saw this one standing at the HIV queue or the STI queue at the clinic" (FGD 1, 17/08/2009).

'...you know what they do the people who are working for, the workers for care, they will read all the folders "hey man man man man, you HIV positive this side, you that side, you you TB you go this clinic, HIV people that side, TB people that side"' (FGD 2, 14/10/2009).

The difficulties experienced by these men in accessing health services were also related to the fact that the clinic staff often live in the same areas as them. They stated that they did not believe that the staff would respect their confidentiality, particularly if they were diagnosed with HIV.

'...most of the sisters are our neighbours they know where you are staying, they will tell you "it's because of this thing you are doing, sleeping with this one" they don't like they don't actually sit with you and counsel you, instead of helping you they criticise you"' (FGD 2, 14/10/2009).

'...most of the nurses there in the township they are our neighbours my mothers friend...she knows me and she knows my status and she knows that I am gay so she will tell these other nurses "you see that one, he is HIV and he is gay"' (FGD 2, 14/10/2009).

The combined fear of being 'outed' and of having one's HIV status known in the broader community is a significant barrier to accessing health care and HIV services in the townships.

Participants reported that they preferred to access clinics outside of the areas in which they lived, and some reported using private doctors in order to avoid these consequences.

'They say for confidentiality purposes, they'd much rather go into other areas outside of the area where they live in' (Key Informant 1, 07/07/2009).

'Most of the gay guys they go outside, they don't go there by the hospital. The services from those clinics, they are not good for the gay guys' (Key Informant 3, 13/08/2009).

The fear of discrimination was also reflected in the concerns raised by some participants around focusing on MSM in HIV prevention campaigns.

Some 'coloured' gay men feared that focusing HIV campaigns specifically on gay people would serve to increase the homophobia they experienced. They felt that this could occur through campaigns directly associating HIV with gay people. Several participants argued that rather than focusing HIV prevention specifically on the gay population campaigns should be inclusive and target both the heterosexual and homosexual populations.

'It depends you know, it depends how you put it and also what you want to get across to people ...we don't just want to portray gay people or just associate them with sex, maybe two guys dressed, um loving, showing affection you know?' (FGD 3, 04/11/2009).

'That's why maybe a picture where you have maybe two guys, two lesbians and maybe a straight couple, maybe something like that as well' (FGD 3, 04/11/2009).

'You can always move it, if you want to promote the gay thing, you can move them to the front, put a lesbian couple at the back, and put a heterosexual couple on the other side' (FGD 3, 04/11/2009).

These participants felt that HIV prevention campaigns should have a dual focus and aim to address both HIV and homophobia. The experience of homophobia and discrimination has a potentially important role in contributing to HIV risk through making it more likely that MSM will engage in hidden and hurried sex rather than risk being exposed as having sex with men. Whether or not condoms and lubricant are used in such encounters depends on their availability and the process of negotiation of sexual contact.

3.2.2. Socialising

The social options available for gay men in the 'black' townships are also limited by the high prevalence of homophobia. In the various different townships there were reportedly particular shebeens, or taverns, where gay men were accepted, although none of these were exclusively gay.

'[We go to] shebeens yes, because we don't have, we gay people we don't have a safe social and sexual place where we can meet gay people...' (FGD 2, 14/10/2009).

This pattern of socialising has important implications for HIV risk behaviours, as noted by Kalichman *et al.* (2008), who found that people who met sexual partners at shebeens in Cape Town were more likely to engage in unprotected sex than people who did not meet partners at shebeens.

Where individuals choose to socialise therefore also affects their HIV risk. Participants from 'coloured' areas also noted that there were few gay venues in their own communities and similarly to the 'black' townships some gay men tended to socialise at taverns or shebeens ('smokkies'). Participants noted that gay men in their communities would also frequent a particular gay club in Cape Town's northern suburbs.

Several participants from 'coloured' areas stated that they preferred to go to 'straight' clubs when they were looking to meet a sex partner. This preference was based on the idea that in a gay club they were unable to tell whether partners that they met would be 'tops' or 'bottoms'.

'P1: There is gay clubs that they used to go to like in town, in the gay village, there was a lot there for us. But now our gays tend to go to straight clubs' (Key informant 5, 23/9/2009).

'P5: Ja, I'm very scared for gay clubs, I'm like straight clubs, meet a straight man and just going' (FGD 3, 04/11/2009).

Several participants also discussed how gay men, and particularly young gay men, would meet at houses where the owners were open to them. These houses most often belonged to other gay men and provided spaces in which individuals could be open about their sexuality without fear of violence or discrimination.

The sexual partners that gay men meet at shebeens were often reported to be straight-identifying men, and the dynamics around sexual negotiation were directly affected by these contrasting identities. 'Straight' men who have sex with men were known as 'after nines' in both the 'black' and 'coloured' areas. This refers to the fact that they pretend to be straight during the day, but sleep with men at night. Sexual negotiation with 'after nines' was often reported to have a transactional nature, with gay men paying 'straight' men for sex, either with cash, or by purchasing drinks for them.

'...because in our townships in shebeens if you want a man you have to buy it. Either you buy three beers, or you give him twenty bucks, they very cheap the guys...' (FGD 2, 14/10/2009).

'So whatever you do there's always financial implications in between...' (Key Informant 2, 09/07/2009).

'Sometimes they even come back, because they know if they sleep with R--, R-- will give them fifty Rand' (Key Informant 2, 09/07/2009).

'Ja there is some gay guys that pay younger guys to have sex in terms of buying them gifts, or clothes, or in exchange for money' (Key Informant 7, 19/10/2009).

The prevalence of transactional sex was reported by participants to be related to the idea that gay people have more money or are better off than straight people.

'These guys if they saw maybe this one you've got lots of money, I'm going to try just to propose him' (Key Informant 4, 19/08/2009).

'...it's not because of they want to get involved because of they are attracted to them, they just want to become involved with them because of they will gain something at the end of the day' (Key Informant 1, 07/07/2009).

So I don't know if it's because we are gay that people think we have lots of money, or they have security...it's like paying for our services' (Key Informant 6, 23/09/2009).

In some cases participants reported that gay men gave straight men cash in return for sex.

'...then he goes straight to that guy and he says "listen here: I need some money and can't you help me?", and in those words then that guy will say "listen here: what is out for me?", and then that guy will say "you know mos what is out there for me- sex, now when?"' (Key Informant , 21/10/2009).

'They buy alcohol for the girls [gay men], and then they end up fucking the girls [gay men], we also do it. But the thing is where you actually pay, like hand over money and stuff, that don't happen, unless it's certain queens that we also know of that needs to pay these guys for that favours...And these boys are very, very aware that if they show their dick, they will get paid' (Key Informant 6, 23/9/2009).

'P: Ja, in the sexual life. Because a gay has to entertain all these things and put himself on the table you know. The gay have to provide the money...It's not all about drugs and so, but the money, nowadays it would be money...' (FGD 3, 04/11/2009).

Johnson (2007) notes that this stereotype of gay and lesbian Africans as rich is common across the continent. This seems to be based on the idea that same-sex practising people do not have families to support and therefore have larger amounts of disposable income (Johnson, 2007).

The association noted here by participants between transactional sex and alcohol and drug use is of importance in understanding the nature of HIV risk behaviour in these communities and emphasises the close association between unsafe sexual encounters and the use of alcohol and drugs. This has important implications for HIV prevention efforts in these communities, both in terms of the messages that should be emphasised and the locations that are targeted.

The process of negotiating a sexual encounter reportedly varied according to where partners were met, and whether partners were straight or gay.

In transactional encounters between straight and gay men, participants stated that straight men usually initiated these encounters. In social situations, such as at bars or shebeens, the process of negotiating sex was indirect, as discussed by this participant:

'P4:It's always an undercover sort of, you know, um operation, I think, both parties sort of know, nobody really approaches- they make it look social, you know, and then from there they take it, you know "can we go somewhere, can we go afterwards, can we go?", but like in a, no-one will really pick up anything- unless you know the scene or the vibe' (FGD 3, 04/11/2009).

In terms of HIV-risk, sexual encounters with 'after nines' were characterised by several risk factors for HIV infection. As noted previously, this sex often happens under the influence of alcohol.

'...then you just find a guy and you been looking for this guy, he's drunk, you drunk, whatever, and he has also got a girlfriend around, then you just go quick side side then you go to the toilet then you just pull finish' (FGD 2, 14/10/2009).

'...most of the time you meet people you are under the influence, maybe you meet at the club or whatever' (FGD2, 14/10/2009).

'...in townships alcohol does affect most of the gay people, even straight people, because when you drink you don't follow whatever you know your goals and whatever you had before you got drunk. As soon as you are drunk someone come touch you, you don't even look this guys face, is he nice is he right or what, you just going to go and have sex' (FGD2, 14/20/2009).

Being drunk was suggested by several participants as a reason for not using condoms in these sexual encounters.

'...drugs and alcohol are not good to a person that sleeps around and that will not use condoms' (FGD 2, 14/10/2009).

'[If you] Have alcohol, it's not easy to access condom although condoms are right here' (Key Informant 2, 09/07/2009).

'So when you under influence like any drug you taking, like alcohol whatever, your mindset is like changing, you not thinking properly. Although you know that you told yourself you know whenever you going you gonna have sex you gonna make sure that you use a condom. But once you on alcohol or you on drugs, your mindset change' (FGD 2, 14/10/2009).

3.2.3. Where sex happens

Whether or not condoms and water-based lubricants are used for sex is in part dependent on their availability. The places where sex occurs are therefore important considerations for HIV prevention initiatives. Participants reported various places where sex would take place and these also varied depending on the sexual orientation of the sex partner. When sex took place between straight men and gay men it was often reported to occur in places such as vacant lots, in cars, or in toilets. This participant noted that this sex tended to be unprotected because of its hurried and hidden nature.

'Exactly, it's unsafe sex, especially when we say that things sometimes are being done in a hurry you know, because those places are not really gay friendly, you must go to the bush, you must go to this place so you don't have all the things with you' (FGD 3, 04/11/2009).

'[Men have sex in] Any open spaces- it could be a field, it could be the back of a hall, it could be near to an electrical box or something um... even if they go out of the clubs they will go into their cars, have sex there um... just have a quickie and come back' (Key informant 7, 19/10/2009).

Participants also noted that men often had sex at the houses where they socialised. In these situations both partners were reported to be more likely to self identify as gay, or as gay-friendly.

'P: Look in people's homes, I mean going to people's homes I meet somebody I mean and that's it, you know we do it, if you look at _____ I mean it's easy. There's nice boy there, OK let's go into the room, shut the door, and do it - nobody will say anything' (Key Informant 9, 20/11/2009).

'P5: If I think about that in _____, you know, uh in the 90's it was always my house was the focus point to be the gay area, and to meet gays, and there was sleeping like 20 to 30 gays in my house, and they were fucking- all those things' (FGD 3, 04/11/2009).

Identifying these houses and working with their owners to ensure that they have condoms and water-based lubricants available could therefore also be an important aspect of HIV prevention in these areas.

3.2.4. HIV risk

The main risk behaviour reported by participants was unprotected anal intercourse linked to alcohol and drug use. Participants felt that while people know about the importance of using condoms and water-based lubricant they would 'forget' to use these precautions when they were drunk or high.

'It's when boys come together, have a few drinks something like that, some of their alcohol goes to their bottom part anatomy and then they're horny now they go out looking for [sex]' (Key Informant 1, 23/09/2009).

