

# THE IMPACT OF AN HIV COMMUNITY ENGAGEMENT PROGRAMME AMONG MEN WHO HAVE SEX WITH MEN IN A RURAL COMMUNITY IN SOUTH AFRICA

**J. N. Mampane, Doctoral candidate (Health Studies)**

Department of Adult Education and Youth Development

University of South Africa

mampajn@unisa.ac.za

## ABSTRACT

Men who have sex with men (MSM) are regarded as a high-risk group for human immunodeficiency virus (HIV) infection worldwide. In South Africa, which is home to the largest number of people living with HIV, research has revealed that HIV prevalence and incidence rates among MSM have reached crisis proportions. African MSM in particular are more susceptible to the risk of HIV infection due to increasing homophobia on the African continent, coupled with poor socioeconomic backgrounds such as poverty, unemployment and low educational levels. In this regard, there is a need to develop appropriate and relevant interventions such as community engagement approaches which have shown to be effective in improving the health and wellbeing of marginalised and minority populations in underprivileged communities. In the context of this study, the latter refers to black MSM who live in rural areas. The purpose of this study was to explore and describe the experiences of MSM and health care providers (HCPs) regarding the impact of an HIV community engagement programme among MSM in a rural community in South Africa. Individual in-depth interviews were conducted with four MSM and four HCPs who had been involved in an HIV community engagement programme in these rural villages. In a nutshell, the findings of the study reveal that community engagement has encouraged MSM to access and utilise HIV testing, prevention, treatment, care and support more than they used to previously.

**Keywords:** community engagement; health care providers; HIV programme; men who have sex with men; rural community; South Africa

## INTRODUCTION AND BACKGROUND INFORMATION

First and foremost, a community can be defined as a group of people who have common characteristics. Communities can be defined by location, race, ethnicity, shared interests (such as using the same service) or affinity (such as religion or faith). A community can also be defined as a group of individuals living within the same geographical location (National Institute for Health and Care Excellence (NICE) 2008, 38). Community engagement, according to the Centers for Disease Control (CDC) in the United States of America (USA), refers to the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with regard to issues affecting their health and wellbeing (CDC 1997, 9). Tamarack, cited in Chuang and Lacombe-Duncan (2016, 445), describes community engagement as “a group of people working collaboratively, creating inspired actions and bold visions for their common future”. According to NICE (2008, 12), community engagement is “the process of getting communities involved in decisions that affect them. This includes the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities”. Lane and Tribe (2010, 106) contend that community engagement should take into account the needs of those who are underprivileged and are at an increased risk of poor health. According to NICE (2008, 12), this may include people from ethnic minorities, those living with HIV or those living in rural communities. The latter formed an integral part of this study because the researcher conducted this particular study among human immunodeficiency virus (HIV) infected and affected black men who have sex with men (MSM) who live in rural areas.

Globally, MSM are viewed as a population which is at risk of HIV infection. In developed countries such as the USA and other European countries, research on MSM and HIV started when the epidemic emerged in the 1980s. However, in developing countries such as those in Africa, research on MSM and HIV only started in the last decade. For example, the first large behavioural survey on MSM and HIV in Africa was conducted in 2001 in Senegal (Muraguri, Temmerman and Geibel 2012, 137). Since then, researchers worldwide have started to conduct studies on MSM and HIV in other African countries. Most of these studies have confirmed that HIV prevalence and incidence rates among MSM in some African countries are increasing at an alarming rate and are well above those of the general population (Baral, Sifakis, Cleghorn and Beyrer 2007, 339). For example, in South Africa, which is home to the largest number of people living with HIV, research found that HIV prevalence and incidence rates among MSM have reached crisis proportions. According to Burrell, Mark, Grant, Wood and Bekker (2010, 149), MSM in South Africa have an elevated risk of acquiring HIV when compared to heterosexual men of the same age group. Rispel and Metcalf (2009, 136) also mention that the South African National Blood Transfusion Service (SANBS) has refused MSM blood donations by stating that “men who have sex with other men are universally barred as blood donors because this is recognised as high risk behaviour for HIV infection and transmission... [However,] SANBS recognises that there are no

local data to support the view that in South Africa, as elsewhere, men who have sex with men pose a significant risk to the blood supply”.

