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Our Village Is Watching

Sociocultural and Attitudinal Factors Related to
HIV Sexual Risk Behaviors among Black South
African Men Who Have Sex with Men

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ABSTRACT—The aim of this study is to explore the attitudes, cultural norms, and social factors among South African black men who have sex with men (MSM) residing in the Eastern Cape in the context of HIV sexual risk behavior. Data were collected from demographic questionnaires and six focus group discussions with 41 men residing in the cities of East London and Port Elizabeth, Eastern Cape Province, South Africa. Participants were in agreement that many black South Africans in their locality view homosexuality as something that Western whites do, and that South African black MSM are generally not open about their sexual identity. Participants expressed, “our village is watching,” as a concern among some South African black MSM for not being open about being gay and their same sex sexual orientation. The findings provide additional insights into the nature of HIV risk behavior of South African black MSM, and offer considerations for future research and intervention efforts.

KEY WORDS—MSM, Black, South African, men, gay, homosexuality, HIV, AIDS, family, religion, peers, community, Eastern Cape.

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SUB SAHARAN AFRICA IS AMONG THE COUNTRIES HAVING THE largest HIV rates in the world. Amid the nine provinces in South Africa approximately 9 percent of the population in the Eastern Cape (730,000) is comprised of people who are living with HIV (NDA, 2011). Recent research reveals the odds of being infected with HIV are higher among men who have sex with men (MSM) than among men in general in sub-Saharan Africa (Cloete et al., 2014; Muraguri, Temmerman, & Geibel, 2012; Price et al., 2012). Using respondent driven sampling, Lane and colleagues (2011) estimated the HIV prevalence among gay-identified black men was 33.9%, compared to 6.4% among bisexual-identified black men, and 10.1% among straight-identified black MSM. A study of HIV prevalence among MSM in Cape Town, Durban and Johannesburg showed MSM to be disproportionately affected by HIV across all three cities (Cloete et al., 2014). The overall HIV prevalence for MSM in general was 22.3% in Cape Town, 48.2% in Durban, and 26.8% in Johannesburg (Cloete et al., 2014). HIV prevalence among black MSM varied across the three cities with 31.3% in Cape Town, 45.1% in Durban, 27.0% in Johannesburg (Cloete et al., 2014). Such statistics has resulted in increased attention to South African black MSM by researchers and health professionals seeking ways to reduce HIV transmission in South Africa.

Developing understandings of the cultural meaning about gender and sexuality continue to challenge the field of HIV prevention and treatment (Epstein, Morell, & Moletsane, 2004). The aim of the present study is to develop a basic understanding of social, cultural, and attitudinal factors related to HIV sexual risk-taking behavior among South African black MSM. This paper begins with a brief overview of the historical, cultural and social factors affecting the lives of South African black MSM. Next, we review the literature on social and cultural factors related to HIV sexual risk behavior among MSM in general, and specifically with regard to South African black MSM. We then turn attention to discussing a study to examine attitudes, cultural norms, and the life experiences relevant to understanding HIV sexual risk behavior among black MSM residing in the Eastern Cape. Finally, we offer recommendations for future research, policy, and practice directions.

Literature Review

Sexual identity constitutes a chief component of an individual's health and well-being. The efficacy and effectiveness of HIV prevention and treatment

interventions is dependent upon the success of researchers and practitioners in responding appropriately to the cultural, social and economic factors influencing how people construct and give meaning to their sexuality. Fiereck (2015a) uses the term “authenticating sexuality” in conducting an ethnographic study to examine sexual personhood in relation to HIV science in South Africa. Authenticating sexuality as used by Fiereck (2015a) involves examining multiple cultural fields of sexual and gender identities. Viewed from the perspective of social ecological theory (Moos, 1975, 2003) cultural fields focuses attention on understanding the relationships among the personal, social, political and economic environments affecting sexuality and gender identity.

The political environment of South Africa is one of the most progressive countries in the world with respect to gay and lesbian rights. The apartheid regime ended in 1994; the new constitution barred discrimination based on sexual orientation (Hassen, 1998). In 2006, South Africa became the fifth country in the world, and the first in Africa, to legalize same-sex marriage (Oswin, 2007). Same-sex adoption was legalized in South Africa in 2002 (Hassen, 1998; Oswin, 2007). However, incongruences appear between legislation and implementation of legislation, as revealed through reports (Brouard, 2009; Cloete et al., 2014) and as we learned in the present study.