'I mean I saw one- actually saw one in town coming out of Adult World the other day, and he's the one always getting involved, he gets piss drunk, and then he gets fucked all over the show but "nee meneer dis nie ek, dis die wyn" (no sir, it's not me, it's the wine) ' (Key Informant 9, 20/11/2009).

Drugs were mentioned more frequently among 'coloured' participants than among 'black' participants. Crystal methamphetamine (tik) was noted by one participant as having particularly negative effects in terms of HIV risk behaviour.

'And the big one is Tik. I mean there you can forget about it, and then Tik is not just with one, it's multiple partners. Because their libido is so up, and they just want to so they just - anybody I always say it's like a post box, everybody can come and deposit their letters' (Key Informant 9, 20/11/2009).

Sex partners' refusal to use condoms was noted as an important reason for not practising safer sex. Participants stated that this was particularly the case with 'after nines', and that if their partner did not want to use condoms, they would rather go ahead and have unprotected sex than risk losing the opportunity to have sex.

'Ja it's really, because people they don't want the condom, if you just tell them about the condom, yoh you'll be in trouble!' (Key Informant 4, 19/08/2009).

'...you think you are going to lose this man, and then I have to do the sex, unprotected sex...' (Key Informant 1, 07/07/2009).

'...so it's difficult to use condoms when you are interested in a person because all that you are interested in is sex, and if that person doesn't want to use a condom then you don't use it because all you are interested in is the sex after all...' (FGD 1, 18/08/2009).

The use of water-based lubricant was also limited. Reasons given for the lack of use of water-based lubricant included that it was not easily available, that it was too expensive, and that 'straight' identifying MSM were unfamiliar with it and did not allow it to be used. These participants, for example, noted:

'You see, and then they [straight men] are "why should I use the lube?", you know? Because now they are getting involved with the gay people, and then gay people are producing something new to them,

and then they will make them to start and then "what is this, why should I use this?"` (Key informant 1, 07/07/2009).

'I know the KY Gel, the KY, but if it's someone who doesn't have an understanding of that who says "no, no don't put that on my penis", you know, it's easy for an African man to say "no, no don't put that. What is that? No don't put that"' (Key informant 2, 09/07/2009).

Another participant, in a similar vein, told of an incident that one of his friends experienced:

'And then this guy said 'what you apply here?', he said 'no I use a lubricate, lubricate is for making everything to be easy', he said this guy 'no, no, no, no I don't like this. Uh, uh you are a witch, I can't sleep with you', and then the guy run away, he left my friend alone there!' (Key informant 4, 19/08/2009).

The idea that it was easier to use lubricant with other gay men than with 'straight' men is problematic, especially in light of the reported frequency of sex with these 'straight' men. Where water-based lubricants were not used, or were not available, saliva was the most common lubricant reported. Other lubricants that were commonly used included Vaseline, aqueous cream, hand and body lotions, and cooking oil.

The experience of homophobia and discrimination has a potentially important role in contributing to HIV risk through making it more likely that MSM will engage in hidden and hurried sex rather than risk being exposed as having sex with men. Whether or not condoms and lubricant are used in such encounters depends on their availability and the process of negotiation of sexual contact.

3.2.5. Sex practices

Most of the participants in this part of the research reported preferring the receptive role during male-male sex, and it appears that there could be a similar dynamic among 'coloured' communities and 'black' communities around sexual identity and sexual role preference – with men who self-identify as gay generally assuming the receptive role in sexual intercourse.

Multiple concurrent sexual partnerships have been argued to play an important role in increasing the transmission of HIV in Africa. Data on multiple partnerships among MSM in South Africa are not widely available; however, some participants reported that such partnerships were relatively common.

'...most of the gay people, they sleep with one man and another man like, lots of guys' (Key Informant 4, 19/08/2009).

'Ja, that's what happens. That's just normal for people to sleep with a few partners' (FGD 1, 18/08/2009).

'...most people they have multiple partners, some people they don't get satisfied with one man...' (FGD 2, 14/10/2009).

Multiple partnerships in the context of 'after nines' may be an important bridge between the hetero- and homo-sexual HIV epidemics in South Africa. Reported prevalence of men sleeping with both men and women differed between participants, this may reflect different dynamics within the various townships, and the relative levels of acceptance of homosexuality between these areas.

'Some of them they do have sex with women, but some of them they were involved with women before and then they get involved with gay people, and now they just leave their girlfriend and they become involved with gay people' (Key Informant 1, 07/07/2009).

'I have this guy, is thirty four years of age and he's got a girlfriend which he's been seeing for almost for fifteen years before me, and he is still seeing this girl' (Key Informant 2, 19/08/2009).

'And also people feel very comfortable to sleep with men and also sleep with women. There's no way that you will experience a real man who's in a relationship with a gay person only' (Key Informant 2, 19/08/2009).

Based on participants' reports of the sexual dynamics in their communities, there may be a social pressure for men who are not openly gay, but who have sex with men to maintain relationships with women in order to fulfil their expected positions as men. The participant's statement above, that 'a real man' would not be in an exclusive relationship with a gay man alludes to this pressure. Several authors, in studies with heterosexual men in South Africa, have noted a 'normative' pressure to engage in multiple sexual partnerships as a means of affirming one's masculinity (Hunter, 2005, Lynch et al., 2009, Vincent, 2008, Barker and Ricardo, 2005, MacPhail and Campbell, 2001). The contrast between this participant's views of 'real' men and gay men seems to extend to the sexual roles that individuals assume:

'...we even approached this one man, which he was very shy, you know, like "we're you, my God, I think, I still think you are a man, and you are getting fucked!" You know? "*So it means you are not a man*"[my emphasis]' (Key Informant 2, 09/07/2009).

While most participants reported preferring the receptive role in male-male anal sex, several participants discussed how they had encountered straight men who they gone to bed with and who had asked to be the receptive partner. Participants found this disconcerting as they specifically chose to sleep with straight men because they assumed that they would be the receptive partner. This demonstrates some of the complexity of the considerations necessary for designing HIV prevention campaigns for MSM in these areas.

'P: Look at ___ she's extreme queen, she's got breasts and all that drama, but when guys come around her, and this is straight guys mind you...or so called identifying straight guys, guys that call themselves that, they will come to her house and she will end up fucking them' (Key Informant 5, 23/9/2009).

'P1: And that's the problem that I have, because I'm so to in straight, because I like really a male-male looking you know, not a bit like me, so you'll find a male-male looking like that, you go to him- 'no I like to be bottom' so aggg....Because I remember I had with a guy, and I find after that he was married to a woman, but he wanted me to fuck him,

and I couldn't really, I thought that he was really male, male, male but he wanted it, really I couldn't' (FGD 3, 04/11/2009).

'P5: Ja they come in male in your house and they leave as a woman, or so ever. That piss me off when I was in as far in, and they tell me 'please it's now my turn', and they sing first a song, sing the song they want to be fucked' (FGD 3, 04/11/2009).

3.2.6. HIV awareness, knowledge, and campaigns

This study focused specifically on the HIV risks that MSM encounter in Cape Town's townships. Theories about risk behaviour posit that individual choices with regard to engaging in risk behaviour are based on their knowledge of, and attitudes towards, these risk behaviours (Barnett and Whiteside, 2002). HIV awareness campaigns are therefore often based on the assumption that by providing knowledge about HIV and how to protect oneself from infection, individuals will decrease their risk behaviours, and this has been the focus of most HIV awareness campaigns in South Africa (Hutchinson et al., 2007). However, there have been very limited efforts to target MSM for HIV prevention in South Africa. It is therefore important to understand the ways that MSM interpret and incorporate the information about HIV that they are exposed to on a daily basis into their own lives, and how this information affects their risk behaviours.

Participants in both 'black' and 'coloured' communities reported that they had good knowledge of how HIV is transmitted, and they felt that most people knew about HIV. This did not translate into consistent condom use, or regular HIV testing. And in spite of the reported high level of knowledge around HIV, participants reported that people were very reluctant to talk about HIV or to disclose HIV positive statuses.

'...all those areas that I'm working with, I found that most of gay men are HIV and AIDS. But the problem is they are not openly free to talk about it' (Key Informant 1, 07/07/2009).

'...we are quite very, very sort of laid back when it comes to the issues of STD's. We tend to ignore the STD's' (Key Informant 2, 09/07/2009).

In addition to this lack of discussion about HIV, other responses to HIV infection were noted by participants. Some participants felt that HIV was simply ignored along the need for safer sexual practices.

'P: Well those people that knows they have that virus they couldn't get to fuck, so they still fuck around. Our friends do it. There's a few of our friends that has the virus, there's a few that passed on, they still kept on, they still did what they did' (Key Informant 6, 23/9/2009).

'P: You know? But lots of people has been tested positively in this area. But still having unprotected sex with other people...The thing is they know how to...how they contracted HIV and AIDS, they know what the symptoms are, they have the information, but yet they're still ignorant by not using a condom, not informing their partner- ja that is the way they operate' (Key Informant 7, 19/10/2009).

The desire to 'pass the infection on' was a reaction that two individuals felt was fairly common when people in their communities discovered their HIV positive statuses.

'...they know their status...they want to pass the virus to other people' (Key Informant 1, 07/07/2009).

'Just to promise lots of promises. All along that guy only want...only he want...he want just to transfer this disease to me' (Key Informant 4, 19/08/2009).

Participants reported that sexual partners sometimes deliberately broke condoms, and they saw this as proof of these peoples desire to pass on their HIV infections.

'...if you sleep this guy maybe you meet the first guy you never have an affair before, this guy maybe want to share something to you, he's going to just break it...It happen many, many times' (Key Informant 4, 19/08/2009).

'...because you can see when someone is trying to break the condom' (FGD 2, 14/10/2009).

Other responses to HIV included simply ignoring it, or denying one's vulnerability to infection.

'...the HIV thing is something that we are ignoring...' (FGD 2, 14/10/2009).

'Like in gays people there's some people they just hide their status, they don't want to talking about, if like I'm talking about something like HIV and all that stuff, some of them they feel sensitive' (Key Informant 4, 19/08/2009).

Participants from 'coloured' areas also noted that HIV was generally discussed in their communities.

'P: So the topic itself- people don't freely talk about HIV and AIDS' (Key Informant 7, 19/10/2009).

'P: Um... the thing is HIV and AIDS is a subject- it's a dying subject- people don't want to talk about HIV and AIDS' (Key Informant 9, 20/11/2009).

When asked about their perceptions of existing HIV prevention and awareness campaigns, participants noted that these campaigns did not address their needs.

'I used to work for LoveLife, and I worked for some organisation at the townships ne, but what I've noticed is that they are not focused to gay people' (FGD 2, 14/10/2009).

'...they only focus on straight people and then they forget that there are gay people' (FGD 2, 14/10/2009).

'But LoveLife never specifically focused on gay men' (Key Informant 2, 09/07/2009).

Through ignoring the needs of same-sex practising people in HIV prevention, these campaigns may indirectly legitimate the continued social marginalisation of these people. It is also possible that in 'coloured' areas the lower rates of HIV infection and therefore the less 'visible' nature of HIV in these areas has contributed to this lack of interest around the disease (Shisana et al., 2009). One respondent suggested that among the young people he worked with, the lack of attention to HIV was due to the fact that they were inundated with HIV prevention messaging throughout their school careers and had hence reached stage in which they were experiencing 'AIDS fatigue'.