In addition, the latest HIV/AIDS and STI National Strategic Plan for South Africa 2012–2016 identified MSM as a key population which is at risk of HIV infection. HIV risk determinants for MSM in both developed and developing countries seem to be congruent, but it is evident that in developing countries these determinants are aggravated by homophobia and poor socioeconomic conditions. For example, the criminalisation of homosexuality as well as poverty, unemployment and low levels of education have been proven to be some of the factors that influence the risk of HIV infection among MSM in many African countries (Makofane, Beck and Ayala 2014, 14). In South Africa, where this study was conducted, section 9(3) in the Constitution of the country provides that the state “may not unfairly discriminate directly or indirectly against anyone on one or more grounds including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, **sexual orientation**, age, disability, religion, conscience, belief, culture, language and birth”.

Although the Constitution of South Africa prohibits discrimination of people on grounds of their sexual orientation, it is worth noting that this policy does not translate into practice because many South African MSM are still stigmatised and discriminated against by the government and general society. There have been instances of state-sponsored homophobia in which African presidents and religious leaders have publicly uttered homophobic statements to denounce lesbian, gay, bisexual and transgender (LGBT) people. This state-sponsored homophobia has inevitably inculcated a culture of hostility and hatred towards LGBT people on the African continent. Therefore, there is a need to engage the community in mitigating homophobia in the communities where LGBT people live.

## STATEMENT OF THE RESEARCH PROBLEM

The researcher contends that most of the research that has been conducted on MSM and HIV in South Africa has paid little attention to black MSM who live in rural areas. Most of the research that is available has focused mainly on black MSM who live in urban and peri-urban areas, particularly cities and townships, respectively. This argument is corroborated by a recent study in which Imrie, Hoddinott, Fuller, Oliver and Newell (2013, 70) attest that research into MSM and HIV in South Africa has been largely confined to urban areas and has overlooked rural areas. There is therefore a paucity of research among black MSM who live in rural communities in South Africa. Likewise, the Rural Health Advocacy Project and the Rural Doctors Association of Southern Africa made a submission to the South African National AIDS Council in September 2011 stating that the needs of rural communities have been overlooked and neglected, and that these needs should also be included in the HIV/AIDS and STI National Strategic Plans for South Africa. These organisations contend that “HIV prevalence is increasing

rapidly in rural settlements...a big challenge in rural areas is access to appropriate services. A large portion of the rural population has no sustainable livelihood, which contributes to deprivation and ill health” (RHAP and RUDASA 2011).

## PURPOSE OF THE STUDY

The purpose of this study was to explore and describe experiences of MSM and health care providers (HCPs) regarding the impact of an HIV community engagement among MSM in a rural community in South Africa.

## DEFINITION OF CONCEPTS

**ART** is the acronym for anti-retroviral therapy.

**HCT** is the abbreviation for HIV counselling and testing.

**Homophobia** refers to prejudice, discrimination and hatred towards people who are attracted to members of the same sex (Peate 2005, 165).

**LGBT** is the abbreviation for lesbian, gay, bisexual and transgender.

**MSM** is the abbreviation for men who have sex with men. The term encapsulates all men who have sex with other men, irrespective of whether they identify themselves as homosexual, bisexual or heterosexual (Stine 2010, 285).

**Sexual orientation** refers to whether a person is sexually attracted to members of the same or opposite sex or both. Homosexuals are sexually attracted to members of the same sex, heterosexuals are sexually attracted to members of the opposite sex and bisexuals are sexually attracted to members both of the opposite and the same sex.

## RESEARCH DESIGN AND METHODOLOGY

Qualitative research methodology was utilised in this study. Polit and Beck (2004, 729) define qualitative research methodology as “an investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials, using a flexible research design”. The research design used was explorative, descriptive and contextual in nature. The purpose of an explorative research design, according to Brink (2001, 11), is to provide more insight into and understanding of the phenomenon under investigation. A descriptive research design, explains Brink (2001, 11), attempts to offer an understanding of underlying causes of the phenomena under investigation. Mouton (2002, 133) defines a contextual research design as a design in which a phenomenon under investigation is studied in relation to a particular or specific context, location or setting.