Disjuncture exists between political mandates and legislative oversight (Oswin, 2007; L. Rispel, 2009; Sember, 2009), societal and community attitudes of same sex behavior among men (Smith, Tapsoba, Peshu, Sanders, & Jaffe, 2009), the social stigma and discrimination associated with HIV transmission through same sex behavior among men (Cloete, Simbayi, Kalichman, Strebel, & Henda, 2008), and cultural beliefs about masculinity (Fiereck, 2015b; Isaacs & McKendrick, 1992; Y. M. Sikweyiya, Jewkes, & Dunkle, 2014). Historically, the affects of racial segregation during apartheid have been viewed as contributing to marginalization of South African black MSM by South African white and colored MSM (Isaacs & McKendrick, 1992).

Discrimination and violence against gays and lesbians is endemic to South Africa culture. Data collected in the 2004 South African Social Attitudes Survey (SASAS) revealed 78% of the respondents felt that sexual relations between adults of the same gender were always wrong (Roberts & Reddy, 2008). To date, South Africa has no formal laws against hate crimes related to intolerance of or discrimination against people on the basis of their race, gender, religion, nationality, sexual orientation or sexual identity (ECGLA, 2012). Comparing data collected for SASAS from 2003 to 2007

Roberts and Reddy (2008) found no difference in the attitudes of tolerance of same sex behavior between men and women across the five year period. Respondents who reported being strongly religious and belonging to a conservative denomination reported having more disapproving attitudes toward homosexuals (Roberts & Reddy, 2008). Similar to findings reported by Dunkle and colleagues (2011), Roberts and Reddy (2008) found black South Africans tend to report higher levels of disapproval of same sex behavior than white and colored South Africans. However, alongside these reports are numerous examples of efforts by the South African government and gay and lesbian organizations to advance equality and social justice for all South Africans regardless of sexual orientation (Oswin, 2007; L. Rispel, 2009).

Constituencies of HIV Sexual Risk Behavior

Sexual identity, age, poverty, belonging and involvement in the gay community, discrimination and stigma, church and religion, and family support have been shown to be related to HIV sexual risk behavior among MSM. For instance, studies have shown how internalized negative feelings about homosexuality are related to risky sexual behavior among MSM (Shoptaw et al., 2009; Tucker-Seeley, Blow, Matsuo, & Taylor-Moore, 2010). Studies and reports reveal how sexual identity among MSM may also influence health care utilization (Lane, Mogale, Struthers, McIntyre, & Kegeles, 2008; Malebranche, Peterson, Fullilove, & Stackhouse, 2004; NTT, 2013; L. Rispel, 2011), and HIV testing (Knox, Sandfort, Yi, Reddy, & Maimane, 2011; Lauby & Milnamow, 2009; Malebranche et al., 2004; Sandfort, Knox, Collier, Lane, & Reddy, 2015; Sandfort et al., 2008).

Age is commonly acknowledged as a significant factor related to HIV sexual risk behaviors among MSM. Studies in the United States show younger men to be statistically more likely to engage in exchanging sex for money compared to older men (Mustanski, Newcomb, & Clerkin, 2011; Peterson et al., 1992). Evidence from South Africa reveal health risks associated with sexual coercion of men, particularly young self-identified heterosexual men, by older men (Y. Sikweyiya & Jewkes, 2009). Other reports suggest that older men may be more likely to hide their same sex sexual attractions and thus may be hidden and more difficult to reach for HIV risk prevention programs (Icard, 1996, 2008).

The sense of community and belonging in the gay community has similarly received considerable attention by researchers studying HIV sexual

risk taking behavior among MSM. Some studies suggest that the sense of belonging and involvement in the gay community functions as a protective factor in buffering men who identify as gay and are open about their same gender sexual orientations from social stigmas and discrimination (Goldhammer & Mayer, 2011; Peterson et al., 1992). Other studies suggest that identification with the gay community may actually have deleterious consequences related to HIV sexual risk taking behavior (Millett, Flores, Peterson, & Bakeman, 2007; Millett, Peterson, Wolitski, & Stall, 2006). Gay communities have also been recognized for serving as a resource for delivering HIV prevention interventions (Crepaz et al., 2008; Kegeles, Hayes, & Coates, 1996; Kelly et al., 1991).