3.2.7. Positive proximal factors

Participants also discussed factors in their daily lives that supported their ability to access healthcare and to manage their HIV risk. Having friends who were also gay, or who were not judgemental, was an important factor supporting participants. This participant, for example, talked about how his group of gay friends supported him when he had TB:

'I was so happy I had like friends, like P_ they always tell me like just take you treatment and you will get over this thing and all that...' (FGD 2, 14/10/2009).

Participants from 'coloured' areas also noted the importance of homes where gay men were accepted, and could meet without fear of discrimination. These homes either belonged to other gay men, or the mothers of young gay men.

'P: Look on the flats there's- it's like I said there's what gay people do- they form their little clique, and I know I can go, and there's also gay huggers- there's Aunties I know, there's F--- in the Steenberg area, and there's A---...she's a mother, so everybody will flock around her, and they all phone her, so you always have your groups, or there's a home I can go to where the mother's fine, she accepts us,

G: Mmm.

P: You know, so this is where they go, they physically have a structure that's set up, they will not go for psychological service to community health, or something like that

P: But they find their little groups that they identify with where they can go, or there's an Aunty in the street who says 'ag you can be what you want to be', and they all flock there.

G: OK.

P: Because there they can act out, and the Aunty just plays along with it, you know, so that is where they find their little niche groups' (Key Informant 9, 20/11/2009).

Having gay friends and a social group in which they could be open about their sexuality, and discuss issues that affected them was important in light of the lack of discussion and openness some participants reported within their families. Several participants stated that their families knew that

they were gay and supported them, they noted that they could not talk about being gay or about HIV with their families.

'At my family they know that I'm gay, but they won't say it, like your family, your mother can see, my child is behaving like this, is behaving but she won't say it or whoever, because the mother is the first person to see in the family' (FGD 2, 14/10/2009).

'...even our parents they know, but they can't discuss it with us, they know everything but they can't discuss it with us' (FGD 2, 14/10/2009).

Tucker (2009) notes that the social nodes that he describes are important as a means of affirming gay individuals' identities. These groups may also provide gay men with a space in which they can discuss issues that affect them without fear of being judged.

3.3.PERSONAL LEVEL

Generally, the personal level is understood to encompass issues such as self-esteem, self efficacy, personal risk perception, and individuals' intentions (Eaton et al., 2003). The fact that most of the participants in this study were openly gay has important implications in terms of their own self esteem and the decisions that they make in terms of HIV risk behaviours. It appears that the decision to be open about their sexuality, or to be visible, in Tucker's (2009) words, has had a positive effect on these men's self esteem.

'But me I don't mind because I know myself, I'm gay and I will die as a gay' (Key informant 4, 19/08/2009).

'I'm exposed, I can do whatever I want to do I'm gay, completely gay, I'm not in the denial...' (FGD 2, 14/10/2009).

'...one thing I like about gay people like, they know who they are, and they respect themselves' (FGD 2, 14/10/2009).

Openness about their sexuality seems to have had a positive effect on some individuals' responses to HIV. One participant who was HIV positive stated that he had begun discussing HIV with people in his community when he was diagnosed:

'As soon as I discovered that I was HIV positive I was able to talk to them, you know, freely about my status and I think that made other young people and gay people to be free, to feel free you know because there is this person, you know, who is talking about his sort of status and so, and what are the pros and cons I'm experiencing. I think sharing was quite a very good thing for me to them, you know' (Key informant 2, 09/07/2009).

Other participants talked about their efforts to raise awareness about HIV among gay men in their communities:

'I like to call them and say "people there's something happening, must be careful. If you get somebody make sure you use a condom"' (Key informant 3, 13/08/2009).

'I thought that lets design a workshop to those communities, and so that people can have information, how risky it is for HIV and AIDS, how important it is to know your status, you know, because to talk about HIV and AIDS is useless for them. I think we have also to look at the risk, and the importance of knowing your status because now when you talk about HIV and AIDS' (Key informant 1, 07/07/2009).

In contrast to these participants' openness about HIV, others thought that HIV was an issue that most gay men ignored.

'Like in gays people there's some people they just hide their status, they don't want to talking about, if like I'm talking about something like HIV and all that stuff, some of them they feel sensitive' (Key informant 4, 19/08/2009).

'...the HIV thing is something that we are ignoring' (FGD 2, 14/10/2009).

One participant noted that he thought that gay people who got infected with HIV were those who were still 'in the closet'. Being 'visible' as gay is an important decision that these men have made and this appears to form an important aspect of the ways that they perceive their identities. These identities are constructed in 'dynamic interaction' with the people they encounter on a daily basis (Campbell, 1997). This means that it is important for these individuals to identify what they 'are' as well as what they 'are not'. By distinguishing between their openness about their sexuality and their ability to discuss issues such as HIV these men distinguish themselves from those who they see as 'people who are in denial like straight people, people who call themselves bisexual' (FGD 2, 14/10/2009).

The 'distance' between openly gay men and those in the closet was also marked by the idea that such closeted men 'used' gay men for sex.

'They want our company because they know they are after nine and the only thing they need is one, they need to just bang, and then they finished' (FGD 2, 14/10/2009).

'When you meet a guy he just want to get over with this, have sex and then must be done now' (FGD 2, 14/10/2009).

Participants also stated that these men would deliberately try to infect them with HIV. For example:

'Someone will tell you that "I don't want to die on my own, I want to kill other people as well", that is another thing that is taking place today communities' (Key informant 1, 07/07/2009).

'Maybe I can say this guy is HIV positive, maybe he's going to see me around there in D___, he's going to come there by me say "A--I love you, maybe A-- I understand your situation so I can have an affair with you, we going to married, I'm going to do this, we're going to

stay together..." something like that. Just to promise lots of promises. All along that guy only want...only he want...he want just to transfer this disease to me' (Key informant 4, 19/08/2009).

The perception that these men are deliberately trying to spread HIV is another interesting aspect of the 'distance' participants place between themselves and 'after nines'. Their understanding of some 'after nines' as having malicious intent towards gay men, and their use of sex as a 'weapon' against gay men provides some insight into the contested nature of sexuality in these areas.

3.3.1. HIV Awareness

The level of awareness of HIV reported by participants is an important factor that may contribute to less risky behaviours in terms of HIV. Participants in the study reported that they were personally very aware of HIV and HIV related risk behaviours. However, most participants felt that while there was a generally high level of awareness of HIV in 'coloured' communities, this did not necessarily translate into safer sexual behaviour.

'P: Well those people that knows they have that virus they couldn't get to fuck, so they still fuck around. Our friends do it. There's a few of our friends that has the virus, there's a few that passed on, they still kept on, they still did what they did' (Key Informant 5, 23/9/2009).

'P: The thing is they know how to...how they contracted HIV and AIDS, they know what the symptoms are, they have the information, but yet they're still ignorant by not using a condom, not informing their partner- ja that is the way they operate' (Key Informant 6, 19/10/2009).

A related concern raised by two participants was around 'AIDS fatigue'. These participants felt that people were tired of hearing about HIV.

'P:...the thing is HIV and AIDS is a subject- it's a dying subject- people don't want to talk about HIV and AIDS...People don't talk - only December (world AIDS day), come December people will start talking about HIV and AIDS, but they won't - I mean it's not the everyday discussion that people have' (Key Informant 6, 19/10/2009).

'P: So sometimes there's a lot of AIDS fatigue. Where they're just: "fuck it ek het genoeg, I don't want to go there", and that is also where we go wrong. I mean last year my fourth years, I wasn't there last year at ____, they rioted to say "enough is enough, no more HIV, we don't want to do it" '(Key Informant 9, 20/11/2009).

The participant above, who works with university students, felt that this feeling was related to the fact that HIV awareness had been covered throughout the school syllabus, and that students were simply tired of hearing about HIV.

Participants also noted the lack of HIV awareness campaigns targeting gay men, and several participants reported that there was a need for messaging to target this population.

3.3.2. Sexual identities

Whether or not MSM self-identify as gay, straight, or bisexual may also affect their risk of contracting HIV. Participants noted a variety of sexual identities among MSM in 'coloured' communities. Several participants felt that gay men in 'coloured' communities commonly expressed their identity through cross dressing, and explicitly adopting a feminine gender identity.

'That is the Coloured community, they are infested with drag queens' (Key Informant 5, 23/09/2009).

'Like for myself...I call myself a female, because I don't classify myself as a man...I am a man, but I classify myself as a female' (Key Informant 5, 23/09/2009).

'They come out more as females, dress up like females, and that is just the way gay people are perceived, or them themselves are only perceiving that' (Key Informant 7, 19/10/2009).

This participant also felt that among younger gay men there was a trend towards adopting more masculine gay identities.

'P: But there's lots of butch guys coming out now-a-days, and just trying to be like a guy, or be like a male- so that trend has also started- maybe in the previous five years or so. That has been started, but there's lots of young gay boys coming out' (Key Informant 7, 19/10/2009).

It is possible that there is an increase in tolerance of homosexual identity among younger members of the 'coloured' community which allows individuals to express their identities more openly. One participant for instance stated:

'P: It's not like before: "ooh die moffie crowd, and you know the straight crowd- we don't mix with them because we will be perceived as being with them and like them", but it's more open now, it's more accepted' (Key Informant 9, 20/11/2009).

If this is the case it has implications for the types of HIV messaging that can be used to target younger MSM in 'coloured' areas.

3.3.3. Internalised negativity

The effects of exposure to homophobic environments, stigma and discrimination, may also be an important influence on individuals' risk behaviours. Cloete et al. (2008) note that internalised feelings of shame and guilt have a negative effect on the health status of individuals living with HIV. This participant discussed the effects of stress on daily life:

'P4: And it's not just the physical illness you know, a lot of- I think people don't really understand what damages um ja emotionally, and when you stress, you know, how that also affects your health. When you're down it's really difficult to sort of get up, and do things, and even small things, so it's important that where you go - that you get treated properly' (FGD 3, 04/11/2009).

The high level of internalised stigma among HIV-positive MSM found by Cloete et al. (2008) should be taken into account in HIV prevention messaging, as these factors are likely to affect how MSM respond to prevention messages.

3.3.4. Positive self identity

A related aspect of individuals' HIV risk behaviour is their 'idea of self' – or their perception of their identity and whether this is generally positive or negative. Graziano (2004) for instance argues that a positive self identity is important for South African gays and lesbians as an aspect of resilience in the face of widespread homophobia. Wexler et al (2009) go further to argue that the processes of 'belonging' to a minority group, and resisting a prevailing heteronormative culture can be important in supporting individuals resilience.

Individuals with more positive interpretations of their sexuality, and sexual identity, may be more likely to practise safer sex, or to seek health care when they need it. This participant for instance discussed how he felt it was important for him to acknowledge his relationship with his partner in public, regardless of how other people reacted to this.

'P: And that's why I prefer to be with a man, and what I said also to myself- see that my partner's honest to me, and I'm honest to my partner also, and my partner... that's one thing that I learn also about my partner- to show yourself, to express yourself in the road, you mustn't be afraid- you must actually feel free to go out there' (Key Informant 8, 21/10/2009).

He reported that he had gone with his partner to get an HIV test.

