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Title

Exploring the development and implementation of health and support services in five South African higher education institutions for a key population, men who have sex with men

DECLARATION

I, Sianne Maria Alves, declare that the doctoral thesis, ***Exploring the development and implementation of health and support services in five South African higher education institutions for a key population, men who have sex with men***, is my own work, that all the sources used or quoted have been acknowledged by means of complete references, and that this thesis was not previously submitted by me for any other degree at any other university.

…….

Sianne Maria Alves

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DEDICATION

This thesis is dedicated to *Noelyn Kathryn Blowes (née Alves)*

16 December 1970-17 January 2016

I missed your motivation and support, but I've finished it now big sis.

Your grace, values, sincerity, laughter, love, and gentle guidance will live on through the memories I share with your Declan. I will remind him to always "Give of his best."

Always in my heart and always, always, always in my thoughts.

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Professor Francis, thank you for your tutelage and mentorship. Your intellectual engagement has enabled my own growth as a researcher. I thank you.

To my family, who accepted my absence without question, I thank you and I am indebted to you. My children (my PhD team), I hope that my journey demonstrates to you that all impossibilities can be overcome.

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To all my dear friends, who have supported me from afar. Thank you for your encouragement.

To the five programme coordinators, thank you for your contribution and voice that made this research possible.

Lastly, for all practitioners in higher education, it is hoped that my PhD will be useful in shaping programmatic responses for students who need our support the most.

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AIDS	Acquired Immune Deficiency Syndrome
HCT	HIV counselling and testing
HEAIDS	Higher Education and Training HIV/AIDS Programme
HEI	Higher education institution
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KAPB	Knowledge, attitude, behaviour and prevalence
LGBTQI	Lesbian, gay, bisexual, transgender, queer, intersex
MSM	Men who have sex with men
MSMGF	Global Forum on men who have sex with men and HIV
NACOSA	Networking HIV/AIDS Community of South Africa
SANAC	South African National AIDS Council
UAI	Unprotected anal intercourse
UNAIDS	Joint United Nations Programme on HIV/AIDS

Chapter One: Introduction

1.1 Context

Universities often focus on the academic project, while student wellness and support are, in many instances, of secondary importance, despite evidence indicating that academic throughput is dependent upon student health and mental well-being. My research focuses on the intersection between health, sexuality and institutional management at five universities. The student population that is central to my PhD is referred to as 'men who have sex with men' (hereafter referred to as MSM). The biomedical term MSM reflects the concept that sexual activity, not one's sexual identity, places people at risk of HIV/AIDS (Young & Meyer, 2005).

The intention of the research is to provide new knowledge about what institutional conditions are required to change oppressive systems that discriminate against MSM students. Based on the findings of a systematic review, I identify that hardly any research has been done in any higher education institution (hereafter referred to as HEI), globally as well as within the sub-Saharan context, to establish to what extent health and support systems are being offered to MSM students at universities. This aspect of institutional support within South African HEIs has not been given much attention and, in my PhD, I maintain the position of a scholar who intends to contribute towards institutional practice within higher education for self-identifying populations.

The chapters in my PhD are presented in the following way. In Chapter One, I provide contextual information that troubles the role of the university in the provision of health and support services. I also problematize the use of biomedical terms such as MSM. For the purpose of my PhD, I discuss the preferred use of the term 'self-identifying', which encompasses the diversity of sexuality and emphasizes individual agency in articulating one's own identity.

A systematic review was conducted and the findings thereof are presented in Chapter Two. The review found that there is no published research that focuses on MSM health and support services within HEIs. In light of this, the scope of the review was broadened to include community-based programmes for MSM populations, in order to identify what

effective health and support structures could be established. The recommendations of the seven articles out of the forty-two identified articles in the database were included in the final review. In Chapter Three, I share the research design and methodology. I alert the reader to the breakaway from the traditional presentation of the research methodology that has become a norm. Often, the researchers present a subjective interpretation of the applied research methods, when they themselves are not at the receiving end of the research tools. Therefore, in Chapter Three, I intentionally share the thoughts and perceptions of the programme coordinators who were the recipients of the research tools.

I present the axial codes that emerged from the cross-case analysis conducted in Chapter Four. In Chapter Five, I discuss the four overarching selective codes that emerged from the research data. Chapter Six concludes the PhD with a summary of the research presented and puts forward recommendations that articulate new avenues of research and offers suggestions for practitioners in higher education institutions who intend to enhance their institutional programmes for self-identifying students.

1.2 Key population

I begin with a presentation of the challenges facing MSM populations globally and within South Africa.

Globally, the decline in new HIV infections in 2013 dropped below 40% and the uptake of treatment by over 23 million people worldwide demonstrated that current responses in HIV health management and prevention were having a positive effect (UNAIDS, 2014). Currently, three sub-Saharan African countries contribute towards 48% of the global burden of HIV. South Africa is one of the three and, contrary to the global decline, South Africa continues to experience an increase in HIV prevalence (Shisana *et al.*, 2012). As part of the response to decrease the incidence of new HIV infections, there has been a call for increased services for key populations where new HIV infections have been reported (UNAIDS, 2014).

One of the key populations identified and of relevance to my PhD is the population referred to as MSM. It was recognized that HIV programmatic responses seldom included interventions, resources and funding for MSM populations during the course of the HIV epidemic. This may have exacerbated the incidence of HIV among this key population (Rebe & McIntyre, 2014).

According to the UNAIDS gap report, MSM populations are nineteen times more likely to be living with HIV than the general population (UNAIDS, 2014). In a global incidence study that pooled available HIV prevalence data among MSM as of 1 May 2013, sub-Saharan Africa was identified as the second highest HIV prevalence among MSM (Beyrer *et al*., 2012b), as depicted in Figure 1.

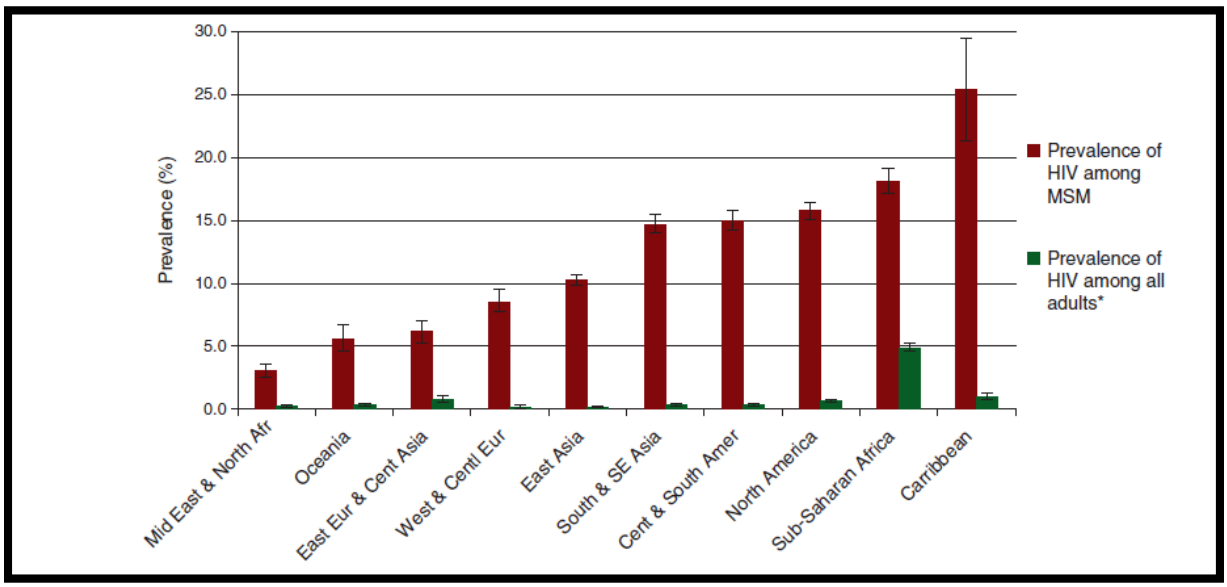


Figure 1: Pooled HIV prevalence among MSM and among all MSM by reproductive age, by region 2012

(Beyrer *et al*., 2012b)

As portrayed in Figure 1, there is more research in the local MSM populations in countries such as Thailand, China and America. However, of greater concern is that sub-Saharan Africa currently ranks second highest for HIV prevalence among MSM (data sourced from Botswana, Côte d'Ivoire, Kenya, Malawi, Namibia, Nigeria, South Africa and Uganda). Yet few studies, identified in the Chapter Two systematic review, provide biopsychosocial support for local MSM populations within a sub-Saharan African context.

As the high prevalence of HIV among MSM is becoming an increasing concern, the findings in Figure 1 would suggest that sub-Saharan Africa has a crucial role to play in responding to, and providing relevant healthcare services for their MSM populations.

Physiologically, MSM are particularly prone to HIV infection if they engage in unprotected sex, because of the extraordinarily high efficiency of HIV transmission across

the mucosal surface in anal sex (Baggaley, White & Boily, 2010). In a forecast modelling exercise, researchers are concerned that current methods used in behaviour change interventions to reduce HIV transmission will be rendered useless, unless 60%-80% of eligible MSM receive comprehensive prevention packages (Baggaley, White & Boily, 2010; Beyrer et al., 2013). Therefore, there is a dire need in sub-Saharan Africa to provide an improved, relevant and exemplary standard of comprehensive prevention services to MSM that currently exceeds the norms and practices for HIV prevention (Beyrer *et al.*, 2013).

Due to the lack of specific responses for MSM in HIV combined prevention programmes, the incidence of HIV among gay men and other MSM continues to rise in several parts of the world (UNAIDS, 2014). While there is evidence of biomedical and psychosocial responses for MSM populations in specialized healthcare clinics, there is a need to provide health systems at a national level in South Africa that are relevant, accessible and free of prejudice, in order to better assist and support MSM populations (Baral et al., 2007; Lane et al., 2008; McIntyre et al., 2013; Rebe & McIntyre, 2014).

With the age of sexual debut decreasing in youth and 15- to 24-year olds having the highest HIV prevalence in South Africa, student populations within HEIs cannot be exempted from HIV comprehensive prevention and care (HEAIDS, 2010b; Shisana *et al.*, 2012). Certainly, within South African universities, students experience health and socio-economic challenges, similar to those found in the broader South African society. Students who are living with HIV already experience high levels of stigma at university (Volks, 2014). There are, however, groups of students who experience multiple layers of stigma and micro-aggressive forms of marginalization, due to the institutional culture and heteronormative discrimination that conflict with their sexual orientation (Msibi, 2013; Brink, 2014).

My research draws attention to an externally funded programme that saw the development of a biopsychosocial programme at fourteen universities from March 2014 to March 2016. In my PhD, I analyse five of the university programmes that were developed to provide health and support to this key population at higher education institutions. The value of my research will provide guidance to universities in their consideration of their role and extension of services towards MSM students, beyond that of academic support. Furthermore, my research documents how leaders, peer educators, psychosocial support and omissions in the application of human rights and academic engagement influence the efficacy and

sustainability of health and support services within a university setting. It is hoped that universities glean the learnings identified in my PhD, in order to contribute towards knowledge about their institutional responses for MSM students. This arguably extends the university's function beyond the traditional provision of academic services.

1.3 The sub-Saharan context and MSM

There are several reasons for the lack of comprehensive HIV services and/or research related to MSM in sub-Saharan Africa. The stigma associated with 'being MSM' is one of the most debilitating factors that prevent access to, and/or delivery of inclusive health and support.

Within the sub-Saharan context, MSM remain one of the most stigmatized at-risk groups and are often subject to discrimination and criminalization by their state and/or community (Smith *et al.*, 2009; Geibel *et al.*, 2010). MSM sexual behaviour is illegal in thirty-one sub-Saharan countries and potentially attracts the death penalty in four (Ottosson, 2010). The consequences of state homophobia or the criminalization of same-sex behaviour has the divisive effect of further marginalizing MSM, lesbian, gay and bisexual (hereafter referred to as LGB)[1] people. The legal repercussions result in some MSM living in fear of prosecution or persecution (Tamale, 2014). Their heightened vulnerability impacts on their ability to access healthcare or seek counsel for testing and treatment (Tamale, 2014).

Criminalization of same-sex relations is at odds with African history; indeed, the growing body of literature that contextualizes same-sex partners prior to colonialization demonstrates the role of global north foreigners who used religion to vilify same-sex practices (Reddy, 2004; Muraguri, Temmerman & Geibel, 2012; Tamale, 2014; Matebeni & Msibi, 2015). Owing to this acquired hegemonic norm, assistance for MSM in some parts of sub-Saharan Africa is limited by unfavourable political, cultural, and religious barriers towards MSM, thus presenting challenges to biopsychosocial health programmes for this population. However, comprehensive services for sexually diverse populations, even in those countries that are not subject to discriminatory legal policy, remain limited.

[1] The definition of the acronym LGB is a limited representation of a spectrum of sexual orientations and should not be read as referring only to Lesbian, Gay, Bisexual. Currently, there is no term that is accepted within the African context to refer to sexual diversity; hence, the reliance on the labels of the global north.

Despite early evidence of HIV prevalence among MSM in South Africa (Rebe *et al.*, 2011), limited resources were made available to the MSM programme through the previous South African National Strategic Plan (hereafter referred to as the NSP) for HIV and AIDS, STIs and TB (2007-2011) (Makofane *et al.*, 2013). However, positive developments took place through international funding to provide specific clinics for MSM healthcare and counselling support. It is only recently that the NSP for HIV and AIDS, STIs and TB (2012-2016) specifically mentions and provides for MSM. Through this national plan, healthcare practitioners are urged to uphold and maintain the human rights in order to provide relevant and accessible healthcare for all sexual behaviours. The NSP further details what monitoring mechanisms and standard operating guidelines and training should be undertaken by health practitioners, in order to ensure that the healthcare they provide is accessible and unprejudiced for MSM populations (National Department of Health Republic of South Africa, 2011). The NSP's specific focus on relevant services for varying sexual risk behaviour calls for a much-needed review in conventional health services and practices. The change demands a reframing of personal beliefs and heightened objectivity to limit prejudice within the healthcare system. Like the public health services, reframing university processes that influence change at both an individual and an institutional level, is deemed necessary, in order to catalyse the inclusion of MSM and sexually diverse students within higher education institutions.

1.4 These labels – they are not *ours*

Throughout this research process, I emphasize my unease with my position as a researcher in relation to the topic at hand. I find myself in conflict on two fronts. First, the premise of my research focuses on the biomedical and psychosocial intervention *created* for a population that has been highlighted as '*vulnerable*' to HIV. The relationship between one's sexuality, physiology and disease reduces sexual behaviour to a category of identity, in this instance, MSM (Vance, 1991). Researchers before me have alluded to the use of disease by practitioners to garner findings, or by scholars to acquire credibility and publication when writing about the "other", which is usually justified as giving a voice to the voiceless (Hames, 2007). My study and purpose is no different, nor do I consider my justification for delving into this research area to be infallible. Continuing this research is based on the perceived value-add that the research will have for universities that intend to develop a biopsychosocial

HIV programme for a key population in their university. As the researcher, I focus on how the institutional programme was developed and the management's response towards the programme rather than on researching how MSM students experienced the programme, in order to avoid interpreting the lived reality of a perceived vulnerable group (Bauer & Wayne, 2005).

Secondly, I am conflicted by the external funder's (The Global Fund) use of terms to identify the key population. The funder employs the term MSM, which is a label that was constructed in the global north medical disease discourse. This contrasts with nascent terms of sexual identity being constructed in the African context.

Biomedically, the Western forms of sexual categorization MSM-LGB have not been accepted into African discourse and I agree with African scholars who have written extensively on the possibility of further stigmatization that the imposed terms have on populations that do not identify with the labels (Epprecht, 2008; Tamale, 2011; Msibi, 2013; Matebeni & Msibi, 2015). Some of the authors' research highlights the tension that is created when these labels are imposed upon individuals in the African context. The contention, as identified by the researchers, is that sexually diverse individuals reject the notion of a "static sexuality" (Butler, 1993) which limits an individual's sexual identity to a label that is laden with meanings that have hardly any to no application within an African context. For example, Msibi (2012) notes that his research participant rejected the term 'gay' as the effeminate meaning associated with the term denigrated the participant's understanding of his own masculinity.

Furthering the call for more nuanced terminology, Jagose (1997) contends that sexuality is fluid and rejects the categorization of sexual identity by means of labels. The effect of imposing labels upon sexually diverse populations within the African context results in a dissociation from those services, resources and education that use these labels. I grapple with the knowledge that students are being asked to conform to these labels to ensure that their institution can access funding. Therefore, I remain conflicted, as I write about a programme that relies heavily on these labels in order to dictate identity.

The requirements of the grant confine the recipients of the programme to the labels of MSM, lesbian, gay, and bisexual. This results in an assertion of these labels upon students

who may also dissociate themselves from the very programme that is intended to heighten the inclusion of sexually diverse populations within the institution.

I present this discussion to emphasize my position in avoiding the use of labels in my PhD. African scholars who are involved in the epistemological and ontological production, which challenges hegemonic norms and language, tend to use generic terminology such as 'non-normative' or 'queer' as a way to describe sexually diverse populations, in order to avoid the biomedical identity categories of MSM-LGB. Although I acknowledge and use terms such as 'same-sex', 'queer' or 'non-normative', I definitely move away from categorizing individuals with the terms MSM-LGB, as this has the same effect as the acquired and enforced biomedical categories of sexual orientation (Msibi, 2013). I acknowledge the arguments that 'queer' terminology and knowledge for same-sex African populations is necessary and that one would benefit from the proposed renaming forum, in order to grapple and locate accepted language and terminology for sexual identities in South Africa (Matebeni & Msibi, 2015).

Therefore, in my PhD, I attempt to avoid asserting these labels, unless I quote research that specifically refers to the terms 'MSM' and/or 'LGB'. As an alternative, I use generic terms that avoid the subtle reinforcement of a hierarchy. For example, the use of the term 'non-heteronormative' subtly suggests that a person or persons is/are not part of the norm. Throughout my PhD, I attempt to diffuse the discrimination that is enforced through language and rather seek terminology that actively promotes equality and inclusion.

I advocate that there should be no one norm or way of being. Therefore, I invoke the agency located in the term 'self-identifying', which shifts the power discourse to those persons who intend to define themselves, "whilst rejecting an imposition to be externally controlled, defined, or regulated" (Miller, 2015b). It is under the ambit of the abovementioned politics of naming and context that I explore the institutional structures created for self-identifying populations in five South African universities.

1.5 Nothing about us – without us

As a critical theorist, employed by a higher education university, whose work focuses primarily on developing anti-oppressive programmatic responses with, (and occasionally) for marginalised populations within higher education institutions, I have been privy to four

student movements that arose in one year that shook structural discrimination at its core. These four movements changed the trajectory of the institution's history in relation to privilege and intersections of race, class, patriarchy and sexuality. All four movements wove their consciousness into the flow and conceptualisation of my work, staggering my progress, as I self-reflected about my own identity as an individual, who bears multiple labels of identity and intersectional oppressions (sexuality, race, class, power) in relation to my position as a researcher and staff member at a HEI.

In this section, I detail information about the four student movements that was made publicly available by these movements on social media and in newspaper articles. The movements had an influential role in heightening my self-reflexivity in my PhD process. I present the student movement discourse to demonstrate how each movement compelled me to consider the privileges and power that I do have. Similarly, the movements influenced my selected research methods, as I did not want to use methods that reinforced tacit and/or implied forms of oppression.

1.5.1 #Rhodes Must Fall

The #Rhodes Must Fall movement (hereafter referred to as RMF) describes itself as a

> *collective movement of students and staff members mobilising for direct action against the reality of institutional racism at the University of Cape Town. The chief focus of this movement is to create avenues for REAL transformation that students and staff alike have been calling for. While this movement may have been sparked around the issue of the Rhodes Statue, the existence of the statue is only one aspect of the social injustice of UCT. The fall of 'Rhodes' is symbolic for the inevitable fall of [W]hite supremacy and privilege at our campus* (UCT Rhodes Must Fall, 2015).

The RMF uprising amassed well over 3,000 students, some of whom were occupying an administration building to protest against the perceived institutionalised racial discrimination at the University of Cape Town (hereafter referred to as UCT). During this occupation, students created educational spaces to which only politically Black (including Coloured and Indian) staff members and students were allowed access. The RMF defined educational spaces for Black students that taught students and staff members about the theoretical

concepts of Black consciousness. Questioning one's racial identity in relation to issues of access, opportunity, privilege and socio-economic status was emphasised in the RMF group spaces. This influenced my own understanding of my role and identity in relation to race, politics and privilege.

During the RMF disruption, I remembered a heated debate I had with a colleague in 2012, where I argued that a 'troubling space' was necessary, in order to subvert dominant oppressive structures in universities. I indicated my support for student agency and claimed that an initial state of crisis would be a healthy and necessary position for the institution to experience any real change. I also shared this position, not from the safety of an observer to the crisis (who would simply be providing commentary, while others are embroiled in managing the crisis), but as a staff member who would also be involved with the concerns of both staff members and students during crisis and, therefore, personally subjected to the tensions. I further clarify that my definition of a crisis does not condone the infringement on the physical safety and security of students and/or staff members.

My idea of a troubled space is encapsulated in the agency of an *en masse* movement that has benefits in garnering the attention of decision makers and media. The presence and purpose of RMF did not shock me; in fact, I was deeply relieved, because RMF signalled a very necessary disruption of hierarchy, privilege, power and related oppressions. Yet my interest in RMF was focused on understanding its emergence. What promulgated the movement into action? What tipped the scales of power in the institution? Was the throwing of decomposed paper mulch the straw that broke the Rhodes' back? Or did the catalyst have a more political (and funded) agenda?

I am not particularly concerned about '*who*' really initiated the student movement, but I am keenly interested in '*what*' it took to shift over 3,000 students to collectively begin maximising inclusion in the university environment. I continue to seek out this answer, in order to understand the mechanics of the RMF in the hope of incorporating this agentic power to garner support for students who experience discrimination based not only on race and class, but also on gender and sexuality.

1.5.2 #TheTransCollective

During the RMF period, a second movement called #TheTransCollective arose as a response to Transphobia at university. The #TheTransCollective is described as

> *a transfeminist movement which positions confronting toxic gender constructs as indispensable to the decolonisation project within and beyond the University of Cape Town (hereafter UCT.* (#TheTransCollective, 2015).

The mission of #TheTransCollective is,

> *threefold, firstly to ignite consciousness; secondly, to create a proactive and radical community and, lastly, to lobby with UCT to institutionally see and hear gender non-binary bodies and psyches* (#TheTransCollective, 2015).

This movement led to the creation of several spaces. In educational spaces, any member, regardless of sexuality and gender identity, was encouraged to attend and learn more about Trans* identity and sexuality. In other spaces, however, access was limited to Trans*-identifying students. Within institutional discourse, the voices that spoke for, and with #The TransCollective were limited to only Trans*-identifying people. The meso-level power, agency and politic held by #TheTransCollective was relegated to some spaces on the University of Cape Town campus, where their art of disruption demanded attention, response and action by UCT executive management to force necessary structural and institutional changes. During this student protest, I became aware of an interesting tension in the politic of #TheTransCollective. On the one hand, #TheTransCollective power was effective within the UCT, but #TheTransCollective's agency was entirely dependent on the academic freedom that is fiercely protected by UCT. However, this very dependency trapped #TheTransCollective's agency (and efficacy) within the borders of UCT. Becoming aware of this tension, I realised that there is a very rare opportunity to create an ideal health and support services system for students that would only have an effect within the borders of the university. While this is ideal for students, universities may be creating unrealistic expectations for students once they graduate and enter health and social systems that are to a large extent, oppressive towards difference.

1.5.3 The UCT Queer Revolution

The UCT Queer Revolution (hereafter referred to as UQR) emerged after a Students' Representative Council leader alluded to homosexuality as sin (Petersen, 2015). The movement started in June 2015

> *to raise awareness about the dangers that freedom of speech can pose with a particular focus on student leaders* [… who] *express homophobic views* (Varsity Newspaper, 2015).

The UQR's response was to call for the institution to take a stance against homophobia, even in the face of religious freedom. UQR drew national attention to the tension in the Bill of Rights, which questions to what extent the Constitution balances the rights of religion, freedom of expression and the protected ground of sexual orientation.

An important discussion emerged from the rising of UQR which raised questions about the role of student leaders at UCT and what belief systems they hold and/or (are allowed to) enforce within an academic institution. The lack of proper engagement by UCT on the issue alerted me to the gap in institutional responses and approaches in matters that were homophobic in nature, and how often popular culture and religious beliefs overshadow one's right to express and practice their sexual orientation.

1.5.4 #PatriarchyMustFall

Lastly, #PatriarchyMustFall (hereafter referred to as PMF) arose in relation to misogynistic, cisnormative and patriarchal culture that was entrenched within some institutional spaces such as residences (#PatriarchyMustFall, 2015). Queer, allies and female gender identities banded together to overthrow oppressive systems of patriarchy through education, advocacy and the creation of safe spaces where female gender identities could support and lobby for change in perceived heterosexist spaces at UCT. Within the PMF spaces, female-identifying bodies were allowed to access spaces of dialogue, whereas, in other educational spaces, the general public were allowed to attend, regardless of their gendered identity.

These four movements influenced the way in which I conduct the research, the language I use and my choice of research methodology. More importantly, the movements alerted me to four interrelated topics that are of relevance to my PhD. The first topic is the notion of access to spaces and, at a meso-level, who controls access within the university

setting. Secondly, I became aware of the use of labels and the related tensions for self-identifying populations in the South African context. The third topic considers the role of the university in providing a non-discriminatory environment as well as inclusive healthcare services. Lastly, I consider how the university system enabled the discourse and agency encapsulated by the movements.

1.6 The privilege of access

The student movements compelled me to query the notion of access and who controls access. I raise this tension in light of previous critiques of the position and identity of researchers in relation to perceived vulnerable groups (Herek et al., 1991; Bauer & Wayne, 2005; Berger, 2015).

The four student movements challenged individuals to 'check' their privilege, identity and power prior to accessing spaces of engagement and dialogue. This experience made me realise that the very nature of this research compelled me to make myself 'uncomfortable' with the status quo, in order to better understand the narratives of those who are forced to articulate 'who' and 'what' they are. Therefore, I embrace my discomfort and, as part of my self-reflection process, I embed my personal narrative into the research method so that, I share 'who' Sianne is with the programme coordinators. I utilise a personal narrative to assist in levelling the power dynamic so that the programme coordinators 'see' and 'understand' why I am invested in this research. However, in Chapter Three, I describe the limitations of the personal narrative through the perceptions of the programme coordinators who were the recipients of this research tool. Therefore, I do not suggest that a personal narrative is entirely effective or the only way in which one could attempt to subvert the power dynamic between the research and the participant.