Church, religion and family relationships add to the complexity of factors affecting HIV sexual risk-taking behavior among MSM. For example, reports in the U.S. revealed how condemnation of same sex relationships in black churches is related to HIV sexual risk taking behavior among African American MSM (Icard, Schilling, el-Bassel, & Young, 1992; Miller Jr, 2007; Stokes & Peterson, 1998; Ward, 2005; Woodyard, Peterson, & Stokes, 2000). Consequently, the involvement of churches and religious groups from the U.S. and other countries in South Africa raise questions with regard to affecting HIV sexual risk behaviors among South African black MSM (Eriksson, Lindmark, Axemo, Haddad, & Ahlberg, 2009; Haddad, 2005).

Over the years the function of the family in HIV prevention and treatment has received increased attention among researchers and health promotion professionals domestically in the U.S. and internationally (Beyrer et al., 2010; Bor, 1990; Iwelunmor, Airhihenbuwa, Okoror, Brown, & BeLue, 2006; Lane et al., 2011; Szapocznik, 2000; Yoshikawa, Alan-David Wilson, Chae, & Cheng, 2004). Still, understandings on the family with regarding to HIV sexual risk taking behavior among South African black MSM are sparse. The current study seeks to provide insights to contribute to understandings on HIV risk taking behavior among South African MSM black with attention to sexual identity, age, poverty, involvement in the gay community, discrimination and stigma, church and religion, and family support.

Methods

Study Site

The Eastern Cape is the second largest province in terms of land area, the third largest province in terms of population size, and poorest province,

situated in the southeast part of South Africa (SSA, 2014a, 2014b). The study was conducted in two cities located in the Eastern Cape, Port Elizabeth and East London. Port Elizabeth and East London are approximately 190 miles (km = 310) apart, and serve as urban hubs in the Eastern Cape. About 87% of the population is black, the majority of whom live at or below poverty level (64%)(SSA, 2014a). Based on antenatal clinic data, the HIV prevalence rate in the Eastern Cape for 2011 is 28%, which ranks the region fourth among the country's nine provinces (NDA, 2011).

The present study utilized qualitative methods to identify factors related to HIV sexual risk-taking behavior among South African black MSM residing in the Eastern Cape. Participants were asked to complete a brief demographic survey for describing the composition of the focus groups. A structured interview protocol was used to capture participants' collective views, and insure consistency in data collected from participants across groups and between the two cities.

Active recruitment strategies were used to recruit participants (Corbin & Icard, June 2005; Yancey, Ortega, & Kumanyika, 2006). Participants were recruited directly in local pubs, taverns, shebeens (i.e., typically a home where alcoholic drinks are sold and consumed), and retail establishments frequented by black MSM, and through word-of-mouth. Potential participants were recruited by one male isiXhosa speaking recruiter in East London and by two male isiXhosa speaking recruiters in Port Elizabeth. Inclusion criteria were, age 18 or older, biological male, and self-identifying as a man who has sex with men. A total of 41 men participated in six focus groups. IsiXhosa speaking South African black men in the two cities recruited all of the participants two to three days prior to each focus group.

Focus groups are generally viewed as a good method with high external validity for understanding how people feel and think about an issue (Hollander, 2004), and are commonly used to collect normative rather than personal information. Three focus groups were held in a conference room in a university research center in an office building located in East London, and three groups were held in a seminar room on a university campus in Port Elizabeth. We used these venues because the Eastern Cape is considered the hub of black education in Southern Africa with the first missionary schools opened here in the first half of the 19th century. Thus, the settings for the focus groups have a historical association with personal progress and achievement. Participants received R50 (approximately US\$7) as compensation for transportation and other personal expenses (e.g., cell phone

charges to confirm attendance). Participants also received a light meal as most discussion groups were held during times for lunch or dinner. The institutional review boards of Temple University, University of Pennsylvania and the University of Fort Hare approved human subjects protections. The authors one of whom spoke isiXhosa facilitated all focus groups. Focus group discussions were recorded on audiotape, and authors who were not serving as facilitators took notes during the focus discussions and recorded non-verbal communications to assist in the interpretation of data. Each focus group lasted approximately 90 minutes, and printed transcripts were prepared from written notes and audiotapes of sessions. Permission was given by all participants to audiotape-record the sessions.