'P: First of all I was afraid, but the reason I was afraid was that I said to myself 'ay I wonder tomorrow what is the people going to say, and what are they going to think if me and my partner and going to went into the clinic and we're going to have this test?', and after that my partner did have a chat with me, and we did talk about it, and he let me feel more confident' (Key Informant 8, 21/10/2009).

Other participants felt that being positive about their identity was important for them to be able to assert their rights, and to engage with their local communities as gay men.

P1: Actually one of the things which we train also to do, me and L---, try to get the gay to be involved in you know the community, you know action and decision, not to have like this kind of- the gay community are apart, and because we are all living in the same community, and we're facing the same issues if I can say. So we try now to put people to work together with us, you know, without thinking that the gay are just good to do that (laughs). You understand what I mean? (FGD 3, 04/11/2009).

The point that this participant makes about solidarity among communities as a whole in the face of shared challenges, is important. Given that homophobia was identified by participants as one important factor related to HIV risk, prevention efforts that aim to increase solidarity between gay men and their local communities could form one aspect of a comprehensive HIV prevention package.

4. DISCUSSION

HIV risk among MSM communities in Cape Town is affected by multiple factors, both structural and individual, and the multiple interactions between these factors. Compelling HIV prevention programming needs to, at the very least, acknowledge the complexity of HIV risk for these men. Much of South Africa's population is subjected to structural violence³ that is reflected in the unequal nature of the HIV epidemic. In addition to the effects of poverty and economic exclusion, MSM in South Africa experience a further degree of structural violence as a result of the homophobic social and cultural context in which they live; this possibly increases their risk of contracting HIV (cf. White and Carr, 2005, Cloete et al., 2008).

Social and cultural intolerance of homosexuality, high levels of HIV-related stigma, and high levels of poverty and unemployment create a broad context in which individuals' daily interactions with their communities, their partners, and their environments place them at increased risk of HIV infection. Direct experiences of discrimination and homophobia affect how MSM choose to socialize, the socialising options available to them, and the types of sexual encounters they engage in. These encounters are often in situations that create an increased risk of contracting HIV.

Kane (1998, quoted in Schoepf, 2001) notes that risk is situationally determined; but each situation occurs in a broader context of risk. Particular risk situations are made riskier by the lack of HIV prevention focusing on MSM and MSM risk for HIV infection. Personal level factors, such as poor mental health, and low levels of knowledge and experience of HIV, also affect how individuals negotiate these situations and increase an individual's chances of engaging in risky behaviour for HIV transmission. The likelihood of HIV transmission is further increased when this behaviour occurs in contexts that are already risk inducing.

Comprehensive HIV prevention for MSM therefore needs to focus on factors affecting risk environments, and those that affect risk situations. Prevention programming needs to be coordinated between organisations to prevent duplication of effort.

4.1. From risk environment to risk situation

The process of HIV transmission occurs in specific risk situations which are affected by the broader risk environment. Barnett and Whiteside (2002) define risk environments in terms of infectious disease transmission, as those environments in which 'infectious disease can expand and develop rapidly into an epidemic'. There is a need for more in-depth analyses of risk environments for HIV transmission, and how these risk environments influence the specific risk situations in which HIV transmission occurs. Using a distal-proximal-personal framework to analyse the risk environments for at-risk populations provides a means to identify and understand specific factors within these environments that affect risk and resilience, and which can be focused on in HIV prevention programmes.

³ Parker (2001) notes that the term 'structural violence' describes the interactive effects of social factors such as poverty, economic exploitation, gender power, sexual oppression, racism, and social exclusion on the social vulnerability of groups and individuals.

Leclerc-Madlala (2002) similarly, discusses how research and interventions focussing narrowly on high-risk sexual attitudes and behaviours conflict with what she terms 'dis-enabling' contexts in which people live, to produce a situation in which HIV continues to spread. It is therefore important to understand how risk environments affect different populations within them; and how risk environments, and dis-enabling contexts in turn affect how individuals negotiate risk situations within these broader contexts.

Important distal factors identified in this research that create the broad risk environment for MSM in Cape Town include: cultural, religious, and social intolerance of homosexuality; HIV related stigma; and poverty and unemployment. Individuals' daily proximal-level interactions with their communities also contribute to this risk environment. These interactions are affected by factors that include: discrimination and stigmatisation; limited social options; the location of sexual encounters; transactional sex; and the lack of compelling HIV prevention programmes.

While there may be common distal factors affecting the hetero- and homosexual population, the interactions (or causal chains) differ, and hence HIV transmission in these different populations occurs in different risk situations and is affected by different proximal and personal factors. Ross and Ferreira-Pinto (2000) argue in this vein that while 'environmental aspects are often considered insofar as they enable, reinforce, or predispose to healthy or risky behaviours in the individual' they are not generally considered in terms of immediate risk situations. Individual characteristics such as attitudes and beliefs are important, but research into these characteristics does not explain the fact that the same individual may engage in very different risks in different situations (Ross and Ferreira-Pinto, 2000).

Parker *et al.* (2000) discuss the importance of understanding the 'situational specificity' of erotic desire when examining HIV risk among MSM. This situational specificity refers to the specific contexts in which sexual practices take place and Parker *et al.* (2000) note that these contexts may '...make reasonable and acceptable, patterns of behaviour that might in other circumstances be unthinkable and untenable'. While Parker *et al.* discuss this situational specificity in terms of sexual segregation in prisons, the military, and religious settings, in this study there are also specific situations reported where it appears that sexual interactions between men become 'reasonable and acceptable' in spite of the broad homophobic context in which they occur. For 'straight' sexual partners of participants in this study, the consumption of alcohol at shebeens and taverns seems to provide this context; the use of alcohol being the factor that makes same-sex sexual behaviour 'reasonable and acceptable'. For example, this 'straight' participant stated:

'...alcohol plays a major role, you pick up someone at the shebeen, you not 100 percent sure that this person is male, you are under the impression that, that it's a female, you find out at home then it's too late, then you already busy having sex kind of a thing' (FGD 1, 18/08/2009).

Similarly, another participant noted that students that he worked with would associate their same-sex sexual behaviours with alcohol consumption:

'...he's the one always getting involved, he gets piss drunk, and then he gets fucked all over the show but 'nee meneer dis nie ek, dis die wyn (no sir, it's not me, it's the wine)' (Key informant 9, 20/11/2010).

The situational specificity of erotic desire in these cases is related to a pattern of social interaction involving alcohol consumption, primarily in informal establishments. Understanding this specific context as important for HIV risk behaviour must then also include an understanding of how these risk situations are bounded, or located, in terms of their temporal, physical, social, and geographical locations (Ross et al., 2004).

4.2. Immediate risk situations

The specific characteristics of risk situations, if they can be identified, provide points of intervention for HIV prevention initiatives. The immediate risk situations described by participants frequently involved consumption of alcohol at informal drinking establishments, and sex with straight-identifying men (after nines). Using Ross et al.'s (2004) 'boundaries' of risk situations the following general characteristics of risk situations reported by participants in this study can be identified.

4.2.1. Temporal characteristics

- Late night
- Short duration

4.2.2. Physical characteristics

- Having sex while drunk
- Unprotected – inconsistent condom use; water based lubricants not used.

4.2.3. Social characteristics

- Often transactional – gay men 'paying' straight men for sex
- Uneven power dynamics – partners' reported insistence on unprotected sex.
- Multiple sexual partnerships
- Differing sexual behaviour with partners who self identify as gay to those who self identify as straight

4.2.4. Geographical characteristics

Hidden sex:

- Toilets at shebeens
- Vacant lots
- Parks
- Dark corners

These characteristics of risk situations provide a specific set of issues, or points of intervention, that can be addressed in HIV prevention programmes to make HIV transmission in particular risk situations less likely. This requires active work with the owners of drinking establishments to ensure that condoms and lubricants are easily available, visible, and accessible to their customers. Other interventions need to be run with men around negotiating safe sexual encounters and insisting on safer sex. The need for clear and concise messaging about water-based lubricant is particularly important, as is making free water-based lubricant easily available.

5. TARGETING MSM IN CAPE TOWN FOR HIV PREVENTION

The adaptation of the framework used by Eaton *et al.* (2003) in this study, using qualitative data, attempts to provide a means of understanding the contexts of HIV risk and transmission among MSM in Cape Town. In describing both the broader and more immediate contexts of HIV risk it argues that it is necessary to target HIV prevention efforts at immediate and more distant levels from the individual, with a view to changing both the direct and indirect drivers of HIV incidence.

Given the complexity of the factors affecting HIV risk among MSM communities, both in Cape Town and throughout South Africa, there is a need for tools to be developed to assist in the analysis of these factors, and the planning and co-ordination of HIV prevention initiatives. Using the distal-proximal-personal framework adopted by Eaton *et al.* (2003) for a specific population ('black' and 'coloured' MSM in Cape Town in this case) is one such means of doing this. This framework can accommodate both qualitative and quantitative approaches, and provides a means of plotting interactions between the levels at which various factors affect HIV risk behaviour.

Eaton *et al.* (2003) however, focus only on factors that increase HIV risk behaviours at the various levels. This one-sided approach to HIV prevention may exclude other important factors that also affect HIV risk, but which act positively to reduce risk. Using a public health conception of risk and resilience (Wexler *et al.*, 2009), it is useful to divide the framework into positive and negative factors. This allows organisations to plot and analyse causal chains affecting individual behaviour that increase or decrease risk and resilience in terms of vulnerability to HIV infection.

This type of analysis therefore provides a means of identifying points at which to target interventions, as well as providing a basis for the evaluation of interventions efficacy. Using this framework to co-ordinate efforts within and between organisations may also prevent duplication of efforts and assist in providing more comprehensive HIV prevention programmes to at-risk populations.

This means that HIV prevention campaigns need a dual focus. They must aim to reduce individuals' risks of contracting HIV, while simultaneously increasing their resilience in avoiding HIV infection, or in taking action to prevent the spread of HIV.

5.1. Promoting resilience – reducing risk

The aim of an analysis of HIV risk must be to identify points at which interventions can be targeted to reduce HIV incidence. The use of a distal-proximal-personal framework as a means of understanding the risk environments and risk situations in which MSM in Cape Town live is one way to identify these points. At each level of distance from the individual it is important to consider strategies that can decrease risk, and also those which can increase resilience. The wide range of factors affecting HIV risk in these areas means that it is necessary to use a multi-disciplinary lens in attempting to understand the contexts in which HIV transmission occurs, and hence to intervene in ways that decrease transmission rates.

5.2. Distal level

The effects of distal level interventions are likely to be the most difficult to measure in terms of changes in HIV incidence. However, interventions at this level address issues that have broad effects (i.e. effects not limited to HIV prevention) and which are important in terms of human rights and social and economic justice; and these provide further justification in undertaking such interventions. Interventions at this level, therefore, aim to change the broad environment in which risk behaviour occurs and require co-ordinated effort from a range of organisations. This represents a somewhat 'ideal world' scenario; but the following provide a basic framework of the types of interventions that could be undertaken.

1. Create and engage in dialogue with traditional authorities, cultural institutions, and religious organisations about MSM (LGBTI) rights, discrimination, and stigma.
2. Organisations need to participate in local, regional, and national forums that debate and decide HIV policy to ensure that MSM needs are included in policy and legislation.
3. Where opportunities exist, efforts that promote local economic development should be supported and encouraged to explicitly include MSM.
4. Mainstream HIV prevention messaging organisations should be lobbied to include MSM and LGBTI issues and concerns.
5. HIV-related stigma needs to be addressed explicitly.

