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PRISM PROJECT: NEEDS ASSESSMENT REPORT

Resourced Gay Men in Tshwane aged 18-40 2007/8

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ABOUT OUT Lesbian/Gay/Bisexual/Transgender (LGBT) WELL-BEING

OUT is a progressive non-profit LGBT organisation in Pretoria. In operation since 1994, the organisation works in the following domains: direct Sexual and Mental Health services, Research, Mainstreaming and Advocacy. Their website address is www.out.org.za

ABOUT THE SCHORER FOUNDATION

Founded in 1967 in The Netherlands, Schorer provides direct services to LGBT people, conducts research, and engages in mainstreaming general health care settings. Schorer is specialised in HIV prevention and HIV care, and works with LGBT communities through educational materials, websites, workshops, and buddy care. Schorer is active in The Netherlands, as well as in Europe, Latin America, and Southern Africa. Schorer's work is financially supported by, among other donors, the Dutch Ministries of Health and Foreign Affairs. Their website address is www.schorer.nl

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1. BACKGROUND TO THE NEEDS ASSESSMENT

The completed needs assessment discussed in this report forms part of a broader programme. This programme is done as a collaborative effort between Lesbian/Gay/Bisexual/Transgender (LGBT) partners in Southern Africa, Latin America and the Schorer Foundation (located in the Netherlands). Over 4 years (2007-2010), the broad aim is to upscale HIV/AIDS prevention programmes targeting LGBT people. The needs assessment is a first phase, which will inform programme design and implementation. In itself, the needs assessment, and its findings, is useful in light of the fact that little researched knowledge is available on sexual practises of LGBT people in a region such as Southern Africa. The collaborative programme in Southern Africa is called the PRevention Initiative for Sexual Minorities (PRISM) and is funded by the Dutch Ministry of Foreign Affairs, in collaboration with the Schorer Foundation. In Southern Africa, the participating partner organisations are OUT-LGBT Well-being (Tshwane), the Durban Lesbian and Gay Community and Health Centre (Kwa-Zulu Natal), the Triangle Project (Cape Town), the Rainbow Project (Namibia), Lesbians and Gays in Botswana (LEGABIBO), and the Gay and Lesbian Association of Zimbabwe (GALZ).

In the needs analysis phase, each participating organisation had to identify relevant target groups. OUT identified gay men who engage in sexual risk-taking during casual encounters as its first group and lesbian women who also engage in sexual risk-taking during casual encounters, as the second group (see 'PRISM PROJECT: NEEDS ASSESSMENT REPORT – Resourced and Under-resourced Lesbian Women in Tshwane aged 18-40, 2007/8'). The decision to focus on sexual risk-taking in casual encounters is because these casual encounters seem to provide an ideal opportunity for increased risk-taking behaviour to occur. More details on the selected target groups are discussed under 3.1.

2. AIM OF NEEDS ASSESSMENT

The needs assessment has two primary aims:

- To contribute to the body of knowledge on risky sexual behaviours among gay men in Tshwane; and
- To use such knowledge to inform programmes for the selected target group.

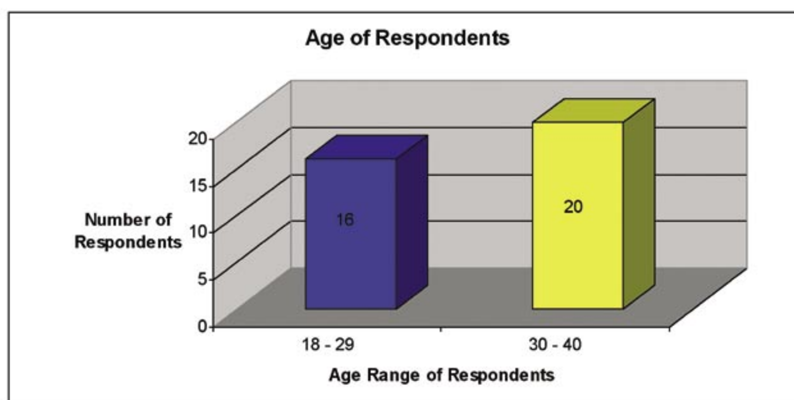
3. THE NEEDS ASSESSMENT RESULTS

3.1 Target Group

Thirty-six (36) self-identified gay, white males were included in the needs assessment. The profile of the respondents is as follows:

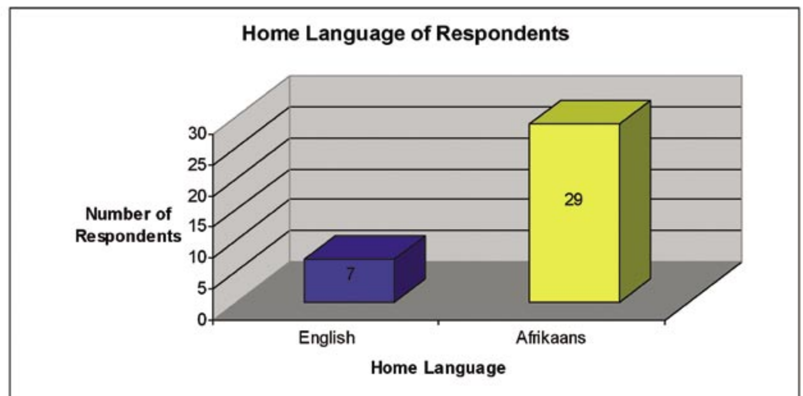
Age:

The mean age of respondents was 31 years. 44% were between the ages of 18 and 29 and 56% were between the ages of 30 and 40 years old.



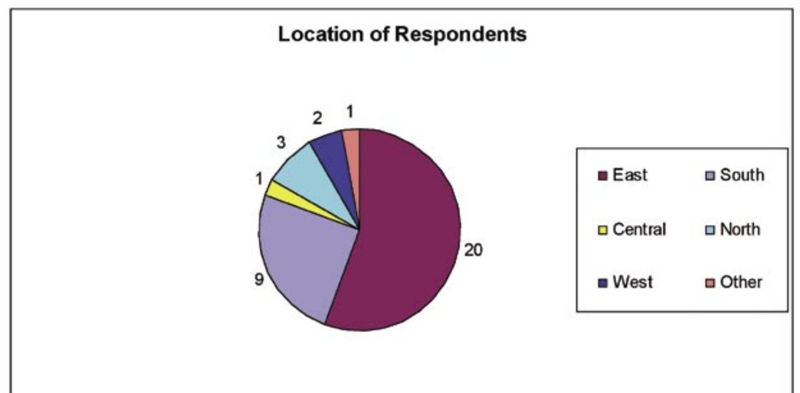
Home Language:

19% of the sample is English speaking and 81% is Afrikaans-speaking.



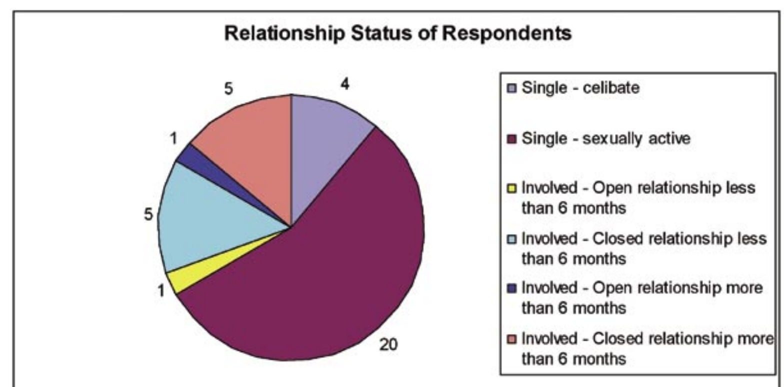
Location:

The majority of respondents reside in the East of Pretoria (56%). This is followed by the South of Pretoria (25%),the North of Pretoria (8%), the West of Pretoria (5%), and Pretoria Central (3%). 3%, noted as 'Other', reside just outside Tshwane but work and socialise in Tshwane.



Relationship Status of Respondents:

67% respondents indicated that they were currently single. Of those respondents 17% indicated that they were not sexually active and 83% indicated that they were. 33% indicated that they were currently involved in a relationship: 8% in an open relationship of less than 6 months and 8 % in an open relationship of more than 6 months; 42% in a closed relationship of less than 6 months and 42% in a closed relationship of more than 6 months.



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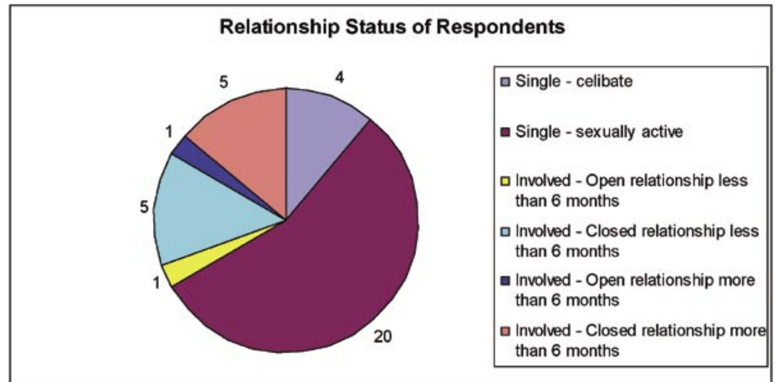
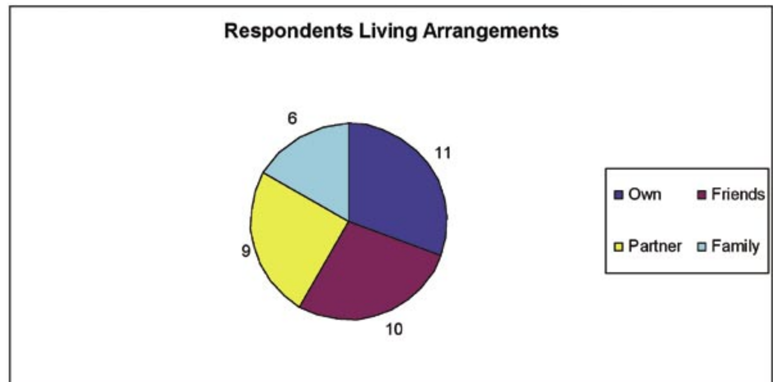


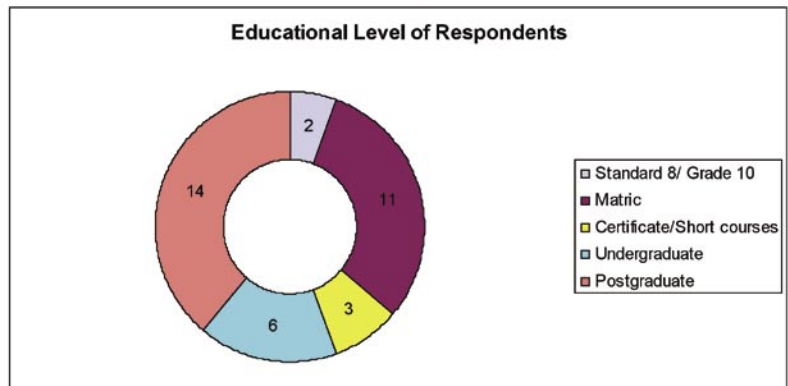
Living Arrangements:

The majority of respondents indicated that they lived on their own (30%). This was closely followed by respondents who lived with their friends (27%), with their partner (25%) and with their family (18%).