Measures

Group discussions were guided by probes regarding identity, socializing, community, HIV risk attitudes and belief, venues for risky sexual behavior, including the Internet, discrimination and stigma, family and friends, and church and religions. Regarding identity participants were asked: What terms (names) do people use to describe men who have sex with men; and what terms do men who have sex with men in your community use to describe themselves? We explored issues related to age by asking participants to tell us about any differences between younger men and older men who have sex with men, about the situations where younger men have sex with older men, and what are some of the reasons for younger men and older men having sexual relationships. Insights about the role of community were explored by asking participants how they would describe the community for men who have sex with men; the positive things and challenges or problems about the community for South African black men who have sex with men; the types of places where people go to meet other men; and the places in their neighborhood or townships where men go to meet other men.

Insights about HIV sexual risk behaviors were explored through the questions: Where do men who have sex with men go to meet other men for potential sex partners; what happens in these places; and what types of sexual behavior put men at risk of getting HIV/AIDS? Information on social support was elicited by asking participants: What kinds of resources (e.g., clubs, organizations, advocacy groups, or groups for social support) are available for men who have sex with men?

Focus group participants were asked to share their views on stigma by first hearing the statement that the way a person looks, acts, talks, or

dressess sometimes influences how they are treated. We then asked participants to tell us how men who have sex with men are treated by other people in the community; how these experiences differ for the different groups of men who have sex with men; how these experiences influence the ways men who have sex with men see themselves; and how these experiences influence the sex lives or experiences for men who have sex with men?

Our last set of questions elicited opinions and attitudes about family support and friendships, and whether the church, religion and spirituality play a role in HIV risk-taking behavior. Participants were asked: What role does religion play in the lives of men who have sex with men? Does the church play a role in HIV and AIDS among men who have sex with men? What role does a family or friends play in HIV risk behavior?

Data Analysis

Analysis was conducted in two phases. Summaries of notes taken during the focus group discussions were reviewed by group participants at the end of each focus group session for accuracy, clarifications, and additional elaboration. Post session preliminary analysis occurred with several of the authors and note takers at the end of each focus group discussion based on notes and observations made during the discussions. Focus group interview discussions were transcribed verbatim from audiotapes. Field notes and transcripts were reviewed with audiotapes where applicable by one of the authors and a research assistant for completeness and accuracy. For the second phase of data analysis one of the authors and a research assistant reviewed transcripts and identified common issues and themes. Two authors corroborated the issues and themes identified from the transcripts and notes. Quotes were selected within the transcripts that exemplified the themes identified. Classification of issues was based on internal homogeneity or the extent to which the data was congruent (Patton, 2002). A consensus model was used to determine inter-rater reliability of coding. Quantitative data collected through a brief survey was used to describe the composition of the focus groups and to provide background breadth and depth for analysis.

Results

Participants ranged in age from 18 to 35 years, with a mean age of 23.8. Seven (17%) of the participants had less than 12 years of education. Three

(7%) of the men reported that they were separated or divorced; thirty-seven (92%) reported being never married; eighteen (43.9%) of the men reported having one or more children. Regarding language, nineteen (46.3%) reported speaking English and isiXhosa equally well, with the remainder reporting speaking English (19%) or isiXhosa (16.7%) better. Twenty-three (57.5%) of the men were not employed. Among the participants, 3 (7.3%) reported that a doctor or nurse had told them that they were HIV positive. Ten (24.4%) of the men reported that they had ever received information from a doctor or nurse that they had had a sexually transmitted infection (STI).

Twenty-two (53.9%) reported that they had had anal intercourse with a man in the past six months. Of the men who reported having anal intercourse in the past six months, 12 (29.3%) reported that they had used a condom with a male partner during anal sex 100% of the time. It is important to note that of the twenty-two participants who reported having engaged in anal intercourse with a man in the past six months, approximately 12% (5) stated that there were times when a condom broke or came off, with an additional 9.8% (4) reporting that there were not sure.

The men also shared that although they had performed the male rite of passage (circumcision), they were not considered to be a man if they disclosed their sexual identity as MSM. Participants in all groups spoke about self-identified heterosexual men commonly having sex with men who self-identify as a MSM. The men also stated that heterosexual men would not have anything to do with a MSM after they had a previous sexual encounter.