5.3. Proximal level

Individuals' daily lives and their interactions with their communities and local environments have a direct effect on the types of HIV risk behaviours that they engage in. There are a range of interventions that can be undertaken at this level to decrease HIV risk for MSM.

1. Prevention efforts should focus on shebeens that are frequented by MSM. These need to include condom and lubricant distribution and need to involve shebeen owners to ensure that prevention materials remain prominently displayed and accessible. Messages in drinking establishments should aim to appeal to openly gay, and 'straight' MSM.
2. Publicly visible HIV prevention materials should address risk behaviours without directly associating these with MSM. For example, messages promoting the use of condoms and water-based lubricant for anal sex should be about anal sex rather than about sex between men.
3. Negotiating condom and water-based lubricant use should be workshopped with MSM, and participants should be encouraged to share the knowledge they gain with other MSM.
4. Peer networks linked to MSM focused organisations can provide a means of reaching MSM with targeted messaging, condoms and water-based lubricants. Such targeted messaging can be explicitly about MSM related risks and can be more detailed than publicly visible messages.
5. Clinic visits provide an important opportunity to address these issues, and prevention materials need to be readily available in clinics used by MSM.
6. Department of Health staff need to be engaged around homophobia in their facilities, and this prejudice needs to be addressed constructively.
7. Messaging in 'coloured' communities must specifically include transgender individuals.

8. Houses where gay men socialise should also be identified and their owners should be approached about providing condoms and lubricants, and HIV prevention information. This information should be explicitly gay focused.

5.4. Personal level

Living in an environment where homophobia and discrimination are the norm can have very negative effects on individuals' mental health, potentially leading to low self esteem, depression, and anxiety among other issues. These issues may in turn affect individuals' likelihood of engaging in risky behaviour for HIV infection and transmission (Kalichman, 1999). HIV prevention efforts therefore need to focus on engaging with MSM in ways that encourage self-esteem and self-efficacy.

1. HIV prevention messaging needs to encourage positive interpretations of homosexuality and emphasise sex-positive interpretations of MSM sexual behaviours.
2. Solidarity with other MSM should be encouraged, with the idea of 'belonging' to a unique group being emphasised. Such understandings can be an important way to increase self esteem and self efficacy for HIV prevention.
3. HIV prevention information needs to focus on issues directly affecting MSM. Specific issues that should be addressed include transactional sex, sex while under the influence of alcohol and drugs, and the use of water-based lubricant and condoms.
4. Social groups of gay men in the townships need to be supported to encourage safer sexual behaviour. These groups should be encouraged to participate in distributing HIV prevention materials, condoms, and water-based lubricants.
5. MSM-sensitive psycho-social support and counselling services need to be implemented.
6. Mental health assessment should be included in health care protocols for MSM where indicated.

6. CONCLUSION

The complexity of HIV risk and vulnerability necessitate a broadening of the focus of HIV prevention efforts to include the social, cultural, political, and economic factors that affect individual behaviour (Rao-Gupta et al., 2008). This research has identified a number of important factors that affect the vulnerability of MSM in Cape Town to HIV infection. These factors at a distal level (cultural and structural issues) included homophobic cultural norms and stigma, HIV-related stigma, and poverty. Proximal factors (interpersonal relationships and the immediate environment) included verbal abuse and violence, lack of safe social and sexual spaces, multiple partnerships, transactional sex, alcohol use, discrimination at health care facilities, and a lack of HIV prevention resources (including condoms and water-based lubricant). Personal factors (within the individual) included self esteem and whether individuals were openly gay or not.

While individual behaviour-change strategies remain an important aspect of HIV prevention, their effectiveness is limited when these broader structural issues are not addressed (Coates et al., 2008). Coates et al. (2008) argue that for HIV prevention to achieve the 'radical behaviour change' necessary for reductions in HIV incidence countries need to implement combination prevention. This is prevention that combines behaviour change strategies, structural strategies, biomedical strategies, and HIV and STI treatment (Coates et al., 2008).

Our research has highlighted some of the critical points of intervention that require attention for a combination prevention strategy to be implemented for MSM in Cape Town. While the data reported are based on research done in Cape Town, it is likely that these issues are similar across South Africa and they should be considered in the design and implementation of HIV prevention strategies for MSM more broadly.

REFERENCES

- ADHIKARI, M. 2004. 'Not Black Enough': Changing expressions of Coloured identity in post-Apartheid South Africa. *South African Historical Journal*, 51, 167-178.
- AVALOS, L. A., MERTENS, J. R., WARD, C. L., FLISHER, A. J., BRESICK, G. F. & WEISNER, C. M. 2009. Stress, Substance Use and Sexual Risk Behaviors Among Primary Care Patients in Cape Town, South Africa. *AIDS and Behavior*.
- BARKER, G. & RICARDO, C. 2005. Young men and the construction of masculinity in sub-Saharan Africa: Implications for HIV/AIDS, conflict and violence. *Social Development Papers*. Washington D.C.: The World Bank.
- BARKER, J., HLADIK, W., BAGENDA, D., TENYWA, T., MUYONDA, M., SSENKUSU, J. & TAPPERO, J. 2010. HIV infection among men having sex with men in Kampala, Uganda. *XVIII International AIDS Conference*. Vienna, Austria: International AIDS Society.
- BARNETT, T. & WHITESIDE, A. 2002. *AIDS in the twenty-first century: Disease and globalization*, Basingstoke, Palgrave-MacMillan.
- BERG, R. 2008. Barebacking among MSM internet users. *AIDS and Behavior*, 12, 822-833.
- BEYRER, C. 2007. HIV Epidemiology Update and Transmission Factors: Risks and Risk Contexts-16th International AIDS Conference Epidemiology Plenary. *Clinical Infectious Diseases*, 44, 981-987.
- BEYRER, C., TRAPENCE, G., MOTIMEDI, F., UMAR, E., IIPINGE, S., DAUSAB, F. & BARAL, S. 2010. Bisexual concurrency, bisexual partnerships, and HIV among Southern African men who have sex with men (MSM). *Sexually Transmitted Infections*, Online first
- CAMPBELL, C. 1997. Migrancy, Masculine Identities and AIDS: The Psychosocial Context of HIV Transmission on the South African Gold Mines. *Social Science & Medicine*, 45, 273-281.
- CARRIGAN, T., CONNELL, R. & LEE, J. 1985. Towards a new sociology of masculinity. *Theory and Society*, 14.
- CLOETE, A., SIMBAYI, L., KALICHMAN, S., STREBEL, A. & HENDA, N. 2008. Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa. *AIDS Care*, 20, 1105-1110.
- COATES, T. J., RICHTER, L. & CACERES, C. 2008. Behavioural strategies to reduce HIV transmission: How to make them work better. *The Lancet*, 372, 36-51.
- CONNELL, R. 1992 A very straight gay: Masculinity, homosexual experience, and the dynamics of gender. *American Sociological Review*, 57, 735-751.
- CONNELL, R. 1995. *Masculinities*, Stanford, Stanford University Press.
- DEPARTMENT OF HEALTH 2007. HIV & AIDS and STI Strategic Plan for South Africa 2007- 2011. Pretoria: Department of Health.
- EATON, L., FLISHER, A. J. & AARO, L. E. 2003. Unsafe sexual behaviour in South African youth. *Social Science & Medicine*, 56, 149-165.
- FOLCH, C., MUNOZ, R., ZARAGOZA, K. & CASABONA, J. 2009. Sexual risk behaviour and its determinants among men who have sex with men in Catalonia, Spain. *Eurosurveillance*, 14.
- GRAZIANO, K. J. 2004. Oppression and resiliency in a post-apartheid South Africa: unheard voices of Black gay men and lesbians. *Cultural Diversity & Ethnic Minority Psychology*, 10, 302-16.
- HALPERIN, D. T. & EPSTEIN, H. 2004. Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention. *The Lancet*, 364, 4-6.
- HENDERSON, N. & SHEFFER, T. 2008. Practices of power and abuse in gay male relationships: An exploratory case study of a young, isiXhosa speaking man in the Western Cape, South Africa. *South African Journal of Psychology*, 38, 1-20.
- HUNTER, M. 2005. Cultural politics and masculinities: Multiple partners in historical context in KwaZulu-Natal. *Culture, Health & Sexuality*, 7, 209-233.
- HUNTER, M. 2007. The changing political economy of sex in South Africa: The significance of unemployment and inequalities to the scale of the AIDS epidemic. *Social Science & Medicine*, 64.
- HUTCHINSON, P. L., MAHLALELA, X. & YUKICH, J. 2007. Mass Media, Stigma and Disclosure of HIV Test Results: Multilevel Analysis in the Eastern Cape, South Africa. *AIDS Education and Prevention*, 19, 489-510.
- IRWIN, T. W., MORGENSTERN, J., PARSONS, J. T., WAINBERG, M. & LABOUVIE, E. 2006. Alcohol and sexual HIV risk behaviour among problem drinking men who have sex with men: An event level analysis of timeline followback data. *AIDS and Behavior*, 10, 299-307.
- JOHNSON, C. A. 2007. *Off the map: how HIV/AIDS programming is failing same-sex practicing people in Africa*, New York, International Gay and Lesbian Human Rights Commission.
- KALICHMAN, S. 1999. Psychological and social correlates of high-risk sexual behaviour among men and women living with HIV/AIDS. *AIDS Care*, 11, 415-427.
- KALICHMAN, S., SIMBAYI, L., JOOSTE, S., CHERRY, C. & CAIN, D. 2005. Poverty-related stressors and HIV/AIDS transmission risks in two South African communities. *Journal of Urban Health*, 82, 237-249.
- KALICHMAN, S., SIMBAYI, L., KAGEE, A., TOEFY, Y., JOOSTE, S., CAIN, D. & CHERRY, C. 2006. Associations of poverty, substance use, and HIV transmission risk behaviors in three South African communities. *Social Science & Medicine*, 62, 1641-1649.