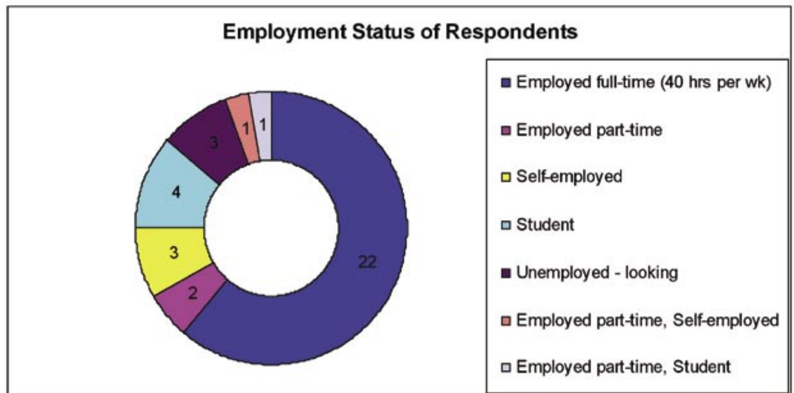
Educational Level of Respondents:

5% of the respondents indicated that they did not advance beyond a grade 10 level of education. 31% indicated that they had successfully completed their matric and did not study further. 8% indicated that they went on to complete a number of short courses. 17% indicated that they achieved an undergraduate level of study and 39% indicated that they have obtained a postgraduate degree.



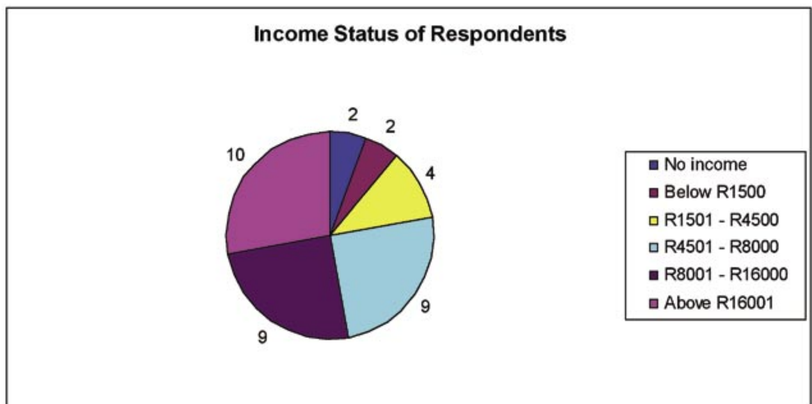
Employment Status of Respondents:

The majority of respondents indicated that they were employed full-time (62%). 5% indicated that they were employed part-time and 8% indicated that they were self-employed. 3% indicated that they were partly employed and partly self-employed. 3% indicated that they were studying and worked part-time. 11% indicated that they were only studying. And 8% indicated that they were recently unemployed and looking for work.



Income Status of Respondents:

2% of the respondents indicated that they received no income and 2 % indicated that their income was below R1500. 12% indicated that their income was between R1501 – R4500. 25% indicated that they earned between R4501 – R8000 and between R8001 – R16000, respectively. 28% indicated that their income was above R16001.



Summary comments

The target group consists of White, well-educated and relatively resourced gay men. It can be assumed that they are 'Westernised' and operate within 'Western Frameworks'. It is noticeable that a large proportion is single and sexually active. In relation to those who are in a relationship, a small percentage of respondents indicate that they are in an open relationship. The majority of respondents live independently from their families.

3.2 The Research Question

The research questions focussed on the determinants of casual sexual risk-taking among resourced gay men in Tshwane. The research questions explored biographical data and background information, perceptions on health issues facing gay men, as well as respondents' own experiences of risk behaviours. Please refer to the appendix for a further discussion on the research methodology.

3.3 The Health Problems

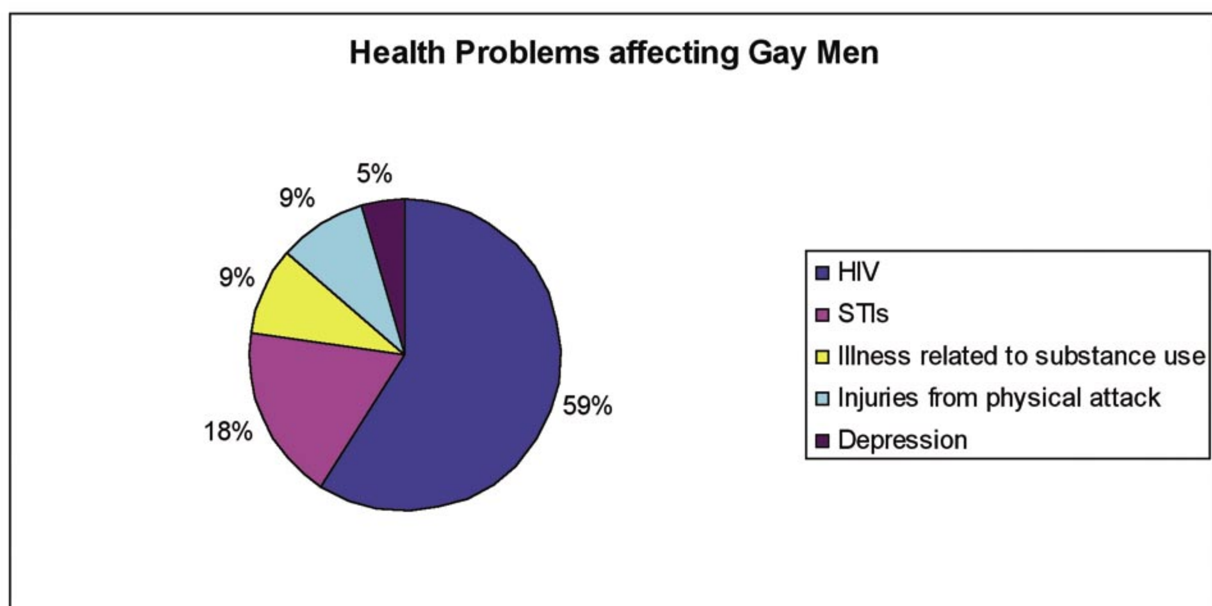
3.3.1 The Health Problems

The health problems identified are Sexually Transmitted Infections (STIs), including HIV, and the risky sexual practices that contribute to their transmission.

Sexually transmitted infections (STIs) are a major public health concern in Southern Africa, and it has been estimated that more than 1 million patients seek treatment for STIs every year (van Dyk, 2001). As has been well documented, the presence of STIs is problematic for the following reasons:

(i) The presence of an STI increases one's susceptibility to HIV infection (statistics suggest that individuals who are infected with STIs are at least two to five times more likely than uninfected individuals to acquire HIV through unsafe sex);
(ii) The presence of an STI may be an indication of engaging in unprotected sex with multiple partners, thus increasing one's risk of coming into contact with STIs and HIV.

In previous research conducted by OUT in Gauteng, it was found that 15.5% of white males indicated that they had had an STI in the past 24 months, and 2.6% indicated that they were not sure (Wells & Polders, 2004). In addition, 8% indicated that they were HIV-positive (Wells & Polders, 2004). The importance of STIs and HIV as a health problem was supported by the findings of the needs assessment. Of the 36 respondents, 59% indicated that HIV was the biggest health problem confronting gay men in South Africa. This was followed by STIs (18%), illness related to substance use (9%), injuries from physical attack (9%) and depression (5%).



3.3.2 Risk Behaviour: Sexual Risk-taking in Casual Encounters

What follows in the sections below (particularly 3.3.2.1 to 3.3.2.4) is a fuller description of the concept of risk within casual sexual encounters, and a closer look at the individual and contextual factors that might place respondents at increased risk. In the discussion of individual factors, the aim is to group some of the preliminary determinants of risk-taking behaviour (as outlined in *'A Proposal for Funding to Conduct a Needs Assessment on Two Target Groups in Tshwane, South Africa as part of the PRISM Project at OUT-LGBT Well-being'* document) into larger groups of determinants. These preliminary determinants of risk-taking behaviour were: substance use, escapism, inability to delay gratification, impulsivity, feeling of emptiness, poor self-image, thrill seeking tendencies, pursuit of the masculine ideal, negative mood states, fatalistic attitudes, sense of invulnerability, very little internalisation of safer sex information, anxiety, poor frustration tolerance, internalised homophobia, destructive tendencies towards the self, sex as a means of connection and affirmation, fear of intimacy, desperation, defiance of the heterosexual model and poor insight. These factors were identified based on already completed studies on this target group and expert knowledge developed by the project team and the advisory group (see appendix). In section 3.3.2.2 these factors are then grouped and further discussed.

Sections 3.3.2.3 and 3.3.2.4 discuss two specific environmental/contextual factors, namely the gay sub-culture and relationships, and how these mediate sexual behaviour. These environmental factors came to the fore during the analysis of the data. They also cover much of the environmental factors listed in the needs assessment funding proposal: availability of sexual encounters, peer norms, cultural norms, peer pressure, lack of role models, the heterosexual model as an ideal, economic prosperity, and easily accessible sexual spaces and locations. Although relationships are not strictly an environmental factor, they are bigger than the individual and include issues that are not limited to individualistic dynamics.

The following sections also explore sexual behaviour, including the barriers that stand in the way of safer sex and the factors that facilitate safer sex. Moving towards programme design (the next phase in the PRISM Project), it is aimed that the analyses contained in this report will inform interventions that move beyond the first generation HIV prevention campaigns. In these first generation campaigns, there was a considerable emphasis on behavioural change through information giving, and developing positive community norms, which were effective to some extent.

The discussion starts with a brief description of the concepts of risk and casual encounters. This will assist in placing individual- and relationship dynamics, as well as community norms, within a conceptual understanding of the behaviours discussed.

3.3.2.1. The Concepts of Risk and Casual Encounters

a) The concept of risk

The concept of risk is seen simply as any danger from future damage (Douglas, 1992). Elsewhere, risk has been referred to as "the probability of a generally negative outcome, accompanied by the magnitude of the damage which it will do" (Joffe, 1999, p.4). Theorising risk therefore involves universally applied standards that indicate the 'deleterious consequences' attached to certain behaviours and the probability of adverse outcomes developing if such behaviours are not avoided or adapted.

In public health, considerable attention has been placed on establishing a hierarchy of risk associated with STI and HIV transmission (see Shernoff, 1988). The hierarchy ranges from minimal risk (abstinence) to highest risk (anal intercourse with internal ejaculation without a condom).