In summary, I use the learnings from the student movements to revisit my held beliefs and perceptions about research methods, access and the co-construction of knowledge, in an attempt to relinquish any power that I may have as a researcher. In considering who controls access to the field of study, research has shown that researchers may be affected by a lack of access to the field of interest, because participants may not trust the intention of the researcher (De Tona, 2006). With regard to the latter, as the researcher, I recognise that I could have been prevented from accessing the research sample group (namely, the

programme coordinators), had it not been for my engagement with the programme coordinators over a two-year period that afforded me a role as 'insider' and resulted in two advantages, namely, easier access and conceptual knowledge about the topic at hand (Kacen & Chaitin, 2006; Padgett, 2008). Further adjustments to the research process are outlined in Chapter Three, where the key focus was to provide increased opportunities for engagement and representation of the data generated by the programme coordinators' interviews.

1.7 For whom are we self-declaring?

In the spaces created by the student movements, self-declaring one's identity was a practice to which students had become accustomed. I found myself questioning whether this act of declaration is an inclusionary practice that *has* to occur, in order to be included by self-identifying populations. When considering if one should feel compelled to declare one's sexuality, I found this to be particularly contentious, as the recipients of the programme were compelled to self-declare for reporting purposes required by the grant funder. There was also an assertion of the biomedical labels which the recipients had to appropriate when signing registers and/or receiving health services. I queried *for whom* this act of self-declaration serves? In my deliberations, I came to the conclusion that, as a rule, only sexually diverse individuals are required to declare their sexuality, and this act of self-declaration is an asserted (and unacceptable) heteronormative practice. I raised these questions with the programme coordinators and queried whether one can (or should) remain non-disclosing about one's sexual orientation when implementing a sexuality programme in a university setting. Their responses are incorporated in the findings of Chapter Four.

1.8 Higher education HIV response students in South Africa

A tension that often arises when considering the university space is how relevant health and support services are for university students. Two portentous moments define the role of the university in providing healthcare and support. The first was the onset of the HIV epidemic in Africa and, secondly, through the Ministerial report that localized the transformative obligation within the function of the university.

Since 1994, the role of universities has been re-examined, as the global pandemic of HIV called for extraordinary measures to be taken, in order to curb its spread and raise awareness about individual responsibility in reducing stigma and risk behaviour within one's

own community and/or workplace. However, as the HIV discourse extended beyond that of health and into the intersecting areas of transformation, the role of universities began to shift.

In 1997, the Ministry of Education articulated that universities had an obligation to create mechanisms that reformed the institutional culture. More specifically, section 3.4 of the Education White Paper 3 (1997) first made reference to the creation of a "safe and secure campus environment, that discourages harassment or any other hostile behaviour [...] directed towards persons or groups […] on grounds of [...] sexual orientation" (Department of Education, 1997 p.32). This call began to redefine the role of universities as sites of consciousness that influenced students' thought and discourse (Bernstein, 2001; Hames, 2007). Later, in 2008, the former Minister of Education, Naledi Pandor, announced the establishment of a *Ministerial Committee on Progress Towards Transformation and Social Cohesion and the Elimination of Discrimination in Public Higher Education Institutions* to focus on transformation that included, among other focal areas, racism, gender and sexuality. The report from this Committee was to provide appropriate recommendations to combat discrimination and to promote social cohesion (Department of Education, 1997).

In addition to documenting how to achieve a values-led culture within universities, the Education White Paper 3 changed the role of South African universities from being not only places of learning, but also sites of community of engagement that provided nurturing spaces that were highly aware about issues of access, governance, management, curriculum, pedagogy, inclusion, and support services that promoted the development and throughput of students (Department of Education, 1997).

It is evident in the Education White Paper 3 that the role of universities extended beyond that of academic development and contribution. Indeed, the Ministerial Commission Education White Paper 3 stipulated the emerging role of universities as pivotal in the political, economic and cultural reconstruction and development of South Africa – one that contributed to community development; and the building of a new citizenry (Department of Education, 1997).

The contention I have with the report from the Ministerial Committee is that it does not move beyond broad objectives and places the onus on universities to define how and what transformation goals are achieved. For example, the Ministerial Committee assumed that academics knew how to teach and enable a transformed environment, which provided spaces

for self-determination by students. However, they did not recommend sensitization of academics to prepare themselves to engage appropriately with all self-identifying students at university (Pattman & Chege, 2003; Hames, 2007; Bennett & Reddy, 2009). Without the explicit reframing of language and praxis in the academe of the university, students are in danger of becoming culturally marginalized by the very institutions that were intended to enable their personal and academic development (Reddy, 2004; Bennett, 2006; Bennett & Reddy, 2009; Francis & Msibi, 2011).

1.9 Universities as sites of intervention

Through the work of the Ministerial Committee, it was found that insufficient consideration was given to gender and sexism in transformation. The Ministerial report proposed that systemic interventions be introduced to remove gender discrimination and sexism in universities'.

As the institutional culture and transformation strategies within HEIs were being formulated, HIV programmes were developed. Universities were viewed as feasible sites of HIV prevention programming, where students could be assisted through health and psychosocial support services.

With its support, the Higher Education and Training HIV/AIDS Programme (HEAIDS) was established by the Department of Higher Education and Training (DHET) to assist universities in their programmatic responses to HIV. In addition, funding was made available to universities to upgrade or develop their HIV programmes (HEAIDS, 2006).

In order to identify whether HIV was a concern for universities, HEAIDS commissioned a baseline survey to establish the HIV prevalence; risk-behaviour; and the students' perceptions in relation to HIV (HEAIDS, 2010a). The HEI population consisting of staff and students was stratified into clusters and then further randomized to form the sample population of 25,000. The final sample comprised 23,375 individuals (n = 17,062 students; n = 1,880 academic staff; n = 4,433 administrative and service staff) (HEAIDS, 2010a). From the male cohort of the study (6%), it was found that MSM students (4.1%) were twice as likely to have HIV, than other sexually active students (HEAIDS, 2010b). This finding resonates with research that emphasised the global omission of non-specialized programmatic responses for MSM populations (Rebe *et al.*, 2011).

In 2013, HEAIDS collaborated with The Networking HIV/AIDS Community of South Africa (hereafter referred to as NACOSA) who was nominated by the South African National AIDS Council (hereafter referred to as SANAC) to manage a Global Fund grant with a specific focus on MSM services and support in South African tertiary institutions. Through this grant, fourteen universities were given funding to develop, implement and advocate for MSM-friendly health and psychosocial support services at their university.

Phase one of the grant funding was a needs assessment administered at fourteen universities via an electronic survey developed by Jaco Brink from the University of Stellenbosch. This was a landmark survey for South African universities, as this was the first time research was conducted specifically on the knowledge, attitudes, perceptions and experiences of MSM students at universities in South Africa (Brink, 2014). The standardized instruments that were used, gathered information on HIV knowledge, HIV risk, substance abuse, the institutional climate for MSM students, and self-esteem. From the total sample of (n = 8,869), students self-identified as follows: heterosexual (n = 6,087), homosexual (n = 1,470), 'other' identifying (n = 778), and bisexual (n = 533) students (Brink, 2014).

Brink's (2014) report identified significant findings about the South African MSM student population. It was found that alcohol and drug use scores were significantly higher for MSM whilst lower self-esteem scores were identified among MSM students than other sexually diverse students (Brink, 2014). Of notable concern was the finding that

> *more than one tenth of the MSM sample reported having been forced to have sexual intercourse against their will, and three percent indicated that they have threatened to use force to get someone to have sex when they did not want to* (Brink, 2014).

In the survey, MSM students reported not only their substance abuse, but also the presence of physical abuse, and a lack of access or willingness to use health services at university. More notably, MSM students were of the opinion that the HEIs are not safe (7.5%) and/or enabling environments (9%) for LGB students (Brink, 2014). Brink's (2014) survey findings are similar to biopsychosocial research that depicts the clustering of health and social effects among MSM, known as the Syndemic Effect (Singer, Davison & Fuat, 1987; Stall et al., 2003). Similarly, research by Lyons, Johnson & Garofalo's (2013) identify that the immediate environment has a direct effect on one's health. Therefore, in light of the

substance use; lowered self-esteem and the lack of access/use of health services, one could conclude that the propensity for being affected and/or infected by disease and psychosocial challenges is significantly higher for MSM students (Lyons, Johnson & Garofalo, 2013).

Brink's (2014) study raises concerns about what (if any) institutional structures currently exist to support the psychosocial and biomedical factors that specifically affect MSM students at institutions of higher education. Whilst some tertiary institutions offer a variety of services to self-identifying students, these services are not necessarily linked to a sensitized comprehensive health service (Brink, 2014).

However, during the students' time at university, there is an opportunity for all who identify as MSM to be introduced to relevant and accessible healthcare. Furthermore, under the ambit of transformation, inclusive and enabling spaces could be cultivated through curricula and institutional reforms that seek to catalyse the ethos and values of inclusion. The current literature sources in South Africa provide some insight into the experiences of self-identifying students in higher education, but there remains a paucity of literature that provides guidance on the structural design and programmatic activities that effectively support MSM students in tertiary institutions. The absence in knowledge about appropriate responses for MSM students at South African universities is indicative of a non-responsive environment, which further marginalizes self-identifying students. Indeed, international theorists would support the assertion that, even in educational environments, there exists a micro-aggressive role that reinforces hegemonic norms through policy, curricula, residence gender allocation and non-specific health services, to which MSM students cannot relate (Kumashiro, 2000; Miller, 2012; Miller & Gilligan, 2014).

1.10 Summary

Research and best practice on MSM community-level programmes in the global north and south are well documented. To date, no studies have documented the structural factors associated with MSM populations within South African universities. In fact, the report by the *Ministerial Committee on Transformation and Social Cohesion and the Elimination of Discrimination in Public Higher Education Institutions*, led by Soudien (2008), found that, in relation to homophobia and sexism, there was no university among those audited that was not in need of transformation in these areas. Soudien (2008) found that "in the area of sexism and

homophobia there [were] no HEIs among those audited that can claim to have completely solved these issues" (HESA, 2010 p. 46).

With many South African institutions 'largely ignoring' sexual orientation in relation to transformation, there is a gap in knowledge concerning systemic responses in the institution (HESA, 2010). This paucity of knowledge yields potential harm for self-identifying groups, particularly if institutions are developing systems and structures that inadvertently discriminate against certain student populations. My PhD is aimed specifically towards contributing to HEIs in their endeavour to form support structures for the key population of MSM.

This study aims to explore the programmatic responses developed by the programme coordinators, in general, and bring to light similarities and contrasts in their programme design. In undertaking this study, I use five guiding questions:

(1) What health and support services do HEIs provide?

(2) How are MSM students in HEIs targeted in seeking health and support services?

(3) How are internal stakeholders in HEIs organised to respond to, and support MSM students?

(4) How do internal stakeholders in HEIs respond to the needs of MSM students?

(5) What are the factors that facilitate and/or impede the development and implementation of health and support programmes for MSM students in HEIs?

While previous research in the sub-Saharan context has not specifically addressed university responses for self-identifying student populations, my study is designed to remedy that weakness by contributing knowledge that articulates institutional approaches for self-identifying populations at university.

The first chapter begins with mapping out some of the concerns and the rationale that led me to conduct this study. Chapter Two details the process of my systematic review used to gather and analyse published literature on higher education MSM health services and psychosocial programmes. Chapter Three provides content on the research design, methodology and the critical theory adopted for this research. The findings, presented in Chapter Four of this study, build in particular on the work of some of the researchers

reviewed in Chapter Two, which leads me to Chapter Five where I analyse the four overarching themes that emerged from the research data. I conclude the PhD with an overview of how five phenomenal programme coordinators navigated an institutional system within a two-year period that challenged homophobia, reframed gender norms, and deconstructed heterosexist beliefs, while simultaneously influencing the quality of, and access to services provided to self-identifying students. In the concluding chapter, I allude to some of the implications of biopsychosocial interventions for self-identifying populations in HEIs, which introduces the agentic power of institutional stakeholders (not necessarily in executive management positions) that enabled the inclusion of health and support services for self-identifying students at univeristy.

Chapter Two: Systematic Literature Review

2.1 Introduction

For the purposes of my PhD, I have chosen to conduct a systematic review to establish whether research exists on this topic. A systematic review is a useful method that assists in distinguishing between "real and assumed knowledge" and helps explain and produce evidence for emerging phenomena such as my study (Petticrew & Roberts, 2006: 2).

Systematic reviews of qualitative studies is still a fairly new practice, which has not yet established a set protocol for the synthesis of evidence that differs from the standardized approaches available for quantitative reviews. Despite this, researchers are utilising more than one way to critically appraise qualitative research. In this chapter, I have selected the Critical Appraisal Skills Programme (CASP, 2014), which intends to assess the results, ethics and relevance of the outcomes (Hill & Spittlehouse, 2003). The results of the critical appraisal assist in determining the quality, validity and generalizability of the research. It is more important for this research that the systematic review can demonstrate gaps in knowledge and/or the available research about a particular topic. For this reason, I present a systematic review that articulates a current gap in knowledge that shows, strikingly, the lack of higher education responses for self-identifying students at university. In Chapters Four and Five, I utilise the findings of this systematic review to compare and discuss the research findings that emerge in my PhD.

However, it is also important to acknowledge the limitations of a systematic review, which narrowly focuses on published research available via particular databases and often ignores grey literature. I find the methodology of a systematic review problematic, as my research is located in praxis where practitioners, at the helm of interventions, often have limited time available to write and publish the results of their intervention. Similarly, another limitation of a systematic review is that there may not be enough reliable studies that can be included in the review. This is particularly true for my research, as very few studies are located in the university context. Yet, as I intend for my PhD to assist practitioners in HEIs, I could not ignore grey literature and solely focus on systematic reviews. Therefore, in addition

to the systematic review, I broaden my literature search to complement the systematic review and to further support the findings of my PhD.

In this chapter, I detail the systematic review process that was followed in order to identify gaps in current knowledge for biopsychosocial support programmes for MSM in South African HEIs. In this chapter, I document the search strategy that was used and the justifications for study inclusion and exclusion. Following this, data synthesis within each identified article was conducted to locate dominant themes and key findings. I present the findings of each article and demonstrate its relevance to my PhD. This is followed by a discussion about key themes and limitations.

The systematic literature review included all available research up to 15 January 2015. The results from the review showed that there is hardly any to no evidence for health and support services for MSM students in South African HEIs. This restricts utility in terms of development and practice. However, I extended the scope of the review to include combined prevention programming that was not localized to a university setting. In order to extend the scope of the review, I broadened the search by using the terms 'community' prevention programme to incorporate combined prevention programmes that were not necessarily implemented within the higher education context. In the ensuing sections, I present the current knowledge about combined prevention programming for MSM. I then discuss the process followed in conducting the systematic review. I conclude this chapter by contextualising the seven key findings that emerged from the available literature identified in the systematic review, within a broader literature review.

2.2 Current knowledge

There is growing evidence about relevant HIV combined prevention programmes in sub-Saharan Africa for the MSM population (Mumtaz et al., 2010; Muraguri, Temmerman & Geibel, 2012). Broader reviews for MSM, including knowledge from the global north, show a varied evidence-base on risk-reduction strategies such as serosorting and strategic positioning, as well as newer ways to deliver interventions through technology use and peer mentoring systems (Halkitis et al., 2004; Rosen et al., 2006; Wu et al., 2010; Rebe et al., 2011; Baker et al., 2013; Fernandez-Davila et al., 2013; Golub & Gamarel, 2013; Lau, Tsui & Lau, 2013; Wirtz et al., 2013; Bengtsson et al., 2014; Vermund, 2014).

As mentioned in Chapter One, countries in the global north as well as in sub-Saharan Africa have conducted some research on HIV prevalence among MSM groups. With the rates of MSM HIV prevalence varying between 10.4% and 34.5% across various studies, a combined focus on the biomedical and psychosocial issues affecting MSM populations is required, in order to reduce increasing rates of HIV transmission (Lane et al., 2008; Rispel et al., 2009; Lane et al., 2011; Lane & et al., 2014).

Certainly within the sub-Saharan context, a broader range of interrelated factors such as culture, stigma and structural discrimination have been reported to increase the risk of MSM acquiring HIV (Baral et al., 2007; Reddy & Sandfort, 2008; Onyango-Ouma, Birungi & Geibel, 2009; Baral et al., 2011; Beyrer et al., 2012a; Jobson et al., 2013; Tucker et al., 2013; Rebe & McIntyre, 2014).

One factor is that of stigma experienced by MSM in healthcare settings, the latter ironically, being tasked with providing healthcare and support (Rebe et al., 2011; Rebe & McIntyre, 2014). The repercussions of stigma limit access to, and uptake of health services by MSM. However, recent innovations demonstrate an increase in the uptake of healthcare via psychosocial programmes that establish relationships of trust through peer social networks.

Thus, emphasis is placed on the combined prevention approach, which has produced results in reducing HIV transmission among MSM (Herbst *et al.*, 2005). Prevention methods, therefore, cannot be static, but need to continuously evolve in order to remain relevant to the healthcare needs of MSM (Katz, 1997; Beyrer *et al*., 2012a). Good practice in combined prevention and support for MSM is one important approach that is addressed in the systematic review, presented in this chapter. Identifying what models of healthcare and support for MSM could be created under the ambit of the university's institutional culture directly responds to the need for new research that interrogates a university's role and responsibility towards MSM populations. Chapter Two documents the process of my systematic review, which seeks to contribute to the South African knowledge base in higher education programmes for self-identifying populations attending university.

2.3 Methods

2.3.1 Search strategy and selection process

To identify eligible studies, I searched the electronic journal databases of PubMed, SCOPUS and CINHAL. For the database searches, I used the MESH database to generate a variation of terms (see supplementary data) for the word search, using keywords and their synonyms, relating to HIV prevention, programme, MSM, gay and university. No limiters were applied. The search extracted twenty-nine articles from PubMed, thirteen from SCOPUS and one from CINHAL. I then used the Refworks software to identify exact duplications, one of which removed the CINHAL article from the remaining forty-two articles.

2.3.2 Study inclusion

This systematic review intended to identify phenomena that hinder or facilitate increased access to relevant healthcare. Therefore, in order to assess the studies, I deviate from the PICO (Population, Intervention, Control, Outcomes) assessment framework which is used in the development of literature search strategies (Schardt *et al.* 2007), and focus only on the population (P) and outcomes (O) of combined prevention programmes for MSM populations. In addition, I apply the CASP checklist to screen the quality of the articles. The CASP checklist reviews the methodology, the internal validity, the ethics, data analysis and the generalizability of each article (CASP, 2014). Three reviewers usually conduct this level of review independently by applying the CASP checklist to each article. After their independent review, they meet to discuss and record their findings. However, the use of three reviewers was not possible in my PhD and, therefore, I only present my application of CASP in this chapter.

Initially, I intended to include only the articles that focused on MSM students in HEIs; however, none of the articles identified in the search strategy met these criteria. This was an important finding, as it means that, as of 15 January 2015, there were no publications relating to MSM and/or gay healthcare and support services in HEIs. It was, therefore, necessary to broaden the scope of the inclusion criteria, and place more emphasis on any combined prevention programmes (CPPs) for MSM, with the view that elements of CPPs could demonstrate best practice for higher education students.

Peer-reviewed qualitative or quantitative studies were included, provided that recommendations were offered that could improve combined prevention programming for MSM, bisexual or gay identifying men. All the studies within the above-mentioned databases were peer reviewed and, therefore, I assumed that the research articles were considered to be methodologically sound. However, in order to synthesise the evidence and determine the relevance of the outcomes to the MSM population, I applied the CASP checklist to each article and determined that all the articles met the criteria listed in CASP (CASP, 2014).

Studies from low-, middle- and high-income countries (hereafter referred to as LMICs and HICs) were included as long as the studies provided descriptions of the programmes and guidelines that addressed aspects of improving healthcare and support services for MSM. Study participants were broadly defined to include health practitioners, clinical staff, community members, policymakers, programme managers, community health workers, and MSM participants.

Three key criteria for inclusion were applied to the total of forty-two articles located in the database search. The first was that the research study must focus on the MSM population. Secondly, that the study had to provide information on psychosocial and/or biomedical prevention, care and support (combined prevention programming) for MSM. Lastly, that the study needed to move beyond mere descriptions of the study to include recommendations and/or guidelines that could influence and/or improve MSM biopsychosocial programming.

Articles were excluded when studies did not respond to both criteria of MSM and combined prevention programmes and/or were not written in English. In total, nineteen studies were excluded, as they were not focused on MSM populations and combined prevention programmes. Of the remaining studies, fifteen articles were excluded, as they focused on the HIV prevalence among MSM populations, but not combined prevention studies. One study was excluded, as it was not written in English. Seven studies remained in the review, as they satisfied the criteria for research conducted on combined prevention programmes for MSM populations.

Table 1 lists all forty-two articles as well as the reasons for inclusion and exclusion. As described earlier, all studies regardless of location were included in the review as long as the three main criteria were satisfied.

Table 1: Systematic review articles

Study ID	Author, Year, Title	Location	HEI	CPP	MSM	Recommend-ations	Included or Excluded	Description of Study
1	**Ackers, M-L., et al.** 2012 High and Persistent HIV Seroincidence in Men Who Have Sex with Men across 47 U.S. Cities	USA	No	No	Yes	No	Excluded	Although this research article focuses on MSM and HIV seroincidence and sexual risk behaviours. The article raises awareness about the need for prevention education that incorporates discourse about sexual risk practices but does not provide recommendations on what content should be included.
2	**Beyrer, C., et al.** 2013 The increase in global HIV epidemics in MSM	Global	No	Yes	Yes	Yes	Included	The article is a global overview of epidemic drivers of HIV among MSM. The authors provide recommendations on combined prevention services that are effective in low-middle income countries.
3	**Bobrova, N., et al.** 2005 Social-Cognitive Predictors of Consistent Condom Use Among Young People in Moscow	Russia	No	No	No	No	Excluded	This survey gathered research on sexual risk behaviour among young people. The article did not include specific focus on MSM nor did it provide programmatic recommendations.
4	**Braine, N.,et al.** 2011 Sexual contexts and the process of risk reduction	USA	No	Yes	Yes	Yes	Included	The authors conduct a Sexual Risk Behaviour survey with a small sample of MSM in New York. Data that emerges from the analysis of the survey results, detail risk reduction strategies and interventions.
5	**Carter, J., et al.** 2014 Provider Barriers Prevent Recommended Sexually Transmitted Disease Screening of HIV-Infected Men Who Have Sex With Men	USA	No	Yes	Yes	Yes	Included	Unlike other MSM prevalence studies, this author specifies the strategies and content that should be included for MSM prevention programmes. This is useful information to incorporate for health programmes and services.
6	**Chimbiri, A., et al.** 2007 The condom is an 'intruder' in marriage: Evidence from rural Malawi	Malawi	No	No	No	No	Excluded	This research study focused on heterosexual couples and condom usage and was not relevant to the MSM population.
7	**Conner, R., et al.** 2005 The Solaar HIV prevention programme for gay and bisexual Latino men: Using social marketing to build capacity for service provision and evaluation.	USA	No	Yes	Yes	Yes	Included	This research provides guidance on an aspect of programming for MSM. Health communication, recruitment and retention are key aspects in this research article that could be considered for MSM programming interventions

Study ID	Author, Year, Title	Location	HEI	CPP	MSM	Recommend-ations	Included or Excluded	Description of Study
8	**Desclaux, A., et al.** 1997 Dix ans de recherches en sciences sociales sur le sida au Burkina Faso Elements pour la prevention	Burkina Faso	No	No	No	No	Excluded	This study is a review that questions the efficacy of prevention methods after 10 years of the HIV pandemic. Desclaux, reports that more work should be done to understand the practices of key populations in order to develop combined prevention programmes that are culturally responsive to sexual risk and risk behaviour. However, no specific recommendations are mentioned.
9	**Elam, G., et al.** Risky sexual behaviour in context: qualitative results from an investigation into risk factors for seroconversion among gay men who test for HIV.	UK	No	Yes	Yes	Yes	Included	The INSIGHT study provides indepth programmatic guidance for psychosocial issues affecting MSM. The useful recommendations assist in shaping effective responses for MSM.
10	**Essien, E., et al.** 2005 Strategies to prevent HIV transmission among hetero-sexual African-American men	USA	No	No	No	No	Excluded	Heterosexual study that focuses on HIV prevention strategies.
11	**Eustace, R., et al.** 2010 HIV disclosure among HIV positive individuals: a concept analysis	USA	No	No	No	No	Excluded	The review by Eustace et al, highlights the importance of the clinical space with respect to HIV disclosure. She emphasises reconstituting the consultation to allow for disclosure - which is much broader than just following the standard protocol for HCT. However, this study is not specific to MSM populations.
12	**Farid, R., et al.** 2003 Knowledge about AIDS/ HIV infection among female college students	India	Yes	No	No	No	Excluded	The research from the KABP survey conducted among female students in Lahore identifies hegemonic constructions of gender and sexuality but does not provide programmatic recommendations that are specific to MSM.
13	**Fox, J., et al.** 2009 Reductions in HIV transmission risk behaviour following diagnosis of primary HIV infection: a cohort of high-risk men who have sex with men	USA	No	Yes	Yes	Yes	Included	In this MSM KAPB study the author identifies prevalence and risk behaviours among MSM. The research article documents strategies and content that could be included for MSM prevention programmes and services.

Study ID	Author, Year, Title	Location	HEI	CPP	MSM	Recommend-ations	Included or Excluded	Description of Study
14	**Golub, S., et al.** 2013 From Efficacy to Effectiveness: Facilitators and Barriers to PrEP Acceptability and Motivations for Adherence Among MSM and Transgender Women in New York City	USA	No	No	Yes	No	Excluded	The research explores PrEP usage among MSM and Transgender Women and identifies that further education must include a discussion about PrEP usage. The article does not provide guidance on how, where or what content could be considered in prevention education.
15	**Guanira, J., et al.** 2008 Prevalence and Correlates of Human Herpesvirus 8 Infection among Peruvian Men who have Sex with Men	Peru	No	No	Yes	No	Excluded	This study identifies that HIV-8 infection is common among both HIV-infected and negative MSM in Lima, Peru. Despite identifying the incidence of this strain of HIV, the research does not detail prevention methods; recommendations or CPP for MSM.
16	**Harding R., et al.** 2010 Outcomes and lessons from a pilot RCT of a community-based HIV prevention multi-session group intervention for gay men	UK	No	No	Yes	No	Excluded	This research raises awareness of facilitator barriers to care. The author does not however provide specific recommendations to improve access or create inclusive spaces.
17	**Hong, Y., et al.** 2009 HIV/AIDS Behavioral Interventions in China: A Literature Review and Recommendation for Future Research	China	No	No	No	No	Excluded	This literature is a review of HIV prevalence in China. It provides information on factors that increase risk and identifies key populations. It does not meet 4 of the inclusion and is therefore excluded.
18	**Huang, J., et al.** 2005 Knowledge, Attitudes, Behaviors, and Perceptions of Risk Related to HIV/AIDS among Chinese University Students in Hunan, China	China	Yes	No	No	No	Excluded	Although set in the tertiary institution - the KAPB survey provides useful information on the stigma towards MSM. No intervention description is mentioned for alleviating stigma within this context.
19	**Kelly, J.A., et al.** 1991 Situational Factors Associated with AIDS Risk Behaviour Lapses and Coping Strategies Used by Gay Men Who Successfully Avoid Lapses	USA	No	No	Yes	No	Excluded	The content of this article is a research method that explores unsafe sex lapses. No recommendations are made nor is any detail provided for CPP.