- KALICHMAN, S., SIMBAYI, L., VERMAAK, R., JOOSTE, S. & CAIN, D. 2008. HIV/AIDS risks among men and women who drink at informal alcohol serving establishments (shebeens) in Cape Town, South Africa. *Prevention Science*, 9, 55-62.
- KANE, S. 1998. *AIDS Alibis: Sex, drugs, and crime in the Americas*, Philadelphia, Temple University Press.
- KOBLIN, B., HUSNIK, M. J., COLFAX, G., HUANG, Y., MADISON, M., MAYER, K., BARRES, P. J., COATES, T. J., CHESNEY, M. A. & BUCHBINDER, S. 2006. Risk factors for HIV infection among men who have sex with men. *AIDS*, 20, 731-739.
- KOMETSI, K. J. 2007. *Coloured subjectivities and black Africanness*. DPhil, University of the Witwatersrand.
- LANE, T., MOGALE, T., STRUTHERS, H., MCINTYRE, J. & KEGELES, S. 2008a. "They see you as a different thing": the experiences of men who have sex with men with healthcare workers in South African township communities. *Sexually Transmitted Infections*, 84, 430-433.
- LANE, T., RAYMOND, H. F., DLADLA, S., RASETHE, J., STRUTHERS, H., MCFARLAND, W. & MCINTYRE, J. 2009. High HIV Prevalence Among Men Who have Sex with Men in Soweto, South Africa: Results from the Soweto Men's Study. *AIDS and Behavior*.
- LANE, T., SHADE, S. B., MCINTYRE, J. & MORIN, S. F. 2008b. Alcohol and Sexual Risk Behaviour Among Men Who Have Sex with Men in South African Township Communities. *AIDS and Behavior*, 12, S78-S85.
- LECLERC-MADLALA, S. 2002. Youth, HIV/AIDS and the importance of sexual culture and context. *Social Dynamics*, 28, 20-41.
- LECLERC-MADLALA, S. 2003. Transactional sex and the pursuit of modernity. *Social Dynamics*, 29, 213-233.
- LUSENO, W. & WECHSBERG, W. M. 2009. Correlates of HIV testing among South African women with high sexual and substance-use risk behaviours. *AIDS Care*, 21, 178-184.
- LYNCH, I., BROUARD, P. W. & VISSER, M. J. 2009. Constructions of masculinity among a group of South African men living with HIV/AIDS: reflections on resistance and change. *Culture, Health & Sexuality*, iFirst, 1-13.
- MACPHAIL, C. & CAMPBELL, C. 2001. 'I think condoms are good but, aai, I hate those things': Condom use among adolescents and young people in a Southern African township. *Social Science & Medicine*, 52, 1613.
- MAUGHN-BROWN, B. 2010. Stigma rises despite antiretroviral roll-out : A longitudinal analysis in South Africa. *Social Science & Medicine*, 70, 368-374.
- MYER, L., MATHEWS, C. & LITTLE, F. 2002. Condom use and sexual behaviors among individuals procuring free male condoms in South Africa. *Sexually Transmitted Diseases*, 29, 239-241.
- O'LEARY, A., FISHER, H. H., PURCELL, D. W., SPIKES, P. S. & GOMEZ, C. A. 2007. Correlates of risk patterns and race/ethnicity among HIV-positive men who have sex with men. *AIDS and Behavior*, 11, 706-715.
- PARKER, R. 2001. Sexuality, culture, and power in HIV/AIDS Research. *Annual Review of Anthropology*, 30, 163-179.
- PARKER, R. & AGGLETON, P. 2003. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science & Medicine*, 57, 13-24.
- PARKER, R., KHAN, R. & AGGLETON, P. 2000. Conspicuous by their absence? Men who have sex with men (MSM) in developing countries: implications for HIV prevention. *Critical Public Health*, 8.
- PARRY, C., PLUDDERMANN, A., STEYN, K., BRADSHAW, D., NORMAN, R. & LAUBSCHER, R. 2005. Alcohol use in South Africa: findings from the first Demographic and Health Survey (1998). *Journal of Studies on Alcohol*, 66, 91-98.
- RAO-GUPTA, G., PARKHURST, J. O., OGDEN, J., AGGLETON, P. & MAHAL, A. 2008. Structural approaches to HIV prevention. *The Lancet*, 372, 764-775.
- RISPEL, L. & METCALF, C. 2009a. Breaking the silence: South African HIV policies and the needs of men who have sex with men. *Reproductive Health Matters*, 17, 133-142.
- RISPEL, L. & METCALF, C. 2009b. The Johannesburg/eThekweni Mens Study: A rapid assessment of the HIV epidemic among men who have sex with men. Cape Town: HSRC.
- ROSS, M. W. & FERREIRA-PINTO, J. 2000. Toward a public health of situations: the re-contextualisation of risk. *Cadernos de Saude Publica*, 16, 59-71.
- ROSS, M. W., HENRY, D., FREEMAN, A., CAUGHY, M. & DAWSON, A. G. 2004. Environmental influences on safer sex in young gay men: a situational presentation approach to measuring influences on sexual health. *Archives of Sexual Behaviour*, 33, 249-257.
- SANDFORT, T., NEL, J., RICH, E., REDDY, V. & YI, H. 2008. HIV testing and self-reported HIV status in South African men who have sex with men: results from a community-based survey. *Sexually Transmitted Infections*, 84, 425-429.
- SCHOEPF, B. G. 2001. International AIDS research in anthropology: taking a critical perspective on the crisis. *Annual Review of Anthropology*, 30, 335-361.
- SEGAL, L. 1990. *Slow motion: changing masculinities, changing men*, London, Virago Press.
- SHISANA, O., REHLE, T., SIMBAYI, L., ZUMA, K., JOOSTE, S., PILLAY-VAN-WYK, V., MBELLE, N., VAN ZYL, J., PARKER, W., ZUNGU, N. P., PEZI, S. & THE SABSSM III IMPLEMENTATION TEAM 2009. South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers? Cape Town: HSRC.

- SONN, C. & FISHER, A. T. 2003. Identity and oppression: differential responses to an in-between status. *American Journal of Community Psychology*, 31, 117-128.
- STATISTICS SOUTH AFRICA 2007. Community Survey. Pretoria: Statistics South Africa.
- STATISTICS SOUTH AFRICA 2011. Quarterly Labour Force Survey. Pretoria: Statistics South Africa.
- SWARR, A. L. 2004. Maffies, Artists, and Queens: Race and the Production of South African Gay Male Drag. *The Journal of Homosexuality*, 46, 73-89.
- THE PRESIDENCY OF THE REPUBLIC OF SOUTH AFRICA 2009. Development indicators 2009. Pretoria: The Presidency of the Republic of South Africa.
- TUCKER, A. 2009. *Queer Visibilities: Space, Identity and Interaction in Cape Town*, Chichester, Wiley-Blackwell.
- VINCENT, L. 2008. 'Boys will be boys': traditional Xhosa male circumcision, HIV and sexual socialisation in contemporary South Africa. *Culture, Health & Sexuality*, 10, 431-446.
- VISSER, M. J., MAKIN, J. D., VANDORMAEL, A., SIKKEMA, K. & FORSYTH, B. W. C. 2009. HIV/AIDS stigma in a South African community. *AIDS Care*, 21, 197-206.
- WEXLER, L. M., DIFLUVIO, G. & BURKE, T. K. 2009. Resilience and marginalized youth: Making a case for personal and collective meaning-making as part of resilience research in public health. *Social Science & Medicine*, 69, 565-570.
- WHITE, R. C. & CARR, R. 2005. Homosexuality and HIV/AIDS stigma in Jamaica. *Culture, Health & Sexuality*, 7, 347-359.

APPENDIX: PARTICIPANTS RESPONSES TO MSM-FOCUSED HIV AWARENESS CAMPAIGNS.

Introduction

One aspect of this research involved discussing a range of gay-focused HIV-awareness advertisements. Most of these were from campaigns run by the London based organisation 'GMFA – the gay men's health charity' (www.gmfa.org.uk). The aim of this process was to identify what types of HIV messaging appealed to participants, and whether they felt that these were appropriate for the areas in which they live.

Responses to particular advertisements were classified in terms of the images, messages, and formats that participants liked or disliked. Participants also shared their thoughts on where it would be appropriate to place such advertisements in terms of targeting gay men in Cape Town's townships. The images were ranked according to the number of men in each group that chose particular images as their favourites, and which they liked second and third after those.

Process

This discussion was used as an ice-breaker at the beginning of the focus group discussions. A4 size copies of the various campaign messages were handed round the group and participants were asked to choose their favourites. Once each participant had looked at each of the advertisements they were placed in the centre of the group and each participant was asked to discuss the advertisement/s they had chosen and to explain why they had selected particular images or messages.

RESPONSES FROM 'BLACK' PARTICIPANTS

Images that received positive responses

The most popular images across the focus group sample as a whole (both gay and straight identifying MSM) were the following two:



Figure 1 Courtesy of GMFA London, www.gmfa.org.uk

In the gay identifying MSM group the 'road sign' image above was the most popular.

'...but as for me, are you done (to P3), I like this one, with the road sign. Basically I like the message portrayed by the whole thing, that you must know your HIV status, that's the best thing' (FGD 2, 14/10/2009).

Another participant agreed that the road sign image would be suitable for placing in public:

'...can I just...cos I was also, I like those other pictures, but I go for this (road signs) and I go for that (cell phone pic) because they are not obvious. Because you know what there are men who have sex with men but at the same time they also have sex with women. Let's say we advertising those things, for them to come into the clinic, it will be easy than focusing on these messages (explicitly gay ones) because these messages are fine for us because we understand them... we don't have a stigma of anything, of being gay whatever, but for a bisexual man, it won't be easy for him to come if we advertise these

outside the clinic. But for these, it's a message for everyone' (FGD 2, 14/10/2009).

This participant notes that this message will not discourage non-gay identified men from attending the service it was advertising because it does not make specific reference to gay men. The concern that gay-focused HIV prevention materials would lead to increased stigma for gay men was a common concern in the group of gay-identifying men.

Q: Which of these condoms is suitable for gay sex?

A: All of them.

Any thickness of condom can protect you and your partner from HIV. Use loads of silicone or water-based lube and change the condom if you're having a long session.

We recommend that gay men use condoms with a kilenark. Avoid condoms with spermicidal lubricants, such as Monogard 9, as they can cause irritation. Boxes of strong, regular, extra large and trim condoms are available at low prices from Freedom. Call 020 7530 3941 or order online at www.freedom-shop.com

More choice – Just as safe

For more information about condoms and sex visit www.metromate.org.uk

GMFA's campaigns and actions are designed, planned and executed by positive, creative and untested volunteers. To volunteer for GMFA, write, phone or email: Unit 43, The Ladbroke Grove, 49 Little Street, London SW2 1LZ. 020 7739 9672. info@gmfa.london.gov.uk Registered Charity No: 1076284

Part of the London Gay Men's HIV Prevention Partnership

GMFA - Active for gay men's health

LONDON GAY MEN'S HIV PREVENTION PARTNERSHIP

Figure 2 Courtesy of GMFA London, www.gmfa.org.uk

The 'stick figure' was the most popular image among straight identifying MSM. This seemed to be related to a dislike of 'Choice' condoms, more than relating to the message about condom use and gay sex per se.

'P4: he says because he don't like those cheaper ones, he says these ones are too protective, those cheaper ones they say they are not protective' (FGD 1, 18/08/2009).

'...we don't like certain condoms, not mentioning names, because certain condoms are inferior to others. We feel that this one shows which condoms to use as opposed to...' (FGD 1, 18/08/2009).

The misinterpretation of this message by the group of straight-identifying men is important to note, and points to the need for materials – especially those that are publicly available – to be as unambiguous, and straightforward as possible.

The next most popular image across both groups was the following:



Figure 3 Courtesy of GMFA London, www.gmfa.org.uk

The reasons given for their choice of the cartoon image were similar between the groups. A straight identifying man who chose the cartoon image above gave the following reason for his choice:

'...it says if you drink alcohol, or you do drugs, it can affect your decision. If you can get the girlfriend today, sleep with her, it can affect you. Cos you don't know that girl if she is infected or not' (FGD 1, 18/08/2009).

In the gay identifying group a participant expressed similar sentiments:

'Most of the time you meet people you are under the influence, maybe you meet at the club or whatever, maybe you in Bronx then you meet the guy there ... You can take that person to your house maybe when you there, gonna have sex not knowing that guys status, that guy doesn't know your status either, and you decided to have flesh to flesh. Maybe that guy can be negative, maybe you are the one who's positive, then you can transfer that like that. So when you under influence like any drug you taking, like alcohol whatever, your mindset is like changing, you not thinking properly. Although you know that you told yourself you know whenever you going you gonna have sex

you gonna make sure that you use a condom. But once you on alcohol or you on drugs, you mindset change' (FGD2, 14/10/2009).