Although seemingly clear, it seems that there are differences between public health and folk constructions around relative risk of HIV and STI transmission (Levine & Siegel, 1992). Certain activities are seen as ambiguous in terms of evaluating risk. These include unprotected sex in ongoing relationships, being the insertive partner in anal sex, anal sex without ejaculation, fellatio with ejaculation, fellatio without ejaculation, and anilingus (Adam, Sears & Schellenberg, 2000). This ambiguity is reinforced by inconsistent mass media messages given by prominent leaders in South Africa. Faced with such ambiguities, it appears that gay men incorporate official and unofficial knowledge in order to arrive at a personal solution, which may include being overly safe or simply not safe enough (Adam et al, 2000). Ross and Ryan (1995) suggest that as a result gay men have constructed their own hierarchies of risk and tend to make choices accordingly. In terms of gay men's sexual preferences, international research has found that anal intercourse (either/both active/insertive and passive/receptive) appeared to be the most preferred activity, followed by oral sex, kissing, and mutual masturbation respectively (Boxford, 2001). This is supported by research conducted by OUT, where it was found that 84% of participants engaged in anal sex, 70% reported being either/both the receptive partner and insertive partner, and that 16% indicated that they were exclusively the receptive partner (OUT, 2005). Given these results one can see that the hierarchy of preference correlates significantly with the hierarchy of relative risk behaviour.

b) Casual encounters

Research conducted by OUT found that 12% of respondents engaged in casual sex at least once a week and 14% reported having casual sex 2-3 times a month (OUT, 2005). When looking at casual sex, and its potential role in the transmission of STIs and HIV, there is the common perception that casual sex is itself problematic. The aim of this needs assessment is not to stigmatise but rather to explore and uncover the determinants of sexual risk-taking in the context of casual encounters and steady relationships, both of which are seen as important sites that appear to facilitate risk-taking. International research has shown that men without a primary relationship are more likely to report having unprotected sex as a result of being sexually aroused or due to a combination of sex and alcohol or drug use or a lack of condoms at the time that sex occurred than are men in monogamous relationships (King, 1994). Furthermore, there is the finding that a higher reported rate of partner turnover (between 20 and 90 sexual partners in the last year) is often associated with an increased likelihood of having unprotected anal intercourse (Boxford, 2001; Prieur, 1990). What complicates the picture further is the finding that a vast majority of newly infected gay men seemed to contract (an STI or) HIV within a stable relationship (Swedish Federation for Gay and Lesbian Rights, 1992, in Henriksson & Mansson, 1995).

A possible reason for the finding that men in monogamous relationships are more likely to report having unprotected sex as a result of being in love and having the same sero-status as their partner than men without primary relationships (King, 1994). Given these findings it is possible that gay men are consistently engaging in unprotected sex with their primary partner (if in a relationship), and in certain cases, engaging in unprotected sex with a casual partner. Given these findings it becomes important for us to explore casual encounters and steady relationships as important sites that appear to facilitate sexual risk-taking behaviour. According to one of the respondents in this study, casual sex can be seen as follows:

> *"Casual sex is about meeting someone for the first time and either getting to know their name or not…and then have intercourse or jack off…until orgasm is reached"*

(26, involved in open relationship)

In the above quote, the respondent speaks about making contact with a perpetual stranger, establishing limited information about them, engaging in a sexual activity, and deriving some sort of pleasure. In the two quotes below, the respondents make it clear: a chance encounter that is purely physical, devoid of any romantic notions or emotion, and is time limited (temporary).

"With casual sex there is no love…you pick up a person, have sex and never see them again"

(25, single and sexually active)

"It is a quickie…it might be a quick blow job or a quick fuck…no addresses, no names…and no interest in being involved"

(37, involved in closed relationship)

In the next quote, the respondent indicates that the encounters may involve partners from various levels of familiarity:

"Casual sex can take place between strangers or with your friends or with acquaintances of your friends…anybody really."

(26, single and sexually active)

And for one respondent casual sex is a rapid way of establishing and experiencing a deep emotional attachment to another:

"Casual sex is a short way to brief love…"

(30, single and sexually active)

As is evident from the above quotes, the majority of respondents in the needs assessment view casual sex as: primarily between strangers (but not exclusively), is not overtly about emotions and romantic notions, and involves a type of sexual activity (that is at times risky), and ultimately results in pleasure. In certain cases the casual encounter could involve people who are known (like a friend or a friend of a friend), but still remains devoid of any overt romantic/emotional attachments. In contrast to the prevailing pragmatic view of casual sex, a small number of respondents associate casual sex with love, possibly pointing to a need for connection (explored further below).

3.3.2.2. Individual Determinants of Risk-taking Behaviour

a) Lack of knowledge and little internalisation of public health information

Considerable attention in the literature has been given in the past to knowledge, attitudes and beliefs and how these components translate into behaviour (Joffe, 1998; Kippax, Connell, Dowsett & Crawford, 1993; Naidoo, & Wills, 2000). As such, it has been suggested that risk-taking behaviour is a result of cognitive processing errors, and that an increase in knowledge, and changes in attitudes and beliefs automatically result in risk-aversive sexual behaviour/practice (Joffe, 1998; Kippax, Connell, Dowsett & Crawford, 1993; Naidoo, & Wills, 2000). However, numerous studies challenge this notion by showing that while many gay men have managed to integrate safer sex (to varying degrees) into their everyday lives, there are others who have never adopted safer sex to any great degree (Adam, Sears & Schellenberg, 2000). These findings reinforce the criticism that the Knowledge-Attitudes-Beliefs-Practices Model fails to provide a clear understanding of how HIV messages interact with meanings and reasoning that gay men use in understanding and expressing their sexuality (Adam, 1992; Dowsett, 1996).

The results of the needs assessment support these findings. Despite an awareness that HIV (including STIs) is the most serious health problem facing gay men in South Africa, there remains a large proportion of respondents who engage in unprotected sex within their primary relationship (described mostly as intentional or voluntary) and within casual encounters (described mostly as inadvertent or involuntary). Casual sex, and the possibility of unprotected sex, is a reality for most respondents even if in a relationship.

It can be argued that the meanings attached to these behaviours are part of how respondents understand and express their sexuality. It links with the norms within the gay sub-culture, especially since the early 1990s, where sexual freedom is not limited by the serious threat of HIV/STIs.

> *"... I engage in casual sexual encounters about three times a year, sometimes more, it depends. In terms of using protection, I would say that for every five men that I have sex with, one might be an accidental unprotected encounter…we [my primary partner and I] don't use protection."*

(26, involved in open relationship)

In the following quote, the respondent admits to having had unprotected sex but maintains that these encounters were safe as these sexual partners were his friends:

> *"It [casual sex] can be dangerous…but I like it, I can't see anything wrong with it…I will have casual sex about four times a month…I am usually careful, but have had unprotected sex with four of my friends…it was safe because I know them."*

(25, single and sexually active)

The next quote is from a respondent that admits engaging in unprotected sex outside his primary relationship, while continuing to have unprotected sex with his primary partner:

> *"… yes, there have been times where I have had unprotected sex outside of my relationship and have not told my partner…and my partner and I continue to have unprotected sex."*

(37, involved in a closed relationship)

As is evident in the above quotes, the majority of respondents engaging in casual sex do seem to know what the risks are and tend to moderate their sexual practices accordingly. However, there are points where most of these respondents don't practice safer sex (e.g., intentionally due to partner familiarity, or inadvertently due to some intervening variable). Further, they are not likely to disclose these encounters to their primary partner, with whom they consistently have unprotected sex.

b) Poor self-efficacy

Perceived self-efficacy is seen to influence the likelihood that a person will engage in a particular behaviour, the amount of effort they will devote to the behaviour, and the length of time they will continue to perform the behaviour (Smith et al, 1996). The concept can be applied to adopting new behaviours, discontinuing old behaviours and avoiding others. As such, self-efficacy is seen as a potential skill needed to manage the risky behaviours that can lead to the transmission of STIs, including HIV (Smith et al, 1996). Using condoms and negotiating safer sex are examples of behaviours that can be affected by efficacy expectations (Basen-Engquist, 1992).

In general it would seem from the needs assessment that respondents don't consistently use condoms and don't negotiate safer sex practices. This applies to respondents who are in a relationship and engage, or don't engage, in casual sexual encounters, and to those who are single and also engage in casual sex.

In the words of the following respondent:

> *"…basically anything goes, depending on your preference…intercourse with or without condoms depending on the other guy's choice…I don't generally ask them about their status. Sometimes they just tell you and then we will try and be safe… generally I don't ask"*
>
> (35, involved in a closed relationship)

Here the respondent appears passive and places the responsibility of safer sex with the casual partner. What follows are two quotes where respondents indicate that they don't talk about safer sex but do take the initiative to use protection nevertheless:

> *"In most cases you don't even know each other at all…I never know for sure if they are infected, but I take a chance anyway…I don't ask them…I don't think to ask them…It has never come up… I just use a condom anyway."*
>
> (30, single and sexually active)

> *"No, you don't really talk about safer sex…you just put it on, it is not really a decision…I am nervous about being tested…I don't feel comfortable going for the test"*
>
> (25, single and sexually active)

This quote does point to considerable anxiety around testing despite taking precautions. In the next quote the respondent describes how he used protection inconsistently and never spoke about safer sex.

> *"I have occasionally had unprotected sex with other guys…it just depends…sometimes I asked them to put a condom on and at other times they just put one on…but at other times we had unprotected sex…I never asked about their status"*
>
> (40, single and sexually active)

From these responses it is clear that there are a range of behaviours taking place in these sexual encounters. Whether not talking about safer sex and not using condoms consistently has to do with a lack of self-efficacy remains unclear. Unfortunately it was not explored more fully in the needs assessment.

It would seem though, that based on the needs assessment findings of inconsistent condom use and safer sex negotiations with steady and casual partners, despite viewing HIV/STIs as a major health issue, that the majority of respondents do not demonstrate self efficacy when necessary (e.g., while still sober and when having casual sex with complete strangers). The needs assessment revealed that the more "known" or "familiar" the sexual partner is (for example a friend), the less likely it is that condom use will take place. In addition, substance use (which appears linked to venues, such as night clubs, and time of day, mostly at night) was indicated by the majority of respondents as a contributing factor to increased sexual risk-taking (seen in the quote below).

> *"…it is important to ask about their status…but when it comes to drinking you don't always think of asking him…"*
>
> (34, single and sexually active)

c) Sense of invulnerability

In looking at attitudes and beliefs, a number of studies have shown that individuals have a strong, yet unjustified, sense of invulnerability and immunity, when confronted with risk, irrespective of their educational background and knowledge about HIV/AIDS (Leclerc-Madlala, 2002; Levine & Ross, 2002). One explanation for this underestimation of personal risk has to do with a particular adaptive survival strategy (Douglas, 1986). As an adaptive strategy, it allows people to function calmly in the midst of certain threats or dangers, and to dare to experiment and take chances in the midst of uncertainty. Another explanation suggests that most people have the belief that certain 'risk groups' outside of one's own group are more at risk of HIV, such as prostitutes, drug addicts, the poor, those lacking in formal education and certain races (Caldwell et al, 1992; Crewe, 2001; Joffe, 1999; Levine & Ross, 2002; Sontag, 1990). In this way people maintain their sense of invulnerability to risks, by attributing threat and blame to people identified as 'the other'. This dangerous defensive strategy is clearly implicated in the maintenance of the epidemic. The results of the needs assessment appear to support notions of invulnerability as a contributing factor. The following quote was taken from a respondent who claims to have unprotected sex once out of every five casual sexual encounters, while maintaining a sense of safety:

> *"I know what my and my partner's status is…I don't always know the other guy's status…but I think I am safe."*

(26, involved in open relationship)

Another respondent spoke about using visual cues as an adequate means of establishing risk, thereby maintaining a sense of invulnerability:

> *"I usually look down there to see if there is anything suspicious…if there is nothing then we can have sex…in general I don't think I am at risk of anything."*

(30, single and sexually active)

In the absence of any visible signs, the respondent assumes that the sexual encounter will be safe. Here, he uses his own method of risk calculation, which is factually questionable, in order to sustain a sense of being safe. In contrast a large proportion of respondents did in fact indicate that they were at some risk of contracting an STI or HIV:

> *"It is possible that I am at risk…sometimes…when drinking and when the other guy does not want to use a condom…then it is risky"*

(37, involved in closed relationship)

> *"Without a doubt! Without a doubt! When drinking I am more likely to take more risks…and have unprotected sex"*

(40, single and sexually active)