Study ID	Author, Year, Title	Location	HEI	CPP	MSM	Recommend-ations	Included or Excluded	Description of Study
20	**Kelly, J.A., et al.** 1992 Psychological interventions with AIDS and HIV: prevention and treatment	USA	No	No	No	No	Excluded	This study raises awareness about the linkage between biomedical practices and psychosocial interventions but does not provide detail on the components of a CPP nor does it focus on MSM as a population.
21	**Kelly, J.A., et al.** 2005 Predictors of high and low levels of HIV risk behaviour among adults with chronic mental illness	USA	No	No	No	No	Excluded	This research study raises awareness of the intersection between mental health and patients living with HIV. The study is not focused on MSM nor does it include content about combined prevention programming.
22	**Kelly, J.A., et al.** 2003 REVIEW: The newest epidemic: a review of HIV/ AIDS in Central and Eastern Europe	Central and Eastern Europe	No	No	No	No	Excluded	This literature review focuses on research about HIV prevalence in Europe. It provides information on HIV prevalence and factors that increase risk and identifies key populations. It does not meet the 4 of the inclusion criteria as and is therefore excluded from the study.
23	**Kelly, J.A., et al.** 2013 Levels and Predictors of HIV Risk Behaviour Among Black Men Who Have Sex with Men	USA	No	No	Yes	No	Excluded	The article details a research method that explores KAPB and the social context as having an influence on MSM sexual risk behaviour. No recommendations are made nor are combined prevention methods mentioned as a recommendation for reducing risk.
24	**Landovitz, R., et al.** 2012 A Novel Combination HIV Prevention Strategy: Post-Exposure Prophylaxis with Contingency Management for Abuse Treatment Among Methamphetamine-Using Men Who Have Sex with Men	USA	No	Yes	Yes	Yes	Included	This pilot data demonstrates the feasibility, safety, and acceptability of combined prevention programme for methamphetamine-using MSM. The coupling of pre-exposure prophylaxis in a CPP holds promise as a combination HIV prevention strategy for methamphetamine-using MSM.
25	**Li, H., et al.** 2010 High Multiplicity Infection by HIV-1 in Men Who Have Sex with Men	USA	No	No	Yes	No	Excluded	This biomedical research did not include recommendations for combined prevention methods for MSM.

Study ID	Author, Year, Title	Location	HEI	CPP	MSM	Recommend-ations	Included or Excluded	Description of Study
26	**Malta, M., et al.** 2010 HIV Prevalance among female sex workers (FSW), drug users and men who have sex with men in Brazil: A Systematic Review and Meta-analysis	Brazil	No	No	Yes	No	Excluded	The study explains complex differences in HIV epidemic dynamics, and brings additional evidence of high HIV prevalence rates among FSW, MSM, and drug users. Although the research emphasis the need for CPP, it only serves to raise awareness of the gap in services but does not detail what the CPP components should be.
27	**Mitchell, J., et al.** 2012 Patterns of HIV and STI testing among MSM couples in the U.S.	USA	No	No	Yes	No	Excluded	This research raises awareness of facilitator barriers to care. The research does not include recommendations to change nor does it provide information about CPP components.
28	**Nair, M., et al.** 2013 ARSH 3: Reproductive and Sexual Health Knowledge: A Comparison Among Married Male and Female Young Adults (15–24 y)	India	No	No	No	No	Excluded	This study focuses on heterosexual married couples and is not relevant to MSM nor does it provide detail on CPP that would be relevant to a MSM population.
29	**Nyondo, A., et al.** 2013 Assessment of strategies for male involvement in the prevention of mother-to-child transmission of HIV services in Blantyre, Malawi	Malawi	No	No	No	No	Excluded	This study focuses on the role of a heterosexual male in PMCT, but does not generalise the findings to MSM.
30	**Ramanathan, S., et al.** 2013 Consistent condom use with regular, paying, and casual male partners and associated factors among men who have sex with men in Tamil Nadu, India: findings from an assessment of a large-scale HIV prevention program	India	No	No	Yes	No	Excluded	This project evaluated the efficacy of four behavioural drug abuse treatments for reducing methamphetamine use and sexual risk behaviours among MSM. But it only seeks to reify the link between substance abuse usage and sexual risk without detailing a responsive CPP.
31	**Rehan, N., et al.** 2006 Profile of men suffering from sexually transmitted infections in Pakistan	Pakistan	No	No	No	No	Excluded	This survey maps HIV prevalence in Pakistan but is not specific to MSM nor does it provide any CPP strategies or interventions.

Study ID	Author, Year, Title	Location	HEI	CPP	MSM	Recommend-ations	Included or Excluded	Description of Study
32	**Sachdev, P., et al.** 2008 AIDS/HIV and University Students in Delhi, India	India	Yes	No	No	No	Excluded	Although set in the tertiary institution - the KAPB survey raises awareness about the existence of stigma towards MSM. However, no interventions are detailed for alleviating stigma within this context nor are recommendations provided for a CPP.
33	**Sanit, G., et al.** 2010 Increase in the prevalence of HIV and in associated risk behaviours in men who have sex with men: 12 years of behavioural surveillance surveys in Catalonia (Spain)	Spain	No	No	Yes	No	Excluded	This study describes trends in HIV prevalence, in risk behaviours associated with HIV transmission, and in knowledge and attitudes related to antiretroviral therapy (ART) among men who have sex with men (MSM) recruited in Catalonia between 1995 and 2006. The recommendations suggest that preventive programs targeting this population should be intensified and should include new risk reduction strategies, as well as other educational messages about ART. However no specific recommendations are made. Therefore this study only raises awareness about the need for intensified services.
34	**Seng, R., et al.** 2011 Trends in unsafe sex and influence of viral load among patients followed since primary HIV infection, 2000–2009	France	No	No	Yes	No	Excluded	This study only raises awareness about prevalence but does not provide recommendations for improving efficacy of combined prevention programmes
35	**Shoptaw, S., et al.** 2004 Behavioral treatment approaches for methamphetamine dependence and HIV-related sexual risk behaviours among urban gay and bisexual men	USA	Yes	No	Yes	No	Excluded	This project evaluated the efficacy of four behavioural drug abuse treatments for reducing methamphetamine use and sexual risk behaviours among MSM. But it only seeks to raise awareness about the link between substance abuse usage and sexual risk without providing recommendations for CPP treatment approaches.
36	**Sindiga, I., et al.** 1993 Kenyan university students' views on AIDS	Kenya	Yes	No	No	No	Excluded	This study was conducted with university students in Kenya. The recommendations focus on reducing stigma. The author suggests that the Ministry of Health needs to put more effort into counselling AIDS patients and to reduce the hopelessness and stigmatizing of persons with AIDS.

Study ID	Author, Year, Title	Location	HEI	CPP	MSM	Recommend-ations	Included or Excluded	Description of Study
37	**Squassi, A., et al.** 2003 Knowledge, behaviour, and attitudes of adolescent university students towards HIV infection and AIDS	Buenos Aires	Yes	No	No	No	Excluded	This KAPB survey was conducted with University students. The results show the sexual behaviours practices but the research does not detail what type of interventions should be created for students. A significant finding in this study is that students identified that the university's assistance in providing such support structures are part of the university's social obligation.
38	**Sullivan, S., et al.** 2010 A Cognitive Analysis of College Students' Explanations for Engaging in Unprotected Sexual Intercourse	USA	Yes	No	No	No	Excluded	This study focuses on heterosexual sexual behaviour and risk and is not relevant to the MSM population.
39	**Twisselmann, W., et al.** 2000 An integrated concept for contraception counseling and HIV prevention for young women: the Project Nécessaire	Germany	No	No	No	No	Excluded	Although this research focuses on youth - it is relevant only to heterosexual youth. The publication was not in English.
40	**Wirtz, A., et al.** 2013 Uncovering the epidemic of HIV among men who have sex with men in Central Asia	Central Asia	No	No	Yes	No	Excluded	This study raises awareness about syndemic factors that affect MSM. No recommendations are provided.
41	**Zaric, G., et al.** 2008 The Cost-Effectiveness of Counselling Strategies to Improve Adherence to Highly Active Antiretroviral Therapy among Men Who Have Sex with Men	USA	No	No	Yes	No	Excluded	This research is a cost analysis of HIV treatment protocols for different groups of PLWHA including MSM. However the focus is on cost and does not provide detail on the content or efficacy of counselling strategies for MSM.
42	**Zhou, F., et al.** 2012 Willingness to Accept HIV Pre-Exposure Prophylaxis among Chinese Men Who Have Sex with Men	China	No	No	No	No	Excluded	The research explores PrEP usage among MSM and Transgender Women and identifies that further education must include a discussion about PrEP usage. This finding does not explore methods of inclusion in prevention education or what content would be appropriate to include for the target population.

2.3.3 Data synthesis

Initial data extraction was performed on the seven remaining articles, using a template informed by the UNAIDS framework for combined prevention programmes (UNAIDS, 2010). The UNAIDS framework defines the elements of combined prevention programmes to include behavioural interventions, biomedical responses, political and/or legal regulations, social and cultural mediations, as well as physical environment structure (UNAIDS, 2010).

Using this framework, I analysed the articles, seeking out components of combined prevention programming for MSM populations. Through preliminary synthesis, key findings and emerging themes were identified in the studies. I then synthesized these themes into categories, in order to organize the findings of each study. An overview of each of the seven articles is presented below, with a brief analysis of the key learnings that emerged from the study and its importance when considering MSM combined prevention programming in the higher education sector.

2.4 Overview of studies and interventions

A total of forty-two titles and abstracts were identified for screening. I included seven papers in this review. The studies focused on the components of MSM combined prevention programming and their efficacy among MSM populations. Of the seven studies, six were based on components of combined prevention programmes in high-income countries of the United States of America and the United Kingdom. The remaining article was a meta-analysis of global data that documented emerging evidence on epidemic drivers and combined prevention services for HIV-positive MSM.

In the analysis of the systematic review articles, I used an inductive rather than a deductive approach. The inductive approach was preferred, because support services for MSM is an emerging phenomenon, with only a few fragmented areas of combined prevention services being documented on the subject area of MSM (McMillan & Schumacher, 2001). Secondly, because the knowledge of MSM-relevant support services is in the development stage, inductive reasoning becomes a useful tool that generates "highly probable conclusions, using credible supporting evidence" (Babbie & Mouton, 2002: 642). The seven articles elucidated in the systematic review are referred to by their study IDs (for example, Beyrer *et al.*, 2013 [Study ID 2]) located in Table 1. A description of each study is provided below.

2.4.1 Article 1

Beyrer *et al.* (2013) [Study ID 2] describe the global overview of epidemic drivers of HIV among MSM. The international research team conducted a meta-analysis of global data that documented new HIV incidence and prevalence. The findings provide evidence that current barrier technologies, prevention education and healthcare practices are producing modest results in curbing HIV infection rates among MSM. In order to have any effect in reducing new incidence of HIV, over 60% to 80% of MSM will have to successfully receive, adhere to, and be retained in combined prevention services (Sullivan *et al.*, 2012).

Key findings in this article focus on the extraordinary efficacy of HIV transmission across the mucosa surface during anal sex (regardless of sexual practice, i.e. heterosexual or homosexual) and identify a trend in the acquisition of new HIV infections among MSM sexual networks. The findings from this study indicate that new HIV incidence occurs within a 17-month time frame in an MSM sexual network.

The research also emphasises the role of stigma, which continues to limit access to, and uptake of services by MSM populations, thus contributing to the spread of HIV across sexual networks. Modifying healthcare intervention and prevention education is a strong theme in this research, as the lack of culturally competent healthcare results in a hostile environment impacts on the risk behaviour practices of MSM.

The authors advocate for innovative interventions that are responsive to existing practices of MSM and to tailor prevention packages to include discourse about the use of substances, mental health, serosorting, early treatment, use of pre-exposure prophylaxis, periodic HIV testing, and health interventions introduced at vulnerable points in the HIV transmission cycle.

For a MSM biopsychosocial programme, it would be important to retain MSM in a system of support where prevention education and risk information can be shared. This means that, beyond the healthcare setting, an established and trusted peer network that provides relevant education and prevention methods would be required, in order to circumvent new incidences of HIV.

2.4.2 Article 2

Conner *et al.* (2005) [Study ID 7] describe a partnership that focused on the development of a social marketing plan for MSM populations. The purpose of the social marketing plan was to promote the accessibility and uptake of psychosocial support services by MSM populations within a specific geographical location.

The primary learning from this study was the use of a community-research partnership between independent stakeholders over an extended period of time. The duration of the partnership had a pivotal role in establishing trust, which assisted the partners during high-stress periods. The usefulness of the community-research approach was particularly valued during collaborative problem-solving sessions, where the knowledge shared between researchers and practitioners resulted in a solution that was relevant to the community.

During the implementation of the social marketing plan, the authors describe appropriate communication media that influenced the number of MSM utilizing the psychosocial support service. The study promoted media that fostered a sense of community, imparted HIV prevention messaging, and monitored overt sexual innuendos.

A key learning from Conner *et al.* (2005) [Study ID 7] would be for institutions to review their media and messaging in a collaborative and representative manner, in order to articulate an inclusive response that is representative of all students. Therefore, in terms of good practice for HEIs, communication, media and institutional messages should be used to validate the university's position, ethos and inclusive culture. This could also be accompanied by education campaigns to raise awareness about the institutional values that support the protection of human rights.

2.4.3 Article 3

Elam *et al.* (2008) [Study ID 9] explore the contextual influences of serodiscordant unprotected anal intercourse (hereafter referred to as UAI) among MSM. The INSIGHT "case-control study confirmed that HIV serodiscordant unprotected anal intercourse (SdUAI) remains the primary risk factor for HIV infection in gay men in England" (Elam *et al.*, 2008: 473). In-depth interviews were conducted with forty-eight participants from a diverse demographic profile and sexual behaviour contexts.

Drawing on the qualitative data that emerged from interviews with serodiscordant MSM partners who engage in UAI, the authors argue for a diversity of information in prevention education that should include discussions about probable risk assessment, which is a discretionary exercise used by MSM to assess what type of sexual practice can be experienced with a partner prior to intercourse or after UAI, and what recourse one should take if HIV is suspected (Elam *et al.*, 2008). Similarly, the inclusion of pleasure discourse about recreational drugs to "relax, reduce pain and increase enjoyment" in MSM sexual behaviour is a highly relevant aspect of prevention education for MSM (Elam *et al.*, 2008: 475).

As part of a university biopsychosocial programme, it would, therefore, be important that discourse extends beyond the biomedical prevention education and incorporates discussions about pleasure and emotion. This article emphasized that, among MSM, the risk of an unfulfilled sexual and emotional need is as important as not being infected by HIV (Elam *et al.*, 2008). The careful balance between satisfying desires while avoiding the risk of HIV infection is yet another aspect that needs to be intricately weaved into prevention and barrier methods discourse. Therefore, the article provides in-depth programmatic guidance for psychosocial issues affecting MSM that could be used in the formation of MSM programmatic responses in HEIs.

2.4.4 Article 4

In Landovitz *et al.* (2012) [Study ID 24], a single-arm pilot study demonstrated the feasibility, safety, and acceptability of a combined prevention programme for methamphetamine-using MSM. The authors claim that the coupling of pre-exposure prophylaxis holds promise as a combination HIV prevention strategy for methamphetamine-using MSM (Landovitz *et al.*, 2012). Brink (2014) indicated that the use of substances by South African MSM tertiary students is apparent. Therefore, the findings from this study are useful in shaping the biopsychosocial response.

Landovitz *et al.* (2012) [Study ID 24] found that drug use limited the ability of MSM to adhere to medical protocol; yet substance use by some MSM is known to be a common practice when engaging in sexual behaviours. This finding is challenging for HIV-positive MSM individuals who are also drug users, as this influences their ability to adhere to ARVs. Therefore, if interventions do not acknowledge drug usage and measures of safety,

conventional prevention education will be rendered irrelevant. Interventions that appropriately engage with substance-use discourse should, therefore, include information about post-exposure prophylaxis and simultaneously emphasize the continued use of condoms, with the latter having the highest efficacy in preventing the transmission of HIV.

2.4.5 Article 5

Braine *et al.* (2011) [Study ID 4] conducted a Sexual Risk Behaviour survey with a small sample of MSM in New York. The qualitative data that emerges details comprehensive risk-reduction strategies and interventions that respond to MSM's social context, interpersonal interaction and individual desire. The study revisits HIV risk-reduction strategies for MSM.

Findings from this research demonstrate that HIV prevention continues to treat risk behaviour as a product of ignorance and psychological problems. But it does not account for MSM practices where risk becomes a calculated aspect of conscious sexual engagement that prioritizes sexual pleasure and fulfilment, with HIV risk being a consequence of sating one's sexual needs. By refusing to engage with probable risk, the authors argue that prevention education will become "increasingly tangential to sexual practices of a growing number of MSM" (Braine *et al.*, 2011: 810).

In light of Braine *et al.*'s (2011) research, it would be important for university biopsychosocial programmes to review the healthcare service and prevention education provided by the institution. The intention of the review would be to reframe current norms and practices, in order to "address questions of probable risk rather than predictable safety" (Braine *et al.*, 2011: 810).

2.4.6 Article 6

Carter *et al.* (2014) [Study ID 5] conducted semi-structured interviews with forty health providers in HIV clinics in six cities in the United States of America. The objective of the study was to investigate the barriers encountered by HIV care providers in adhering to STD-screening guidelines for HIV-infected MSM.

Key findings that emerged from this study and that are relevant to this research were that the patient's perceptions of the health provider had an influential role in obtaining a complete and accurate sexual history and assessment. Therefore, the manner in which the

health provider fosters trust and creates an enabling environment may affect the level of disclosure during clinical assessments.

Carter *et al.* (2014) suggest that diversity training should be incorporated into health provider education. This could help foster an environment with the patient that is perceived as non-judgemental and culturally sensitive. Diversity training and the provision of culturally competent care are essential, as the article found that race, ethnicity, sexual identity (of the provider) and the provider's language skills were viewed as barriers that limited the uptake of STD screening and the disclosure of a full sexual history.

Furthermore, findings from the study also showed that medical providers felt uncomfortable asking about sexual practices and behaviours that limited the sexual assessment and STD-screening processing. The critical flaw in such approaches is that, without screening for STDs, MSM are more vulnerable to HIV infection.

Whilst health providers do receive training on conducting screening and assessment with a patient, there is a perception that clinicians come across as "insincere" (Carter *et al.*, 2014: 139). It is perceived that health counsellors would receive a more accurate sexual history assessment if they are able to foster a trusting and less formal environment for the patients to disclose intimate information about their sexual practices. Other barriers experienced by health providers was the patient's fears about sharing sexual history and detail, with some stating that divulging such information was an "intrusion into their privacy" (Carter *et al.*, 2014: 139).

Recommendations from Carter *et al.*'s (2014) research that could influence the healthcare services in HEIs for self-identifying students would be to "promote culturally competent health care and to pilot electronic self-assessment tools" (Carter *et al.*, 2014: 142) that could be completed privately by the patient, in the hope of obtaining a more accurate sexual history assessment, in order to increase STD screening and prevent HIV transmission.

2.4.7 Article 7

Fox *et al.* (2009) [Study ID 13] focused on the prevention of the onward transmission of HIV among newly diagnosed MSM in the primary phase of HIV infection (hereafter referred to as PHI), which is the most infectious stage of the HIV life cycle. The authors argue that, in a

resource-restricted economy, HIV funding should be targeted towards the most infectious stage of the HIV life cycle, in order to reduce onward transmission.

Of notable importance, the authors found that onward transmission of HIV by the men in the sample was significantly reduced, due to the intensive behaviour change intervention following the diagnosis. The authors, however, did not detail what methods or content was used to establish behaviour change in the short space of time. Further findings from this study show that the MSM sample acquired PHI in one or more of the following ways: during high levels of recreational drug use, commercial sex, high number of sexual partners, and low levels of condom use.

In light of this, the article recommends that routine testing in multiple healthcare settings would be beneficial in early detection of HIV. The authors suggest that non-healthcare professionals be trained to identify early symptoms of infection and that intensive and sustained behaviour change counselling be considered part of preventive education for MSMs who have PHI. This study is important, as it demonstrates good practice in terms of the prevention of new incidences of HIV via a psychosocial programme. The latter could possibly be replicated by the university.

2.5 Discussion

Seven themes were derived from the data synthesis and the individual analysis process. These themes and the related findings are detailed below and are further supported by additional literature reviews conducted over and above the systematic review.

2.5.1 Epidemic drivers of HIV in sexual networks that practise anal sex

Based on comprehensive global reviews of MSM prevention, psychosocial programmes and policy development in Beyrer *et al.*, (2013) [Study ID 2], it was identified that there is a high efficiency and rapid onward transmission of HIV among MSM sexual networks. The spread of HIV among young MSM is of further concern, as adolescent men are least likely to be receiving or accepting healthcare and/or treatment (Beyrer *et al.*, 2013) [Study ID 2]. The rate of HIV onward transmission between MSM networks occurs within a median time of 17 months, which is of significance for identifying novel approaches and interventions that attach the human immunodeficiency virus at its most vulnerable point in its life cycle (Landovitz *et al.*, 2012) [Study ID 24].

Braine *et al.* (2011) [Study ID 4] extend the argument that current HIV prevention information is "tangential to the sexual practices of a growing number of MSM" (Braine *et al.*, 2011: 811) [Study ID 4]. The authors suggest that HIV prevention should include relevant discourse such as probable risk assessment, serosorting, negotiated safety, and strategic positioning, in order to provide relevant information to MSM practices. Probable risk assessment describes a subjective rationalization by individuals that takes into account the interrelated areas of the social context and risk. Braine *et al.*'s (2011) research explains that communication, knowledge of, or assumptions about a potential partner's HIV status influence the type of sexual engagement and the types of risk-reduction strategies used.

Similarly, substance use would influence the level of risk that one is willing to take, as inhibition is reduced. Furthermore, the study shows that open discussions are taking place online between MSM to discuss sexual desires; sexual activity in which one is willing to engage; drug use; and one's HIV status. It is highly unlikely that face-to-face disclosure about one's HIV status would occur. Braine *et al.* (2011) found that openly declaring one's HIV status did not prevent sexual activity from occurring. Instead, other discussions about sexual positioning and serosorting were held. Serosorting was used as part of a risk-reduction practice where the status of the partners is openly declared and unprotected sexual encounters take place between persons with the same HIV status. Lastly, the sexual position (top or bottom) determines the level of risk that dictates whether a condom is used by the insertive and/or receptive partner and whether the insertive partner withdraws prior to ejaculation.

Thus, in summary, traditional HIV prevention education may not include these risk-reduction strategies used by MSM. It would be an opportune time for health and support services to include information about what is relevant. It is also important to note that more disclosure about HIV status and sexual desire took place in an online forum. Therefore, this signals another opportunity for online prevention education, which may provide more relevant support to self-identifying students. Such information would, in addition to the condom usage, be messaging, which has higher efficacy in reducing HIV transmission among MSM networks (Jin *et al.*, 2009).

Whilst primary health clinics in HEIs may not have the capacity and/or resources to manage such a biomedical response, the clinics could motivate students to test frequently throughout the year, in order to prevent undetected HIV. Furthermore, HEIs would need to

consider health interventions that include discussions about the use of drugs during sexual practice and while on antiretroviral treatment for HIV. HEIs' health and support services cannot afford to ignore discussions about substance use, as drug use in MSM networks is common practice and has a direct influence on rates of HIV infection in the sexual network (Landovitz *et al.*, 2012) [Study ID 24].

There is an urgent call for innovative practice that is relevant to MSM sexual practice, as current behavioural interventions are underserving the needs of self-identifying populations. With the rate of transmission and the high efficiency of HIV transmission in crossing the mucosa surface, considerations should focus not only on access to preventive treatment such as pre-exposure prophylaxis, but also on the influential factors that increase risk such as substance use and probability-based risk assessment. For MSM programming in HEIs, the complexity of MSM behaviour and HIV infection cannot be limited to current biomedical interventions, but have to holistically respond to the efficiency of HIV transmission during anal sex.

2.5.2 The role of stigma

People living with HIV/AIDS already experience stigma at university (Volks, 2012; Volks, 2014). However, MSM experience multiple layers of stigma that limit their access to and uptake of healthcare services (Beyrer *et al.*, 2013) [Study ID 2].

Baral, Burrell *et al.* (2011) found that stigma among MSM is perpetuated by societal persecution, which limits access to healthcare services and uptake by MSM. While good practice can be learnt from stigma-reduction programmes for people living with HIV, MSM experience multiple layers of stigma that require more nuanced programmatic responses (Baral *et al*., 2009).

Stigma is also perpetuated by the discourse of masculinity. The tensions surrounding masculine identity in relation to MSM have been extensively discussed (Morrell, 2001; Tamale, 2011; Muraguri, Temmerman & Geibel, 2012; Sandfort & Reddy, 2013). The authors' shared belief is that, due to cultural norms of masculinity, a person who does not identify with heteronormative gender roles and norms experiences high levels of external and internalized stigma, lowered self-esteem and inaccessibility of heteronormative support services. Collectively, these factors result in the delegitimization of the lived realities of MSM, forcing MSM to hide (Wolitski *et al.*, 2001). The effect of stigma on an individual is

well articulated by syndemic theorists (Wolitski *et al.*, 2001; Stall *et al.*, 2003) who define homophobic culture and stressors such as MSM stigma and discrimination as cultural marginalization.

The theorists suggest that, in order to reduce the effect of stigma, discourse should move away from pathologizing sexual behaviour and sexual identity and rather focus on mutually reinforcing health disparities such as substance abuse, violence, and mental health that exacerbate HIV infection in culturally marginalized populations (Singer, 1994). From an institutional systems perspective, it becomes important to respond to the ecological relationship between substance abuse, violence and mental health, in order to curb HIV risk among a highly marginalized population. This would reduce stigma and its effects on MSM students.