## Research Setting

This study was conducted in rural villages of the North West province in South Africa. The province is one of the poorest in South Africa, with more than half of its people living in rural areas. According to the South African National AIDS Council Report of 2013, the HIV prevalence rate in North West ranks fourth highest in all nine provinces of South Africa, after KwaZulu-Natal, Mpumalanga and the Free State. Poor socioeconomic conditions of people in North West, including poverty, and the lack of educational and employment opportunities, are believed to exacerbate the risk of HIV infection in the province. The Medical Research Council Provincial Mortality Report of 2000 reports that HIV by far remains the leading cause of death in North West. Due to the fact that MSM are identified as one of the high-risk populations for HIV infection in South Africa, and with North West being one of the provinces with a high HIV prevalence rate, it is obvious that MSM living in North West are susceptible to the risk of HIV infection. It is also worth noting that LGBT organisations that usually offer HIV programmes to MSM seem to be unavailable in this province, let alone in the rural villages where this study was conducted. The provision of public health care services in these rural villages is relatively poor. Two public health care clinics that are available in the community are underresourced and understaffed. Deteriorating infrastructure such as water and sanitation at the two clinics seems to be a recurring problem which creates hygiene hazards for the patients. Major health care services such as HIV-related services are usually accessed at a hospital which is situated at a distance away from the villages where this study took place. In this regard, an HIV community engagement programme for MSM was deemed to be necessary in these rural villages. The programme was initiated and run by six MSM community peer educators (MSM CPEs) as well as four HCPs. The MSM CPEs and HCPs visited gay-friendly venues where MSM congregated and socialised to conduct education and information sessions on the sexual and mental health issues of MSM. These venues included friendship circles, stokvels (social networks), shebeens and taverns. Materials such as information leaflets and booklets as well as posters and pamphlets about the sexual and mental health issues of MSM were distributed at these venues. Condoms and water-based lubricants were also distributed. MSM were requested to further disseminate these materials in their social and sexual networks.

## Population and Sampling

The population for this study was MSM and HCPs who had been exposed to an HIV community engagement programme for MSM in rural villages in North West province. Due to time constraints and availability of participants, the sample for this study consisted of four MSM and four HCPs. The MSM population included two MSM CPEs and two other MSM who had been exposed to the HIV community engagement programme in these rural villages. The inclusion criteria for MSM were that they had

to be 18 years or older, residents in one of the villages where this study was conducted and they had to have been exposed to the HIV community engagement programme in their villages. The HCP population included a nurse and a social worker from the two local clinics as well as a psychologist and a public health specialist working with MSM sexual and mental issues. The purposive sampling technique was used to recruit the HCPs. Snowball sampling was utilised to recruit MSM.

## Data Collection

Data for this study were collected from September 2015 to January 2016. This study emanated from the mother study that the researcher conducted for his doctoral studies on factors influencing the risk of HIV infection among MSM in rural villages in North West. Individual in-depth interviews were conducted with eight participants who had been involved in the HIV community engagement programme. The researcher conducted unstructured interviews in which he asked a “grand tour” question to all the participants. The grand tour question asked was: What are your experiences regarding the impact of the HIV community engagement programme among MSM in this community?

The researcher then probed further to elicit relevant information and to pursue more information pertaining to the study. In this regard, the researcher used the interview strategy of “funneling”, which Minichiello, Aroni and Hays (2008, 329) describe as the process of starting an interview with a broad general question and thereafter continuing to narrow the discussion using more specific questions which ask directly about the issues that are of interest to the researcher. The interviews were conducted in both the local language (Setswana) and English. The interviews conducted in Setswana were later translated into English. The interview conversations were recorded using an audiotape in order to be able to capture the responses of the participants verbatim. Field notes were also taken during the interviews to record non-verbal information such as facial expressions and body language. All interview sessions lasted for approximately 60 minutes. All of the interviews were conducted at a quiet place selected by the participants.

## Data Analysis

The thematic data analysis method was adopted in this study. The researcher followed the six steps of thematic data analysis as identified by Braun and Clarke (2006, 87): (1) familiarising oneself with the data, (2) generating initial notes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes and (6) producing the findings.

## Measures to ensure Trustworthiness

Lincoln and Guba, as cited in Polit and Beck (2004, 430), argue that in order to maintain the trustworthiness of data in a research study, four criteria need to be taken into consideration: (1) credibility, (2) transferability, (3) dependability and (4) confirmability.