From the above two quotes, it appears that substance use plays a role within a sense of invulnerability. Interestingly though, is the general finding that although seeing themselves at some degree of risk, the majority of respondents continue to take occasional risks. It is possible that despite a conscious awareness of personal risk, deep down they posses a strong sense of unwavering invulnerability. Or alternatively, another contributing factor (e.g., substance use) prevents them from taking action that ensures their own safety.

d) Thrill-seeking and escapist tendencies

Despite the dominant discourse that holds that risk and risk-taking are generally negative, there is the counter discourse that presents risk-taking in a far more positive light (Lupton & Tulloch, 2002). A few studies have shown that risk-taking behaviour is often seen as a way of life amongst the youth (Maart, 1998), and is framed as thrill-seeking behaviour (Gullone, Moore, Moss & Boyd, 2000). People appear compelled to take risks voluntarily when experiencing a need to display strength and courage, when in need of pleasure and excitement, and when wanting to overcome a life of boundary and restriction (Lupton & Tulloch, 2002). Risk is perceived as dangerous, but also exciting, in its lack of certainty and challenging of the borders between the known and the unknown (Lupton & Tulloch, 2002). This is apparent in the following quotes:

> *"The feeling that you can get caught…it is so exciting! The excitement gives you an edge…There is so much freedom in having casual sex…no strings attached"*

(33, single and sexually active)

> *"…it is more like a thrill when you have casual sex…you feel wanted and you feel worth it…you get a major kick out of it…"*

(29, involved in closed relationship)

> *"I see casual sex as a form of entertainment…it helps you to relax and to forget about your problems…it is part of life"*

(30, single and sexually active)

The thrill and excitement mentioned in these quotes is in reference to casual sex and not unprotected sex. In these cases, thrill-seeking tendencies can be seen as a motivating factor for increased casual sex (perceived risk-taking) and not necessarily the choice to have unprotected sex (actual risk-taking). However, it is clear in the literature that an increase in sexual partners is linked to an increased likelihood of risk-taking behaviour to occur (Elford et al, 2005). Elsewhere, thrill-seeking tendencies may be seen as a motivating factor for unprotected sex, but this was not supported in this needs assessment.

e) Erroneous risk perception

Research has found that people tend to make automatic assessments about each other when they meet. People tend to make assessments of potential partners based on such attributes as their social class, appearance, social demeanour and whether or not they are judged to be 'like me' (Lupton & Tulloch, 2002). Decisions about trust are established quickly and possible concerns around infection dissipate (Lupton & Tulloch, 2002). Sex with that person is no longer seen as risky. This superficial assessment is illustrated in the following quotes:

> *"I was just sitting there, having my red wine…I looked at this guy sitting at the other end of the bar…I could smell him…I thought 'Aaah, very nice'…I liked his face, very strong face, nice eyes…I was immediately drawn to him…I walked up to him and tapped him on the shoulder…I asked him to follow me and he did…we then had sex…I didn't even know him…you can go anywhere, you can sit in a room and just look around and pick someone up. It might be in a bar, it might be in a club, it might be in a restaurant, it might be in a shopping mall, it might be anywhere, in any place"*

(30, single and sexually active)

"I will chat to a guy on the internet for a while, trying to find out about him…I will chat to him on the Friday night and then have sex with him on the Saturday. It is different when you go to bar…the bar is totally oriented for casual sex...you walk in there and you can have your pick of whoever is in there…you can choose who you want to play with or not"

(26, involved in open relationship)

It is a strong possibility that others are assessed according to their appeal as a sexual partner, within a gay culture where sex is definitive and seen as highly important. As such, a level of familiarity and trust is established rapidly. And as indicated previously, the more "known" or "familiar" the sexual partner is, the more likely it is that risky sex will occur.

f) Internalised homophobia

Society in general can be described as heterosexist and homophobic. Given this, gay men in general are pathologised, and seen as unnatural, immoral, deviant, inferior (Davies & Neal, 1996) and carriers of death (Isay, 1993). Given these prevailing attitudes, many gay men have experienced some form of rejection or another by society, family and friends because of who they are. Furthermore, many gay men have internalised and generalised this rejection to some degree, often at an unconscious level (Davies & Neal, 1996). As such, many gay men feel inadequate, insecure and ashamed, exhibit a low self-esteem, and become fatalistic and self-destructive (Davies & Neal, 1996). This may give rise to a 'spoiled identity' (Goffman, 1963). Research conducted by OUT found that 15% of respondents presented with high levels of internalised homophobia (OUT, 2005).

It has been shown that fatalistic attitudes, particularly in South Africa, coupled with negative coping strategies tend to result in reckless and irresponsible sexual behaviour (Leclerc-Madlala, 1997). Furthermore, the association between negative self-images, negative mood states and sexual risk-taking behaviour is also supported in the literature (Adam et al, 2000). Low self-respect and insecurity make it easy to do something that will be regretted afterwards (Prieur, 1990). A positive association has been identified between unsafe sex and using sex as an escape from everyday life, and between sexual risk-taking and depression (Adam et al, 2000). Research conducted by OUT found that 15% of respondents presented with a high risk of being depressed (OUT, 2005). Furthermore, it has been found that unsafe sex is often linked to overt and covert self-destructive intent (Odets, 1995). Linked to this finding is the suggestion that many gay men get so caught up in the 'AIDS as punishment for their deviancy' discourse, that they inadvertently increase their risk of exposure to STIs and HIV through unsafe sex, thus becoming a self-fulfilling prophecy (Adam et al, 2000).

The following quote illustrates the fatalism, shame and doubt, low self-respect, and denial as a form of coping (where the respondent talks about moving on and forgetting):

"In the moment I will ask myself 'what are you doing?', 'you are being stupid', but then I think to myself 'whatever' and just go for it…and then later I feel a bit ashamed of what I did…but then I move on and forget about it."

(26, involved in open relationship)

In the next quote the respondent talks about the shame and the secrecy attached to engaging in casual sex:

"I am not proud of having casual sex…everyone does it but no one talks about it…you do it but you don't talk about it…you keep it quiet…you hide it…"

(33, single and sexually active)

Another respondent demonstrated the negative self-images and self-destructive tendencies attached to a casual encounter:

> *"At the time I feel cheap and sluttish…but oh God, I need it…"*
>
> (40, single and sexually active)

In the following quotes respondents talk about feelings of loneliness and depression beforehand, feelings of guilt and anxiety while engaging in the casual sex, and then brief exhilaration afterwards:

> *"With casual sex you get to be with somebody…the loneliness gets to me…I get depressed…I am very emotional…and then when I meet up with a guy I feel on top of the world again…there is somebody interested in me, there is somebody with me again…I then feel that I can go on."*
>
> (30, single and sexually active)

> *"When I have casual sex I am usually very, very drunk…and at other times because I am very depressed and lonely."*
>
> (32, involved in a closed relationship)

> *"I sometimes feel guilty about it [casual sex], because it is not really necessary…it is actually rather silly and stupid…it is only sex and not love…one should find other things in life to concentrate on…but then you get lonely and sad…"*
>
> (26, single and sexually active)

Another respondent spoke about a need to escape a great deal of internal pain:

> *"Most will take drugs to escape their reality…and their past…especially if they had a bad childhood…but it doesn't help because you can't forget…it is always there… those bad feelings"*
>
> (30, single and sexually active)

In order to manage a 'spoiled identity' it is possible that many gay men try to compensate by pursuing the masculine ideal, which is revered by most of society. Notions of masculinity are associated with strength, power, control, rationality, and virility. Being male is also associated with a biologically driven increased sexual drive and decreased self-control often leading to a higher partner turnover than women (Foreman, 1999). As such, it is possible that many gay men compensate for their 'spoiled identity' by attempting to downplay any feminine attributes in favour of being strong, non-emotive, and virile. This compensation is possibly intensified by an increased sexual drive as is shown in the following:

> *"So it is like a man has to do what a man has to do…it is a manly thing…men have something in them…I can see it [sex] coming a mile away…I can smell it…I want it…I need it…if I walk past someone I feel this energy…we look at each other…I know what he wants and he knows what I want…and we do it…it is all about lust…as men we need to have sex to get rid of that lust"*
>
> (30, single and sexually active)

The quote above seems to illustrate the widely held notion that men have a strong biologically driven need to satisfy a sexual desire or impulse. In the next quote, the respondent supports the idea that he is powerless to resist the innate urge to have sex:

"It can be extremely terrifying…but you want it [sex] so bad…and your hormones kick in and you just go for it…it is in our genes…we can't help it"

(26, involved in open relationship)

In the following two quotes, the respondents merge the idea of a biological drive with a pursuit of the masculine ideal (e.g., physical cues, physical action, no commitment or attachment):

"What gets me going is the size of a guy's dick…that really gets me going…looks and age don't matter, because I don't want to get involved with that person…it's just sex."

(37, involved in closed relationship)

"It is a physical experience between two men…no commitment, no love, no relationship…just fucking and pleasure"

(35, involved in closed relationship)

g) Meaning attached to condom use

Research conducted by OUT indicates that 27% of respondents use condoms most of the time and 24% indicated that they did not use condoms, citing their relationship as a reason (OUT, 2005). Furthermore, 17% of respondents found it difficult to insist on condom usage in casual encounters, and 23% found it difficult to do so in their relationship (OUT, 2005). Research has shown that condom use has been associated with notions of unfaithfulness, distrust, a lack of love, a sense of inauthenticity, disease and incompatibility with manliness (Leclerc- Madlala, 2002; Levine & Ross, 2002), as well as barriers to pleasure (Collins & Hoosen, 2002). It has also been shown that the non-use of condoms is often a demonstration and expression of trust in an ongoing relationship, whereas the use of condoms is reserved for sexual encounters that are considered less meaningful and non-permanent in nature (Boxford, 2001). This is supported by the finding that men in monogamous relationships are more likely to report having unprotected sex as a result of being in love and having the same sero-status as their partner than men without primary relationships (King, 1994). However, men without a primary relationship are more likely to report having unprotected sex as a result of being sexually aroused or due to a combination of sex and alcohol or drug use or a lack of condoms at the time that sex occurred than are men in monogamous relationships (King, 1994). And in this needs assessment it became clear that the more familiar the sexual partner is the less likely it is that protection will be used. In the case where unprotected sex is seen as a primary sign of a special trust between two people, it is a challenge to re-introduce protection into the relationship as this may be interpreted as an accusation of infidelity and expression of distrust (Collins & Hoosen, 2002; Leclerc-Madlala, 2002; Levine & Ross, 2002).

Whether in a closed or open relationship it appears that condoms are not being used in the primary relationship, and that condoms are not being consistently used during casual encounters:

"Me and my partner don't use condoms…we trust each other…we have agreed that when we have sex with others that we will use protection…we try to stick to this…but you know how it goes…sometimes you drink too much and you meet this guy…and you are in the moment, you forget about protecting yourself…but I am open with my partner and I tell him everything."

(26, involved in open relationship)

Unlike the quote above, it appears that a number of respondents won't tell their steady partner about the casual encounter:

> *"I have been with my current partner for about six months…we are having unprotected sex…we care about each other…but…when drinking and when the other guy does not want to use a condom…then it is risky…because then we have unprotected sex…I won't tell my partner because it doesn't help to talk about it…it would destroy the relationship."*
>
> (37, involved in closed relationship)

h) Sex as a means of connection and affirmation

Research has shown that most men engaging in high risk sexual behaviour tend to have a loose social network, are lonely or primarily have only superficial contact with others (Prieur, 1990). For gay men without close connections to other people, an active (and often exaggerated) sex life can be the only tie they have to a group or community (Prieur, 1990). All social needs are released there; for many it is the only means of experiencing closeness to others (Prieur, 1990). For them, a loss of sex life also means losing most of one's social life and connection with others; it is not surprising that most will dread it (Prieur, 199). As such, they stand to lose the most by changing their sex life because they have so little else (Prieur, 1990).