Stigma is also exacerbated by disingenuous claims that same-sex sexual behaviour is not part of African culture. In fact, there is historical evidence of MSM prevalence in sub-Saharan Africa being documented as early as the 1800s. Indeed, early ethnographic and anthropological researchers (Evans-Pritchard & Seligman, 1976; Werner, 1987; McKenna, 1996; Murray & Roscoe, 1998; Niang et al., 2003) write that, although same-sex (including MSM) relationships occur in approximately fifty African cultures. However, terms such as 'gay' or 'lesbian' that defined roles and identity were not part of African vocabularies and discourse which may have contributed to the myth that same-sex unions were not part of African culture.

The consideration of global north concepts for self-identification of sexual orientation in sub-Saharan Africa is complex, particularly when many people who participate in MSM relationships do not self-identify as 'gay' or 'bisexual'. The role that language plays in the African discourse is important, as it has resulted in same-sex relations being absent (and, therefore, vilified) from historical discussions in Africa's cultural history. The cultural divide about African same-sex relations has deepened with the assimilation of Western terminology such as LGB into South Africa's biomedical discourse. The pathologization of sexual diversity has affected people from being freely vocal about their sexual identity (Nyanzi, 2014; Matebeni & Msibi, 2015). In addition, self-identifying populations often feel forced to identify with the Western labels of lesbian, gay, bi-sexual, intersex, trans* and asexual, as well as the characteristics that accompany each of those labels. The absence of 'language-ing'

(Nyanzi, 2014) African sexualities may also contribute towards the exclusion of sexual diversity, particularly in institutional systems in HEIs, despite the prominent existence of sexual identities in universities.

2.5.3 Prevention education and communication

Elam *et al.* (2008) [Study ID 9] indicate that relevant messaging for MSM needs to "build confidence and control over safer sex practices that are responsive to men's wider needs but also maintain existing protective behaviors" (Elam *et al.*, 2008: 473). In addition, Braine *et al.* (2011) argue for the inclusion of risk-reduction strategies as an embedded discourse in prevention; this goes beyond the promotion of condom use. Placing emphasis on the necessity of frequent HIV testing (when participating in unprotected anal intercourse) and discussing the role of serosorting as a practice in sexual networks, in addition to discussions about strategic positioning and negotiating safety, are useful elements of inclusion in HIV education for MSM. Research suggests a change in educational material about HIV transmission and prevention for MSM, as the range of sexual practice and current risk-reduction strategies extend beyond that of conventional condom use behaviour (Carter *et al.*, 2014).

2.5.4 Structural interventions

Unsupportive environments can result in higher anxiety and depression among MSM (Colfax & Guzman, 2006). This, in turn, may affect a student's academic performance at university (Volks, 2012; Volks, 2014). If left unchecked, hostile local norms could increase the likelihood of MSM students' use of self-medication to treat anxiety and/or depression (Herrick *et al.*, 2013). Furthermore, in a study by Lyons *et al.* (2013), MSM youth attributed their acquisition of HIV to "a lack of gay-specific HIV prevention education; an absence of role models; and a lack of productive future goal-related activities" (Lyons, Johnson & Garofalo, 2013: 1).

A recent study by Brink (2014) found that, within university spaces, a clustering together of health disparities such as violence, substance abuse and stigma are currently affecting MSM students. Further findings by Brink (2014) suggest that structural discrimination occurs, to some extent, within university spaces; it can thus be asserted that institutional barriers could potentially contribute to the cultural marginalization of MSM students. Taking the above findings into account, it is evident that there is a need to shift the

focus beyond that of health education and consider structural change within universities, in order to circumvent the challenges experienced by MSM. Structural changes within higher education could include community-level interventions such as "access to mentors, and assistance with future goal setting and planning [should be] provided" for, in MSM programming (Lyons, Johnson & Garofalo, 2013, p.1).

2.5.5 Peer education

The role of peer education in self-identifying networks is a necessary tool in prevention programming because of the high levels of trust among the peers. Partnerships between peer educators and institutional structures such as those established in Conner *et al.*'s (2005) [Study ID 7] research can enhance an institution's holistic response for self-identifying students. Over a number of years, many researchers have validated peer education as a supporting structure to HIV testing (Scott *et al.*, 2013) and counselling, and it continues to be a key strength in community-based interventions (Trapence et al., 2012; Scott et al., 2013; Pettifor et al., 2013; Lyons, Johnson & Garofalo, 2013; Lau, Tsui & Lau, 2013; Batist et al., 2013).

Batist *et al.*'s (2013) study established additional benefits of peer education, which saw improvements in MSM self-efficacy, self-esteem and social isolation, while also imparting theory-based communication and training to complement the educational component that is being shared. Lau *et al.*'s (2013) study contributes further details about the content of peer education, which his study found to be useful and relevant for MSM. The content areas similar to current HIV education modules are mainly based on health belief theories that focus on increasing one's self-efficacy in relation to one's perceived HIV risk (Rosenstock, Strecher & Becker, 1988).

Previous research has evidenced the association between MSM and the peer network. MSM are known to have expansive peer networks (Kelly *et al.*, 2010) and, therefore, peer education engagement should be considered within institutional settings, in order to improve self-efficacy in risk prevention and possibly treatment adherence. Batist *et al.* (2013) found that peer education, in small groups, contributed towards an enabling environment within the context of larger stigmatizing communities. Relevant knowledge, shared in peer networks, has, therefore, been proven to decrease risk behaviour and reduce HIV incidence among MSM. Furthermore, Fox *et al.* (2009) identified that non-healthcare providers should be

capacitated with behaviour-change counselling skills. This role could potentially be entrusted to a peer network who are often first responders and who already support students at university. Thus, the studies by Lau *et al.* (2013), Kelly *et al.* (2010) and Batist *et al.* (2013) place importance on the role of peer educators in MSM interventions within institutional settings.

Innovations in MSM peer education networking may also take place via online social networking sites (Young, Szekeres & Coates, 2013) and, to a lesser extent, in local studies (Brink, 2014). More recent works demonstrate MSM's high willingness to access internet-based information for HIV prevention and care (Purcell *et al.*, 2014). This is an important consideration for using online social networking as a tool for peer education and/or condom distribution within MSM networks (Trapence et al., 2012; Scott et al., 2013; Pettifor et al., 2013; Young, Szekeres & Coates, 2013).

Although these studies have produced favourable results in the short term, there is a need for rigorously evaluated research that effectively links risk-prevention behaviour to online peer education networks (Bull, 2010). Advances in online peer education models is, therefore, an aspect that could be explored within an institutional setting and is an option that would circumvent challenges in terms of providing anonymity, time limitations, and accessibility (Rhodes *et al.*, 2010; Rhodes *et al.*, 2011; Hightow-Weidman *et al.*, 2011; Young, 2013).

Limitations with peer education systems are that they experience a lack of retention of MSM. However, Conner *et al.* (2005) [Study ID 7] achieved some success. They found that the use of incentives had a useful role in retaining MSM students in peer support groups over a period of one year. The authors found that loss to follow up was minimal among MSM in the peer support group, when tokens of appreciation were distributed at appropriate times and with explicit messages that distinguished what the token was for (*i.e.*, a thank you gift or an incentive to ensure the person returns later).

Innovations in peer education for HEIs would need to incorporate relevant training content, consider online peer education systems, and the use of incentives to retain MSM participation. Retention would be a key factor affecting the efficacy of a student-based MSM peer education system, particularly when university students' time is focused primarily on academic work.

2.5.6 Curriculum

Although the systematic review did not focus on curriculum, I would be amiss if I did not consider the role of academia in actively querying the institutional teaching and learning spaces within the university setting.

The debate of pedagogy and teaching content in reframing discourse about sexual diversity (where relevant) has been documented in research conducted in South African institutions and abroad (Bennett, 2006; Bennett & Reddy, 2009; Francis, 2012; Miller & Gilligan, 2014).

Nyanzi (2014), Miller and Gilligan (2015) and others share a similar opinion, namely that the teaching space should invoke intellectual discomfort for both the teacher and the student, particularly when "challeng[ing] current understandings of gender and sexuality norms [which left undisturbed] leaves a myopic and vulnerabilized understanding of the evolving lived realities of people" (Miller, 2015b p.7). Francis (2012) speaks of the invisible homosexuality in instances where educators who are not equipped to teach the reframing of gender and sexuality remain silent, but, in effect, reinforce patterns of heterosexism (Francis, 2012; Volks, Abrahams & Reddy, 2015). There are similar challenges in tertiary education, where some academics experience discomfort with the broader role of an educator to engage with content that is not part of their specific discipline (HEAIDS, 2010a).

Nzimande (2015) argues that the absence of sexual diversity discourse in teaching spaces is a result of some educators' opinion that such content makes them vulnerable to the negative perceptions of the learner. However, reframing the teaching space is an important element of creating an inclusive environment in a university. Academics such as sj Miller who specialise in pedagogy of transformation have developed a framework to create neutral spaces for learning. Miller writes about the teachers' ability "to rupture dangerous dichotomies and myths about gender and sexuality" (Miller, 2015a p.39). Therefore, a challenge resides with teachers being able to accommodate a human rights values system in conjunction with their own values, norms and beliefs to prevent the re-inscription of gender and heterosexist norms (HEAIDS, 2010a; Miller, 2015a).

In the absence of policy and sensitized academics in universities, I would extend Miller's argument by stating that structural discrimination not only occurs in secondary schools, but also in tertiary learning spaces, with the result that self-identifying populations

continue to be delegitimized by being silently or explicitly excluded from teaching praxis and rhetoric (Miller, 2015a).

In universities, it is argued that lecturers have their role to play in teaching to transform by developing platforms of critical consciousness. However, this presents logistical challenges in already content-laden curricula. Beyond these logistical barriers, other academics contend that the educators' ability to infuse social justice issues into core curricula is limited, particularly when the lecturer has had no intellectual training or activist experience (Bennett & Reddy, 2009; Francis & Msibi, 2011; Msibi, 2013). Without detracting from these limitations, the impetus continues for universities to recognize their role in cultivating academic discourse that could decrease stigma and structural discrimination in self-identifying populations.

2.5.7 Healthcare systems

Research shows that structural barriers in healthcare settings affect MSM's ability to access support and information for fear of stigma and discrimination. Purcell *et al.* (2014) write that health prevention, education and MSM interventions are in their infancy in the United States of America and that further evidence-based interventions are required. Nevertheless, there are unique examples of specialized services that are successfully supporting MSM. In South Africa, two examples of MSM health provision can be found, namely at Anova Health and the Ivan Toms Centre for Men's Health. The clinics differ from mainstream state sector health services, which MSM find to be "unfriendly, prejudiced" and inexperienced in the healthcare needs of MSM (Rebe *et al.*, 2013: 52).

It is likely that good practice, innovative healthcare and support, among others, have emerged from these two clinics which could be incorporated into HEI primary health services. One of the successful practices that emerged from the Ivan Toms clinic, focused on the provision of anonymity provided for by the clinic's environment and physical infrastructure, which offered services to anyone – not only MSM. Therefore, anonymity was provided for MSM, because no distinctions were made between MSM and other patients waiting in the reception area. Anonymity helped to allay MSM fears of being identified when waiting to meet the health practitioner (Rebe *et al.*, 2011). Furthermore, clinic staff members were professionally sensitized to provide non-discriminatory services to MSM and

transgendered individuals. This includes honorific clarification to promote self-identification of patients in the clinic (Rebe *et al.*, 2011).

MSM's trust in the health practitioner is an essential component of health services (Beyrer *et al.*, 2013) [Study ID 2]. However, establishing this level of trust takes concerted effort by the healthcare practitioner. This trust can be achieved by providing an enabling environment and culturally competent care for MSM clients. This includes understanding the different types of mental health experienced by some MSM, including internalized homophobia and lowered self-esteem. Concerns about MSM mental health was emphasised by Elam *et al.* (2008) [Study ID 9] who found that some MSM self-medicate, in order to manage their anxiety and/or depression, which, at times, lowers inhibitions and loss of control over risk-reduction strategies. It is important that, within healthcare spaces, the practitioner is able to create a non-judgemental environment where the self-identifying person can comfortably disclose information relating to sexual practice and mental health (Carter *et al.*, 2014) [Study ID 5].

Recent research shows emerging trends for MSM couples' HIV counselling and testing (as opposed to individual level HIV prevention), which is proving efficacious in increasing condom usage (Wu et al., 2010; Sullivan, Grey & Simon Rosser, 2013; Purcell et al., 2014). Emerging practices also include electronic self-assessment by MSM (Adebajo *et al.*, 2014), which has produced information about significantly higher levels of risk behaviour.

The above literature presents an opportunity for further healthcare innovation that could include health practitioner training in diversity and culturally competent care; the provision of neutral health care spaces that provide anonymity; the use of an online sexual history and self-assessment tool before counselling, and motivating MSM couples' HIV testing. All of which is yet to be piloted within university primary healthcare clinics.

2.6 Limitations in the literature

A limitation with the seven identified articles was that the findings were localized to specific contexts. Furthermore, the research scope was much more advanced than the current South African MSM research where, as a country, we are battling to identify MSM, let alone modify current public health systems to provide relevant biopsychosocial care.

In terms of methodology, it was apparent in the clinical research studies that researchers were required to partner with MSM clinics and/or institutions that already had a database of MSM patients within a system of care. By partnering with a clinic and/or organization that already had established relationships with MSM, the researchers eliminated the challenge of locating MSM within the broader population. With regard to the five university contexts, there was no luxury of working with already established MSM groups; therefore, my study advances the knowledge by identifying the methods used to locate MSM students within a university setting.

Furthermore, in three articles, incentives were used to retain MSM within the research trial and/or programme. When considering my own methodology, I also thought of providing a stipend that would cover the programme coordinators' travel costs (if any) and/or time. However, I moved away from providing monetary compensation and rather gave the programme coordinators their interview transcriptions for use in report writing and/or programme related work.

My PhD therefore, contributes further advances in knowledge, namely the formation and composition of combined prevention programming for self-identifying students within the higher education context that would respond to both the academic project and the social project within the university environment.

2.7 Summary

A systematic review conducted up until 15 January 2015 showed that there is a gap of knowledge in university health and support services for MSM students at university. Despite the lack of evidence-led programming for MSM psychosocial support (Purcell *et al.*, 2014), a great deal can be learnt from existing community-based programmes.

National policy redefined the role of South African universities in providing services beyond those of research, teaching and learning; yet transformative responses with regard to sexual orientation are yet to be seen.

With a global urgency for effective responses for MSM populations, universities will need to reconsider what health and support services should be provided in their primary health clinics. Effective results have been noted in biopsychosocial programmes (combined

prevention programmes) for MSM and it is from such programmes that best practice can be adapted and applied within the university context.

The systematic review and additional literature searches highlighted peer-reviewed content that could contribute to the development and/or enhancement of MSM health and support structures within universities.

In Chapter Two, seven themes emerged from the systematic review. The first theme considered the epidemic drivers of HIV among MSM. Understanding what is extraordinarily different in MSM practice is useful in shaping relevant prevention education and biomedical intervention responses for healthcare services in universities. A review of psychosocial and biomedical content is necessary so that relevant prevention education for MSM includes information on substance use, lowered inhibition and probable risk assessment. Secondly, by understanding the role of stigma relating to MSM, universities could begin to shape responses in universities to reduce stigma and raise social awareness through informative peer-education programmes.

In summary, a tension was presented between the traditional role of universities and the modern expectations of educators within lecture spaces, particularly concerning issues of staff's willingness and ability to queer curricula and related pedagogies. Reframing curricula, the role of the educator, and staff engagement via institutional policy will progressively eliminate stigma and discrimination within universities. Lastly, reviewing current healthcare practices and services in universities, is a critical step that will serve to destigmatize and provide an inclusive environment for self-identifying students. Efforts to reframe sexuality norms in health, support and academic contexts are necessary, in order to prevent delegitimization of self-identifying students within the higher education context.

Chapter Three: Research Methodology and Design

3.1 Introduction

In Chapter One, I emphasized the need for appropriate health and support services for a key population that was experiencing an increase in new incidences of HIV infection. Chapter Two documented the available literature, which could inform appropriate health and support services for self-identifying students at universities. In the ensuing paragraphs, I describe the theoretical perspective and contextual background that influenced the choice in research tools used in my PhD. I discuss the research design, methodology, data collection and analysis. Lastly, I focus on the research evaluation and cite the ethical considerations of this research study.

The reader should note that, in this chapter, I use quotations that capture the perceptions of the programme coordinators to describe their experiences of the research method. It was my intention that, under the advocacy paradigm, opportunities for participation and engagement with the programme coordinators be increased.

3.2 Theoretical perspective

In this section, I discuss my position as a critical theorist who oscillates between modern and postmodern views. Defining my theoretical position occurred much later in the writing up of my PhD, as I had initially intended to omit this section, basing my conviction on the fact that I was not applying any theoretical framework that could potentially influence my perception of the programme coordinators work.

In fact, it was my intention to decipher whether grounded theory would emerge through the implementation of the programme and the analysis of the data. However, it was only later in the write up when the following important revelations occurred, which ultimately defined my theoretical position as a critical theorist.

The first revelation was contextualised in the very nature of my PhD, which is steeped in anti-oppression discourse, with the sole objective of defining an institutional system for higher education that would better support self-identifying students who experience one or

more forms of discrimination. When articulating my research objective, I realized that there were many points of synergy with Horkheimer's (1972) deliberations about critical theory, which primarily sought the emancipation of people who experience oppression.

The second revelation had to do with how I had interpreted the programme coordinators' positionality, which was in relation to the power held by the social and political actors who influence the university system. Within my deliberations of power, I realized that I was, in fact, locating the programme coordinators within Habermas' ideology of power and domination (1987). Extending this concept of power, I aligned more readily with Habermas' definition of action, which calls for change beyond human emancipation, but requires the oppressed to identify the changes they require in order to empower themselves (Habermas, 1987).

Thirdly, I was intent on contributing towards praxis that would enable practitioners to enhance and/or develop institutional systems that would better support self-identifying students in higher education. This is customary for critical theorists who seek change beyond merely providing new theoretical perspectives.

Althusser (1970) another philosopher of critical theory, suggests that institutions can replicate societal ideologies through action and practice. Based on this interpretation of Althusser's critical theory position, the reader will note my emphasis in Chapter Five, where I imply that universities are potentially complicit in replicating societal norms and related practices, some of which are discriminatory and oppressive. The alignment with Althusser's perspective reinforced my positionality as a critical theorist and my perceptions of power as held by institutions.

The last and most important revelation was the self-reflexive position that I adopted in the research methodology. The benefit of this position was twofold. First, the self-reflexive position sought to address one of the primary contestations of critical theory, namely that the critical theorist has an omniscient advantage, which the oppressed do not have. Further criticisms emphasize that critical theorists fail to listen to those who are oppressed, resulting in solutions that are unworkable and too distanced from the reality of the oppressed. In order to circumvent the weaknesses of critical theory, I used a number of methodological techniques.

The first technique was to adopt a position of "uncomfortable reflexivity" which Visweswaran defines as the extent to which we can be "… accountable to people's struggles for self-representation and self-determination" (Viswerswaran, 1994,p.32). In this chapter, I use my personal narrative and express my discomfort in placing myself within this context. Secondly, in order to circumvent overpowering the voice and reality of the programme coordinators, I increased the number of dialogical opportunities to allow for the programme coordinators' reality and perception to be present in the analysis of their interviews. In this way, the programme coordinators were able to discuss my analysis with me and actively change and/or remove information they viewed as misinterpreted and/or misrepresented.

In summary, the position of a critical theorist in this research fits succinctly with a theoretical approach that I had as yet not defined. I intended to contribute to praxis, while also ensuring that my research methods were cognisant of the dynamics of power. Both of these intentions emerge from the critical theorist approach with the sole purpose of emancipation and/or enlightenment of people who experience forms of oppression.

3.3 Contextual background

In 2014, the NACOSA grant was disseminated among fourteen universities to develop biopsychosocial programmes for MSM students. This grant included funding for the employment of one programme coordinator per university to implement activities within his/her respective institution. At the inception of the programme, the fourteen programme coordinators were simultaneously trained in the programme indicators and the possible ways in which one could achieve these indicators. Training also included biopsychosocial information that was relevant for MSM students. This information included guidance emanating from a San Francisco-based organization that had some success in establishing support groups for MSM youth.

In addition to this knowledge, the programme coordinators also received training in facilitating psychosocial workshops and delivering HIV testing, counselling and prevention education. During this training, collegial relations were formed between the fourteen programme coordinators. This later proved to be particularly helpful in sharing innovative practice in implementation, as well as in providing emotional support to one another. Over the two-year period (2014-2016), the programme coordinators met quarterly and the ethos

that was cultivated in these meetings was signified by the supportive friendships. As one of the fourteen programme coordinators, the relationship that was established between the five programme coordinators and myself influenced the research design used in my PhD. I wanted to use the approach that maintained sound methodology, while balancing the informal undertone during research implementation.

Furthermore, I was aware that the programme coordinators might have experienced discrimination. It was, therefore, important for me, as the researcher, to remain reflexive in my research methodology, so that I could be aware of potential areas in the design and approach that may unintentionally reinforce patterns of discrimination through language and/or gesture.

As mentioned in earlier, the critical theory lens informed the research design was methodology which interrogated how the institution influenced the programme design and, potentially, the programme coordinator's decision-making (Gramsci, 1971; Denzin, 1978; Neuman, 2013). Whilst not seeking to evaluate the efficacy of the structure that is created, this dissertation contributes to knowledge about what programmatic structure produced actionable change for self-identifying students studying at institutions of higher education. In the ensuing discussion, I provide detail on the research methodology used in my PhD.

3.4 Research design

Babbie and Mouton (2002) state that the research design provides structure to execute the research and to maximize the validity of the findings. In this section, I present the components of the research design and methodology: the pilot study, the programme coordinator sample profile, the data-collection method, and the data analysis. I complete this section with a discussion about the research evaluation methods, ethical considerations and the stages of the research study.

3.4.1 Pilot study

Prior to commencing the semi-structured interviews, I conducted a pilot study with two other programme coordinators who were not part of my research sample. This provided me with an opportunity to test the semi-structured interview questions for repetition and clarity. In the pilot study phase, I used a video recorder to capture the non-verbal communication that could

occur through the facial and body expressions. In addition, to help me collect the data, I used an audio recorder, which was also useful during transcription and data analysis.

During the pilot study, I explained to the programme coordinators that the data would not be used in any way in the PhD and that this was an exercise to test the research instrument and the use of recording equipment in a semi-structured interview. Three observations emerged during the pilot study.

The first observation was the location of the pilot study interviews. The interviews took place in the programme coordinator's office, which I mistakenly assumed would not have an effect on the interview. However, in the second pilot study interview, interruptions by colleagues and other institutional stakeholders occurred, as the programme coordinator was obligated to respond with information and/or support. These interruptions influenced the flow of the dialogue in the semi-structured interview, which resulted in having to repeat the question and the partial response of the programme coordinator in an attempt to resume the interview where it had abruptly ended. When considering the location of the interviews with the five programme coordinators, I thought that interruptions would be avoided, as I assumed that all five programme coordinators would be travelling away from their institutions in order to attend the quarterly meetings and, therefore, an uncontested interview environment would be possible to achieve.

The second observation was the use of the video recorder. Not only did I experience several difficulties in using the technology, which caused time delays, but, more importantly, the use of the video recorder made the programme coordinators uncomfortable. Although I attempted to fix the technical glitches and tried to place the camera out of the line of sight of the programme coordinators, the use of the video recorder became a disruptive element, as the technological issues continued and the programme coordinator was more conscious of the video equipment than of the voice recorder, with the result that nervous glances towards the equipment were observed. As a result, the video recorder was discarded after the first interview.

The third observation emerged after the analysis of the pilot study data. The analysis of the data identified whether the research instrument was producing data that was directly responding to the research question. On conclusion of the analysis, one minor change was

made to the question sequence and terminology in order to provide clarity and avoid repetition.

The role of the pilot study in my PhD was important, as it validated the research instrument and ensured that the questions that were asked produced responses that were relevant to the research question. Furthermore, the pilot study provided an opportunity for me to discern whether the questions, language and my approach unintentionally reinforced discrimination. Therefore, I found the pilot study to be a beneficial element of the research design.

3.4.2 The programme coordinators: Sample group

Each of the programme coordinators worked at five diverse universities where historical, cultural and social contexts differed. The diverse demographics of the universities reflect a multicultural population of South African, sub-Saharan African and international students.

While all five universities were geographically dispersed, the infrastructure of each university was comparable. Considerations about resources, affluence and private income within each university are an important factor, as the existence of infrastructure, or lack thereof, may impact the programmatic outcomes. Without disclosing the university names, I provide a snapshot of income sources for each university participating in this research.

Table 2: Sources of income

2013			
University	Government funds	Student fees	Private income
A	26%	29%	45%
B	44%	29%	27%
C	46%	31%	23%
D	46%	40%	14%
E	54%	33%	12%

Source: http://chet.org.za/data/sahe-open-data

Table 2 demonstrates a disparity of private income and student fees at the various universities. Political interest, student throughput, research areas and/or the university's global ranking are factors that would influence private funding. Similarly, the number of students varied from 40,000 to 7,000 which influences the overall income available to the university.

While the data shows that universities received similar allocations, some universities were only developed post-1994 which I had assumed would influence the infrastructure and resources available in the programme. However, despite the historical disadvantage, it became evident during the interviews that each institution had the necessary infrastructural resources that would be required for the programme to work in its university.

A purposive sample was undertaken in this study, because a finite number of programme coordinators (fourteen in total) had developed a MSM programme for their institution. The programme coordinators were invited to identify interviewees among the institutional stakeholders who had been influential in the development and/or implementation of the MSM programme within their institutions. However, they did not identify any stakeholders, and thus no other interviewees were included in the sample group.

The programme coordinators who formed part of this research were situated at five geographically dispersed universities in South Africa and, for reasons related to the protection of the programme coordinator and the university, the names of both will remain anonymous. To protect the identity of both the programme coordinators and their institutions, I have used pseudonyms for each programme coordinator.

Furthermore, as part of my research approach, I deliberately did not ask the programme coordinators for identity descriptors such as sexuality, race and/or gender. The association with gender identity is implied in the use (or non-use) of a pronoun that was selected by the programme coordinator. The pronoun was requested purely to assist with the grammatical conventions required for my PhD. The request for a pronoun (or non-use) used by the programme coordinator emphasizes the practice of self-identification advocated for earlier in Chapter One. Therefore, rather than impose/assert my own assumptions of the pronoun they use, I asked the programme coordinators to indicate what pronoun, if any, they would like to be associated with. In light of this, the reader should note that, in one instance, the programme coordinator did not associate 'themselves' with any pronoun and, therefore, throughout my PhD, I refer to this programme coordinator by name only. Furthermore, the reader should note that some programme coordinators' outward gender expression did not correlate with the pronouns associated with the physiological trinary of male or female or intersex.

With regard to sexuality as an identifier, the decision to not request (and/or disclose) the sexuality of the programme coordinator was to avoid asserting a heterosexist norm that is usually asserted upon only sexually diverse individuals who may feel obligated to respond to curiosities about their sexuality. For this reason, I deliberately do not identify any of the programme coordinators' sexualities.