Credibility refers to the correctness and truthfulness of the data supplied by the participants. The researcher established the credibility of the data by sharing the transcripts of the interviews with the participants to confirm and verify whether the transcripts were a true reflection of what the participants meant.

Transferability refers to the degree to which the findings of a study can be applied to other contexts or settings. The researcher established the transferability of this study by using purposive sampling where he deliberately selected participants who he knew would provide rich and relevant information pertaining to the study. In addition to purposive sampling, the researcher also used snowball sampling where participants referred the researcher to other possible participants who could provide rich and relevant information. Because all the participants selected were exposed to the HIV community engagement for MSM, there was a possibility that they would provide similar responses. Hence the duplication of the findings of this study in other contexts or settings was enhanced.

Dependability refers to the consistency and stability of the data supplied by the participants. The researcher established the dependability of the study by documenting authentic accounts of the participants. Due to the fact that the researcher is an experienced researcher in MSM and HIV, the participants were able to identify with the researcher and were comfortable to discuss their knowledge, experiences and perceptions with someone who understood their context and perspective. Therefore, the study participants trusted the researcher with the information they provided and felt at ease to communicate with someone who was an insider rather than an outsider. Moreover, the insider role of the researcher increased the consistency and stability of the data because he could identify with the issues the participants raised.

Confirmability refers to the degree to which the findings of the study could be confirmed or substantiated by others. To ensure confirmability in the study, the researcher used the concept of triangulation by comparing and matching the responses of the participants to see if they corroborated each other.

## Ethical Considerations

Ethical clearance to conduct the study was obtained from the Higher Degrees and Ethical Clearance Committee in the Department of Health Studies at the University of South Africa where the researcher is completing his doctoral studies. To ensure confidentiality and anonymity of the participants, pseudonyms were used instead of the real names of the participants. The names of the rural villages where the participants resided were also not divulged. All the participants were required to sign a form to consent to be interviewed and audio-taped. The consent form provided information about the study and stipulated the right of the participants to withdraw their involvement in the study at any time without being questioned.



## FINDINGS AND DISCUSSIONS

The tables below denote the biographical information of the participants of this study:

**Table 1:** Biographical information of MSM

Participant	Age	Education level	Occupation	HIV status
MSM1	20	High school	Unemployed	Untested
MSM2	32	High school	Shopkeeper	Unknown
MSM CPE1	26	Middle school	Dressmaker	HIV positive
MSM CPE2	35	High school	Hairdresser	HIV positive

**Table 2:** Biographical information of HCPs

Participant	Occupation	Qualifications	Specialisation	Experience in MSM health and wellbeing
HCP1	Nurse	Diploma in Nursing	HIV and STIs	2 years
HCP2	Social worker	Bachelor of Social Work	Community welfare services	2 years
HCP3	Psychologist	Doctor of Philosophy in Psychology	Clinical and counselling psychology	18 years
HCP4	Public health specialist	Master of Public Health	HIV/AIDS	12 years

After data analysis, it was discovered that MSM experienced barriers in accessing HIV testing, prevention, treatment, care and support. The following themes emerged as discussed below:

### Access to HIV counselling and testing (HCT)

All HCPs in the study indicated that HCT is a crucial access point to other HIV-related services such as prevention, treatment, care and support. However, some MSM who participated in this study mentioned that they had experienced difficulties in accessing HCT. These are some of their responses:

*“I’m afraid to go for testing at the clinic because the nurses there know me and they will spread the news about my status around the village” (MSM1)*

*“I only have sex with men so I don’t see the need to go for testing because I don’t have sex with women” (MSM2)*



One peer educator reported that:

*“Some MSM in our village perceive themselves not to be at risk of HIV so they don't go for HCT” (MSM CPE1)*

One HCP mentioned that:

*“Since we have instituted a community engagement programme for MSM in these villages we have seen many MSM come forward to the clinic for HCT, however; we have a problem of some MSM who don't come back for their results. I must say MSM who don't know their status are highly infectious to their sex partners” (HCP1)*

Another HCP from an LGBT organisation reported that:

*“When we started a community engagement programme in these villages we realised that there were too many MSM who have not gone for HCT. After the informational and educational talks with them about the benefits of HCT many went for testing” (HCP3)*

Although problems were identified with the utilisation of HCT in these villages, it was clear that the community engagement programme had increased access to HCT among these MSM.