One respondent spoke about losing connection with his casual partner once the sex was over. He expressed a need for an ongoing connection with the casual partner. But he realises that it could never be more than what it was:

> *"Things changed after we had sex…he had to leave…I wanted to see him again but he didn't ask for my number…he is in love with another guy in Durban…so I probably wont see him again."*
>
> (30, single and sexually active)

The same respondent goes on to explain that he feels rejected after the fact, given the temporary nature of the connection during casual sex:

> *"Casual sex is about meeting somebody, going out and then having sex. Afterwards you don't hear from the person again…or they walk past you without even noticing you."*
>
> (30, single and sexually active)

In this quote, the respondent expresses a secret longing to be liked and wanted even after the encounter:

> *"There are a thousand thoughts going through your mind…is this guy nice or is he bad, will he take my number afterwards…or is this a once-off deal…does he want to see me again…"*
>
> (33, single and sexually active)

Another respondent spoke about a strong need to feel connected to another person, even if for a brief moment:

> *"When you meet you feel connected…and sometimes you know this is only for one night…but you get to a point where you are so desperate to have the physical contact that you actually basically throw out all your inhibitions…and think to hell with it…I am going for it…even if it is one night"*

(30, single and sexually active)

And then another respondent spoke about the benefit of having a brief connection:

> *"Casual sex suits most gay men who are still in the closet…for example if you still live with your family and you are in the closet then it would be very hard to have a regular partner…so casual sex is a way of connecting with someone without having a relationship"*

(40, single and sexually active)

As such, for many respondents, sex (be it in a steady relationship or a casual encounter) is a means of connection and affirmation. And for many, their vulnerability lies in the extent to which they will place themselves at risk while pursuing that connection and sense of worthiness.

i) Impulsivity and inability to delay gratification

In the literature, impulsivity is described as the inability to delay gratification or the inverse of self-control (Monterusso and Ainslie, 1999, as cited in Arce & Santisteban, 2006). Furthermore, it has been suggested that people tend to engage in risky-taking behaviours when in a deprived state, without much regard for the long-term consequences (Arce & Santisteban, 2006). Research conducted by OUT found that 9% of the respondents exhibited higher rates of impulsivity (OUT, 2005). The notion of impulsivity being a contributing factor to risk-taking is supported by the following quotes:

> *"I saw him…I walked up to him and asked his name…I could tell he was horny…he invited me back to his place…he poured some wine…I looked at his dick and told him to drop his pants…I took my clothes off…we both got hard…I gave him a blow job and it then turned into sex…we didn't talk…we just fucked…it was like I needed it so badly"*

(30, single and sexually active)

> *"It can start with a look, two men look at each other in a way…you can see it in their eyes, you can see it in the body language…you give each other signals…and so the casual sex starts…either at the club or at his place."*

(33, single and sexually active)

> *"…there is no love…you pick up a person, have sex and never see them again"*

(25, single and sexually active)

> *"It is all about having sex with the next available guy…that is all it is about."*

(31, single and sexually active)

"You meet a guy at a bar, chat a while, and then have sex with him that same night"

(34, single and sexually active)

It is not clear in the needs assessment whether the impulsivity experienced by many respondents relates to poor self-control around sex or poor decision-making around the use of protection, or both to varying degrees. Nevertheless, impulsivity has been linked with increased sexual risk-taking, thus placing many respondents at increased risk.

j) Substance use/abuse

Some studies suggest that substance use impedes safer sex (Ekstrand & Coates, 1990; Lewis & Ross, 1995). Research generally shows that substance use/abuse is related to impairment of judgement, a decrease in inhibitions, an increase in sexual risk-taking, an increase in number of sexual partners, and an increase in the odds of engaging in unprotected sex. Research conducted by OUT revealed that:

- 47% of respondents in the study between the ages of 16 and 35 drank alcohol at least twice a week; 22% indicated that got drunk at least twice a week;
- 35% indicated that they sometimes used condoms, and 19% never or almost never used condoms, after consuming alcohol/drugs;
- 17% indicated that they enjoyed the moment and did not worry about safer sex after consuming alcohol/drugs; and
- 5% could not recall what they did, and 15% could mostly not recall what they did, after consuming large quantities of alcohol/drugs (OUT, 2005).

In the following quote, the respondent talks about using a substance to decrease his inhibitions:

"…using drugs helps to make the moment more acceptable…make the atmosphere a bit more relaxed…just to help you enjoy yourself…and not care…"

(25, single and sexually active)

This is also echoed in the following quotes:

"Khat takes away all my inhibitions…but you remain conscious and aware…and then poppers gives you an immediate rush."

(26, involved in open relationship)

"The more alcohol you use the easier it is to hook up with somebody…it helps with your confidence…and it makes you ready for action…"

(37, involved in closed relationship)

Another respondent spoke about using substances to escape reality:

"People try to escape from the truth, from reality…most use drugs for entertainment… to forget about what happened at work…and relax"

(30, single and sexually active)

And another respondent spoke about the actual substance improving his sexual performance both quantitatively and qualitatively:

> *"Most of the time, maybe Ecstasy or Coke or Khat…being high gives you more stamina to go further, longer and harder…"*
>
> (33, single and sexually active)

This sentiment is also echoed in the following quote:

> *"For me personally, it depends on what I am using, alcohol and some powders are sometimes not a good idea, especially if wanting a sexual experience…Ecstasy would be the drug of choice for sexual performance."*
>
> (35, involved in a closed relationship)

As such it would seem that substances play a major role in increasing the likelihood of risk-taking behaviour to occur. A possible reason for this is that they appear to intensify other contributing factors (e.g., impulsivity) and override other demotivating factors (e.g., risk awareness). What follows is a closer look at two areas of environmental/contextual factors that contribute to risk-taking behaviour and possibly serve as an obstacle for sustained behavioural change, namely the gay subculture and steady gay relationships.

3.3.2.3. The Gay Subculture

Historically, the Western gay liberation, up until 1982, was synonymous with sexual freedom. After decades of being told that gay sex was wrong, deviant and sinful, many saw the liberation as an opportunity to openly pursue sexual escapades, which eventually became a marker within gay sub-cultures. For most gay men the steady supply of unknown sexual partners was accepted as a rite of passage. However, after the onset of AIDS, the community norm for sexual behaviour shifted from 'anything goes' to adopting safer sex practices, which allowed gay men to remain sexually active. Safer sex and condom use were viewed as core elements of gay pride and as part of the glue that held the community together. Sexual freedom became restrained as a result.

From the early 1980s to the mid 1990s, gay men in the West appeared successful in responding to the 'new' HIV epidemic by addressing risky sexual behaviours. Community-based HIV/AIDS education campaigns were highly effective in bringing about rapid, large scale risk behaviour change, at least initially. Recent research finds that men who forego using condoms feel that there has been a decrease in social support for staying safe, as well as a shift in community norms towards an increased acceptance of unsafe sex (Shernoff, 2006). With the waning of most of the horrific aspects of the epidemic in the West, it appears that the sexual status quo is once again in transition, shifting away from the standard of safer sex, as the pendulum swings back in the direction it had been prior to 1982.

A 2003 study in New York found that Men who have Sex with Men (MSM) were more likely than either heterosexual men or women to use condoms. However, this study also reported that men, engaging in anal sex with a higher number of sexual partners, did not report using condoms regularly. Of those surveyed, 55% indicated that they had not used a condom during their last sexual encounter. In Great Britain, a 2003 survey of more than 14 000 gay men found that 56% of respondents reported having been penetrated by a partner without a condom and over 58% reported having actively penetrated a partner without a condom (Shernoff, 2006). These figures are in contrast to the findings of a study conducted in 1990 that found that 18% of gay men in San Francisco engaged in Unprotected Anal Intercourse (UAI) at least once in the past year.

For many gay men, in the 21st century, there is no longer the same, strong sense of community norm about having safer sex as there was during the height of the AIDS epidemic. In 1995, in the United States, gay men openly showed their defiance by saying that they were tired of using condoms and would no longer use them. The term bare-backing was first used in 1997.

A recent development among Western gay men is that of the internet and its use in accessing and meeting sexual partners with relative ease. Research conducted by OUT found that 97% of respondents used the internet (amongst other reasons) to chat with other men (OUT, 2005). The internet has become the new gay bar. It cuts through the uncomfortable small talk present in face-to-face encounters and alleviates social anxieties (e.g., being rejected). Younger gay men, especially, grew up with the internet as a way to meet partners for sex. For many of them the AIDS crisis is a distant reality, and they appear less serious about HIV/AIDS than their older gay counterparts (Shernoff, 2006).

Another development is the dramatic increase and prominence of substance use within the gay sub-culture. The places and venues where gay men meet have a strong sexual undertone (if not overtly sexualised, such as a sex club) and substance use is largely accepted, if not strongly encouraged, as part of the gay lifestyle.

Very little has been formally documented regarding the LGBT community in South Africa. Gay and lesbian issues in South Africa have always been closely tied up with struggles for political liberation. Progressive LGBT organisations aligned themselves with political liberation forces, and many gay and lesbian activists played a role in the anti-Apartheid movement both within South Africa and abroad. It could be argued that their participation in broader struggles for justice contributed greatly to constitutional protection on the basis of sexual orientation in South Africa.

With the advent of the HIV/AIDS in the mid 1980s, South Africa was in political turmoil and busy with issues of political transformation. HIV/AIDS, in general took a back seat in relation to the struggles encountered by many. Furthermore, the epidemic appears to have struck gay men in South Africa at a time when their sense of community was still in its early stages of formation (Pegge, 1995). Thus, unlike gay men in the West, “we did not have a strong enough movement upon which to build. Worse yet, rather than strengthening our emerging gay movement, AIDS threatened to destroy it entirely” (Pegge, 1995, pp. 301-302). Elsewhere, it has been pointed out the there is no single, essential gay identity given South Africa’s unique history of social division and resistance that characterised the Apartheid years (Gevisser & Cameron, 1995). Isaacs and McKendrik (1992), note that the Apartheid ideology has enforced separate identities among homosexuals as much as it has among homosexuals. This lack of a sense of community continues to today.

In the words of one young respondent, who distances himself from other gay men and their behaviours:

> *“I don’t really think they have the same ideas as me about it because from what I have seen they don’t really think properly before they act. It is really why I am embarrassed about the whole gay community because of their ignorance, they don’t take it seriously”*
>
> (23, single and sexually active)

During the early 1990s, the rate of heterosexually contracted infections in South Africa increased to the point where they equalled the rate of homosexually acquired infections in 1991, and continued to increase to the degree that they have dominated the face of the epidemic ever since (Avert, 2004). This development consequently led to the institutional and political de-gaying and heterosexualising of HIV/AIDS (King, 1994; Patton, 1990) in South Africa during the 1990s.

As such, the government, media and public health sector became focused upon the threatened heterosexual explosion of HIV infection, allocated resources accordingly and ignored the ongoing needs of gay men for education and support, believing that this should be provided by established gay organisations (Akeroyd, 2004; King, 1994). Homosexual issues were seen, and continue in some respects to be seen, as somewhat frivolous and un-African (Gevisser & Cameron, 1995; Reddy, 2000). Denial, shame and stigma, especially in popular blaming discourses, thus ensured that, as a largely voiceless, stratified and varied minority amongst those who were infected in South Africa, gay men were ignored and rendered invisible by a majority in control of resource allocation (Pegge, 1995).