This message touched on a common theme raised throughout the research process – unsafe sex under the influence of alcohol. This suggests the need for safer sex materials to be distributed in the venues where men meet partners and socialise.

Participants in both groups also liked the image below:



Figure 4 Courtesy of GMFA London, www.gmfa.org.uk

This image was interpreted differently by the two groups. In the group of straight-identifying MSM two individuals chose this image as their favourite. Their reasons for choosing this image did not seem to relate directly to the message, as is illustrated by their comments below:

'I like it because it has information about safer sex, and how to prevent ourselves [from getting HIV]' (FGD 1, 18/08/2009).

'I agree with him also, just because they say that you can have sex with different people, but you must think about safety, because of mos (just), you meet this one today you meet the other one, you don't know where you gonna get a infection. So to make it safe I think is what he's doing' (FGD 1, 18/08/2009).

These responses again emphasise the need for messaging to be very straightforward as the misinterpretation of advertisements is a strong possibility.

In contrast to this, the men in the gay identifying MSM group interpreted the image as portraying a sex worker or call boy. This was because of the framing of the image in a cell phone screen. Two individuals felt that the message was important because sex workers needed to protect themselves from HIV. They felt that sex workers tended to be pressurised into unprotected sex, and that this placed them at high risk of HIV.

'And then, I also like the way they drafted this (cell phone pic), because most of those guys they always come prepared, that Ok they're going to use a condom, and then if the client said 'no condom', you don't have any other option' (FGD 2, 14/10/2009).

'The third one that one which is I like it for the rental boys (photo of man framed by cell phone screen), for call boys. Call boys uh... are always get affected to this whole things, they don't like to use condoms because they don't get paid' (FGD 2, 14/10/2009).

However, since none of the participants were sex workers, this interpretation is problematic.

Images liked by gay identifying MSM and disliked by straight identifying MSM

There was a distinct difference between the groups with regard to the following two images.



Figure 5 Courtesy of GMFA London, www.gmfa.org.uk



Figure 6 Courtesy of GMFA London, www.gmfa.org.uk

Both of these images received fairly positive feedback from the gay identifying group. Three of the men in the gay identifying group approved of the image showing the man holding the condom as being suitable for use in HIV prevention campaigns. These men felt that it was necessary to be open about the need for safer sex and that this image emphasised this. For example:

'P4: the third one is that other one (naked man holding condom), reason I pick this one, it shows the condom, safe sex, ja and if we guys would like penetration, one would never penetrate on me, use condom that's teaching' (FGD 2, 14/10/2009).

'P3: after you know your HIV status, you go for the second one (naked man with condom) just try to practice the safer sex, whatever you do, please to use a condom or else if there's no condom try to stay away from sex' (FGD 2, 14/10/2009).

This advertisement was understood, as intended, as promoting safer sex.

The image showing the men having sex outdoors was interpreted by one man as relating to men having sex when they attended traditional circumcision schools. This led to a discussion of the risk of contracting HIV in these schools, with men noting that sex did take place and that there were no condoms available. They also noted the risk associated with the use of a single instrument to conduct multiple circumcisions.

'P4: the reason I say this, if you are 18 or 23 or 24, you go to the bush, to get circumcised, and the person who circumcises you uses a spear or whatever, they use that same spear or blade on every other guy who is there to be circumcised, up to 23 guys at a time they take it, wipe it and that's it, they reuse it. As a gay guy who is HIV negative going to the bush, you might very well end up getting HIV. And also when you go to circumcision school, these things happen, there's lots of sex happening amongst men, and there are no condoms being distributed' (FGD 2, 14/10/2009).

'R: But, after you've been circumcised, do you really want to have sex?

P3: At a certain time, like, you've got a week, then after that week you are well, so after two weeks you go home, but say in three days time you about to go home, you are well, you feeling...

R: you are able to have sex..

P3: you are able to have sex, you have feelings and all that. And people come in they touch your penis and all that stuff' (FGD 2, 14/10/2009).

While this discussion reveals a matter of serious concern in terms of HIV prevention, the misinterpretation of this advertisement remains problematic as it is not perceived to be relevant to individuals' everyday sexual interactions.

In contrast to these interpretations by gay identifying men, most of the men in the straight identifying group indicated that they disliked both of the above images. Their reasons for disliking the images related to the fact that they were too explicitly focused on gay men.

One of the men in this group stated that he felt that the messages and images promoted homosexuality, rather than promoting safer sex; while some participants in the straight identifying group also argued that the more explicit images should not be used because they might be seen by children.

'It might raise too many questions from kids if they see these pictures' (FGD 1, 18/08/2009).

One of the participants in the gay identifying group also felt that both of these images were too explicit to use in a general community setting. He stated that if these images were associated with a particular clinic, people in the community would assume that anyone going there was gay. He felt that this was problematic because it would potentially expose these people to violence and discrimination.

'P2: ...lets say at least if we can have a safer space for gay people in our communities it mustn't be so exposed, whatever is in the picture, it mustn't be like this (naked man pic) there will already be assumptions, he's gay, he's a moffie, maybe I'm going to that clinic with my brother and he's just accompanying me and there's this

picture, very big picture, "ooo he's gay, maybe it's his lover" just like that' (FGD 2, 14/10/2009).

Images disliked by both groups

The image below received negative feedback from both groups of men.



Figure 7 Courtesy of Queensland Association for Healthy Communities

Nearly all participants felt that this image was far too explicit to be used in any HIV prevention campaign. They felt that the image distracted from the actual message that was being put across in the text.

However, one participant chose this as his favourite, noting:

'...this picture tells me, there's two couples there having sex and then it shows sex is between a man and a man, there is no different' (FGD 1, 18/08/2009).

It seems that this man's interpretation of the image was as a validation of sex between men as normal human behaviour.

Images ignored by both groups



Figure 8 Courtesy of GMFA London, www.gmfa.org.uk

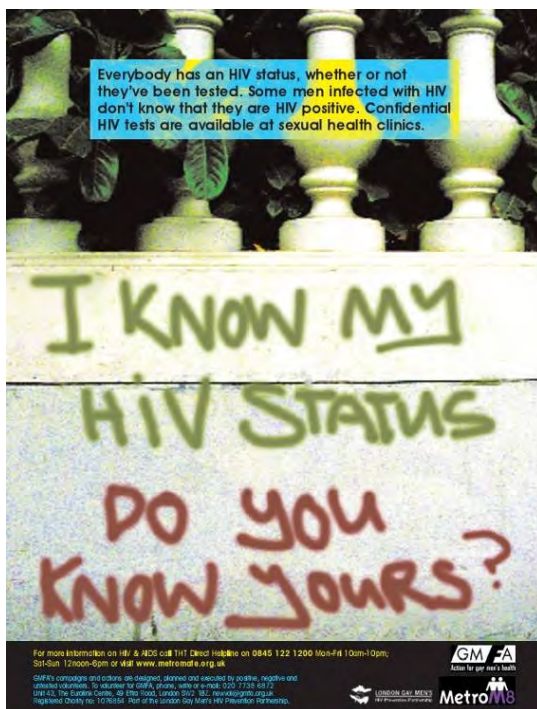


Figure 9 Courtesy of GMFA London, www.gmfa.org.uk

The above two images did not receive any response in either of the focus group discussions. The reasons for the lack of response to these images were not discussed.

Messages with positive feedback

The message that received the most positive feedback across both groups was:

'A hangover could be the least of your worries – If you drink alcohol or take drugs it can affect the decisions you make.'

This was related to the reported high frequency of unsafe sex whilst under the influence of drugs and alcohol.

The next most popular message was the one associated the road sign image about the positive and negative implications of knowing or not knowing one's HIV status.

Messages with mixed feedback

The messages used in each of the advertisements also received mixed feedback from the two groups. Some of the men's interpretations of the advertisements seemed not to relate directly to the text printed on them. In the straight identifying group the main example of this was the advertisement featuring the stick figure and three condoms. As noted above, this was interpreted as showing that the government-supplied 'Choice' brand condoms were of inferior quality to other brands of condoms, rather than as being about using condoms for anal sex *per se*.

In the group of gay identifying men, one participant raised a concern about the wording of the message: "Which of these condoms is suitable for gay sex", noting that this might lead people in the broader community to think that gay men used a different type of condom for sex to straight people, and that this would lead to further distancing of gay men from their communities.

PlayNice images

The PlayNice campaign materials that were discussed in the groups included: a poster showing a range of gay men, the PlayNice logo, and 'scratch cards' showing naked men.



Figure 10 Poster and logo from the 'PlayNice' campaign

The PlayNice logo, and the message 'play nice' were understood as intended, as promoting safer sex. The 'penis halo' around the image did not raise concerns as they noted that the images were not very explicit and could be interpreted as being penises or just being a decorative outline.

'...this could be anything, when a child looks at it, they may not see it as a dick' (FGD 1, 18/08/2009).



Figure 11 'Scratch Cards' from the PlayNice campaign

The 'Scratch Cards' shown above did not receive a positive response from the straight-identifying group, who felt that they promoted homosexuality, rather than promoting safer sex.

IMPLEMENTING HIV PREVENTION CAMPAIGNS AMONG CAPE TOWN 'BLACK' MSM COMMUNITIES

Implementing successful HIV prevention campaigns for in Cape Town's 'black' townships must be undertaken with awareness of several important considerations.

Campaigns must not increase stigma

A concern raised by men repeatedly over the course of the research was that HIV prevention campaigns focusing on MSM could inadvertently increase levels of stigma and homophobia in their communities. Given the widespread experiences of discrimination reported by these men this is an important concern. When designing campaign materials it is therefore vital that the potential for misinterpretation of these materials by the community in general is considered. This is a fine line to tread as the potential for such misinterpretation is high. As one participant noted with regard to the advertisement addressing condom use above:

'Well you see for instance this message saying "which condoms is suitable for gay sex?" imagine you take this to Khayelitsha or somewhere, people will say "are the gay people using different condoms" you know, they won't look at that as a message for everyone' (FGD 2, 14/10/2009).

Campaign messages must address homophobia

A theme that emerged across the interviews and focus group discussions was the need for campaigns that address homophobia and discrimination. The need for normalisation of homosexuality as part of HIV campaigns is an important issue as the high level of discrimination

and homophobia in men's communities plays a direct role in the risk behaviours that they engage in.

Campaign messages must be unambiguous

The potential for misinterpretation of campaign materials also extends to the MSM population. For example the advertisement above in which two men are pictured having sex in a park or forest was interpreted by the gay identifying group as depicting men having sex at a traditional circumcision school. Similarly, the advertisement showing a man framed by a cell phone screen was interpreted as depicting a male commercial sex worker, and was thus not seen as relevant to the group with whom the images were being discussed.

Campaign messages must educate accurately around responsible male-male sexual interactions

While the gay identifying participants in this study knew about safer sex for MSM, they reported that knowledge of how to have safer male-male sex was limited among other MSM in their communities. The use of water-based lubricant for anal sex was an issue that was raised repeatedly. In the straight-identifying group, most of the participants were not aware of the need to use water based lubricants; both groups reported that the use of oil based lubricants, with and without condoms, was common.