## Access to condoms and water-based lubricants

All HCPs in the study indicated that condoms and water-based lubricants are effective in preventing the risk of HIV infection among MSM. However, there have been some problems with accessing and using condoms and water-based lubricants. These are reports from the participants of the study:

*“Although we have distributed enough condoms among MSM through the community engagement programme, the government has not enough funds to also provide water-based lubricants” (HCP1)*

*“At first I didn't know what is a water-based lubricant, I used Dawn or Vaseline” (MSM2)*

*“We don't always have these lubricants here, and we can't afford to buy them” (MSM1)*

*“We usually get water-based lubricants from the LGBT organisation to distribute among MSM in the community, but they get finished quickly” (MSM CPE2)*

*“Before we started the community engagement programme in these villages, some of MSM didn't use condoms consistently and correctly, but so far we have managed to solve this problem through our community engagement programme and many of them now report that they use condoms consistently and correctly” (HCP4)*

*“There is a problem with HIV prevention messages nowadays, the prevention messages need to move away from popular strategies such as the ABC model because these MSM have mentioned that they have developed HIV-related fatigue. This makes prevention efforts difficult” (HCP3)*

Although problems were identified with accessing and using condoms and water-based lubricants among MSM in these villages, it was clear that the community engagement programme had increased access to condoms and water-based lubricants.

## Access to anti-retroviral therapy (ART)

Both MSM and HCPs reported some concerns with access to ART. These concerns are shown in the statements below:

*“The problem that we encounter with regard to access to ART is that we have to travel a long distance to the hospital to get our medication because these pills are not available here at the local clinics” (MSM CPE1)*

*“I’m not working so I sometimes struggle to get bus fare to travel to the hospital so that I can be early to book the queue. If I don’t have money I sometimes miss my appointments and have to wait until I raise the funds to go to fetch my pills” (MSM CPE2)*

*“I sometimes use my own car to transport MSM who are involved in the community engagement programme to the hospital to fetch their ART” (HCP2)*

*“HIV-positive MSM who are on ART sometimes don’t go to the hospital to fetch their medication and they default which can result in HIV being resistant to the medication. Some mention that they are afraid that other people will see that they have HIV if they go to the hospital to fetch their medication” (HCP1)*

*“Alcohol abuse has proven to be one of the barriers to ART adherence among MSM in these villages” (HCP3)*

*“The community engagement programme has helped most of HIV-positive MSM in these villages to access ART at the hospital. This programme has improved the quality of life for many HIV-positive MSM who could have succumbed to HIV” (HCP4)*

Despite some problems with access to ART in these villages, it was obvious that the community engagement programme increased access to ART among these MSM.

## Access to care of HIV-related opportunistic infections

HCPs who participated in this study reported that MSM who were part of the community engagement programme continuously required care for HIV-related opportunistic infections. These are some of their comments:

*“Some of HIV-positive MSM who were part of the community engagement programme were also co-infected with TB, which required that they also receive care to get rid of the TB” (HCP1)*

*“In the beginning, a lot of HIV-positive MSM who were attacked by HIV-related diseases delayed treatment of these ailments and presented themselves for care late when the diseases*

*have progressed to an advanced stage. But after we enrolled them in the community engagement programme most regularly attended the clinic for other ailments such as genital herpes” (HCP4)*

*“Through community engagement programme we have managed to refer many MSM to the local clinic for treatment of STIs” (MSM CPE1)*

*“We have seen MSM patients who are HIV-positive getting care for opportunistic infections like diarrhoea and pneumonia” (HCP1)*

According to the statements above, it is apparent that the community engagement programme encouraged MSM to seek care for HIV-related opportunistic infections.

## Access to social support

HCPs and MSM who took part in this study mentioned that social support forms the backbone for improving the health and wellbeing of individuals. This is apparent in the following statements:

*“Lack of social support from family and community results in HIV-related complacency among MSM in these villages” (HCP3)*

*“Support groups for MSM is the place where we get moral support from each other, I feel at ease when I’m with other MSM” (MSM2)*

*“The problem is that most of these MSM are unemployed and live in poverty, so it is important for me to help those who are HIV-positive to access social grants through the Department of Social Development” (HCP2)*

*“The social grant I receive helps me a lot to buy nutritious food to boost my immune system, but I hear that when I get better they will no longer give me the grant” (MSM CPE2)*

The above statements clearly show that the involvement of MSM in the community engagement programme exposed them to social support initiatives to improve their health and wellbeing.