Controversially, I recognize the methodological implications in programme implementation, if the sexuality of the programme coordinator is not disclosed. One notable implication is that the programme coordinators' level of reflexivity and/or experience of being sexually diverse would influence the implementation and design of the programme. However, the reader will note the finding located in Chapter Four, which identified that all programme coordinators implemented the programme in similar ways and achieved similar levels of success, despite the variances in disclosure and non-disclosure of sexual orientation.

While my PhD does not focus on the perceptions of the programme recipients, in Chapter Four I detail the responses of the programme coordinators who share their own perceptions of whether their sexuality influenced receptivity and engagement with self-identifying students in university. Secondly, self-identifying students may have reacted in different ways to programme coordinators whose sexuality was disclosed and/or undisclosed, and this may have had implications for the programme, particularly if the programme coordinators were advocating for inclusion of all identities. However, in defence of practice to self-identify, an element of inclusion should be; to equally embrace everyone regardless of the disclosure and non-disclosure of sexual identity.

All the programme coordinators were contractually employed by NACOSA and, in consultation with the university, were located on the university campuses with the mandate of implementing the programme for the duration of the grant. The first programme coordinator is Sam who is 26 years old (26y). Sam has specifically requested that I do not use a gendered pronoun when referring to Sam's responses. In Chapter Four, I will refer to Sam's identity in the following way (Sam, 26y). The second programme coordinator is called Thabo. He is 29 years old (29y) and uses the pronoun 'he'. I will refer to Thabo's identity in the following way (Thabo, 29y). Zama is the third respondent who is 24 years old (24y), uses the pronoun 'she' and is referenced as (Zama, 24y). Sipho uses the pronoun 'he' and is 28 years old (Sipho, 28y). The last respondent is Alex who is 27 years old and uses the pronoun 'he' (Alex, 27y). Table 3 presents the programme coordinator profiles.

Table 3: Programme coordinators sample group

Programme Coordinator	Age (years)	Preferred Pronoun	Position within the institution
Sam (26y)	26	NA	External Employee of the university. Contracted by NACOSA
Thabo (29y)	29	He	External Employee of the university. Contracted by NACOSA
Zama (24y)	24	She	External Employee of the university. Contracted by NACOSA
Sipho (28y)	28	He	External Employee of the university. Contracted by NACOSA
Alex (27y)	27	He	External Employee of the university. Contracted by NACOSA

3.5 Research methodology

In this section, I describe the research methodology used in my PhD. I also provide further information on the research tools that were used in my approach, bearing in mind that, earlier in this chapter, I intended to use an approach that deepened the level of inquiry, while balancing the collegial relationship that was developed during the two-year NACOSA programme. I discuss why qualitative research was best suited for this subject matter, and I alert the reader to three research tools (the use of a personal narrative, a semi-structured interview, and increased opportunities for data validation by the programme coordinators) that I used in the qualitative research design to establish the informal tone that attempted to balance the collegial relationship, while conforming to the parameters of good research methodology and design.

3.5.1 Qualitative research

Creswell states that, "if a concept or phenomenon needs to be understood because little research has been done on it, then it merits a qualitative approach" (Creswell, 2013, p.247).

In Chapter Two, I established that, globally, there was no published literature that focused on self-identifying students' health and support services within the university sector. This study would, therefore, be the first contribution that documents the existence of health and support services for self-identifying students at five universities. Therefore, the purpose of the study considered factors that influenced the design of the health and support intervention for self-identifying students in a university.

I used a qualitative method to capture the considerations that influenced the programmatic structures. The qualitative research method is, therefore, useful, as it provides exploratory data that explains the programme coordinators' role in the construction of the intervention and their perceptions of the experience. I have used direct quotations to represent the perceptions of the programme coordinators' in the findings Chapter Four and Five. However, I have carefully edited the quotations, to conform to technical and grammatical conventions for a PhD, yet have maintained the essence of the programme coordinators' opinions.

3.5.2 Research tools

Earlier in this chapter, I provided contextual information that influenced the research design. I indicated to the reader that the topic of sexuality and discrimination might be an issue, which the programme coordinators may have experienced and/or be affected by. It was, therefore, important for me to remain aware of my approach within the research design, so that I did not unintentionally cause further harm and/or risk to the programme coordinators. In this section, I describe how I used the three research tools whilst diffusing any foreseeable harm and/or risk to the programme coordinators.

Prior to the semi-structured interviews, each programme coordinator was emailed an invitation to participate in the research. This invitation consisted of my research proposal and the ethical clearance letter from the University of the Free State. Following their approval, the first interview meeting dates were established. At the interview, once the programme coordinator had read and signed the informed consent form, I began the process by thanking the programme coordinators for agreeing to participate. I outlined the research process and re-emphasized confidentiality. I then expressed my intention to begin the interview process with the first of the three research tools, namely the personal narrative. I explained to the programme coordinators that the personal narrative would emphasize my motivation for

wanting to do this research. Essentially, the personal narrative was used in an attempt to create an enabling and inclusive research atmosphere, before beginning the semi-structured interview.

3.5.2.1 Personal narrative

In considering whether a personal narrative was relevant and/or appropriate, I was cognizant that the programme coordinators may have perceived my interest in the institutional sexuality programme to be part of my job and, therefore, my presence as part of the programme cohort was purely out of professional interest. It was important for me to dispel this potential perception by personally situating myself socially within the subject area of sexuality and discrimination and shed the professional persona that formed part of my identity within the cohort. By doing so, I intended to indicate to the programme coordinators that my personal circumstance had influenced my agency in relation to this topic. I hoped to signal to the programme coordinators that I was also intimately connected to a turning point in my life, which signalled a shift in the way in which I viewed the world and discarded the social constructions imposed on me (Mishler, 1986). I hoped that, in offering the personal narrative, I could nurture a mutual construction of the research relationship, one where the programme coordinator and myself had the opportunity to discover connections and assist in repositioning ourselves in our collegial relationship (Mishler, 1986).

The sequencing of the semi-structured interviews and the personal narrative was an important consideration in the research design. It did not make sense to share the personal narrative at the end of the semi-structured interview, as this would have defeated the purpose of establishing common areas of understanding with the programme coordinator. Secondly, infusing the personal narrative within the semi-structured interview meant that I would need to find an appropriate juncture during the interview, which may not have been easy to identify while simultaneously attempting to deepen the level of inquiry during the semi-structured interview.

I also acknowledged that there was vulnerability in sharing information about the successes and challenges of the programmes with which the coordinators closely identified. As the narrative included a personal turning point, my own vulnerability was brought to the surface, as I hoped that this would assist the programme coordinators' belief that I could connect with them about the content.

Therefore, for my research process, I wanted to establish a common understanding about the complexity of sexuality and discrimination. By using my own personal narrative prior to the semi-structured interview, I was of the opinion that my intention and motivation for conducting the research would be clearer. It must be noted that by using the personal narrative prior to the semi-structured interview, contradicted some researchers' opinions about who speaks first in personal narratives (Mishler, 1986).

The challenges in using the personal narrative took many forms. The first was my anxiety in being judged by the programme coordinators for the role I played within my personal narrative. However, I found that my own discomfort was allayed by linking the personal narrative to my motivation for conducting the research and, secondly, by receiving some positive responses to the personal narrative.

Earlier in this chapter, I indicated that I included the programme coordinators' perceptions within the research chapter, in order to describe how they experienced the research tools. Therefore, in the second set of interviews conducted in October, I specifically asked the programme coordinators about the use of the personal narrative and whether it had any influence on their engagement with me during the semi-structured interview. Some of the positive feedback about the use of personal narrative identified that it is possible to mutually construct a research relationship that is grounded upon a repositioning of the self in relation to the research subject matter. For example, Thabo (29y) expressed that the personal narrative "changed [his] perception about [me] and [he] saw that it's genuine" (Thabo, 29y). Similarly, Sam (26y) indicated that, because of my personal narrative, Sam "felt like [I] could relate …" and therefore could share more with me (the researcher) (Sam 26y). Other programme coordinators were ambivalent about the use of the narrative, as they were of the opinion that "there was somewhat of a rapport that was already established prior to the interview" (Zama, 24y).

In light of the above perceptions, the effect of the personal narrative may assist in signalling to the interviewee that the researcher is aware of the issues and can, therefore, relate to the interviewee and the subject matter. On the other hand, researchers should be aware of the important role of developed collegiality in research methods that require subjective and dialogical processes. Collegiality does, however, bring with it limitations in

terms of the time available to develop a professional relationship with one's interview participant.

3.5.2.2 Semi-structured interview

The second research tool was that of a semi-structured interview. The decision to use a semi-structured interview was based on its utility to engage people and deepen the level of questioning in relation to how people are constituted and positioned. The semi-structured interview tool also offers the opportunity to deepen inquiry, through probing of responses for clarity and when possible, clarifying recurring themes that emerge during the semi-structured interview process.

Furthermore, as I conceptualized what research approach would be appropriate for the programme coordinators, I realized that, because of the professional collegiality constructed over a two year period, between myself and the programme coordinators, the semi-structured interview would not be restricted to only the questions and answers, but would essentially become a safe space for conversation.

Therefore, the semi-structured tool protected and honoured our relationship by allowing for a 'looseness' in conversation whilst adhering to the formalities of a research process and design.

However, I note the limitations of a semi-structured interview may make it difficult to compare data sets. Similarly, it is argued that the flexibility of the semi-structured interview may lessen reliability (Babbie & Mouton, 2002). I addressed these limitations by increasing opportunities that established the validity of the data through the member checking process. Furthermore, transferability of the findings were confirmed during a seminar where the findings were shared with practitioners who were implemented combined biopsychosocial programming for MSM.

By remaining cognisant of the limitations of the semi-structured interview tool, and implementing additional measures to check for validity and reliability of the data; I considered that the semi-structured interview tool was fit for purpose in responding to the research questions in my PhD.

The first semi-structured interview took place in March 2015 and the second in October 2015. I remind the reader that the timing of these interviews was significant, due to

the fact that, in March 2015, the institutional programmes would have been operational for a year. The second interview took place towards the end of the programme at the universities and, therefore, important questions and concerns about the programme beyond the life of the grant were raised during the second semi-structured interview. Before I discuss the interviews in detail, an unexpected learning about interview locations emerged during the first set of interviews.

The interview was located in venues where the programme coordinators were residing, as they had travelled from various provinces. The first set of interviews took place in a restaurant, located within the hotel where the programme coordinators were accommodated. The majority of the interviews took place in the evenings, following the quarterly NACOSA meetings. As the hotel was fairly small, the restaurant was not busy. This was helpful, as the audio was clear. We positioned ourselves a distance away from the one or two diners in the restaurant, so that our conversation could not be overheard. However, two interviews did not occur in the hotel restaurant. One interview took place during an evening in my office boardroom. The other occurred in the programme coordinator's own office space. During the interview process, I had not prepared for the impact that the environment would have on the flow of the conversation. For example, the interviews in the restaurant and in my boardroom were undisturbed. However, in the programme coordinator's office, there were many interruptions (six interruptions) by students and staff seeking information and/or assistance. At each interruption, the audio recording was stopped and restarted. There was also some sound distortion when knocking on the door occurred, which made some words difficult to hear and transcribe. A similar experience occurred during the second pilot study interview where the programme coordinator was often called out of the interview to manage a situation or respond to other stakeholders. However, in the first pilot study interview, which took place in the programme coordinator's office, there were no interruptions at all. This may be attributed to the fact that activities were quiet due to examinations and/or winter holidays.

Having not considered that the programme coordinators may not be available throughout the duration of the interview made me much more aware about issues of programme sustainability, once the grant had ended. This simultaneously signified how necessary the programme coordinator and the programme were to the institutional stakeholders.

For the second round of interviews, I was able to secure a boardroom in the hotel (different to the first hotel) where the programme coordinators were accommodated. Three of the five interviews took place in the boardroom, one in the programme coordinator's office, and the other in the hotel's restaurant. Complications did arise with the latter location, as an offloading bay and construction nearby distorted the sound. As a result, we moved into the hotel restaurant to conclude the interview. Similar challenges were experienced when the interview took place in the programme coordinator's office, with more telephonic than physical interruptions occurring. The boardroom space was the most ideal location as the programme coordinator was physically removed from his/her institutional space, which meant that there was less of a demand on him/her during the interview. Secondly, the closed boardroom space provided clear audio, as there was no surrounding noise to compromise the data.

The location was, therefore, an influential factor during the implementation of the semi-structured interview. Finding a location that was convenient for the programme coordinators, who travelled from other provinces, meant that often the location needed to take place in areas where they resided. Ideally, the use of a venue that gave the programme coordinator physical freedom to converse without being interrupted was helpful to the flow of the semi-structured interview and the audio recording.

The semi-structured interview was useful, as it provided many opportunities to explicate the meaning behind the responses and to induce meaning from the views of the programme coordinators and the external influences in their university. Using a semi-structured interview method also provided opportunities to identify comparisons and contrasts in the programme coordinators' responses and interrogate these responses for further clarity. In addition, because I had employed a critical theory approach, the semi-structured interview as a method provided opportunities to deepen the level of inquiry relating to questions about viable change. During the semi-structured interview, I often found myself simultaneously writing memo notes and actively seeking meaning of contexts and statements.

The semi-structured interviews with the programme coordinators were voice recorded and transcribed. Five open-ended questions were posed in the first interview, to which the

programme coordinators were required to respond verbally. The interview questions were linked to the five research objectives, which I sought to identify:

(1) What health and support services do HEIs provide?

(2) How are MSM students in HEIs targeted in seeking health and support services?

(3) How are internal stakeholders in HEIs organised to respond to, and support MSM students?

(4) How do internal stakeholders in HEIs respond to the needs of MSM students?

(5) What are the factors that facilitate and/or impede the development and implementation of health and support programmes for MSM students in HEIs?

Two more questions contributed towards describing the programme's location within the organizational structure. Programme coordinators were asked to draw the organizational structure of their interventions. While the programme coordinators drew their organizational structure, I also drew an organogram based on the discussion that had occurred in the interviews. Once we had completed the organogram, we compared the structures and interrogated the differences.

Lastly, the programme coordinators were asked to share their perceptions about the semi-structured interviews, in order to gather data on the application of the three research tools. Additional questions arose to extend and clarify content. Table 4 presents the corresponding interview questions (including probes) and the research objectives.

Table 4: Research questions

Research Objective	Interview Question	Probe
1. What health care services and support to Higher Education Institutions (HEI) provide?	1 (a) Please describe what your MSM programme looks like? 1 (b) Why is this service important for MSM on campus?	PROMPTS: Health? Treatment? Psychosocial – counselling? Education – peer networks? Campaign work? Communication?
2. How are MSM students in HEI's targeted in seeking out health and support services?	2 (a) What population was your programme created for? 2 (b) How did you reach your MSM? 2 (e) Were there any difficulties with reaching MSM? 2 (c) What were some of the successes of the programme? 2 (d) What were some of the limitations?	PROMPTS: MSM AND LGB OR MSM If the programme coordinator created a programme that included LGB then ask Did the merging influence the programme design because of LGB inclusion? Why was there a merge of populations do you think?
3. How are internal stakeholders within HEI's organised to respond to and support MSM students?	3 (a) Have there been stakeholders who have influenced your programme?	PROMPTS: Can you describe who the influential stakeholders are? What are your views of the stakeholder's influence?
4. How do internal stakeholders within HEI's respond to the needs of MSM students?	4 (a) How have these stakeholders responded to the existence of the programme? 4 (b) How have the stakeholders responded to the MSM-LGB students themselves?	PROMPTS: If they have influenced positively or negatively then ask for examples
5. What are the factors that facilitate and /or hinder the development and implementation of health and support programmes for MSM students in HEI's?	5 (a) A term that is often used is "Institutional Culture" what do you understand by the term 'institutional culture?' 5 (b) Did any of the components of institutional culture that you have described, facilitate the development and implementation of health and support programmes for the MSM (or LGB) students? 5 (c) Did any of the components of institutional culture, that you have described, hinder the development and implementation of health and support programmes for the MSM (or LGB) students?	PROMPTS: If they define it then ask for an example of institutional culture that they know of. If so why and why not? (In what way?) (Give me examples?)
6. Can we draw your programmatic structure?	Preceded by information about organograms. Followed by individual drawing of the structure and then a collaborative discussion of differences and agreements in the structures (as understood) by the researcher and the programme coordinator	PROMPTS: What do you like and/or dislike about your programmatic structure? What changes if any would you make? What works and doesn't work?
7. Probing the state of inclusion: Before I finish, I would like to know how did you find the interview?	7 (a) What particular questions were demanding? (Oh really, what in particular?) 7 (b) Did you feel you had a chance to put forward your views? Follow up with: This is clearly an area you feel strongly about, what is the importance of this? (Why)? 7 (c) Did you have the opportunity to cover things I missed and please elaborate on specific things I should have covered? or Are there any questions that I didn't ask and please elaborate on specific things I should have covered? 7 (d) Can I ask you those questions now?	PROMPTS: Ask - Why did you enjoy it? What things did you like and not?

3.5.2.3 Member checking

The individual responses to the questions listed in Table 4 were then analysed, compared and categorized. At this point of the research design, I used the third tool of member checking.

Member checking provided the programme coordinators with an opportunity to engage with the analysis of the data that emerged from their interviews and contribute towards the validation of the data (Denzin, 1978; Patton, 1999). In this way, member checking aims to improve the accuracy of the data; deepens the level of inquiry; and situates interpretations within the programme coordinator's context (Denzin, 1978).

The programme coordinators received copies of their full transcriptions and my completed analysis of their interview, which was framed by each of the five interview questions. The programme coordinators were invited to review and propose changes, clarity or thought processes that had emerged during their reading of the transcript and my analysis. Following member checking, the ensuing discussion was audio recorded and transcribed.

The second set of interview questions consisted of no more than five questions in total. Some questions (three in total) were repeated with the five programme coordinators, with only two questions that were specific to the programme coordinators' data. I found that there was a natural flow between the member checking conversation and the second semi-structured interview questions which helped to maintain the conversational tone of the semi-structured interview.

3.5.2.4 Attempting a critical theorist position

During the semi-structured interview, I attempted a critical theorist position in order to facilitate new ways of thinking and/or improving the status quo. I was consciously seeking out clarity, contrasts, and similarities in the programme coordinators' responses. In both interviews, the programme coordinators were invited to share their perceptions about the interview process. The general consensus was that the questions provided them with an opportunity to self-reflect on what they had accomplished and what changes, if any, they could make.

Excerpts from the interviews describe how the application of a critical theorist approach provided the opportunity for the programme coordinator to self-reflect. However, I was aware of my own limitations as a researcher, and I am sure that I was not always aware of all the narratives that could have enabled self-reflection. However, on the occasions where

I was able to critique responses, the programme coordinators were of the opinion that my probing question enabled them to "think of issues that [they were] unaware of" (Zama, 24y), while also giving them time to reflect "… about how has the programme been running all this time" (Sipho, 28y).

Therefore, as the semi-structured interview progressed, I engaged with emerging themes and encouraged the programme coordinators to elaborate on their responses, if they wished to do so. For example, during my engagement with Sipho, I actively interrogated whether the sexuality of the programme coordinator could influence the way in which the programme was implemented within the institution. Sipho's perception was that any other sexual orientation would not be able to advocate as well as MSM, "because they are not the same as a MSM and would therefore not understand the types of discrimination experienced by MSM" (Sipho, 28y). However, later in the interview, I critiqued Sipho's statement. This facilitated a revelation that countered his previous claim that people from different sexual orientations would not understand the types of discrimination experienced by MSM. Therefore, Sipho was left questioning whether the identity of the programme coordinator had any influence during programme implementation. Thus, by maintaining a critical theorist position in the semi-structured interview, some of the programme coordinators experienced new ways of thinking about their programme and the influence of one's identity as the programme coordinator.

3.5.3 Data-collection methods

The audio recordings of the interviews were useful, as this gave me the opportunity to focus solely on conducting the interview, rather than taking detailed notes (Babbie & Mouton, 2002)(Babbie & Mouton, 2002)(Babbie & Mouton, 2002)(Babbie & Mouton, 2002)(Babbie & Mouton, 2002). Audio recordings of the interviews allowed for the transcription of the interviews, which helped provide *verbatim* statements made by the programme coordinators. Having the transcriptions available allowed for immersion in the data and the opportunity to identify topics that were not evident during the interview. The printed copies of each transcription gave me the opportunity to oscillate between the individual data sets. The next phase of the research was data analysis.

3.5.4 Data analysis

In this section, I describe the process of open coding, axial coding and selective coding that emerged from the data. Further preliminary preparation prior to analysis included checking the accuracy of the transcriptions by replaying the audio recording while reading the transcription. This helped me become fully immersed in the data. In addition, memo writing was used throughout the study process, beginning in the early stages of research conceptualization. Memos took the form of handwritten notes that documented my thoughts and interpretations about the themes and categories that were emerging in the data as well as through broader university-related discourse.

The first phase of data analysis was to remove identifying data and assign the pseudonym and pronoun (if any) that was chosen by the programme coordinator. The research questions provided a framework for the analysis of the individual data sets.

Using the framework of the research questions, I began the open coding process in each data set to identify frequent words and/or related inferences. These became the initial codes for my PhD. During the semi-structured interviews with the programme coordinators, some initial open coding analysis occurred, particularly when words, experiences, and feelings were repeated, signalling a pattern that assisted me in deepening the level of inquiry. For example, at times, I queried the programme coordinator's entire response to gain clarity, whereas, on other occasions, I only focused on words used by the programme coordinator to probe the context with which the word or phrase was associated.

Transcripts were coded manually; this increased the level of analysis and provided breadth across all the transcripts, making simultaneous coding much easier. During the open coding process, each code was highlighted in different colours, which helped me quickly refer to related codes within the individual data set. Keeping with the structure provided by the research questions, emergent themes from the data were either subsumed under a higher order theme or were captured as an independent theme. Later, themes were grouped together, thus creating a higher order label that resulted in a category. These initial codes and the related texts were then cut out of the individual data sets (programme coordinators' descriptors were included) and then placed onto an A1 sheet that was affixed to a wall. The related codes were further grouped together to form axial codes.

In this second phase of data analysis, the axial coding process sought out related meaning between codes. In this phase, although related inferences were emphasised, there was a similar emphasis on the absences within the data. The focus on the hidden meaning and/or absences helped me explicate new codes that subsumed some of the first series of codes that were identified in the open coding process. On the A1 page, the colour-coded notes from the initial codes were then grouped below the new axial codes; in other instances, the initial codes were elevated to the level of an axial code. These axial codes are discussed in Chapter Four. Once the axial codes were formed, the final phase of data analysis began, namely selective coding.

Selective coding aims to generate new knowledge, and seeks to uncover more meaning. Thus, on the A1 page, I once again considered the contrasts and similarities of the codes by going back to the individual data sets and reading the colour-coded texts. The intention of reviewing the data was to specifically seek out the absences and inferences that were present within the data. Using this lens, I was able to once again group together similar axial codes to identify four selective codes that form the cornerstone of my PhD.

These selective codes not only identified similarities in process and influences in the university programmes, but also represent the less implied findings in the data. The four selective codes, discussed in Chapter Five, are central to the new knowledge that my PhD has produced. The selective codes emphasize the new knowledge in relation to institutional health and support services for self-identifying students at universities.

3.6 Research evaluation: Establishing credibility in the study

Lincoln & Guba (1985) define authenticity as the extent to which the data and data analysis are credible and that this can be achieved through the researcher's reflexivity and data triangulation, in order to increase the trustworthiness of the data. In the ensuing sections, I provide detail on how I attempted to authenticate the data.

3.6.1 Enacted reflexivity

To ensure that this study was reliable and valid, it was critical that before, during and after my research I reflected on who I am as a researcher. Before starting my doctoral studies, I managed the South African chapter of an International NGO for three years and, prior to this, I completed a Master's degree in Social Policy and Management which was preceded by a

Bachelor in African Gender Studies. From this context, a strong sense for management systems as a response to social justice issues emerged. Being aware of this, I was able to apply the thinking of interdisciplinary collaboration and processes. I am also aware that, because of my understanding of systems, there may also be a likelihood of not finding systemic responses within the research data.

Being a programme coordinator on the sexualities programme with other coordinators helped facilitate trust and confidence in the researcher-programme coordinator relationship and allowed me to establish a rapport with the programme coordinators early in the data-gathering process, providing access into their world, thoughts, perceptions and experiences. In order to maintain reflexivity, I used the conceptual framework, the guidance of my supervisor, and the research paradigm to help interpret the data analysis. In addition, I maintained 'hermeneutics alertness', which occurs in situations where researchers step back to reflect on the programme coordinators' views within the broader context (Ajjawi & Higgs, 2007). Thus, as the researcher I remained aware of my positionality and practiced self-reflexivity in an attempt to limit researcher bias.

3.6.2 Credibility

Credibility seeks confidence in the 'truth' of the findings. Lincoln & Guba (1985) denote strategies for increasing credibility in the findings, one of which is member checking. The latter formed part of the research design and was instrumental in increasing the programme coordinators' engagement with their interview data and my analysis. By including member checking as one of the three research tools used in the research design, I attempted to fulfil the participatory aspect that is entrenched in the advocacy/participatory paradigm.

3.6.3 Transferability

In quantitative data, external validity verifies the extent to which findings can be generalized to contexts outside the actual study context. Transferability of qualitative data is considered equivalent to external validity. Challenges with transferability are attributed to the subjectivity of the researcher who is the primary instrument in the data-collection process. Seale (1999) advocates that transferability can be achieved by providing a detailed and rich description of the settings studied, to determine the generalizability of the findings to other settings.

In my PhD, I provide in-depth information regarding financial and historical context of the university, which may influence and inform the university culture. In addition, I presented my findings to researchers, academics, and health professionals at a seminar comprising of the other MSM programme coordinators. The intention of sharing the findings was to test the relevance of the findings in a community that was actively implementing combined prevention programme for self-identifying students. The comments from the seminar participants were fed into the data analysis and minor adjustments were made. In this way, inferential generalization can be applied from the context of this research study to other higher education settings or contexts.

3.6.4 Confirmability of the findings

Confirmability is the extent to which data can be verified or corroborated by others. Whilst auditing could be used to establish confirmability (Seale, 1999), it is suggested that researchers archive all collected data in an easily accessible format so that it can be made available to auditors, should findings be challenged. During this study, I stored my audio data and transcriptions on two password-protected cloud servers, namely Dropbox and Gmail Drive. Thus, should the data be requested for verification, I am able to electronically share the folders with, or email the data to an external auditor.