In the words of a respondent:

> *"I will not say that the Government is doing enough. I don't think they are doing anything towards a gay perspective..."*

And,

> *"…I think it is stigma one hundred percent…it is stigma in the workplace, cultural stigma…religious communities everywhere, there is a lot of stigma and it is a big problem"*

(28, single and sexually active)

Organisations, such as OUT, were very small in the mid 1990s and had a limited capacity to significantly work with gay community norms, values and institutions. They could not significantly engage with the required multiple strategies focussing on individuals, mass media and personal testing and counselling, and on full scale community mobilisation, the use of local gay media, interpersonal communication within informal peer networks, grass roots outreach, building community, and participation and involvement in volunteer work. But since then, there has been a growth in community structures and the scope of their work. HIV/AIDS (including STIs) prevention has become a stronger focus point. More recently, attempts have been made at 're-gaying' the epidemic in order to challenge the increasing complacency about its ongoing impact on gay men (King, 1994; Wilton, 1997). The organised LGBT sector has taken the lead in ensuring that their target groups are reached by developing and implementing much needed programmes.

> *"What I have heard about OUT is good…every time I hear something about OUT it is about the good work they are doing…"*

(30, single and sexually active)

But the gay 'community' remains invisible and uninvolved. Without a sense of community, there is little opportunity to normalise sex, and develop norms around issues of safer sex, truthfulness and trust in relationships, and secrecy and shame in casual sex, for example. Many gay men appear apathetic (as can be seen in their resistance to getting involved in the needs assessment despite known benefits), distanced, and loosely organised around social spaces, which primarily serve to enhance and maintain an easy availability of sex and pleasure (Foreman, 1999; Isay, 1993). Historically (and in certain cases today), it was often difficult for gay men to meet others socially outside the opportunities offered by gay bars, clubs and spaces. It is for this reason that gay men in general tend to engage in brief sexual encounters more often than heterosexual men (Isay, 1993). The importance placed on these social spaces is evident in the finding that over 77% of gay men identify gay bars and clubs as places to meet and socialise with other gay men (Boxford, 2001). A study conducted by OUT found that 29% of gay participants socialised at dinner parties, 24% at night clubs, and 17% at house parties (OUT, 2005). As mentioned previously, it is in these spaces that most gay meet their social needs. For many, this is the only means of experiencing closeness with others.

What is troubling is that gay men in South Africa appear to be demonstrating the shift identified in the West. In the words of some respondents:

> *"with gay HIV infections because one moment is was actually stabilised and stable and yet people are feeling comfortable and then they convert back into their old ways, thinking it does not affect me, it is not part of my life, it is not my problem and then they take risks"*
>
> (37, involved in closed relationship)

It is not clear from the needs assessment which specific sources white gay men in Tshwane use to inform their sexual behaviours and potential risks. There are developing community norms (through programmes of organisations such as OUT), as well as shifting international norms, but no present indication of where gay men's safer sex conversations take place (if at all), the impact of these conversations, how these conversations are internalised, and what difference it makes to the individual.

3.3.2.4. Steady Gay Relationships

In recent years, the proportion of HIV infections that can be attributed to steady partners has surpassed that of casual partners, reaching 67%. Within this, young sero-positive gay men today have a higher likelihood of contracting a STI/HIV from their steady partners than ever before. In the early years of the HIV epidemic, only 15% of young gay men were infected within their steady relationships. Younger gay men today have not lived through the norms of sexual safety, and the seriousness of HIV/AIDS, as has older gay men. It could also be that young gay men are more romantic and infatuated in their attitudes towards relationships (Davidovich, 2006).

When looking at steady relationships and its possible risks, it is not enough to only concentrate on UAI. In conjunction, one needs to consider Negotiated Safety (NS) and Negotiated Safety Compliance (NSC). NS is where steady partners negotiate sexual risks within and outside of the relationship, and NSC is the compliance to these agreements (Davidovich, 2006).

When one looks at UAI, Hays et al (in Shernoff, 2006) found in their sample of young gay men (ages 18-27) that 51% of the men with steady partners had engaged in UAI in the last 2 months. In another study, slightly more than one third of Swiss gay men in relationships reported engaging in UIA with their partners. In a study assessing the sexual risk behaviour of young gay men in primary relationships, it was found that there was a 10% rate of non-compliance with NS agreements (Davidovich, de Wit & Stroebe, in Davidovich, 2006). Other studies put this figure higher, in the region of 17%. It is possible that rates of non-compliance with negotiated safety could be higher than reported because of the social desirability to report compliance. The mentioned studies focused on one partner only and if the other partner was included the rates could be higher. The results were also measured over a short period of 6 months and it could be higher if the measurement took place over a longer time.

It could be argued that gay men operate according to a hetero-normative model when it comes to steady relationships. There is an assumption and expectation of exclusivity. To raise the matter of casual sex outside the relationship could be read as 'not being in love', 'not being relationship material', 'being shameful' and so on. Such a model appears to limits openness and honesty between partners, including NS and NSC.
This needs assessment did not specifically measure rates of NS and NSC. However, most respondents reported that they did tell their partners when they have engaged in casual sex. But it seems that these disclosures are about past experiences and not current casual sexual encounters.

In the words of one respondent:

> *"It happened once and I told him and it was World War 3 for a month… and I caught him cheating on me once…I won't tell him because it will hurt him. If he has casual sex now I don't want him to tell me because I do not want to know and I don't think he is an angel anyway… I don't want to know about it as long as he comes home every night"*

(36, involved in closed relationship)

Another respondent says:

> *"for example you are involved and you trust your partner but there is always the chance that you fight, he goes out and get laid…he comes home and you make up and have unprotected sex and you get something"*

(39, involved in closed relationship)

And then in the words of a younger respondent:

> *"I am paranoid, I don't like nonsense and I don't like fools and shit. I must say from what I know there is always a certain amount of distrust in a relationship…it is always there, you always see the same thing over and over again"*

(27, involved in closed relationship)

The trend from the needs assessment of not telling partners about recent casual sex encounters is alarming. Davidovich, de Wit and Stroebe (in Davidovich, 2006) looked at the Rusbult investment model to see if it can predict the sexual risk behaviour of gay men in steady relationships. Briefly, the Rusbult model stipulates that high commitment to a relationship results in staying in the relationship. Commitment is viewed as a result of extensive emotional and material investment, high satisfaction and poor qualities of alternatives. It assumes relationship commitment mediates the effect of investment, satisfaction and alternatives to the relationship. In the mentioned study above, it was found that when there is higher relationship satisfaction, there is higher probability of safer sex. Low relationship satisfaction tends to involve more risky UAI or no engagement in NS. It could be that high relationship satisfaction implies good co-operation and communication. If partners find it difficult to openly talk about their sex outside of the relationship, it could signify low relationship satisfaction, with its implied lack of co-operation and open communication.

3.3.2.5. Summary of Determinants

In the West, gay community norms have shifted from sexual safety (mid 1980's and early 1990's) towards 'free sex', reminiscent of the early gay liberation. Unlike the West, white gay men in South Africa did not develop experiences of sexual safety norms, due to a largely lacking gay movement, poor community norms, political transformation, and the heterosexualisation of the HIV/AIDS epidemic. But things are changing. At present, there is a stronger, more visible gay movement and greater attention is being paid to their HIV/AIDS experiences. However, an international development around 'free sex' complicates the development of sexual safety community norms.

On an individual level, the results of the needs assessment have shown that respondents believe that STIs/HIV/AIDS are serious health issues confronting gay men, and are aware of the adverse consequences to

risky sexual behaviours. Despite being so aware, it would appear that on a deeper level they do not consider themselves to be at considerable risk, whether single or not. It is possible that by possessing a sense of invulnerability they are able to remain 'calm' amidst compelling evidence to the contrary. But their risk lies in the fact that they tend to construct their own, mostly inaccurate hierarchy of risks (which is potentially problematic), attach their own meanings around risk and safety to various relationships and encounters, and show a preference for anal sexual activity (which carries the most potential risk of HIV transmission). In general, they experience some form of internalised homophobia, which is possibly linked to negative mood states, an inability to delay gratification and thrill seeking tendencies, and a strong desire or need for connection and affirmation. With a sense of inadequacy, insecurity and shame many gay men are prone to becoming depressed and fatalistic about their lives. It is thus understandable that many develop thrill seeking tendencies (including substance use) to seek immediate pleasure and excitement to overcome life's restrictions and boundaries, to challenge heterosexist norms, and to challenge the borders between what is known and unknown. Sex has become synonymous with merging, connecting, and becoming one. For many, sex has become the only means of connecting with others, even if superficial and brief. And it is through sex that they experience a sense of belonging, of being wanted, and a recognition of their worth. In the end casual sex (with a potential for risk-related behaviours) is presented as a viable option for many, either on its own or in addition to a steady relationship.

Gay men possess the ability to develop self-efficacy and a sense of agency. But self-efficacy and a sense of agency are undermined by the use of substances, which are ingrained in gay life and spaces. Substances impair judgement and decrease inhibitions and results in sexual risk taking and an increase in the number of sexual partners. The appeal lies in the effects substances have on the self (more confident, more potent, more desirable, and intensified pleasure) and the escape from daily life, stresses and demands.

Turning to relationships, it is an area with great risks. The results of the needs assessment showed that partners are not negotiating safer sex and are not open with each other about casual sex. This could illustrate poor relationship satisfaction and its accompanying poor communication channels.

3.3.3 Consequences of the Health Problems for the Individual

The presence of an STI can increase an individual's vulnerability to contracting HIV. STIs weaken the immune system and the stage is set for HIV infection to take place via sores and cuts. STIs, if left untreated, can have other health consequences. For example, Hepatitis B can, in the long term, result in life threatening liver damage.

Both STIs and HIV would necessitate the need to seek health care at some point or another. In South Africa, a resourced individual can access adequate treatment and care through Health Insurance at a cost of approximately R1400.00 (approximately 140 Euros) per month. This will allow the individual ongoing routine medical check-ups, treatment and care. For all chronic illnesses, Health Insurance will provide individuals with a chronic care plan. Under-resourced individuals, however, would need to make use of Government Clinics and Hospitals. Appointments are provided on a first-come-first-serve basis and anti-retroviral therapy (ART) is available to limited numbers.

3.3.4 Effects of the Health Problems in Society

The number of people estimated to be living with HIV is 5.5 million; 18.8% of adults 15-49 are HIV-positive. More than 70% of people infected with HIV in the world are found in sub-Saharan Africa. This represents two thirds of the world prevalence rates. Beyond this, 90% of all people living with HIV/AIDS are found in developing countries (Kometsi, 2004).

In 2006 more than 300 000 people living with HIV started treatment in public and private sectors making it one of the largest programmes in the World. In 2006 the national funds spent by government from domestic sources amounted to $446 461 994.00. Only 21% of infected HIV individuals were receiving anti-retrovirals (ARVs) (UNAIDS, 2006).

The new National Strategic AIDS Plan (NSP) in South Africa aims to provide ARVs to 80% of individuals needing treatment by 2011. Beyond availability is the question of accessibility. Stigma and discrimination as well as the lack of access to accurate information impact on people's ability to make informed choices, and influence access to appropriate health care. Confusing and/or inaccurate information about HIV treatment options and the use of ARVs impact on the extent to which people are in the position to access available HIV treatment services (Kehler, 2008).