Beyrer, Sullivan, Sanchez, Dowdy, Altman, Trapence and Mayer (2012, 424) contend that community engagement is an integral part of rendering holistic and comprehensive HIV-related services to address the scourge of the epidemic among MSM. A recent study on community engagement with HIV-positive MSM in Taiwan found an increase in HIV knowledge among MSM in order to combat the spread of the virus and to protect themselves from becoming reinfected with the virus (Chuang and Lacombe-Duncan 2016, 445). For MSM, community engagement is associated with an increased sense of belonging (Trussler, Perchal and Barker 2000, 295), empowerment (Roy and Cain 2001, 421), improved health status (Rawstorne, Prestage, Grierson, Song, Grulich and Kippax 2005, 589) and decreased stigma and isolation (Harrington, DiClemente, Wingood, Crosby, Person, Oh and Hook 2001, 468). In Africa in general, and in South Africa in particular, there is a paucity of research on community engagement

approaches to public health promotion with MSM. However, researchers have recently started to conduct studies in this field. In sub-Saharan Africa, for example, Makofane et al. (2014, 16) conducted a study in which they discovered that community engagement has a positive impact on the health and wellbeing of MSM. In another study conducted in Cape Town townships in South Africa, Tucker, De Swardt, Struthers and McIntyre (2013, 33) also discovered that community engagement yields positive health outcomes for MSM infected and affected by HIV.

## CONCLUSION

Based on these findings, it seems that community engagement has proven to be an effective strategy for improving the health and wellbeing of MSM, especially those who live in homophobic, HIV-stricken and poor socioeconomic environments. Moreover, it seems that community engagement has also proven to reinforce community solidarity and social cohesion among MSM in order to combat homophobia in communities where these MSM live. In terms of sexual and mental health, this study reveals that community engagement seems to play a pivotal role in encouraging and sensitising MSM to access and utilise HIV testing, prevention, treatment, care and support services. Through community engagement, MSM in this study were able to create “safe spaces” where they could mingle with each other without experiencing prejudice and also offer each other moral and social support.

## RECOMMENDATIONS

Due to the fact that community engagement has proven to be an effective strategy to improve the health and wellbeing of MSM in disadvantaged and underprivileged communities, HCPs should consider implementing this approach when working with MSM in other similar communities. In addition, it is recommended that HCPs who work with MSM tailor-make their services to be MSM appropriate and MSM friendly in order to be able to sensitise MSM to access and utilise those services without hesitation. It is vital that HCPs render quality health care to MSM as a vulnerable group without being judgemental based on their personal views and beliefs. Negative experiences with HCPs often create barriers to health care service utilisation by clients.

## LIMITATIONS OF THE STUDY

The study was conducted at only one research site and with a limited number of participants. Therefore, the findings of this study cannot be generalised to other villages in the North West or even the entire country.

## ACKNOWLEDGEMENTS

The researcher wishes to thank all the participants of this study for giving their time to provide information which resulted in the production of this research article. Financial support in the form of a doctoral scholarship from the National Research Foundation is also acknowledged.