3.6.5 Triangulation

Triangulation is the use of multiple methods to produce depth in understanding and meaning. For the purposes of this study, I use one of the four methods of triangulation, namely the triangulation of sources, which examines consistency in the data. This method uses multiple data-collection methods at different points in time (Denzin 1978; Patton 1999). After the conclusion of the pilot study, I conducted the semi-structured interviews. The data was then analysed and each corresponding programme coordinator in the study checked my analysis of their interview data. I also used the audio recordings while reading through the transcriptions to ensure accuracy. Thus, the triangulation exercises were done at various intervals to increase the richness and clarification of data.

3.7 Ethical considerations

Creswell (1998) states that researchers have an obligation to respect the rights, needs, values and desires of the informants. This study includes the following ethical considerations such as informed consent, risk mitigation, confidentiality, and anonymity.

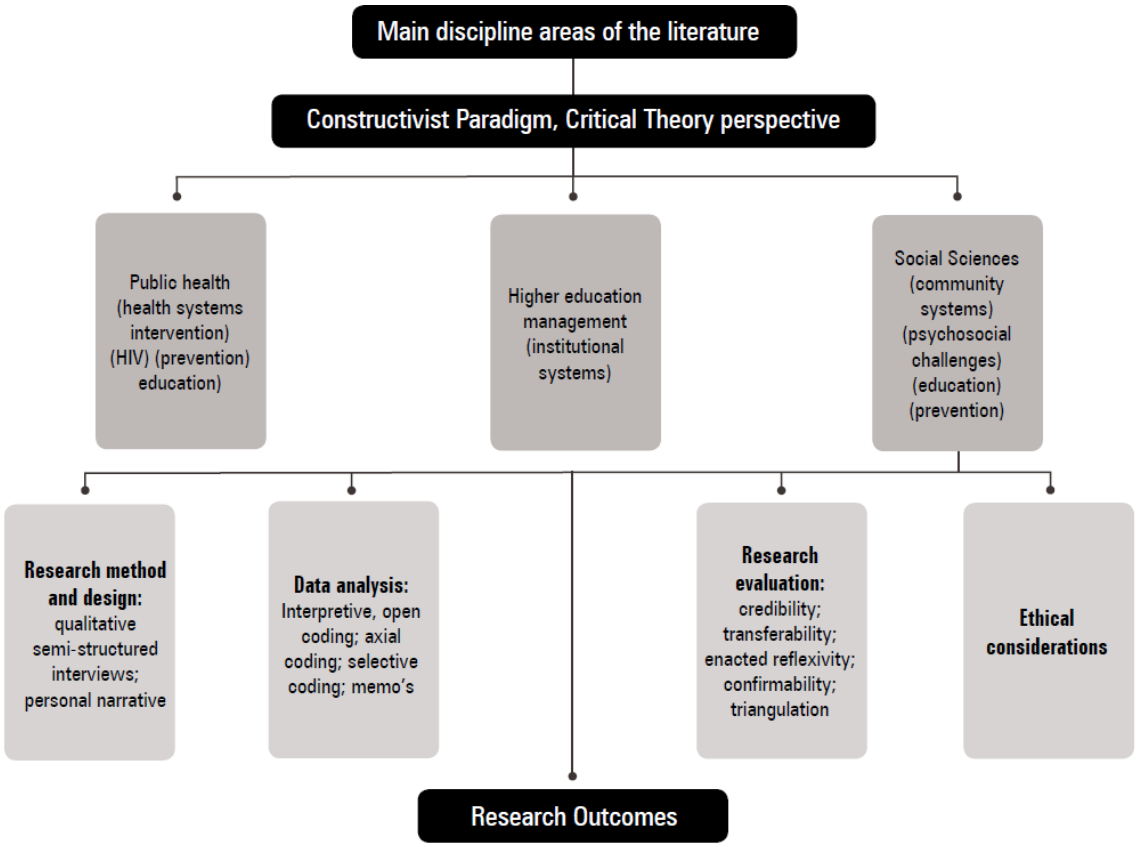
Honesty and trust were cultivated over a period of two years, as the researcher worked with the programme coordinators in the same grant-funded programme. Owing to the collegial relationship between the programme coordinators and myself, I was critically aware of the ethical balance I needed to maintain in the research process. Therefore, I ensured that all aspects of the study were deemed acceptable according to the University of the Free State's Ethics Committee Research Ethics Guidelines (UFS-EDU-2014-048). The guidelines adopted in this study emphasize the mitigation of risk to the programme coordinators, particularly because they are externally contracted by the university and the latter cannot be brought into unintentional disrepute. Therefore, in order to provide complete anonymity for both parties, I have guaranteed that the programme coordinator's name and the university's name will not be mentioned in this dissertation.

The informed consent included a full disclosure to the programme coordinators about the research; what they would be expected to do as programme coordinators, and the methods being used. Confidentiality of the data was secured by storing all data on a password-protected electronic server. In addition, all programme coordinators were reminded that their participation was entirely voluntary, and that they could remove themselves from the process at any point in time prior to the wider dissemination of the findings. Once this information was shared with them, all programme coordinators voluntarily signed the informed consent.

3.8 The stages of the research study

The aim of this study is to explore health and support structures for self-identifying students in the university environment. In the process, a critical theory paradigm was applied with the intention of developing actionable change in oppressive systems. The research flow depicted below was used to link concepts from literature, to establish evidence, to support the need for the research question, and to specify the forms of reasoning that constitute the research outcome.

Figure 2: Research design and methodology framework



3.9 Summary

This chapter outlined the research paradigm, research methodologies, strategies and design used in the study, including processes, programme coordinators, data-collection tools, data collection, analysis methods, and research-evaluation methods. Semi-structured interviews were used to collect data, which was later analysed using content-analysis methods. The chapter briefly included descriptions of the research design and development processes in this study. The next chapter provides the analysis and findings of the research data, with a specific focus on the axial codes.

Chapter Four: Findings and Analysis

4.1 Introduction

The MSM programme, as it is referred to by NACOSA, was a two-year grant that was initiated in March 2014 and ended in March 2016. In May 2015, I conducted my first set of interviews with all five of the programme coordinators. The timing of these interviews is significant, as the programme coordinators would have been implementing the programme in their university for just over a year. The second set of interviews occurred in October 2015, during a close-off period, which occurs in the last quarter (a quarter being defined in three-month intervals) of the grant funding.

Student activity at all South African universities was limited in the last quarter of the year, as institutions began preparing for final-year examinations. Therefore, any programme activities were unlikely to be implemented during the months of October, November and December.

The findings presented in this chapter combine the responses received in May 2015 and October 2015. Table 5 presents the research questions and my analysis of the programme coordinators' responses. The findings respond to each of the research questions:

(1) What health and support services do HEIs provide for MSM students?

(2) How are MSM students in HEIs targeted in seeking health and support services?

(3) How are internal stakeholders in HEIs organised to respond to, and support MSM students?

(4) How do internal stakeholders in HEIs respond to the needs of MSM students?

(5) What are the factors that facilitate and/or impede the development and implementation of health and support programmes for MSM students in HEIs?

Research questions one, two, four and five produced similar themes, which are collated under the axial codes of 'Reframing health and environments and services' and 'Developing the psychosocial environment'. Responses to question three produced a unique theme, which I defined as 'Programme efficacy and motivation'. Lastly, I conclude the

analysis with selective codes that overarch the axial codes. I discuss the selective codes in Chapter Five.

In Table 5, I detail the coding process described earlier. The first column contains the research questions and the remaining three columns consist of the corresponding codes that emerged during the data analysis. It must be noted that multiple open codes are subsumed under axial codes, the latter being grouped under selective codes.

Table 5: Codes

<table>
<tr><th>Question</th><th>Open Coding</th><th>Axial Code</th><th>Selective Coding</th></tr>
<tr><td>Q1. What health and support services do HEI's provide for MSM students?</td><td rowspan="4">Inclusion
Prevention education
Sensitization
Human rights education</td><td rowspan="4">Reframing health and environment and services
Developing the psychosocial environment</td><td rowspan="4">Leadership and the perceptions of power
Legal frameworks</td></tr>
<tr><td>Q2. How are MSM students in HEI's targeted in seeking out health and support services?</td></tr>
<tr><td>Q4. How do internal stakeholders within HEI's respond to the needs of MSM students?</td></tr>
<tr><td>Q5. What are the factors that facilitate and /or hinder the development and implementation of health and support programmes for MSM students in HEI's?</td></tr>
<tr><td rowspan="2">Q3. How are internal stakeholders within HEI's organised to respond to and support MSM students?</td><td rowspan="2">Work conditions
Programme efficacy</td><td rowspan="2"></td><td>Biopsychosocial strategies to include MSM students</td></tr>
<tr><td>The absence of the academic in university programming</td></tr>
</table>

I discuss each theme that is presented, using the literature from the systematic research as well as a broader literature search. I conclude Chapter Four with a summary of the core findings in most, if not all of the programme coordinators' data. In Chapter Five, I reflect on the selective codes tabulated earlier and specifically seek absences in what was not

verbally articulated, but implied. The ensuing sections outline the strategy of developing an inclusive environment and inclusive health and support services for self-identifying students in HEIs.

4.2 Reframing the healthcare services

The national strategic plan developed by the National Department of Health (2012-2016) denotes specific areas in primary healthcare services that progressively realise the establishment of inclusive healthcare practices. In light thereof, university primary healthcare providers are encouraged to align themselves with the national guidelines for healthcare practices and services, which include specific services for MSM.

However, prior to the implementation of the programme at the five universities, "not much attention [was] paid to MSM" (Sam, 26y). In fact, five programme coordinators found that there were no specific health and/or support services for MSM students. Sam's perception is that the absence of relevant MSM services is a reflection of the majority of public healthcare settings, where "you will find that the health professionals are not equipped enough, they don't have enough knowledge on how to look after MSM or assist them in any way possible" (Sam, 26y). To rectify the lack of knowledge and training, the programme coordinators began widespread dialogues and introduced specific training for healthcare practitioners to ensure that students in university were receiving inclusive and relevant care.

To assist with their engagement with the clinicians in university, some programme coordinators worked with non-governmental organisations that had expertise in reframing the healthcare environment, medical services and practice. In this way, relevant and specific training for healthcare staff in university was implemented. As a result of this training, some programme coordinators experienced better support from clinic staff. For example, Zama explains that, once the workshops were concluded, some clinic staff helped embed the programme with healthcare practice (Zama, 24y).

Training of healthcare staff was necessary, because, similar to research that identified teachers' hesitancy in discussing sexual orientation in classroom settings (Francis, 2012) and HIV (Volks, Abrahams & Reddy, 2015), some health practitioners also experienced some hesitancy when engaging with patients about sexual identity and related practices. This hesitancy can affect the content and quality of diagnosis and assessment delivered in health-

practitioner settings (Elam *et al.*, 2008; Rebe *et al.*, 2011; Carter *et al.*, 2014). Furthermore, the data showed that, despite the training of health staff, students expressed some hesitancy in receiving counselling services from the health practitioners. Thabo stated that self-identifying students preferred receiving counselling from him rather than using the university counselling service. He described that students often grapple with the risk involved in sharing personal information with someone with whom they have limited interaction, and questioned, "Whether it is safe for me? Who is going to get access to this information?" (Thabo, 29y). The resistance in using the institution's clinic may be attributed to a lack of trust between the self-identifying student and the clinic staff, with the result that some self-identifying students do not disclose information and/or use clinic services.

For Alex, the reframing of healthcare services was carefully considered in partnership with other institutional practitioners in the university. Alex focused on the provision of biomedical services, in order to avoid contention with an existing sexuality unit that had been providing psychosocial support to sexually diverse students (not specifically MSM students) studying at the university. By defining the programme as a biomedical support programme, Alex was able to develop a partnership with the colleagues in the sexuality unit who then collaborated on the programme by providing the activism and theoretical information to support the programme. The importance of his approach highlighted the valuable partnerships created in the university that assisted in the implementation of the programme. Alex stated that "a whole lot of other people are more experienced. So I have to bring my stance of the health seeking gay behaviour [and] testing" (Alex, 27y). This ethos has helped Alex develop a number of collegial partnerships in the university, which have resulted in curriculum inclusion, the revision of healthcare services, and the establishment of peer networks.

In summary, in order to reframe healthcare services and provide inclusive healthcare practice at universities, health practitioners received training that encouraged them to employ extraordinary measures to verbally articulate that the services they provide are non-judgemental and relevant to all types of sexual behaviours. In accordance with the literature, leadership within the community can negatively or positively affect the progress of a sexual diversity programme. The programme coordinators focused on developing key partnerships in their universities that would assist in linking the programme with existing services and programmes within their institutions. Therefore, the careful positioning of the programme and the management of institutional relationships may assist in embedding the programme

within the university (Trapence *et al.*, 2012; Beyrer *et al.*, 2012a; The Global Forum on MSM and HIV MSMGF, 2013).

4.2.1 Resources

Resources provided by NACOSA were used to complement the biopsychosocial programme. These resources included condoms, lubricant, posters, and prevention education materials, the latter being referred to as information, education and communication material (IEC). IEC materials formed an important component of the programme, given that there were variances in the government-issued resources that were available at each university. It was also noted that none of the government-issued HIV prevention resources were specifically relevant to sexually diverse students.

The programme coordinators emphasized the value of the IEC material and indicated that the resources became useful conversation starters for prevention education. Thabo, for example, indicated that IEC posters are used in the institutional programme to "start a conversation [where] people [were] able to open up to [the health promoter] and disclose their sexual preferences" (Thabo, 29y). These conversations also took place in the clinic space, which was resourced with condoms, lubricant and posters that provided visible representations of same-sex couples to signal to students that the clinic and, by association, the clinic staff were inclusive of all sexual identities. Thabo indicated that "if people don't see themselves in the clinic in the posters, then they might even think that they are not even affected by whatever issue is being addressed" (Thabo, 29y). Thus, changing the images in the clinic was a subtle way of indicating that the clinic fostered a non-discriminatory and inclusive environment (Carter *et al.*, 2014).

On the other hand, Sam describes how some of these resources such as lubricant inspired teaching moments for some students who did not know about the importance of lubricant in sexual activity. Sam stated that the "IEC material and the condoms and the lubes, [were] put [into] little packs" which were handed out by peer educators in residences and at Sam's office; however, further training was necessary because students "don't know how to put on condoms, they don't know how to use condoms and lubes and they don't know what lube is" (Sam, 26y). Sam goes on to problematize not using lubricant during the sexual practice of a gay identifying student as "the probability of the condom tearing is higher and [the student could have been using] unsafe lubricants like Vaseline" (Sam, 26y).

Sam linked students' lack of knowledge about lubricant to their remote geographic location of origin, and suggests that access to prevention resources is scarce in such areas. Literature would support Sam's belief that one's remote geographical location minimizes access to accurate HIV education and prevention resources, resulting in higher levels of internalized homophobia and other internalized psychological distress (Niang *et al.*, 2003; Vu *et al.*, 2013; Beyrer *et al.*, 2013; Henderson, 2015). However, in the systematic review conducted in Chapter Two, it was found that, in various urban areas, the prevention resources and education being shared were not relevant to the MSM population (Harding *et al.*, 2004; Eustace & Ilagan, 2010; Carter *et al.*, 2014). Therefore, geographic location may not be the only factor affecting the provision of education and appropriate services for MSM. There is, however, an onus on health practitioners and their governing bodies to make extraordinary efforts to remain abreast of current information regarding prevention methods and resources for all sexual behaviours.

In summary, the findings indicated that universities did not have prevention materials that were relevant for self-identifying students. This resulted in NACOSA providing IEC materials, including condoms and lube, to help reframe health services, institutional culture, psychosocial support, to curb the risk of HIV transmission and new incidences of HIV. The lack of relevant resources for self-identifying students is an area that may require careful consideration by government and universities and is necessitated by the guidelines set out in the National Strategic Plan (2012-2016), which calls for health services to become holistic and inclusive.

4.3 Developing the psychosocial programme

In this section, I detail how the programme coordinators developed the components of the psychosocial programmes. I begin by describing the sudden shift in focus by the grant funder to achieve more biomedical indicators that influenced institutional stakeholders' and self-identifying students' receptivity of the programme. I then discuss the value and successes of the peer education programme and the social network, the innovations in biopsychosocial care, institutional stakeholder receptivity, and the challenges in locating and retaining MSM students.

4.3.1 Emphasising biomedical indicators over psychosocial indicators

During the course of the programme, the programme coordinators found that the grant funder placed more emphasis on the attainment of the biomedical HCT indicators than on the psychosocial indicators. This shift in goals produced contention for the programme coordinators, as it overshadowed the other programme objective, namely to create an enabling and inclusive environment for self-identifying populations.

The programme coordinators found that the focus on the biomedical elements of the programme compromised the "*advocacy*" work, by isolating the rest of the institution from the discourse of sexual diversity and inclusion (Sam, 26y). In some ways, confining the programme to the provision of HCT may have contributed to the ideologies that pathologize sexual diversity, which was counterintuitive to the discourse of inclusivity being disseminated through the programme. The myopic approach, which focused solely on biomedical indicators, shed light on the synergistic relationship between the psychosocial and biomedical elements of the programme. The programme coordinators noted that, without the psychosocial support of the peers and the programme coordinators, there would have been a minimal uptake of biomedical services by MSM.

The emphasis on biomedical indicators by grant funders is not uncommon in HIV prevention programmes. When the programme coordinators continued with the psychosocial programme and broadened the inclusion of all self-identifying students, an "associated" increase in HIV testing, counselling, risk-reduction workshops, support groups and behaviour-change conversations was observed (Louwrens, *et al.,* 2016: 102). It is, therefore, equally important that grant funders develop and emphasize the attainment of psychosocial programme indicators in their related programmes.

4.3.2 Developing an inclusive environment

The programme coordinators focused on developing an inclusive environment, using education, campus dialogues, sensitization training as well as awareness campaigns to inform university stakeholders about sexual diversity. In addition, these institution-wide dialogues were viewed as influencing the university culture, as an increasing number of university stakeholders began to advocate for a more inclusive environment in the institutions.

By using campus dialogues to disseminate inclusivity discourse, Thabo created "a platform for the university community to engage in conversations around this topic [of sexuality] … whereby everyone is included in … [the] programmes or in the community of the university" (Thabo, 29y). Similarly, Alex used the larger campus dialogues to create "open spaces for engagement where anyone can bring any issues or concerns" (Alex, 27y). These campus dialogues were publicly advertised via Facebook and posters. The campus dialogues were useful in that they provided an educational environment for all institutional stakeholders in the university, regardless of sexuality. Within these spaces, Alex cautioned self-identifying students to the fact that anything could be said in a campus dialogue space, including the use of offensive and/or discriminatory language. In order to circumvent any trauma that may occur within these broader dialogue spaces, Alex provided a debriefing space for self-identifying students where they could access lay-counselling support immediately after the dialogue.

Like Thabo and Alex, campus dialogues at Sam's university were primarily education platforms that facilitated discourse among the student population. These were held "at least twice a month or three times a month, depending on demand" (Sam, 26y). In addition to the larger campus dialogues, other programme coordinators emphasized building partnerships with institutional stakeholders by means of smaller sensitization training workshops. Sam, for example, used these smaller educational spaces to raise awareness about the human rights framework and its application in the university's programme. Some individuals found the educational spaces challenging due to their existing religious and personal beliefs. However, by placing greater emphasis on "social inclusion" through the application of a human rights framework, sensitization training was found to be "the most powerful tool … to actually change people's perceptions", more so than the other programmatic functions (Thabo, 29y).

On the other hand, Alex specifically used the sensitization space with staff who were in contact with students. The sensitization training was used to help reframe perceptions and provide information on the current trends in pronoun use and terminology for self-identifying students. He stated that the training included "informing and raising awareness about subtle discrimination through words and actions which may be more pervasive than physical manifestations of discrimination" (Alex, 27y). The sensitization space created by the programme coordinators was also a forgiving space, where staff and students had "that

opportunity where … you say something [and] make a mistake, so let's know what is right, what is wrong, what to say, [and] what not to say" (Sam, 26y).

Sumartojo (2000) describes an enabling environment to be a result of structural changes to the social, cultural, economic, political and physical environment. Similar to the structural shifts in health services, the programme coordinators recognized that the beliefs and perceptions held and/or reinforced by the institution and/or its stakeholders may exacerbate discrimination towards self-identifying populations. It was, therefore, necessary to create an enabling environment within the institution that could support the changes being made within the health and support services. With this dual approach of campus dialogues and the provision of the sensitization training, the programme coordinators began to notice some changes in the institutional culture, as stakeholders became more receptive towards the programme and its intended purpose in the various universities.

4.3.3 Peer education and social networks

In addition to the campus dialogues, the five programme coordinators focused on training peer educators who could facilitate dialogue and disseminate health prevention education and support. Besides the dissemination of biomedical information such as the navigation of risk, prevention methods, HIV treatment, mental health, substance use and HIV testing, peer educators also provided psychosocial support and education such as lay counselling. Working with peer educators formed an integral part of the programme coordinators' strategy to facilitate self-identifying students' access to health and support services in the university. From the findings, it appears that peer educators were already present at each university, some of whom were self-identifying and others not. Furthermore, the research findings showed that HIV peer educators were also discussing intersectional education about health, culture, and identity to better support self-identifying students (Lauby *et al.*, 2012 ; Landovitz *et al.*, 2012; Scott *et al.*, 2013). In light of recent student movements, the role of peer educators could possibly be developed to include the dissemination of inclusivity discourse.

One of the first steps when working with peer educators was to train them on prevention strategies that were relevant to self-identifying students. Braine *et al.* (2011) propose that health education should include prevention information about "probable risk rather than predictable safety" (Braine *et al.*, 2011: 810). The differentiation between risk and safety is an important distinction, because the negotiation of risk that occurs during MSM

sexual behaviour is purportedly part of MSM sexual practice. For example, concerns about sexual positioning during sexual activity, condom use (when it is used) and substance use are elements of prevention education that are relevant to MSM populations (Braine *et al.*, 2011).

Research has established that the progressive approach of shifting the focus away from one's sexual orientation to only considering sexual practice is useful in removing stigmatic perceptions about sexual orientation and prevention education (Jobson *et al.*, 2013; Kennedy *et al.*, 2013; Lyons *et al.*, 2013). In order to focus on sexual practice, the programme coordinators trained the peer educators to discuss risk from both a biomedical (HIV and STIs) and a psychosocial (stigma, depression, suicide) perspective.

Working with peer educators was of particular importance to Zama, because the sustainability of the programme coordinator post in the institution was not guaranteed. Therefore, building the capacity of peer educators who could continue the programme after the life of the grant was an important aspect of Zama's programme design. Similarly, for Sipho, identifying and training peer health promoters had the additional benefit of extending the reach of the programme across the institution.

For the programme coordinators, working with peer educators expanded the social networks that helped locate and access self-identifying students. Sipho found the collaboration with "LGB students" to be an important element in "[getting] through to other students who do not want to come to our offices" (Sipho, 28y). Alex identified the value of dialogue as important and was of the opinion that "[the self-identifying students] forget that this person … is also going through the same struggle" (Alex, 27y).

Similarly, Alex established social groups that gave self-identifying students "[a] space … [where they could] be themselves and [be] comfortable with who they are" (Alex, 27y). He reinforced that the gatherings were aimed at increasing interaction between self-identifying students, in order to provide "support to each other in being gay … not because students are gay, because the gayness is not the problem" and when necessary, to rely on the established social network for psychosocial care and prevention education (Alex, 27y).

Likewise, Thabo mentioned that the purpose of the risk reduction information shared by the peer educators provided a "platform where the students can share whatever challenges they have", which "created a community [where] people can find friends and share their experiences" (Thabo, 29y). Like Alex, Thabo focused on shifting the concern away from

"being gay or whatever [to] the sexual practice that [the students] actually engage in" (Thabo, 29y). By working with peers, the risk reduction information was delivered in an accessible, informal and engaging manner, while the content was relevant to the students' sexual practice. The purpose of the risk reduction was to not focus on a person's sexuality, but to only consider sexual behaviours and how to maximise safety.

Chapter Two documented the ways in which peers become sources of information about risk, pleasure, prevention education, and lay counselling. Peer education provides a useful, informal learning space where students can rely on one another for a number of social, academic and health-related issues (Lauby *et al.*, 2012). With regard to the latter, studies have found that peer networks are positively associated with a reduction in delayed HIV testing (Peterson *et al.*, 1992; Mashburn *et al.*, 2004; Lauby *et al.*, 2012). From the findings in Chapter Four, it was evident that the programme coordinators from the five HEIs experienced greater efficacy in reaching self-identifying students and retaining them within the system of care and support when peer educators and social networks were incorporated into the programme design and strategy. Furthermore, the capacitation of the peer educators with lay counselling techniques was an important part of the informal support network that was often utilized by students at university. Carter *et al.* (2014) support the capacitation of non-healthcare practitioners such as peer educators to provide this type of lay counselling service.

Understanding current trends in lay counselling approaches is an important aspect of designing health and support services for self-identifying students. In the broader literature search, only one article referred to a lay counselling framework that had proven effective in increasing HCT uptake and related services by MSM in sub-Saharan Africa (Taegtmeyer *et al.*, 2013). Taegtmeyer *et al.*'s article is important in that the framework was developed out of a wider review of counselling programmes for MSM populations that highlighted important considerations for the training of lay counsellors. This training content focused on developing the lay counsellors' skills and knowledge about what triggers risky behaviour and desire, assisting persons with low self-esteem, and strategies for peer educators when their education is ignored (Taegtmeyer *et al.*, 2013).

All of these content areas are as important as the ability to "skillfully counsel students about controlling risk" (Taegtmeyer *et al.*, 2013: 7). Of further importance is the lay counsellors' ability to provide an inclusive space that would also include "activities that can

assist students suffering from low self-esteem as well as methods that the peer educators themselves can use – when prevention education is refused" (Taegtmeyer *et al.*, 2013: 156).

Therefore, despite the peer educators' important role in building social networks of trust, their equally important job is to deliver a myriad of risk-reduction and prevention-education workshops that seek to inform students about safer sexual practice. Peer educators are essentially interlocutors who can facilitate conversations that result in a common understanding. The peer education modality can contribute towards cultivating inclusivity and reframing the institutional culture within the university context.

Of further importance for the South African higher education context is the inclusion of two content areas specific to MSM sexual behaviours that are arguably absent from current HIV prevention education discourse. Currently, HIV prevention education misconstrues risk behaviour as a product of ignorance and psychological difficulties, whereas research evidence shows that risk is a calculated aspect of conscious sexual engagement (Braine *et al.*, 2011). It is noted that probable risk assessment is a discretionary exercise used by some MSM to assess what types of sexual practice can be experienced with a partner prior to intercourse or after unprotected anal intercourse. In order to improve HIV prevention education, two content areas should be included. The first content area pushes the boundaries of prevention education to include risk assessment, negotiating boundaries, assessing risk, and navigating pleasure. Such an inclusion would shift current HIV prevention education from only focusing on "predictable safety" (Braine *et al.*, 2011: 810). Therefore, prevention education can no longer ignore the value of preparing students to negotiate risk and safer sex practices prior to and during sexual intercourse.