Various terms for MSM emerged in the discussion groups to cover a range of interrelated gender role constructions and behaviors, including *Moffie*, *Double Adapters*, and *Divas*. “Moffie” generally carries a negative connotation, implying an individual is an outcast. “Double Adapters” is a term that is used in reference to men who engage in sex with both men and women, as well a term used to refer to a man who performs both inserter and receiver roles when engaging in anal intercourse with another male. The term “Diva,” when used by a self-identified MSM South African black man, may have an empowering and validating connotation. Participants also reported that the term “Diva” could also have a positive self-affirming connotation when used to self-identify by men who appear effeminate in their dress and mannerism. Focus group participants also reported that homosexuality is often viewed by black South Africans in their locality as something that Western whites do, and not something that black South Africans do. The men were generally in agreement that most South Afri-

can black MSM are not open about their sexual identity. As one member stated: "One thing we have to be open-minded about it um . . . lot of people don't want to be discovered." And, as another group participant stated: "Now . . . people are hiding themselves."

Group participants reported that younger men (age 30 or younger) tend to be more open about being gay, whereas older men who are more likely to be married and have children, are less likely to express openly their sexual orientation concerning having sex with another man. As expressed by one participant: "Older men stay in the closet . . . have families, younger men . . . [feel that they have] . . . freedom of choice." Regarding the issue of intergenerational sex, participants stated that some older black South African MSM believed that having sex with a younger partner would cure HIV/AIDS. This is analogous to the belief that having sex with a female virgin cures AIDS (Vundule, Maforah, Jewkes, & Jordaan, 2001). However, participants in all six focus groups noted that the myth and practice of curing AIDS by having sex with a virgin MSM is fading away. Participants attributed this shift in beliefs to HIV education programs. Participants also reported that some younger men prefer to have relationships with older men for economic reasons. Older men were reported to often have jobs and be in a position to provide financial assistance to younger men and were often viewed as more reliable. Sexually intimate relations did not necessarily characterize these financially based intergenerational relationships. Participants explained that some intergenerational relationships were platonic. Focus group participants also reported that some younger MSM have relationships with older men because being with an older man provided a more intellectually stimulating relationship.

Through the discussions we learned about the important connections between jobs, friendship groups, sexual identity, and sexual risk-taking behavior among MSM. Jobs, for example, function for some MSM as a mechanism for meeting and staying connected to other MSM. We learned that women's hair salons and clothing stores not only provided employment for MSM, but also become gathering places for MSM during shift changes or at the end of the work day. Friendship groups provide some South African black MSM social, psychological, and economic support. We also learned that the bond in friendship groups could also possibly extend to peer norms on sharing sexual partners. As expressed by one participant: "Being a Diva and having friends who are Divas is like having family. Sharing your sexual partner with your friend is like sharing your last cup of sug-

ar with him. You don't mind because you know your friend would do the same for you." Other group members did not hold this view.

Discussion participants reported that coerced sex with self-identified MSM is a common practice in prison. It was also reported that it is not uncommon for former incarcerated gang members to return to their communities and continue this practice. The men in all groups agreed that there were few formal gay institutions (e.g., social service organizations, advocacy groups, or support groups) for MSM men in East London or Port Elizabeth. All participants reported that black men who self identify as MSM frequent mainstream taverns and shebeens to party and meet men (often self-identified straight) for possible sex. The groups agreed that black MSM found each other mostly in shebeens, taverns, and hair salons for women. Group participants also stated that some MSM frequent adult sex shops. However, this practice was not viewed as common. Some participants believed that the Internet was being used by some MSM for meeting potential sex partners. Discussion group participants also pointed out that cell phones are most often used for connecting to the Internet for making sexual liaisons.

Participants noted the difficulties that they experienced in their communities with regard to interracial dating. The men commented on the difficulty that some black MSM experience when dating white men. As one participant stated . . . "they [white MSM] don't understand that we cannot be as open as they are about being gay and dating a man. They don't understand—our village is watching!"

Participants noted that in recent years, funerals—which are very frequent in South Africa because of AIDS deaths—have become events for gay men to gather together. As one member stated: "when a friend of a friend dies, the person [MSM] who knows that friend and his friends comes to the funeral." Participants noted that this ritual is often the only ceremony for recognizing the deceased. Otherwise, a gay man is never considered an ancestor for his family because he is less likely to leave children behind. As one participant stated, "we are only uncles, and some are aunties."