Many of these challenges are linked to socio-economic factors such as poverty, unemployment, lack of food security. There is a need to enhance the social security system, including the management of social grants, strengthening social security support networks, and ensuring food and nutrition security.

3.4 Community/Participation

Gay white men in Tshwane are not organised and section 3.3.2.3 provided a more detailed description hereof. There are pockets of organised activity such as the gay church- the Reforming Church- as well as OUT. OUT has increasing programmes for a range of target groups as well as active community building activities such as its OUTside social programme. Working with white gay men as a target group is also relatively new to OUT as the organisation focused much of its previous HIV/AIDS work on black gay men in township areas.

It is assumed that the majority of white gay men in Tshwane belong to informal friendship and sexual networks. Access to these will be very important for future programmes and research. In doing this needs assessment, there were various attempts to access these informal networks. Overall, it was difficult to do this. One can also assume that it takes time and effort to gain credibility within these informal networks.

There are a few key, visible people among the white gay male section. These are OUT staff, staff at gay venues as well as gay/lesbian ministers. They have a willingness to co-operate, initially and in principle. Maintaining this and seeing programme implementation through might be a bit more challenging. It takes time to build commitment to programme implementation and one should secure benefits for both parties.

4. PRELIMINARY ANALYSIS OF DETERMINANTS

Despite the potential benefits of developing programmes to address the target group's needs, a great deal of difficulty was experienced in accessing and recruiting participants in the needs assessment. They appeared apathetic, disinterested and resistant. Among respondents who participated, there appeared to be no informed insights into what was needed in terms of programmes and services. Their answers tended to be vague and general, for example "more information is needed". Their responses demonstrated a level of ignorance around the current state of affairs in South Africa - so detached and so removed. Linked to this was the finding that a significant section of respondents still did not know about OUT and its services to the gay community. It is uncertain whether they truly did not know about OUT or whether they chose to deny its existence. In the latter, OUT and OUT's work on social issues is possibly an unwelcome reminder of what so many try to deny, that they are vulnerable and at risk. All of these aspects point to loose connections and a poor sense of community among White resourced gay men in Pretoria (perhaps even a reflection of South Africa as a whole). This will have a direct bearing on community-based STI/HIV/AIDS programmes.

A priority is to develop a greater sense of community, so as to counter norms promoting a move away from sexual safety towards individual sexual freedom and sexual risk-taking, as well as develop norms that encourage openness and honesty around sex and risk-taking. But that is not to say that complex individual determinants should be overlooked.

On an individual level, it was found that participants' responses could be organised according to three sets of major motivating factors when it comes to casual sexual risk-taking. These sets are not fixed and respondents appear to move between them at different times or at different stages. Please note that the labels used are not intended as formal diagnoses but rather as broad descriptors for the purposes of this needs assessment. The strongest and most common motivating set of factors appears to resemble 'manic-like' factors. We termed this set as such because of its force and strength in compelling someone to act without much thought or reasoning in order to achieve a release for built up tension. According to participants' responses, this set of factors includes an urge/need, desire, lust, physicality, strength, courage, opportunity, availability, impulsivity, release, ritual, excitement, and satisfaction. Sex, as a thrill-seeking behaviour, is seen to afford individuals a temporary release. These elements compel one to act out their internal state as reflected in thrill seeking behaviours. There is a pronounced sense of excitement and pleasure that is derived. These 'manic-like' factors also serve to manage internalised homophobia.

The second set of factors appears to resemble 'depressive-like' factors. We termed this set as such because of the sad undertone of the elements, compelling one to act without much thought or reasoning in order to achieve some relief for internal pain. These elements resemble internalised homophobia (and its associated conditions). According to participants' responses, this set of factors includes isolation and loneliness, depression, shame and doubt, low self-respect, negative self-images, guilt, and considerable internal pain. Sex, whether brief or not, is seen to afford individuals the relief needed. Unfortunately the relief does not last long.

The third set of factors appears to resemble 'neutral/positive' factors. We termed this set as such, because of the positive motivating aspects of the elements causing action that do not fit into either the 'manic-like' and 'depressive-like' sets. According to participants' responses, this set of factors entails entertainment value, relaxation, a welcome escape, an enhanced relationship, connection, affirmation, curiosity, excitement and satisfaction. These elements frame sexual risk-taking in a more positive light.

It is also noted that respondents also felt that there are de-motivating factors to casual sex. These include beliefs that casual sex is a religious sin and therefore shameful, that it negatively impacts trust and raises anxiety within a relationship, that it affects self-worth, and that it may lead to contamination and poor health. These de-motivating factors appear to influence the choice not to engage in casual sexual risk-taking, which holds good news for programmes. The ways that spoiled identities are managed through casual sex and its risks do not sit comfortably all the time. It appears that individuals experience a level of internal tension between the motivating and de-motivating factors.

These three sets of motivating factors and one set of de-motivating factors appear to influence decisions around casual sex and sexual risk-taking. These factors are mediated by certain spaces and codes, as well as substances. Gay bars, sex clubs and venues facilitate the possibility of casual sex. These spaces are, according to respondents, sexually arousing, sexually charged, dis-inhibiting and enabling. These spaces glorify casual sex. In addition to the spaces, there are certain codes around casual sex, which can be used anytime and anywhere. According to respondents, it involves a certain look, a way to indicate that one is available for sex. Gay venues are frequented more often at night and are invariably linked with substance use.

Substances play a major role in facilitating sexual risk-taking. Most respondents acknowledged that substance use increased their risk considerably (i.e. they did not use condoms, did not negotiate safer sex, were more likely to do things they wouldn't normally do). For respondents substances allow escapism, intensity and the removal of inhibitions. Even where respondents demonstrate the self efficacy to manage their sex lives and risky behaviours, substances enable the 'manic and depressive like' motivating factors to come to the fore. As such, gay spaces, codes and substances appear to tip the scales in favour of the three sets of motivating factors.

Behaviourally, the majority of respondents currently engage in casual sex. Roughly about 25% of respondents have engaged in casual sex in the past and no longer do so, and a fewer number claim to have never engaged in casual sex. The general trend appears to be that condoms and protection are used when having sex with a complete stranger and less so when having sex with a sexual partner that is more familiar (such as a lover, friend or a friend of a friend). But as has already been shown, the use of substances invariably interrupts this trend by increasing sexual risk-taking irrespective of who one is with. Of those in relationships, the majority claimed to be in closed relationships. However, their responses demonstrate that many do engage in casual sexual risk-taking to varying degrees. By far the majority of respondents in relationships do not use any protection. And given that anal sex is their preferred sexual activity, high risk sexual activity is taking place. What increases this risk is the finding that although the respondents claim to know their and their partner's sero-status, this is likely to be outdated and not an accurate reflection of their current status. Very few respondents, in steady relationships, indicated that they and their partner were tested in the last 6 months. It would seem that for the majority, having tested a while ago, they hold a reinforced sense of invulnerability.

5. SUMMARISING CONCLUSIONS

The NA was a first step in exploring determinants of casual sexual risk-taking among White resourced gay men in Tshwane. Three broad areas were explored, i.e. biographical data, views of health problems and solutions and lastly, sexual behaviour and the determinants thereof.

It became clear that HIV and STIs are seen as serious health problems confronting gay men. Without a strong sense of community, they appear apathetic and disinterested in taking responsibility for their own sexual health and well-being. Casual sex seems to be occurring in a context where anal sex is a preference, where motivating and de-motivating factors are mediated by the type of venue, the time of day, the codes given and the substance used, where there is no regular testing and no one knows their recent status, where there is no condom use in steady relationships and inconsistent condom use in casual encounters, where there is no negotiated safety in steady relationships and casual encounters, and where monogamy is claimed but not carried out and secrecy surrounds the most recent casual encounter. It is clear that this situates these men as being at a high risk of contracting and transmitting an STI or HIV. An intervention is needed to deal with the developing problem.

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7. APPENDICES

Appendix 1: Research Method

Target Group
From a brainstorming session held by the project team, it was decided that the characteristics of the target group would include the following:

- They are white;
- They are either English or Afrikaans speaking;
- They reside in and around Tshwane;
- They are relatively resourced, in that they are able to:
    - Access night clubs, sex clubs, sex parties, and internet forums;
    - Purchase LGBT publications;
    - Subscribe to messaging services; and
    - Travel to-and-from multiple venues;
- They self-identify as being gay;
- They are between the ages of 18 and 40;
- They engage in a wide spectrum of sexual activities within steady relationships and casual sexual encounters; and
- They may or may not concurrently be in a steady relationship while engaging in casual sex.

Sampling of Participants
For the purpose of the needs assessment the project team decided that 40 participants from the target group would be included in the needs assessment. 40 participants would be interviewed and 10 of these participants would be invited back (on the basis of their availability and eagerness to participate) to attend a focus group session. Furthermore, it was decided that, for the purposes of the needs assessment, the target group would be divided into two sub-groups, defined primarily in terms of an age range. As such, one sub-group consists of participants between the ages of 18 and 29 and the other sub-group consists of participants between the ages of 30 and 40. The rationale behind creating two sub-groups is that although there may be an overlap in health problems, risk behaviour, determinants and environmental factors, there may be specific nuances within each sub-group that may be overlooked if not handled separately. For example it can be suggested that the younger sub-group are more likely to frequent night clubs, whereas the older sub-group are more likely to frequent sex clubs, thereby encountering different environmental factors.

The 40 participants were selected using the non-probability technique of opportunity sampling (see Rosnow & Rosenthal, 1996). The reason for using this sampling technique is that representative gay populations are inherently difficult to access. However, the project team was well situated to gain direct access to a number of participants, from this population. Of the targeted 40 participants, only 37 agreed to participate. Fieldworkers cited the following as reasons why gay men in general preferred not to participate: (i) they appeared highly resistant to talking about sexual activities and drug use while being audio-recorded; (ii) they appeared to have multiple competing obligations and responsibilities, for example jobs and family responsibility; and (iii) appeared apathetic towards participating in yet another study. From the participants who agreed to participate, 1 participant's responses had to be eliminated from the needs assessment as the audio-recording was of poor quality. As such, a total of 36 interviews were included for analysis. This indicates that 90% of the target number was achieved.

Data Collection Instruments and Procedures
From the brainstorming sessions, the project team decided that the data should be collected via one-on-one audio-recorded structured in-depth interviews. As part of a needs assessment (or situational analysis), interviews are useful for (i) identifying areas for more detailed exploration; (ii) yielding in-depth information

that is relatively easy to quantify; (iii) ensuring comparability of questions across respondents; and (iv) ensuring that all the necessary topics to be investigated are included (Breakwell, 1998). It was envisaged that the 60 minute interviews would be followed up by a 90 minute audio-recorded focus group session. The questions for the focus group were derived from observations and analyses of the interviews. The focus group is useful for (i) assessing respondent's reactions to the interviews; (ii) explore the cognitive and social processes involved in answering; and (iii) interrogate certain themes or patterns obtained in the interviews (Millward, 1998).

An interview schedule was developed consisting of three sections: (i) Demographics; (ii) Health-related Problems and Services; and (iii) Casual Sexual Risk Taking. Once developed it was submitted to the advisory group for input. Once amended it was piloted on fieldworkers. Thereafter the interview schedule was finalised and ready for administration. Fieldworkers were given some basic training around the aims of the needs assessment, interviewing skills, and research ethics (including the use of a consent form). Each fieldworker was tasked with doing between 10-14 interviews, depending on how many participants they had access to. After each interview, fieldworkers were requested to invite participants to participate in the focus group. As indicated above, 36 interviews were deemed suitable for analyses.