Campaign messages must be appropriately placed and use appropriate formats

Given the general lack of 'gay spaces' in the townships it is important to carefully consider the types of materials used in HIV prevention campaigns that target MSM and where these materials are placed. Part of this consideration must be the differences between materials designed specifically for gay men, and those materials that will be publicly displayed.

The group of straight identifying men felt that advertisements that were explicitly gay were not suitable for display as posters or in a format that might be accessible to children. This group thought that materials should be put in shebeens and taverns, police stations, and barber shops.

The gay identifying group also felt that it was necessary to use less explicitly gay advertisements in the broader community. They were afraid that these advertisements would lead to an increase in homophobia and discrimination. Some of these men felt that explicitly gay images should be restricted to 'gay spaces', such as Health4Men's clinic, and gay clubs in central Cape Town. In contrast to this view one man felt that explicitly gay images could also be placed in government clinics. He stated:

'They are better, but even it's fine (picture of naked man holding condom), people accept, but this can be put in the government clinic because what is, most of the straight guys they know how do you do sex' (FGD 2, 14/10/2009).

This view was not shared by anyone else in the discussions.

RECOMMENDATIONS

General recommendations

The following general recommendations apply to all HIV prevention materials produced:

- More explicit ideas and messages should be depicted as cartoons
- Where photographs are used they should emphasize non-sexual gay-positive ideas

- Short straightforward messages should be used
- Condom and water-based lubricant distribution are vital, and condoms and lubricants should be accompanied by messaging explaining the use of water-based lubricant and its importance.

Publicly visible messages

- Publicly visible HIV prevention messages targeting MSM need to affirm homosexuality as one of the range of possible expressions of human sexuality.
- These materials must be completely unambiguous, and different possible interpretations of these materials must be considered before they are displayed.
- These materials should focus on key risk behaviours - primarily anal intercourse - and should focus on the use of water-based lubricants with condoms. In public materials, homo- and hetero-sexual anal intercourse should both be addressed, i.e. messaging should address the risk behaviour itself without associating this behaviour with a particular sexual identity.
- The other main risk behaviour reported in this research was unprotected anal intercourse under the influence of alcohol or drugs. HIV prevention messaging therefore needs to target the places where people access alcohol and must include condom and lubricant distribution in these places.

'Private' messaging

- Campaign materials that target MSM specifically should be placed in 'gay spaces', where these exist, and should be distributed by men linked to Health4Men to other MSM within their communities.
- Messaging should include affirmations of homosexual identities.
- These materials should be pocket-sized.
- Materials should, wherever possible, come with condoms and water-based lubricant
- These materials can be more explicit and can include photographs.
- Important themes to emphasize include:
 - Water-based lubricant and condoms
 - Negotiating responsible sex – including in 'transactional' situations
 - HIV status
 - STIs
 - Anal care – what to look out for e.g. bleeding, discharge
 - Positive ideas about sex
 - Erotising responsible sex – condoms as 'invitations'; condoms as sex toys.
 - Emphasise the 'belonging' associated with a gay identity

'COLOURED' PARTICIPANTS RESPONSES TO MESSAGING

In the group of 'coloured' MSM participants did not reach consensus on their favourite HIV prevention messages. However, the use of these images led to a discussion around issues that they felt needed to be addressed as part of HIV prevention efforts in their communities. These participants used the images provided as the basis of a discussion about what they imagined would work in terms of targeting MSM for HIV prevention in their communities.

The discussion initially focused on the campaign message below:



Figure 12 Courtesy of Queensland Association for Healthy Communities

One participant state that he felt that this message was good because it was very direct:

'I think that one is to the point - straightforward. Especially now that with the whole drug scene, that one makes a lot of sense, because I think some of these people beat around the bush, they know what they going to get themselves into, okay they know they going to do drugs together but there's no sort of talk about sex or anything... there's no beating about the bush, you know, it's quite detailed' (FGD 3, 04/11/2009).

Unprotected anal intercourse while under the influence of drugs and/or alcohol was raised as an important risk behaviour by 'coloured' men, both in the focus group, and in individual interviews.

Other participants agreed that unsafe sex under the influence of drugs is an important HIV risk in 'coloured' communities. However, they felt that this advertisement was too explicit, and argued that a cartoon representation, such as the one below, would be equally effective.



Figure 13 Courtesy of GMFA London, www.gmfa.org.uk

'No, there's also this one, because we're talking about drugs, I think this one is more um, I think it can accommodate everybody' (FGD 3, 04/11/2009).

The need for messaging that accommodates a wide variety of people became a repeated theme in this discussion. This may also reflect the fact that there is no single gay identity in the areas where these men live; MSM in these communities include men who identify as 'straight', men who cross dress, and men who simply identify as gay or bisexual.

The discussion moved on to focus on messaging that encourages responsible sex in general. In this vein another participant indicated that he thought the image below made the need for condom use absolutely clear.



Figure 14 Courtesy of GMFA London, www.gmfa.org.uk

This participant felt that the message communicated by this advert was clear and straightforward.

'My favourite one is this one because the reason why it's telling me about this guy he's ready and he's willing to have safe sex with his condom and he's also sober' (FGD 3, 04/11/2009).

However, other participants felt that this image was too explicit to be placed in public places.

'You must know where to put this, this can not go on a bill board you know, must know where to put this, because people are homophobic (FGD 3, 04/11/2009).

This participant felt that the wording used in the subtext of this advertisement ('most gay men enjoy getting fucked...') was very problematic and would lead to an increase in discrimination against gay people. He was particularly worried about religious leaders' reactions to this.

'For me this picture is very good, but 'getting fucked' - God, if pastor T_ is going see this, he's going to say 'Lord', and he's going to march against gay people in M___' (FGD 3, 04/11/2009).

In contrast to this, two participants argued that the advertisements that did not show people at all would be most suitable.

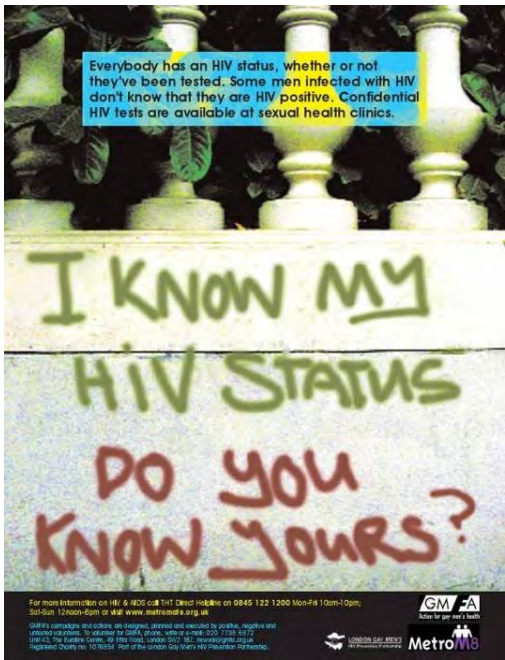


Figure 15 Courtesy of GMFA London, www.gmfa.org.uk



Figure 16 Courtesy of GMFA London, www.gmfa.org.uk

'Because this one, actually a lot of people are worried to get tested, but I think if they understand why they must get tested and discover early their sickness, I think it's something because here it's clear they say, "no HIV test, worry you may be HIV positive, worry about your future." Because once you know you can plan your future, and be able to manage your sickness' (FGD 3, 04/11/2009).

'Ja, this one (graffiti), making people aware, I mean there's lots of people that maybe has got HIV/AIDS or so but maybe don't know their status...Send out the message there that they should have themselves tested if they are sexually active with more than one, or even one partner' (FGD 3, 04/11/2009).

These messages are not specifically focused on MSM, and this may be the basis of their appeal; the participant who chose the 'road sign' message went on to express his concern that HIV prevention messages targeting MSM could potentially reinforce the negative stereotypes that already existed in his community about MSM. He felt that the idea that gay men had money and were *always* interested in sex was one of the reasons for HIV-risk behaviour occurring. He was also concerned that this stereotype contributed to the abuse of gay men by straight men.

'The reason I ask is because, you know the people, the broader community, when you talk about gay it's almost this stereotype of money and sex. You know, I don't want them, by you know, talking about that uhh for them to continue to have this image that gay is about just sex. So we must be careful in the message that we do...it can be naked, but you see like here the message is 'most gay men enjoy getting fucked', so you know it's sending a message that gay is just about sex' (FGD 3, 04/11/2009).

This participant argued that the image below provided an 'intermediate' level of messaging which lies between the explicitness of the images showing fully naked men, and the blandness of the messages that did not show people at all. He also felt that this image was important because the man in the picture was willing to show his face and hence to be explicitly associated with an HIV-related message.



Figure 17 Courtesy of GMFA London, www.gmfa.org.uk

'Because this one the guy wasn't shy to put his face, and talk about it- so it's like also a message to say: 'don't be shy, don't be scared to...talk about it'' (FGD 3, 04/11/2009).

An 'ideal' HIV prevention message

After discussing the images above, the participants in the group talked about what they thought would be the most positive messages and message formats for use in their communities.

The men shared the concern raised in the focus group discussions with 'black' participants about HIV prevention messaging exacerbating homophobia in their communities. They felt that one way to overcome this would be to show gay couples with straight couples in the same materials.

'Maybe, maybe, maybe the picture um, mostly gay make the gay part stand out as such, but involve other sectors as well' (FGD 3, 04/11/2009).

'You can always move it, if you want to promote the gay thing, you can move them to the front, put a lesbian couple at the back, and put a heterosexual couple on the other side' (FGD 3, 04/11/2009).

The consensus about the use of images was that in messaging focusing on sexual issues cartoons should be used; while in other messaging photographs would be better. The ideal message, then, according to this group of men, would be one showing three couples: one heterosexual, one gay male, one lesbian; the couples should not be engaged in sexual acts and the text should emphasise

either the importance of knowing ones' HIV status, the importance of using condoms, or the importance of safe sex when under the influence of alcohol or drugs.

Advertisements that were ignored

The following advertisements were not chosen by any of the participants in the group.



Figure 18 Courtesy of GMFA London, www.gmfa.org.uk

RECOMMENDATIONS

HIV risk behaviours among 'coloured' MSM are similar to those among 'black' MSM, however, the dynamics around these behaviours differ. Unprotected Anal Intercourse (UAI), transactional sex, and UAI under the influence of drugs are key risk factors in these areas.

General recommendations

- Messaging should include a focus on transgender individuals, and should be affirming of homosexuality as an expression of human sexuality.
- Messaging should not perpetuate potentially negative stereotypes about gay people, as noted above, such as that being gay is only about sex.
- There needs to be an awareness of the various sources of discrimination affecting gay people in these communities, and these should be addressed as part of prevention campaigns. Religious communities are one example of such sources of discrimination with whom dialogue could be encouraged.
- Condom and lubricant distribution must be a central aspect of campaigns.

Publicly visible messages

- Where messaging focuses on sexual behaviours, there needs to be an emphasis on the behaviours themselves without necessarily associating them with a particular sexual orientation.
- Condoms, lubricants, and prevention messaging must be available in the places that people access alcohol.

- Where photographs are used they should be aim to affirm messages around living positively with HIV, and living as openly gay.

'Private' messaging

- Messages affirming a gay identity should be used.
- These materials can be quite explicit and should emphasise the importance of negotiating condom and water-based lubricant use.
- The use of alcohol and drugs also needs explicit attention in all messaging.
- Consideration needs to be given to ways to make transactional sexual encounters safer.



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