HIV Risk Behaviors

Participants reported that group sex was becoming popular among some MSM. The men also reported that some men would cut off the tip of a condom prior to engaging in anal intercourse. In response to this threat participants indicated that some men insist that a light is kept on so they can

make sure a man was using a condom and the condom was not cut. Participants noted that although men go to funerals and see friends and family members dying, this did not change their HIV/AIDS sexual risk behavior. The following statement illustrates this view: “[I] do feel bad if a friend dies of AIDS and finds out the he got it from his partner [you]..do not want to go chase that person [man]. For a moment you feel like that, but after some-time it phases out and you don’t mind [are not concerned] about AIDS.” This comment suggests that the participant might eventually have sex with a man who is HIV positive. Another participant stated: “Condom carrying [is] popular, but use is another thing.”

Attitudes toward HIV Testing

Participants explained that there is resistance toward getting tested for HIV. According to the group, about one fourth of gay men are HIV positive but they do not admit it. One participant shared: “I was tested. I brought a friend with me. I thought: ‘what I’m going to do if I was positive.’ But I don’t think about it anymore.”

Family and Friends

Men expressed that South African black men are expected to have families. As one participant stated: “Xhosa men [are] expected to get married [and] have children.” The men in all of the group discussions shared their experiences of the difficulty of being accepted as a gay man by family and friends. Participants expressed how MSM experience pressure, particularly from their fathers, to have sex with women and to marry. As one man stated: “First a gay man comes out and tells his family, it is very hard and strenuous, but later some families become very supportive, some deny it and believe that it is only a passing phase, and some families disown the individual.” Another said: “pressure from fathers especially; fathers threaten sons, take sons to programs in rural areas to teach you about initiation process. Parents feel young people are losing touch with culture. They try to acquaint them with normal culture like sports, like Rugby.”

One participant pointed out that his family did not give him a hard time over his sexual orientation because he was the breadwinner of the family and they needed him. Overall, participants responded that families’ attitudes have become more relaxed for younger generations and that families are more accepting than families’ of the previous generations. When asked if they were still viewed as men by their families, the participants stated

that it depended on the family, but no matter what “you are still a man.” One participant said that because he was the eldest son, he kept his place as a “man” within his family.

Participants in all groups indicated that in general they did not feel welcome in the churches. They believed that the black churches needed to learn more about gay men. One participant said: “They read their bible but don’t take time to understand gayness.” Another participant stated that he stopped going to church because they [church congregation] preach the bible against MSM. Another man stated that he goes to church to worship and pray. As he stated: “You are there for the Lord not people in church.”

Some participants considered women to be more prejudiced toward MSM than men, and believed that women were more “homophobic” than men. They attributed this prejudice to women viewing MSM as being in competition with them. One participant shared:

Except in the Johannesburg region, a man having sex with another man is considered appalling. In the Jo’burg region if a man is a healer, it is believed that by having sex with another man [a healer] he could absorb his energy [become stronger] and become wiser.

Some of the participants reported that law enforcement agents were “sweet” to them, and that they were protective of gay guys. For example, if they knew that the arrested man was gay, they would not put him in a cell with straight guys to avoid harm to the gay man. On the other hand, some indicated that the law enforcement agents viewed them as entertainment and did not take them seriously.

Discussion

Our sample comprised men who self acknowledged their same sex behavior. Consideration should be given to the social context in which these groups occurred. As mentioned by participants in the focus group discussions gay organizations and venues where MSM congregate are limited. Notably, events such as the annual Nelson Mandela Bay Gay Pride provide an opportunity for socializing and establishing a sense of community. The lack of formal organizations and social venues that exclusively serve the needs of black MSM however has implications for the types of strategies used and resources needed to engage members of this population in HIV risk reduction programs. As such, the observations from this study suggest the need

for greater emphasis on direct methods involving social networks and face-to-face recruitment strategies, with less emphasis on indirect methods such as flyers or posters. Efforts to engage members of hidden or isolated people residing in townships may not require greater costs in resources but better use of both human and financial capital for effective recruitment and engagement. Furthermore, as expressed in the focus group discussions, safer sex messages focusing on same sex male behaviors are less likely to reach members of this population who are hidden or do not identify themselves as men who engage in sex with other men. Much progress has been achieved in South Africa through television and public health campaigns marketing same sex messaging. Additional efforts to respond to the needs of South African black MSM include the National Intervention Strategy for Lesbian, Gay, Bisexual, Transgender and Intersex People initiative. This resource initially focused on gender corrective rape experienced by lesbians, and has now expanded to embrace a broader social justice mission for all marginalized and oppressed people (DOJ & CD, 2014; Oswin, 2007).