Of the participants who were interviewed, 15 participants indicated that they would be willing to participate in the focus groups. However, as the scheduled date for the focus group drew closer at the beginning of 2008 only 1 person remained open to participating. With little time to set up another focus group at a later date the project team decided to exclude the focus group and limit analyses to the interviews that had been conducted. This places limitations on the extent to which certain themes could be further interrogated.

Data Analyses

A systematic thematic analysis was conducted on the data obtained in the interviews. A thematic analysis involves (i) examining all transcripts and developing a coding frame; and (ii) then applying these codes to the themes identified in each transcript (Joffe & Yeardley, 2003). A combination of deductive and inductive coding was used in the construction of the coding frame (Joffe & Yeardley, 2003). That is to say that, the themes were identified both by imposing existing theoretically derived themes on the data, and by drawing on emerging themes from the raw data.

The thematic analysis was conducted by three independent analysts in order to minimise bias, reduce potential coding errors, and ensure a relatively high level of inter-coder reliability (Rosnow & Rosenthal, 1996).

Appendix 2: Collaboration

The Project Team

A project team (consisting of a Project Coordinator, a Research Manager [time-limited], an independent research consultant, three fieldworkers and three analysts) was set up during the initial phases (and later stages) of the needs assessment. The aim of the project team was to brainstorm, develop and execute the needs assessment. The Project Coordinator in collaboration with the Research Manager brainstormed what was known about the target group in terms of existing research, commonly held beliefs and professional experience. They then brainstormed the data collection methodology for the needs assessment. Once this was done, they developed a first draft of the interview schedule. The research findings, information and draft interview schedule were then taken to the Advisory Group (see below). Inputs given at that meeting were used to expand on the research findings and information already gathered, and to adjust the draft interview schedule where necessary.

The independent research consultant was then brought on board to pilot the interview schedule, make the necessary final adjustments to the interview schedule, and to train fieldworkers (in interviewing skills and research ethics). Three fieldworkers were recruited and subsequently attended the training session. Once trained, the fieldworkers were given the necessary tools (e.g., interview schedule, consent forms, and contact sheets) to carry out the fieldwork. Thereafter the fieldworkers had two follow-up meetings with the independent research consultant. The first meeting served to monitor each fieldworker's progress, and the second meeting served as a closure and debriefing for each fieldworker.

Once the data was collected and transcribed, the Project Coordinator and independent research consultant set about developing a coding frame. This was then used (and updated) by three analysts. The analysts met on separate occasions to discuss: (i) the coding frame; (ii) updates to the coding frame; (iii) the themes extracted from the interviews; (iii) consistencies and inconsistencies in the themes; and (iv) the interplay between various themes. These themes were then organised and presented to the Advisory Group for input and discussion.

The Advisory Group

An Advisory Group was set up during the initial phases of the needs assessment. The role of the Advisory Group was to serve as a reference point to the needs assessment. They were tasked with providing input, and refining conclusions, made by the project team, in terms of the target group, related health problems, research questions, research methodologies, and research findings. It was envisaged that the Advisory Group would be composed of the following:

- An OUT staff member (Project Coordinator);
- The research consultant;
- An expert in the field of STIs/HIV/AIDS;
- An expert in the field of substance use;
- An expert in the field research;
- An expert in the field of social science; and
- Target group representatives.

The Advisory Group met once during the initial phases of the needs assessment. At that meeting, individuals gave input around the (i) aims of the needs assessment, (ii) themes to be explored in the needs assessment; (iii) research findings and information gathered; and (iv) the interview schedule. Once the data had been gathered and analysed the Advisory Group met again. At that meeting, members cautioned that the needs assessment should not reinforce the notion that casual sex on its own is problematic, but rather emphasise that sexual risk-taking within the context of steady relationships and casual encounters is potentially problematic. For them, the stigma surrounding casual encounters serves to silence any open discussion about issues such as exclusivity, faithfulness, risk-taking, negotiated safety etc. And lastly, they drew attention to the gap that exists in our current understanding of where gay men's safer sex conversations take place (if at all), the impact of these conversations, how these conversations are internalised, and what difference it makes to the individual. These gaps point to further areas of investigation.

Appendix 3: The Interview Schedule

KEY INFORMANT INTERVIEWS FOR GAY MEN IN TSHWANE

Read consent form. Ensure all participants understand and sign consent form.

Note to interviewer: the following must be recorded at the start of the interview:
1. Interviewer's name
2. The date of the interview
3. Acknowledgement that the consent form has been read and signed.

A. DEMOGRAPHIC QUESTIONS
[Note to interviewer: circle appropriate responses]

Sex **[Note to interviewer: code by observation]**
Male 1
Other 2 ____________________

Race Note to interviewer: code by observation
Coloured 1
Black 2
White 3
Indian 4
Other 5 ____________________

Can we start? I would like to ask you a few general questions about yourself.

1.How old are you? ____________________

2. What is your home language? **[Note to interviewer: wait for response]**
English 1
Afrikaans 2
Other 3 ____________________

3. Where do you stay? **[note to interviewer: wait for response]**
Pretoria North 1
Pretoria East 2
Pretoria West 3
Pretoria South/Centurion 4
Other 5 ____________________

4. Who do you live with majority of the time? **[wait for response]**
Stay on own 1
Stay with friends 2
Stay with partner 3
Stay with family 4
Stay with parents 5
Other 6 ____________________

5. What is your current relationship status?
[note to interviewer: wait for response, but prompt for clarification]

Single - celibate 1
Single - sexually active 2
Involved - open relationship less than 6 months 3
Involved - closed relationship less than 6 months 4
Involved - open relationship more than 6 months 5
Involved - closed relationship more than 6 months 6
Married 7
Civil Union 8
Other 9______________________________

6. What is your current (completed) educational level? **[wait for response]**

Standard 5/ Grade 7 and below 1
Standard 8/ Grade 10 2
Matric 3
Certificate/Short courses 4
Undergraduate 5
Postgraduate 6
Other 7 ______________________________

7. What is your current employment status? **[note to interviewer: wait for response]**

Employed full-time (40> hrs per week) 1
Employed part-time 2
Self-employed 3
Student 4
Unemployed - looking 5
Unemployed - not looking 6
Other 7 ______________________________

8. What is your current net (after deductions) monthly personal income?
[note to interviewer: wait for response]

No income 1
Below R1500 2
R1501 - R4500 3
R4501 - R8000 4
R8001 - R16000 5
Above R16001 6

B. NEEDS QUESTIONS

Now I would like to ask you a few questions about issues facing gay men/ men who have had sex with men. Let's start with the health issues...

***1. a. What do you think is the most serious health problem facing gay men/ men who have sex with other men (in South Africa) today?* [Note to interviewer: wait for response and code. If multiple responses given then circle all response]**

HIV/AIDS	1
STIs	2
Illnesses related to drug abuse	3
Illnesses related to alcohol abuse	4
TB	5
Cancer	6
Injuries from physical attack	7
Other	8 ______________________________

b. If multiple responses were given then ASK: Can you say which health problem is the MOST serious ONE.

2. What are some of the contributing factors to this health problem [mention it] that you have mentioned?

3. Who do you think should be involved in addressing this health problem?

4. What do you think government is doing or can do to address this health problem?

a. How can government improve its role?

5. What do you think organisations are doing to address this health problem?

a. How can organisations improve their role?

6. What do you think the private sector/business can do to address this health problem?

a. How can the private sector/business improve their role?

7. What health services do you think are lacking for gay, lesbian, bisexual and transgender persons?

a. If I don't know then skip to question 11.
b. If mentioned some then proceed.

8. Of the health services you have mentioned, which of these would you say are the most important?

9. What obstacles do you think might stand in the way of stakeholders such as government, organisations and private sector/business in providing these services?

a. What suggestions could you make to overcome these obstacles?

10. What obstacles do you think might stand in the way of individuals accessing these services?

a. What suggestions could you make to overcome these obstacles?

11. Do you know about OUT LGBT Well-being?

a. If yes, then proceed to 12

b. If no, then explain who and what OUT is/does (proceed to 12).

12. In what way do you think OUT could play a role in addressing some of the health problems you mentioned?

C. CASUAL SEXUAL RISK-TAKING

Now I would like us to discuss issues around casual sex and sexual risk taking. Again, I'd like to remind you that this is confidential and that your name will not be included in the study.

13. From your own knowledge and what you've heard or observed about other gay men...
Can you please tell me in as much detail as possible about casual sexual encounters that take place between men? For example, can you start by explaining to me...

- How would you define casual sex?
- How casual sexual encounters take place between men?
- Where do they usually or generally take place?
- What happens exactly?
- From what you know or have heard, how close are the people having a casual sexual encounter? Do they generally know each other? What else can you tell me about them?
- What other information or detail can you give me about these sexual encounters?
- On a personal level, how do you feel about casual sex encounters?

14. Have you ever participated in casual sex?

If yes, continue to question 15.

If No, move to relevant parts of question 20.

15. Would you be prepared to talk about your own personal casual sexual encounters?

a. Yes - proceed

b. No [move to Question 21]

16.Thank you for allowing us to proceed. Now, looking at your own casual sexual encounter ą I don't want to know who you were with, but can you tell me...

- How do these encounters take place?
- How often do you engage in a casual sexual encounter?
- What would you consider to be a motivating factor for you to engage in casual sex?
- How were you feeling, thinking and acting?

[NOTE: Ask these questions only if they were not covered under Q16]

17. In terms of VENUE or place and space:

- How do you / did you go about hooking up with a casual sexual partner? Or specifically, where do you meet?
- Is this the best place to hook up?
- Are there other places/spaces you could hook up? Which ones?
- What is it about this place/space/media that enables you to hook up?

18. In terms of SUBSTANCE USE (such as drugs and alcohol) during a casual sexual encounter:

- Were you using any substance? Which one/s?
- What were your motivations for using this substance?
- How does substance use affect sexual activity?
- Would you say you are likely to take more sexual risks when using a substance? Please explain

19. Now, looking at the actual casual SEXUAL encounter, can you please tell me...?

- Was this an unprotected sexual encounter (that is, sex without barriers such as condoms or latex)? (elaborate)
- How safe would you say the encounter was? (elaborate)
- Was there any safer sex negotiation between you and your casual sexual partner? (elaborate)
- Did you tell your primary partner about your casual encounter?

20. With regards to Sexually Transmitted Infections (STI) / HIV:

- At the time of your casual encounter, did you know your STI/HIV status?
- At the time of your casual encounter, did you know your casual sexual partner's STI/HIV status? How did you establish this? Is this important for you?
- Do you consider yourself to be at risk of an STI or HIV?
- How do you feel about being tested for STIs and HIV?

[Remember the interviewee relationship status or go back to QUESTION A5. If not in relationship, ask question 22]

21. If interviewee is in a RELATIONSHIP currently ASK

- In your relationship, are you currently engaging in unprotected sex?
- Would you tell your partner if you had a casual sexual encounter?
- Do you know your partner's HIV status?

22. Do you think that your experience (of casual sexual encounters) is shared by other gay men or men who have sex with men? To what extent and in what way?

23. Well, I have asked all the questions that I wanted to ask you. Are there any comments you would like to add/make or questions you would like to ask me?

We have come to the end of our interview. Thank you very much for your time. Just to remind you again that your name or any identifying information will not be used during this study.