In addition to the inclusion of probable risk assessment and related prevention practices, further information should include the course individuals should follow if unprotected anal intercourse has occurred (Braine *et al.*, 2011). Furthermore, Elam *et al.* (2008) suggest that prevention education should include the psychological factors that occur among MSM, namely the tension between unfulfilled sexual and emotional needs, which is as important as not being infected by HIV. Thus, a considered balance between satisfying desires and avoiding the risk of HIV infection is an aspect that needs to be carefully infused into prevention education and barrier methods discourse.

Secondly, the use of substances as a method of sexual enhancement is an area that could be further developed in HIV prevention education in an attempt to prepare students who use substances as part of sexual enrichment. In this way, students could potentially be equipped to self-assess and peers have the skills to intervene while their friend(s) is/are *non compos mentis* (Elam *et al.*, 2008).

A further inclusion in prevention education is the use of substances when one is taking antiretrovirals, pre-exposure prophylaxis, or post-exposure prophylaxis (Braine *et al.*, 2011). The effect on HIV treatment medication when used in conjunction with substances is an important area of education that students will need to understand. In particular, the strong reinforcement of continued condom use despite access to pre- and post-exposure medication is an important part of education discourse. Landovitz *et al.* suggest that prevention education without the inclusion of substance use discourse renders the education irrelevant to MSM students, in particular (Landovitz *et al.*, 2012). Therefore, prevention education must appropriately provide information about substance use discourse in relation to pre- and post-exposure prophylaxis and emphasize the continued use of condoms, with the latter having the highest efficacy in preventing transmission of HIV.

In summary, the research findings provide evidence that the role of a peer network is an important programme element in the provision of biopsychosocial support to self-identifying students at university. Similarly, current research demonstrates that self-identifying populations, in particular, are likely to turn to peers when seeking healthcare information and support. It is, therefore, essential to train and prepare peer educators within the university setting to adequately provide support, information and referral services. Prevention education that adheres to only barrier methods by peer educators are fast becoming irrelevant to MSM sexual behaviour and, in order to align with current sexual practice, peer educators should include discussions about probable risk assessment within the suite of prevention education. Additional content within the prevention education discourse should include substance use, pleasure, desire, barrier methods, lubricant, frequency of HIV testing, treatment as prevention (pre-exposure prophylaxis, PrEP), treatment post-exposure to HIV (post-exposure prophylaxis, PEP) and antiretrovirals (ARVs). The research findings in Chapter Four showed that, besides the provision of prevention education, peer educators were instrumental in providing support to self-identifying students. Peer education contributes to the development of a strong social support network among self-identifying populations,

resulting in informal hubs of education, referral, and care. Together, peer educators and programme coordinators had a collective identity and agency that presented a united front against institutional barriers that may hinder positive health behaviour, while also providing support and encouragement for self-identifying students. The establishment of a peer network of support is, therefore, an important part of creating an enabling environment and putting in place an informal system of care and support that catalyses the referral of students into more formalised health and wellness services at university.

For four of the five programme coordinators, peer educators and social networks appeared to be a useful strategy that helps extend the reach of the programme in the institution. More importantly, the use of peer educators and social networks provided access to students within informal spaces, which an institutional programme would not ordinarily reach. Collectively, campus dialogues, sensitization workshops, peer education and social networks are deemed to have contributed towards an enabling environment at the four institutions. Preparing peers for their role as peer educators requires careful training, supervision and continuous monitoring, not only to manage the quality of education, but also to support the peer educators in their role as health educators and lay counsellors to students in the university.

4.3.4 Innovations in biopsychosocial care

Biopsychosocial innovations were introduced and ranged from changes on administrative forms, to incorporate gender and sexual diversity, to innovations using social media as part of the health prevention and lay counselling strategy. In this section, I describe the innovations that were introduced by the programme coordinators in the health and support services provided by the university.

A delicate balance needs to be achieved in preventative care and education. On the one hand, prevention education by peers needs to be comprehensive enough for students so that the information assists them in forming rational decisions. On the other hand, pathologizing sexual engagement should be avoided and include discourse about pleasure and desire. Thabo fears that "society is actually struggling [because] they think MSM is all about sexual practice" (Thabo, 29y). However, he suggests that society misunderstands the different struggles experienced by MSM and LGB. He reports that MSM struggle with society's misconception that it is simply about sex, whereas it is much more complex: "it's about who

you fall in love with" (Thabo, 29y). This perception is a broad generalization, in light of research which shows that some MSM seek emotional connections in addition to sexual gratification, while other MSM intentionally do not seek emotional connection and purely focus on sexual pleasure (Elam *et al.*, 2008). Therefore, HIV prevention education needs to avoid moralising norms that contradict sexual practices involving more than one partner and rather provide prevention education that is relevant to all relationships and sexual practices.

All five programme coordinators focused on enhancing the current HCT protocol to become more accessible and relevant to self-identifying students. Novel strategies were considered and implemented, with some strategies enjoying greater success than others. For example, Alex and Sipho utilised mass HIV testing drives for all males at the university, instead of only providing specific HCT for MSM. During the HCT drive, all the males who attended the event completed a survey; the MSM students were identified from this data.

Alex emphasised that "[he has] never ever had [an HCT] drive which has [been advertised] for LGBTI, and … will never have [an HCT] drive for LGBTI" (Alex, 27y). He stated that his HCT drives target men's health which encourages "all men [to attend] so the awareness is around your men's health and you as a man [in order to] make everybody feel inclusive" (Alex, 27y). Later in the interview, Alex indicated that, if he had to only run an MSM programme, he would have conducted the programme in the same way, using a broad men's health focus. From the data gathered in the survey, he began approaching the MSM to attend the counselling, social groups and HCT.

Thabo also concentrated his efforts on innovations in the HCT space, which helped locate and increase access to specifically MSM students at his university. Working with HCT staff referrals and with the permission of the MSM students, Thabo was able to make direct contact with MSM students who voluntarily provided their contact details. After receiving the students' consent, Thabo was given the contact information by the clinic staff and was able to access the MSM students. A similar initiative developed by Sipho assisted him in locating and recruiting MSM. Sipho's innovation utilized the HCT space, where the health practitioner used the available time, after the HIV test, to discuss the MSM programme and its purpose. During this time, if the MSM students were willing, they completed a sexual behaviour card, using their contact details. Sipho would then use this information to contact the students and discuss the programme components and services with them. Although this

innovation has worked in this institution, it may not have worked in institutions where the self-identifying students preferred anonymity (Rebe *et al.*, 2013; Rebe & McIntyre, 2014).

A further innovation in HCT initiated by Thabo was to follow up with the MSM students after the post-counselling session, because "he is aware of the many emotional challenges facing MSM" (Thabo, 29y). When enquiring why he introduced this strategy, Thabo indicated that the current post-counselling provided during HCT is inadequate for the multiple and intersecting psychosocial challenges facing MSM (Thabo, 29y).

Alex implemented prevention-education sessions in the HCT space while students waited for their clinic appointment. This method is supported by research that described the waiting room as an important environment that can reflect the inclusive ethos and practices supported by the clinic (Elam *et al.*, 2008; Fox *et al.*, 2009; Rebe *et al.*, 2013; Carter *et al.*, 2014). Alex focused on using the time spent waiting in the clinic reception area to peer educate students with relevant and inclusive prevention information. Following the peer-education session, the health practitioner offered behaviour-change conversations during the individual consultation. These behaviour conversations also took place with students who came to the clinic for advice and not necessarily to be tested for HIV.

Another noteworthy innovation was the use of social media as a virtual psychosocial support space for self-identifying students. The use of social media in the provision of risk-reduction advice and peer education has been a useful innovation among MSM populations, because it was highly accessible to the students and provided anonymity.

In the South African university study, Brink (2014) found that like heterosexual populations, social networking through online platforms is a common practice among MSM students (n = 833). To extend the reach of psychosocial support, some programme coordinators utilized social media to locate, assist and provide prevention education to self-identifying students. This finding is consistent with research, which suggests that self-identifying populations prefer receiving HIV information from persons with whom they have a personal connection (Sprecher, Harris & Meyers, 2008; Voisin *et al.*, 2013; Khosropour, Lake & Sullivan, 2014; Young & Jaganath, 2014). As identified earlier in Chapter Four, the findings emphasize the important use of social media in providing psychosocial support, prevention education and retaining MSM in systems of care by peers.

Further research among MSM populations shows an emerging body of evidence demonstrates the usefulness of social media platforms as a way of not only disseminating HIV prevention information, but also 'reaching' (identifying and locating) and facilitating the retention of MSM in systems of care and support (Young & Jaganath, 2014).

Social media technology use within the five institutional programmes has been a particularly effective tool in locating and retaining MSM (Mikolajczak, Kok & Hospers, 2008; Phillips *et al.*, 2014; Rendina *et al.*, 2014). This useful mechanism assisted Thabo and Zama in staying connected with self-identifying students via the social media networks that were used to update the groups with biopsychosocial information and care.

Like physical risk-reduction workshops, virtual conversations provided additional support and prevention information between self-identifying peers. Thabo stated that the virtual platform provided a "sense of belonging" (Thabo, 29y). In this virtual space, Thabo also provided lay counselling, which was well supported by self-identifying students. He assumed that the student preferred the lay counselling provided by the virtual platform, because it was readily accessible during student-friendly times.

Zama also used a virtual platform to locate and retain MSM in the programme. Working with a "male student who recruited his friend; [and his friends] knew [and invited] other people, [resulting in an] increase of numbers within the space of the month" (Zama, 24y).

This finding reinforces the notion that peer networks are effective in the physical and virtual recruitment of MSM, and that programmes should be incorporating broader peer networks during their implementation, in order to locate, access and retain self-identifying students in systems of healthcare and support (Shah *et al.*, 2014).

However, unlike Thabo, Zama expressed her discomfort with the virtual social media space, which, she argued, often intruded upon her personal time. Given the high physical and emotional pressures of the programme, Zama cautiously maintained her boundaries, in order to separate her personal time from her work time. Zama was thus able to establish a balance in her work and home life. This helped reduce the amount of stress experienced during the programme.

In delivering prevention education, further considerations should include the modality in which this education is delivered, as online platforms such as Facebook and Whatsapp, among other social media platforms, are sites where additional education and support could be given. Although psychosocial care in the virtual setting has proven to be effective in increasing HIV testing and lowering risk behaviour (Mikolajczak *et al.*, 2008; Justumus *et al.*, 2013), the experiences of Thabo and Zama in using the virtual setting in the provision of counselling, prevention education and peer support is an area that requires further investigation, while taking into account the limitations of the online environment. Given that online platforms could potentially be used in the provision of care and prevention education, one should consider confidentiality and ethics in the online space. These considerations should also include the medico-legal aspects of providing counselling and maintaining anonymity. Lastly, the use of online platforms should initially not seek to replace current methods in health provision and support, but could possibly strengthen current elements of biopsychosocial programmes.

4.3.5 Challenges in locating, accessing and working with MSM students

Previous research articulates the challenges in locating and retaining MSM (Conner et al., 2005; Elam et al., 2008; Carter et al., 2014). These same challenges were evidenced at the five universities, as the programme coordinators had to establish innovative ways to seek MSM students and encourage them to access the university's health and support services.

In this section, I describe the innovations that led to the location of MSM in the university. It is important to note that the efficacy of the innovations was dependent on the creation of an inclusive environment, the latter encouraging self-identifying students to be part of a political and collective identity within the university.

One of the foremost challenges experienced by MSM is stigma, which the programme coordinators found to be present at their universities. Related to the fear of being stigmatized for one's sexual behaviour, Zama found that MSM were more willing to declare their identity in an anonymous questionnaire rather than physically attend a MSM group or verbally state what sexual practices they engage in. Similarly, Sipho found that MSM were unlikely to be "open about it [their sexual practice], they are not" (Sipho, 28y). The programme coordinators' understanding of stigma is similar to the research that confirms that MSM fear being discriminated against and, therefore, do not share information about their sexual

practice. This limits their access to relevant healthcare information and services (Baral, Sifakis *et al.*, 2007; Beyrer *et al.*, 2012a; Beyrer *et al.*, 2012b; Beyrer, 2014).

The second difficulty was the conceptual disconnect about the meaning of MSM among self-identifying students. The term 'MSM' was reportedly not understood and/or used by the students. In fact, Zama found that the students considered their sexual practice to be encompassed under the label of gay rather than MSM. The perception that students do not identify with biomedical terms such as 'MSM' is comparable to the research by Msibi (2011) and Matebeni & Msibi (2015) who write that the current terms, acquired from the global north biomedical terrain, do not resonate with sub-Saharan self-identifying individuals. In the absence of common language, grant funders often resort to using the established biomedical terms. The resultant effect is that the self-identifying population do not know what is being referred to and, therefore, are likely to disengage from the biomedical terms that are used to label sexual identity (Nyanzi, 2014; Matebeni & Msibi, 2015).

The third challenge that was emphasized as a barrier to locating MSM was the institutional culture found within each of the universities. For example, Sam stated that, in the university, "[B]lack people, [particularly] [B]lack MSM … are more open about their sexuality than [W]hite and [C]oloured LGBTI" (Sam, 26y). Sam attributes this finding to the Afrikaans culture, which Sam believes may negatively influence the ideologies about sexual orientation and, in turn, force self-identifying students into hiding (Reddy, 2004; Epprecht, 2008; Du Pisani, 2012).

Alex also found that his institutional environment was not conducive to locating MSM students at university. Despite there being an institutional sexuality unit at the university, Alex was of the opinion that much more specific change was required for MSM support services. He indicated that MSM have never had a unique focus at the university and that there has never been discourse to affirm that their identity is "okay … you don't have to be bisexual; you can just be MSM" (Alex, 27y).

Therefore, the finding suggests that having spaces in universities that affirms this sexual behaviour is still a novel concept for some university stakeholders and requires further engagement in order to reframe the current institutional response towards self-identifying populations in university.

As mentioned in Chapter Two, Conner *et al.* (2005) identified that retention and location of MSM within a biopsychosocial programme has proven to be challenging for the majority of the practitioners who work with MSM. The findings show that four of the five programme coordinators found it impossible to locate *only* MSM students. However, when they discovered that MSM students were positioned among the broader self-identifying population on the university campuses, one of the programme innovations was to broaden the target group to include all self-identifying populations in the university. When I asked why MSM were part of the self-identifying group, Sam explained that it is because "LGBQTI" can empathize and "[MSM can] connect more with someone that knows - that knows how it feels, that's been there" (Sam, 26y). When asked if this level of empathy can only occur among MSM and other self-identifying people, Sam stated: "I feel like [if] you have some sort of knowledge on LGBTI and you've got maybe family members, parents who are gay and so on. So I feel like they know, they've probably experienced [*sic*] in some way" (Sam, 26y). Sam's response to the question was important, as it alludes to the fact that one's sexuality may not necessarily be linked to the ability to empathize with self-identifying populations. This may have implications for how institutional programmes are constructed and/or led in the university.

Similarly, despite Zama reaching out to only MSM students, self-identifying students attended the workshops, because "you cannot separate the gay identifying men … from lesbians. They always come together. They are there all the time" (Zama, 24y). The reality of MSM and LGB students attending the programme together and sharing spaces for dialogue and support has been managed by Zama who provided knowledge that is relevant to both groups. Where possible, the groups have been subdivided to provide specific interventions and support to "WSW, MSM and LGBTI students" (Zama, 24y).

On the other hand, Thabo indicates that seeking out MSM students and retaining them within the programme was not a challenge in his university. Despite the ease with which MSM students were accessed and retained in Thabo's programme, self-identifying students are also included in the programme and receive all the services and resources associated with the programme. His intention was to increase the level of inclusion within the programme and to avoid divisions among self-identifying populations.

Thabo shares two factors that facilitated the easy access to, and recruitment of MSM into the programme. The first factor was the established database of self-identifying students to which he had access prior to being employed by NACOSA. The second factor was the utilization of a peer network to access MSM within the institution. Thabo indicates that

> *most of the MSMs who are part of the group were actually invited by gay students, because it's a network, they know each other. So I do have heterosexual MSM in the structure* [who were] *brought in by gay students* (Thabo, 29y).

An interesting finding that emerged in Thabo's programme, which was contrary to existing research by Operario, Smith & Kegeles (2008) and Schrimshaw *et al.* (2014), is that self-identifying students did not engage with programme services, when the communication and/or related advertising did not specifically mention that the service was for self-identifying populations in the university. Thabo found that there was a sense of distrust when generic communication was used to invite self-identifying students to participate in programmes and/or workshops. This distrust was, however, circumvented when a peer "brings them in" (Thabo, 29y).

Although there was easy access to MSM in Thabo's programme, the programme strategies used to locate and retain MSM students were similar. These strategies included HCT innovations, events and working in self-identifying social networks.

However, an unexpected tension emerged when using the above strategies to locate and access MSM students. This tension concerned the increased visibility of self-identifying students in the university that, at times, compromised the physical security of the students. Alex and Sam grappled with this tension, and had, as one of their main objectives, the safety of the students in mind, while implementing the programme. Thus, the physical security of students became a primary concern for these two programme coordinators, and this influenced the way in which social group gatherings and other safe spaces were advertised. For Alex, the caution about protecting the students and their spaces was attributed to a historical incident where self-identifying students were attacked in the university. Alex's intention was to provide a social space where "the group can feel secure … where [the students] can voice and talk and just be [themselves]" (Alex, 27y). Alex was careful about sharing information about times, venues and dates for dialogues and social groups in public

forums that may compromise the students' physical safety. Thus, the tension also resulted in exposing self-identifying students in the university, thus increasing concerns about the students' physical safety.

In summary, locating *only* MSM students onto the programme was a challenge shared by four of the five programme coordinators. Challenges in seeking out MSM within the institution were exacerbated by the stigma against MSM, as well as the misuse of terms, as some self-identifying students would not consider themselves MSM. In light of these challenges, the programme coordinators focused on creating inclusive and relevant spaces for all self-identifying students, with the result that MSM could be found among self-identifying students.

4.3.6 Institutional stakeholder receptivity

Institutional stakeholders are defined as university staff, students and/or third party service providers within the university environment. The programme coordinators share similarities in that the programme received, what they perceive to be, low levels of resistance from the majority of the institutional stakeholders. In addition to building the capacity of health practitioners, the programme coordinators were of the opinion that the institutional staff would need to be "equipped with this LGBTI knowledge, because at the end of the day … they are the ones who are serving students" (Sipho, 28y).

Despite capacitation and the perceived support of institutional staff, two contradictions occurred in the findings. The first contradiction is that, while some programme coordinators experienced similar levels of receptivity, resistance did arise in all institutions, particularly when reframing institutional norms was required. For example, when Sam began to advocate for structural changes such as gender neutral toilets within the institution, Sam reported that "the VC said no … top management said no; … a lot of people shook their heads" (Sam 26y).

Similarly, in some instances, religion was used to defend institutional norms. Thabo described how, during the initial stages of implementation, the institution "didn't give space or acknowledge LGBTI students" (Thabo, 29y). He recalls how religion and some cultural practices were used to explain "how life should actually be led", because homosexuality was considered to be "*a sin*" (Thabo, 29y). Therefore, in the initial stages of the programme, when Thabo put up posters about LGB meetings and dialogues, "someone would come and

put up a poster about a prayer session or a religious outing and all that" (Thabo, 29y). In addition to the religious beliefs, Thabo was also confronted with cultural beliefs, stating that "a man is supposed to be with a woman" (Thabo, 29y).

Sipho experienced similar responses from academic, administrative and clinical staff who were supportive of the programme and have, to some extent, catalysed the reach of the programme. However, Sipho identified that there were varying levels of support – from the perfunctory to the genuine forms of assistance by stakeholders within the institution. He reports that he

> *could sense a lot of negativity towards the programme, but in terms of me implementing the activities ... they would say give me the go ahead, but them* [*sic*] *to support the programme and be there, I failed to get to a level where I would hear them saying something positive about the programme* (Sipho, 28y).

Therefore, despite the programme coordinators indicating that the university stakeholders offered their support, there were also pockets of resistance by some institutional staff, particularly when cultural, institutional and/or religious norms were challenged. This finding suggests that receptivity towards the programme does not automatically mean support. Furthermore, there are levels of support that may be genuinely provided or perfunctorily performed. Research by the Global Forum on MSM and HIV (MSMGF) indicate that resistance should be expected and that negotiations relating to issues of structural change should ensue. This is likely to produce discomfort for some institutional stakeholders, allies and programme coordinators (The Global Forum on MSM and HIV MSMGF, 2013). While the negotiations can become useful educational moments that contribute towards an enabling environment, depending on the power of the decision makers within the institution, resistance can result in inaction and repulsion; however, the latter is not to be used as motivation for complacency (Nyanzi, 2014).

Another finding that arose was a perception held by the programme coordinators who believed that the work of the programme would be expedited if the executive offered their support and directive. It was believed that "power has so much influence … [and] played a very important role" in influencing the levels of receptivity by institutional stakeholders (Alex, 27y). Thabo describes how a change in executive support influenced receptivity in his university. He claims that during the initial stages of implementation, he experienced major

challenges from the previous Vice Chancellor of the university who "was very vocal about speaking against LGBTI" (Thabo, 29y). However, after the previous Vice Chancellor's departure, Thabo found that the programme progressed very rapidly. He attributes the ease with which the programme was included in the institution to the new Vice Chancellor who supported the programme. Therefore, Thabo considered the role of executive leadership to be a critical factor in shifting the institutional culture to becoming more responsive towards self-identifying students and the related programme.

Similarly, at Sam's university, for example, executive leadership publicly advocated for the inclusion of the programme. Sam states that "[t]op management [was] really interested in the programme because they really want to know … is it making a difference [and] where [the university] could improve" (Sam, 26y).

Sipho experienced similar support from executive management, and described the institutional culture as open to, and inclusive of all students. Executive leadership in his university provided clear support towards the implementation of the programme when the Vice Chancellor stated: "You know what, it's okay to be gay on campus. So that message was just so powerful for us. He said whatever it is that you need, whether you need me to come and say things to students or whatever, just ask" (Sipho, 28y).

With support from executive leadership occurring in only three institutions, the remaining two programme coordinators established different models of institutional support without the expressed support from the executive. However, if one considers that, despite the presence of executive support, the remaining two programme coordinators were able to implement the programme with varying levels of support, receptivity and resistance, one cannot conclude that executive support and/or directives influence institutional stakeholders' receptivity towards the programme. In Chapter Five, I focus on this contradiction as one of the overarching assumptions made when creating an inclusive environment in the university.

4.4 Programme efficacy and motivation

Two factors influenced the programmatic design, efficiency and motivation, namely building institutional partnerships and pressurized work conditions. During the initial stages of the programme implementation, the programme coordinators found themselves having to advocate for the existence of sexuality programmes in their university and seek consensus

with stakeholders about what the programme intended to achieve. Sipho mentions that, initially, stakeholders believed that the programme was "there to change people from being heterosexual to homosexual" (Sipho, 28y). Building consensus in an institution is no small feat. A pattern revealed in the data was the programme coordinators' agentic power that assisted them during the development and implementation of the programme in the institution.

4.4.1 Work conditions

In addition to building partnerships during the day, the majority of the programme coordinators had to engage with students after academic hours (17h00) and/or during weekend activities. Zama experienced limitations with time, and describes how some interventions, which took place at certain times of the academic calendar, were poorly attended, due to the pressures of academic life in the university. This "means [that] anything else that [was] not academic related [was] not a priority" (Zama, 24y). Like Zama, Alex also suggested that the academic calendar does affect the implementation of the programme. For example, obtaining authorization for procedural matters affected the time in which the programme component could be implemented. Furthermore, when the grantor expected monthly indicators, universities would be closed, due to term holidays or examinations. Therefore, factoring the university calendar into a grant programme had a direct influence on how the programme was established in the institution.

The programme coordinators' vulnerability to burnout was particularly high. During the interview, all five programme coordinators indicate that they experience demanding workloads and/or emotional distress from time to time. The pressurized work hours and conditions were a shared experience among all programme coordinators, of whom only two enjoyed flexible hours to balance their workload. The need for flexible work conditions was a concern raised by more than one programme coordinator. Thus, programme design is an important factor which needs to be considered when constructing an institutional programme that targets staff and students. Considerations should, therefore, include unconventional work hours and a degree of flexibility to ensure that the programme coordinators maintain their physical and psychological well-being.

In light of the pressurized work conditions, an important consideration was the type of support the programme coordinator would require in order to effectively implement the

programme within the institution. Like Sam, Sipho and Alex, who relied on an established unit within the institution to assist them, the programme coordinator should be embedded in a unit or a network of people who cross similar boundaries, in order to deal with their own identity being questioned, the time pressure on them, to ensure sustainability, prevent burnout, and to share the load of daily problem-solving (such as safety) when they try to meet. In Chapter Five, I discuss the provision of institutional support beyond that of executive support and advocate for middle management to assist the programme coordinator with implementation and debriefing.

4.4.2 You must be doing this because you are one of them?

The identity of the programme coordinator was another consideration previously related to the efficacy of MSM programmes. Magnus *et al.* (2014) argue that programme coordinators and staffing for MSM projects should come from the community itself. Sipho made a similar claim that any other sexual orientation would not be able to advocate as well as MSM, because they are not the same as MSM and would, therefore, not understand the types of discrimination experienced by MSM. However, later in the interview, I critiqued Sipho's statement, which facilitated a revelation that countered his previous claim that people from different sexual orientations would not understand the types of discrimination experienced by MSM. The dialogue below provides the analogy he uses to emphasize the rationale behind his revelation.

> *Let me say for an example, if it's a [W]hite woman with a [B]lack man, there would be this thing of saying he went to the [W]hite lady because of money. If it's a [W]hite man dating a [B]lack woman, they would say the same thing; she went there because of money. They're not going to see it as love* (Sipho, 28y).
>
> *So aren't those challenges the same as those experienced by same-sex couples?* (Interviewer)
>
> *Exactly, and it's good that you are raising this* [laughter]. *Those are the things that I forgot, that you know, if you had not spoken about it. There is this concept of saying, especially if it's a straight MSM going out with a gay person, there is always this thing of saying the straight man went to the gay guy because of money. It's never seen as feelings or love or whatever. There is always a motive*

behind that, and that motive would either be money or materialistic things (Sipho, 28y).

Thus Sipho realized that, while all relationships may have similar experiences of oppression, some unions might experience more discrimination than others. In light of this revelation, Sipho was favourably inclined to believe that a programme coordinator, regardless of sexual behaviour and/or sexual identity, can coordinate a sexual diversity programme contrary to the findings of Magnus *et al.* (2014).