## REFERENCES

- Baral, S., F. Sifakis, F. Cleghorn, and C. Beyrer. 2007. "Elevated Risk for HIV Infection among Men who have Sex with Men in Low- and Middle-income Countries 2000–2006: A Systematic Review." *PLoS Medicine* 4 (12): e399.
- Beyrer, C., P.S. Sullivan, J. Sanchez, D. Dowdy, D. Altman, G. Trapence, and K.H. Mayer. 2012. "A Call to Action for Comprehensive HIV Services for Men who have Sex with Men." *Lancet* 380 (9839): 424–438.
- Braun, V., and V. Clarke. 2006. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3: 77–101.
- Brink, H. 2001. *Fundamentals of Research Methodology for Health Care Professionals*. Cape Town: Juta.
- Burrell, E., D. Mark, R. Grant, R. Wood, and L.G. Bekker. 2010. "Sexual Risk Behaviours and HIV-1 Prevalence Among Urban Men who have Sex with Men in Cape Town, South Africa." *Sexual Health* 7 (2): 149–153.
- Centers for Disease Control (CDC). 1997. *Principles of Community Engagement*. Atlanta, GA: CDC.
- Chow, E.P.F., D.P. Wilson, and I. Zhang. 2010. "The Next Era of HIV in China: Rapidly Spreading Epidemics Among Men who have Sex with Men." *Journal of Acquired Immune Deficiency Syndromes* 55 (4): e32–e34.
- Chuang, D., and A. Lacombe-Duncan. 2016. "Community Engagement Among Men who have Sex with Men Living with HIV/AIDS in Taiwan." *AIDS Care* 28 (4): 445–449.
- Harrington, K.F., R.J. DiClemente, G.M. Wingood, R.A. Crosby, S. Person, M.K. Oh, and E.W. Hook. 2001. "Validity of Self-reported Sexually Transmitted Diseases among African American Female Adolescents participating in an HIV/STD Prevention Intervention Trial." *Sexually Transmitted Diseases* 28 (8): 468–471.
- Imrie, J., G. Hoddinott, S. Fuller, S. Oliver, and M. Newell. 2013. "Why MSM in Rural South African Communities should be an HIV Prevention Research Priority." *AIDS Behaviour* 17: S70–S76.
- Lane, P., and R. Tribe. 2010. "Following NICE 2008: A Practical Guide for Health Professionals on Community Engagement with Local Black and Minority Ethnic (BME) Community Groups." *Diversity in Health and Care* 7: 105–14.
- Makofane, K., J. Beck and G. Ayala. 2014. *MSM in sub-Saharan Africa: Health, access, and HIV*. Oakland, CA: MSMGF.
- Medical Research Council. 2000. *South African national burden of disease study: estimates of provincial mortality, North West*. Pretoria: MRC.
- Minichiello, V., R. Aroni and T. Hays 2008. *In-depth interviewing: principles, techniques, analysis*. Sydney: Pearson Education.
- Mouton, J. 2002. *Understanding social research*. Pretoria: Van Schaik.
- Muraguri, N., M. Temmerman, and S. Geibel. 2012. "A decade of research involving men who have sex with men in sub-Saharan Africa: current knowledge and future directions." *Journal of Social Aspects of HIV/AIDS* 9(3):137–147.
- National Institute for Health and Care Excellence. 2008. *Community engagement to improve health*. London, UK: NICE.
- Peate, I. 2005. *Manual of sexually transmitted infections*. London, UK: Whurr publishers.

- Polit, D.F. and C. T. Beck 2004. *Nursing research: principles and methods*. Philadelphia: Lippincott.
- Rawstorne, P., G. Prestage, J. Grierson, A. Song, A. Grulich, and S. Kippax. 2005. "Trends and Predictors of HIV-positive Community Attachment among PLWHA." *AIDS Care* 17 (5): 589–600.
- Rispel, L.C., and C.A. Metcalf. 2009. "Breaking the Silence: South African HIV Policies and the Needs of Men who have Sex with Men." *Reproductive Health Matters* 17 (33): 133–142.
- Roy, C.M., and R. Cain. 2001. "The Involvement of People living with HIV/AIDS in Community-based Organizations: Contributions and Constraints." *AIDS Care* 13 (4): 21–432.
- Rural Doctors Association of Southern Africa. 2011. [www.rudasa.org.za](http://www.rudasa.org.za) (Accessed 15 September 2016).
- Rural Health Advocacy Project. 2011. [www.rhap.org.za](http://www.rhap.org.za) (Accessed 15 September 2016).
- South African National AIDS Council. 2013. North West Provincial AIDS Spending Assessment Brief (2007/082009/10). Pretoria.
- Stine, G.J. 2010. *AIDS update 2010*. New York: McGraw Hill.
- Trussler, T., P. Perchal, and A. Barker. 2000. "Between what is said and what is done: cultural constructs and young gay men's HIV vulnerability." *Psychology, Health & Medicine* 5 (3): 295–306.
- Tucker, A.G. de Swardt, H. Struthers, H. and J. McIntyre. 2013. Understanding the needs of township men who have sex with men (MSM) Health Outreach Workers: Exploring the Interplay between Volunteer Training, Social Capital and Critical Consciousness." *AIDS Behaviour* 17 (1): S33–42.