The percentage of men who reported being told by a health official that they were HIV positive is noteworthy. Because of the small size ($n = 41$) of the sample, that 3 (7%) of the men reported knowing they were seropositive must be interpreted with caution. As noted earlier reports suggest HIV prevalence rates for South African black MSM range from 27% to 45% (Cloete et al., 2014). Study participants indicated that many black MSM do not want to be tested for HIV. These observations are similar to the attitudes expressed by black MSM from Tshwane, South Africa (Sandfort et al., 2015). Sandfort and colleagues (2015) observed among a sample of 81 South African black MSM from four townships in Tshwane, South Africa that fear of being tested HIV positive caused some men to avoid testing until they became severely ill. Strategies to overcome fear of HIV testing, denial, anticipated stigma, and the lack of HIV messages targeting MSM are all important for designing strategies to seek, test, and treat MSM.

The diversity among men and the terms used to describe them suggest the need to better understand how the range of gender role constructions—Moffies, Double Adapters, Divas—are related to HIV sexual risk-taking behavior. In addition to the various gender role constructions characterizing MSM as a population, we learned about the importance of men who have been released from prison, who coerce MSM into sex. The findings regarding gender role constructions, the importance of prison gang norms, and attitudes related to gay sexual identity that may be age cohort defined,

provide insights into the complexities and diversity that exist among the various subgroups that make up black MSM in South Africa (Sathiparsad, Taylor, & De Vries, 2010). Of concern is the potential relationship between gender role constructions and individuals' perceived subjective peer norms regarding HIV risk behaviors such as sharing sexual partners. Knox (2010) provides additional insights into sexual risk behavior and beliefs about intimacy among South African black MSM. Studying the beliefs about trust and condom use in a sample of predominately black MSM in the greater Pretoria metropolitan area, this researcher observed many of the respondents having a false sense of intimacy with regard to condom use. Knox (2010) observed in a sample of MSM which 67% were black that men having a higher frequency of past unprotected anal intercourse were more likely to believe that it is not necessary to use condoms with a trusted or steady partner (Knox, 2010).

From the focus group discussions, jobs and places where black MSM are commonly employed emerged as important establishments in the community that perform positive functions providing emotional, social, and economic support for black MSM. Business establishments such as beauty salons and clothing boutiques for women where black MSM are employed may serve as important resources for gaining access to social networks of black MSM. Likewise, the socializing function that funerals perform for black MSM hold importance for connecting with some segments of the black MSM population in the Eastern Cape, and potentially other parts of the country as well. The fact that social supports can be accessed at funerals may be relevant for understanding social networks and black MSM friendship groups.

The expressed views on parental pressures, particularly paternal pressures, for men to engage in sex with women and father children, are important. Such pressures can potentially contribute to MSM feeling stigmatized and hiding their same-sex relationships, as well as leading to men who seek acceptance and approval from their family to engaging in sex with women thus placing their health in jeopardy. Still, some participants reported that they did not experience rejection or being ostracized by their families based on their sexual orientation due to their birth order (i.e., being the oldest son) or their economic importance (as a contributor to family finances). These family relations may serve as potential buffers for vulnerability to HIV risk-taking behavior compared with MSM who do not

enjoy such support and acceptance from their families. Again, these are issues requiring additional attention.

An important issue is that the findings suggest that at least some South African black MSM can be engaged in HIV risk reduction activities, as indicated by their willingness to participate in the focus groups reported. Additionally, public health programs that target MSM have been shown to have some success regarding participation (“ANOVA Health Institute,” 2015). Many of the men who participated in our focus groups stated that they found it difficult to believe that a group meeting was being conducted exclusively for black MSM. It is worth noting that we were able to successfully recruit men to participate in our focus groups in a relatively short period of time.

Although informative, this study has several limitations. The observations are based on men residing in two cities in the Eastern Cape region. Moreover, the findings are based on a convenience sample. Thus, our results may not apply to MSM residing elsewhere in South Africa. Further, the limitations of these results from this exploratory study are in line with what has been found in other studies among South African MSM, with a few differences. The findings underscore the importance of understanding HIV sexual risk behaviors among South African black MSM in the context of social constructions of gender and sexual identity in the locale in which the men are situated.

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