The establishment of the programme often highlighted the sexual orientation and gender identity of the programme coordinators who were of the opinion that they were compelled to declare their sexual orientation or utilise non-disclosure to avoid validating the programme through their personal identity. In some instances, some of the institutional stakeholders labelled the programme coordinator "Minister of gays and lesbians" (Zama, 24y) or "the gay one" (Sipho, 28y). Despite this stigma, Zama's approach differed from Thabo's who did use his identity to validate his position within the programme; yet both programme coordinators managed to attain the same level of engagement with self-identifying students. This contrasts with research findings that effective programming can only be achieved if self-identifying staff from the community implement the programme (Magnus *et al.*, 2014).

Thus, from the programme coordinators' perspective, they had to be ready for the assumptions that would be made, and devise the strategy they wished to use in order to manage the assumptions by institutional stakeholders about their sexuality. For all five of the programme coordinators, their personal identities and sexualities were questioned and some felt compelled to bring themselves into the conversation, in order to gain support and collaboration from stakeholders within the institution. Regardless of whether they shared their sexuality or not, all the programme coordinators were able to achieve the same programmatic design and outputs. Therefore, the necessity for declaring one's sexuality in order to increase the efficacy and receptivity of the programme is debatable.

4.4.3 Validation

Programme efficacy relies on several factors, one of which is recognition. The perception expressed by Thabo earlier describes a phase in which the institutional validation and/or recognition was lacking. While validation from the executive management had a positive

influence on the programme coordinators, Thabo critiques whether "lip service support was sufficient" (Thabo, 29y). Thabo expresses his dissatisfaction with the fact that, during the course of the programme, he did not receive validation and/or recognition for implementing the programme. This took its toll on his psychological well-being, when, at one point, he believed himself to be depressed, but later learned from a doctor that he was, in fact, exhausted. Universities that implement this type of programme should consider innovative and cost-effective ways to reward the performance of staff members by, for example, offering flexible work hours and/or study opportunities.

Therefore, cultivating a supportive organizational environment for an MSM programme within an institutional setting is not the only factor that requires attention. The well-being of the practitioner(s) of the programme must be protected to ensure that the programme and the practitioner remain effective. Magnus *et al.* (2014) found that, in the same way that the programme seeks to validate and support self-identifying students, "relationship building within the [programme] has to … model characteristics about how to interact with … fellow staff" (Magnus *et al.*, 2014: 8). With evidence proving that a lack of recognition had a direct effect on one's level of motivation and job satisfaction, the role of executive leadership in supporting the programme and validation of the practitioners should be a carefully considered part of the structural design and work culture for MSM programming (Herzberg, 1974; Magnus *et al.*, 2014).

4.4.4 Organisational design

During the interviews, the programme coordinators were asked to draw an organogram to depict the programme's location within the institution. The following section describes the programme coordinators' positioning of the programme within the larger institutional structure.

One key finding that emerged from the programme coordinators' analysis of their organogram was how central they were to the sustainability of the programme and its operations within the institution. Although the programme was infused within different services in the institution, all the programme coordinators were of the opinion that a coordinating body was required to track and implement parts of the MSM-LGB programme. The majority of the programme coordinators shared this sentiment and feared for the sustainability of the programme once the grant funding ended. Of more importance to the

programme coordinators was sustaining the relationships with the students and the students' reliance on the programme and the programme coordinator. This was a very real concern that the institutional leadership and the grantor may have not emphasised enough. This concern prevails, despite the programme coordinators' efforts to capacitate students and infuse the programme within the university infrastructure.

Other similarities that emerged from the organogram included the location of the programme within the institution's HIV unit. All programme coordinators, except one, considered this acceptable. During the interview, Sam suggested one structural change, namely to move the programme under student affairs, in order to reduce the stigma associated with being housed in the HIV Clinic. On the other hand, Alex had a different view about being located within an HIV clinic. He believed that all services for self-identifying students should be located in one building so that students can easily access all available services.

Geographically, the functions of stakeholders involved in Alex's programme were located at various points in the institution. This, at times, meant that students would access one space with the understanding that one or more services could be received. However, this was not the case. Alex had to refer the student to a different part of the university campus for HCT or psychological counselling. This presented challenges, as the student would have to walk to another part of the university campus in order to seek the service. This could have resulted in the student not immediately receiving the support required or not accessing the service at all. Therefore, being located in the proximity of other essential support services is a critical factor in considering the location of the programme within the institution.

Another factor that organically occurred within the programme was the role of the 'intermediary' between the institutional stakeholders and the students. Thabo's role within his institution was one of an intermediary between institutional management and self-identifying students. The prevailing belief within his institution was that Thabo advocated for self-identifying students' inclusion and was able to provide expert guidance for the institution.

Despite being recognised as an intermediary in his institution when locating his positon in the organogram, Thabo placed himself at the bottom of the structure, instead of in the middle-management tier of the institution, as I depict in Figure 4.

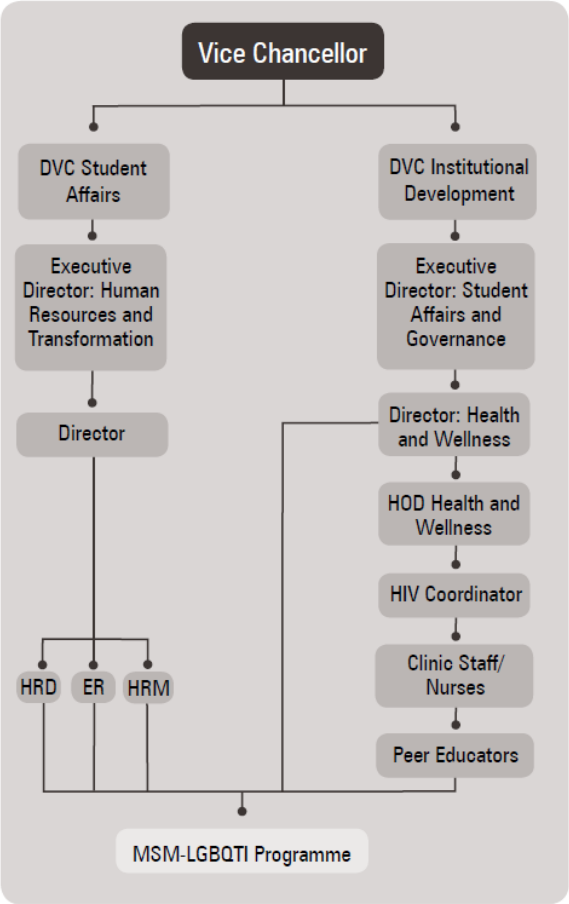


Figure 3: Thabo's organogram

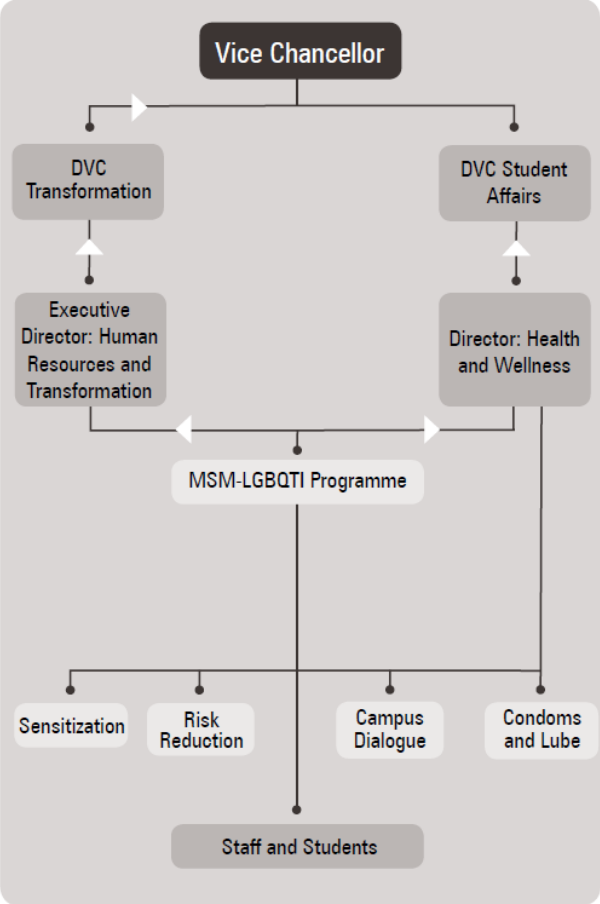


Figure 4: Interviewer's version of Thabo's organogram

When comparing my structure with his own organogram, Thabo was surprised by where I had positioned him within the structure. Thabo comments further: "I never thought [the programme was] that important." He goes on to say that he felt "validated, and [he can see he is] actually creating change within the institution. It also reminds [him] that [he has] got enough power to actually steer the programme in whatever direction [he] sees fit for both [himself] and the institution ... so, I'm in charge" (Thabo, 29y).

I refer the reader to the earlier section on validation in Chapter Four, where Thabo found it difficult to receive validation from members of the institution. The perception that Thabo was not recognized by the institution was repeated in Thabo's positioning of himself (and the programme) in the organogram depicted in Figure 3.

The four other programme coordinators also drew their organograms to depict the location of each university programme and the related lines of authority. These organisational structures are presented in Figure 5. The reader will note that all four programme

coordinators placed themselves within the middle management section of the organisation, which denotes that their role extended beyond programme management, and straddled operations and strategic guidance for the university.

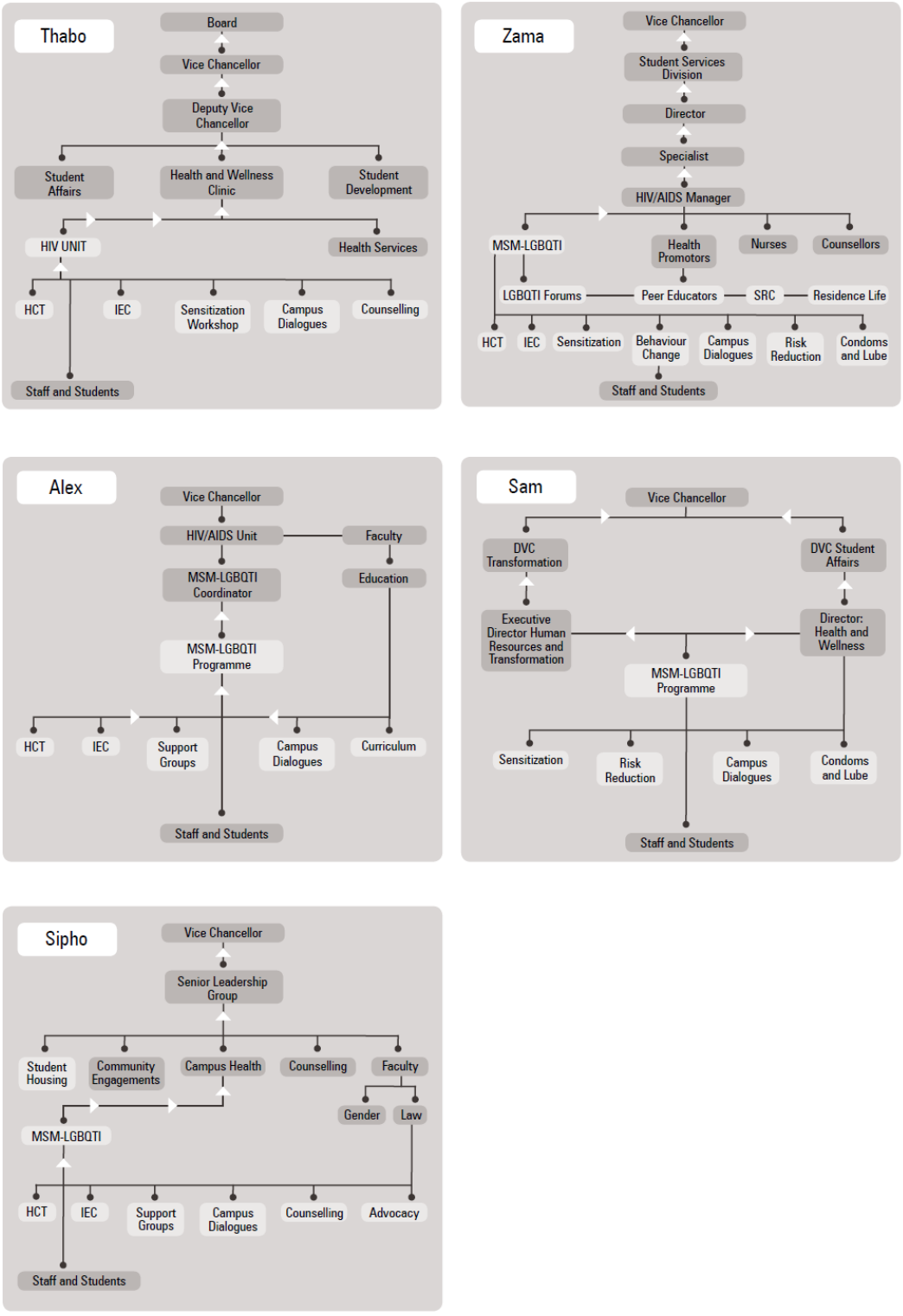


Figure 5: Programme coordinators' organograms

The organograms are useful in that they provide institutional stakeholders with an overview of the programme's location within the institution. One can also note where collaborative partnerships were formed within the institution to extend the reach of the programme. In most of the organograms, the programme's position within the university depicts high levels of collaboration across departments, which the programme coordinator had to develop. Similarly, the programme's position within student affairs and/or the HIV/AIDS unit denotes the centrality of the programme in the provision of health and support services to self-identifying students.

However, the presence of the academic project, which grounds the programme beyond the confines of the university's social support, is evident in only two organograms. This raises the question about the extent to which the human rights discourse catalysed through the programme had any effect, on the way in which academic staff engaged with their students within academic spaces in the university. This finding resonates with my concern raised earlier in Chapter One, where the White Paper 3A, Ministerial Commission Transformation Report (Department of Education, 1997) assumed that academics (and institutional staff members) would know how to appropriately engage and include sexually diverse students within the university. Therefore, the organograms not only highlight areas of collaboration, but also depict the lack of engagement by sector departments within the university.

4.5 Summary

In this chapter, I presented the findings from each of the programme coordinators. I identified similarities, contradictions and innovations. In the health and support services, it was found that enhancing the biopsychosocial programme for self-identifying students was necessary for the location, access and provision of support to MSM students. Innovations in HCT included virtual prevention education and peer education content. This ensured that a psychosocial response would successfully support the biomedical response for the inclusion of self-identifying students in the university. These findings were discussed under the selective codes of leadership and perceptions of power and biopsychosocial strategies to include MSM populations.

In Chapter Five, I discuss these two selective codes and introduce two additional themes, which I have termed ‘academia in absentia’ and ‘who’s right?’ I introduce these themes based on the absence of this discourse in the data and in the programmatic strategy used by the programme coordinators.

Chapter 5: Findings and Analysis

I have a vivid memory of presenting my doctoral proposal to the cohort of gender and sexuality researchers at one of the University of the Free State's postgraduate training workshops. The crux of my PhD proposal was to develop an institutional system within higher education that could better serve and support – what I referred to at the time – "marginalized students". I placed great emphasis on how I intended to contribute knowledge to the higher education sector and was emphatically (and somewhat animatedly) opposed to a "PhD gathering dust on a library shelf". I proposed that my research could inform policy, practice and educational management in higher education.

While I remain resolute that the PhD could inform practice, I propose this intention with a proviso. This proviso alerts potential practitioners, researchers, policymakers and higher education leaders to the fact that the research findings emerge from five diverse universities that have various financial, historical and political advantages. Despite their heterogeneous population, all five universities implemented the programme in similar ways. This success in implementation suggests that the majority of the universities could consider the methods used by the programme coordinators to inform, adapt and/or create a programmatic strategy that would work in their university. Therefore, I am not recommending a 'one-size-fits-all' strategy. Rather, my intention is for the practitioner, researcher, policymaker and higher education leader to consider the successes and challenges that were experienced by the five programme coordinators, and glean from their strategic approach a method that would best serve their purpose.

In this Chapter, I revisit the debate that questions the role of the university in the provision of health and support services for self-identifying students. While some authors strongly contest that the university must fulfil a legal obligation, I present another rationale. In order to become sustainable in the HEI, programmes must be institutionally embedded. I go on to discuss the four selective codes that were implicit in the data, namely leadership and perceptions of power, biopsychosocial strategies for the inclusion of MSM students, academia *in absentia*, and 'Who is right?' With regards to the first theme, I consider the roles of leadership and perceptions of power in relation to the programme implementation and sustainability. I then focus on the biopsychosocial strategies that were used to include self-

identifying students within the five universities. The penultimate theme considers the absences of the academic project within the programme, and troubles the extent to which institutional programming influences academic engagement. Lastly, I question how universities may or may not be responding to their legal obligation to provide non-discriminatory health and support services.

5.1 Leadership and perceptions of power

All of the programme coordinators mentioned the role of leadership in the programme. The findings from the research emphasized that the role of leadership, or lack thereof, is a notable factor that influenced the receptivity of the programme by stakeholders in the institutions.

Sam, Thabo and Alex claimed that executive support assisted in influencing the stakeholder receptivity towards the implementation of the programme in their university. However, some programme coordinators did not have explicit support from executive management. Yet they were still able to implement the programme and achieve the same programmatic outcomes. In this section I focus on the perceived relationship between leadership and power. I then discuss the diffusion of power at the meso-levels of the institution that facilitated the same outcomes for the programme coordinators who had hardly any to no executive support.

Three programme coordinators claimed that executive support influenced the way in which the programme was received in the university.

> … *I think our* [Vice Chancellor] *made it so easy for us to do whatever work we need to do, and our programme falling under the* [Vice Chancellor's] *office … gives us a bit more leeway and clout to implement programmes. So I think in that sense … it's been beneficial* (Alex, 27y).

Thabo identified similar perceptions about the power that executive support would yield over institutional stakeholders:

> *… if you've got someone who is in power and is against a certain thing or a programme, I mean, it's easy for them to influence everyone on the ground … you know how it is, power has so much influence. So I think that* [executive support] *played a very important role* (Thabo, 29y).

I was particularly interested in this finding for multiple reasons. First, the data refutes Thabo's assumption that executive support would guarantee a positive reception of the programme by institutional stakeholders. Instead, it emerged from the data that, despite executive support, there was a presence, albeit, low levels of stigma, discrimination and resistance by stakeholders within these institutions.

This finding may demonstrate that executive support is not necessarily a critical factor in influencing stakeholder receptivity for sexual diversity programmes in the university. In fact, as evidenced in the data, support for the programme does not necessarily have to come from the executive, but can also come from the lower echelons within the university and still produce the same desirable programmatic outcomes. The findings bring into question whether executive support is simply ceremonial and query whether support may be found in other levels of the university.

This brings me to my next point, which considers where power is held within the institution. In Chapter One, I raised a discussion that reflected upon the power of the student movement in compelling university leadership to become more responsive to, and effective against forms of oppression and discrimination. I described the student movements' role in challenging the trajectory of power within the institution and emphasized the needs of students in the university. Similarly, in Chapter Four, the data reified the tension that was identified by the student movements. The data emphasized considerations of institutional power: who yields it, and for what purpose. For example, Zama initially claimed that, whilst there was "no resistance" towards the programme, she jests that

> *management got to realise that eish, we can't run away from this. This* [the programme] *is here to stay. We can't* [resist the programme] *because of the number of students that came out and supported it … SRC is way more powerful than management itself* (Zama, 24y).

Similarly, for two programme coordinators who had hardly any to no support from executive leadership, my research emphasizes their agency in influencing the institutional stakeholders' receptivity towards the programme in the university. The agentic power held by the programme coordinators facilitated alliances, established relationships and identified synergistic access points for the programme to exist in the university. In the same way that universities were forced into introspection by the student movements, it is likely that one of

the navigational manoeuvres used by programme coordinators, who received hardly any to no executive support, was to cultivate the student support in a way that leadership could not ignore or refute. I do not negate the necessity of executive management approving whether an institutional programme takes place, but whether executive management is the only echelon that yields institutional power to influence stakeholder receptivity is questionable. Therefore, while executive support is useful for this type of work, the programme may not be dependent on executive support.

My research, therefore, provides evidence that there may be other navigational manoeuvres that also influence institutional support. Of course, where there was executive support, there were outcomes in the form of sustainability through the institutionalization of the programme; however, it is important to realize that stakeholder engagement within an institution does not only rest on executive support, but that influence and power can exist in multiple levels of the institution, and that there is a much more nuanced experience of power and leadership found within a university environment that can cultivate institutional receptivity and support for sexuality programmes in the university.

Certainly, the development of alliances among stakeholders within the operational levels of the institution was explicit in the data, and the programme coordinators' agency and their ability to develop supportive partnerships determined the extent to which the programme was received by university stakeholders. When there was no executive support, partnerships were formed at various levels of the institution, which catalysed the implementation of the programme within a HEI.

The research data suggests that leadership and power are, therefore, not only top down; it is possible to cultivate influence at multiple levels within the institution that has the same effect as executive support. In order for sexuality programmes to succeed and be sustainable, sole reliance on executive support may be futile, as there is sufficient human capital within and among multiple, interdependent partnerships in the various tiers of the university system that would enable the successful implementation of a sexual diversity programme.

5.2 Biopsychosocial strategies for the inclusion of MSM students

Since 1980, HIV programming has continuously questioned the synergy (and necessity) of psychosocial programmes in HIV biomedical responses. Similarly, current literature grapples with the question as to whether a psychosocial programme has any benefits within a MSM biomedical prevention programme (Harding *et al.*, 2004; Eustace & Ilagan, 2010; Malta *et al.*, 2010; Kelly *et al.*, 2013). Drawing on the findings, one may rightly conclude that a psychosocial programme has a direct influence on the efficacy of biomedical services for MSM students in higher education. While this finding may be obvious to some practitioners, I contribute to the knowledge base for university-based MSM programming, which, to date, has hardly any to no research that can be used to support institutional responses.

In Chapter One, I referred to Lyons *et al.*'s (2013) concerns about the marginalization of sexual behaviours through the clinical disease discourse. One of the complications that emerged in my research findings was the tension between the biomedical focus of the grant funder and the psychosocial approaches used by the programme coordinators within the programmes. While the programme framework emphasized the grant funder's intention, namely to increase the number of HIV tests among MSM students, it emerged from the research data that the biomedical indicators of HIV testing and risk reduction were solely dependent on the efficacy of the programme coordinators' psychosocial support. Therefore, there was an organic shift towards establishing very real relationships based on trust, loyalty and confidentiality. This was of primary importance to both the programme coordinators and the self-identifying students. Once these relationships were formed, gentle discussions about testing, reducing risk and prevention methods were introduced.

One of the key strategies in developing the psychosocial programme used by the programme coordinators was to work with peer educators who could perform a dual function of educating students from a biomedical perspective and providing support that managed anxiety about testing, prevention and/or risk.

The psychosocial approach moved the disease discourse, associated with the biomedical approach, towards a socially real discourse, where sexuality, identity and related sexual behaviours formed part of the human fabric comprising culture, behaviour and social reality. Thus, while the biomedical discourse is necessary for some aspects of the programme,

the findings show that the clinical approach cannot be conducted in isolation of a social programme.

The biomedical objective of the programme focused on increasing the uptake of HCT and related health services for MSM students as a key population group. The concerns with the provision of only biomedical services are that they may result in further stigmatising and isolating the target group that it intends to seek. On the other hand, the creation of a psychosocial programme that creates opportunities for MSM students to be part of a broader self-identifying group within the institution resulted in a collective identity and agency where the students could build relationships, discuss experience and freely express their concerns. Although the psychosocial approach is sometimes contested as taking longer and being more resource intensive, it is important to note that, it was within these informal social spaces that MSM were located, identified and introduced to the health and support services available to them.

One of the main challenges when working with MSM as a key population is the ability to locate MSM students. Soon after implementation of the programme, the programme coordinators solved this problem by establishing the psychosocial programme that built a political identity and collective agency which empowered MSM students to be part of a sexually and/or gender diverse group. While there are instances of dissonance by "LGB students [who] did not want to associate with other queer students" (Alex, 27y), the efficacy of the psychosocial programme was measured at the end of each quarter where it was found that there was a direct influence in uptake of HCT and other health-related services.

My PhD posits that, if there is to be any success in reducing new HIV infections among 'MSM as a key population', then funders, health practitioners and social scientists should work in unison to develop and support a biopsychosocial/combined prevention programme for *all* self-identifying students. Practitioners may need to embrace the organic unison that emerged between MSM and other self-identifying students. Should this occur, there may also be a responsibility on the university to ensure that inclusive spaces are adequately prepared (and staff members have the relevant information) to share specific information, resources, and prevention education not only for MSM students, but for all other sexualities and their related sexual practices.

Drawing on the findings of my PhD and the supporting literature, I foresee that, unless sexuality education and related psychosocial education is introduced into the South African clinical training programme, medical and psychosocial practitioners will continue to reinforce heterosexuality as the only way of being. Furthermore, without sufficient training and exposure that promote inclusive biopsychosocial support, practitioners will be unable to provide relevant, inclusive health and support services for self-identifying students. Therefore, an interrogation of the current practices may be required, in order to ensure that the practice (including staff engagement) is inclusive and adequately provides health and support services to all self-identifying students.

Another important fact that emerged from the data analysis is that heterosexual students also accessed the biopsychosocial programme. The use of the inclusive healthcare service by heterosexual students may point to further research on heterosexual sexual practices, which may also include anal sex. While there may be more than one reason for the inclusion of heterosexual students in the programme, I also speculate that the critical shift towards the inclusion of all identities could be one of the potential reasons for heterosexual students participating in dialogues and using the health and support services provided in the biopsychosocial programme. It is also likely that, under the ambit of the political and social discourse that was catalysed by the student movements, heterosexual students were seeking spaces that actively practised inclusion, which differed from the traditional process to which they had become accustomed. Therefore, if programmes for self-identifying populations are entrenched within the institution, it is perhaps important to note that all students in the university will seek and/or experience sensitized and inclusive health and support services. However, it is important to prepare healthcare and support staff to manage interactions with students who are not sexually diverse, as questions and/or tensions may arise when students view images of same-sex unions and/or are asked about sexual practice that is not usually associated with heterosexual behaviour.

Therefore, not only do medical and psychological practitioners in higher education need to be abreast of inclusive health practice, but there also needs to be a synergistic institutional programme that supports the inclusive shifts within the university. Considerations for institutional programmes include providing services during accessible hours to students. This may mean that innovations in work conditions for support service staff need to be considered. Similarly, for staff working in anti-oppression programming,

opportunities need to be made available for their own psychological support. Lastly, the biopsychosocial approach would require a monitoring and evaluation system that would reduce complacency and maximize inclusion.

In summary, I propose a synonymous biopsychosocial approach within a HEI when working with sexually diverse students. The biopsychosocial approach challenges current medical curricula, which, in many instances, remain silent about health practitioner care for, and services to self-identifying students.

5.3 Academia *in absentia*

Habermas writes that, if students perceive academia to be distanced from the realities of society, it is likely that they will question the knowledge economy and the purpose of a university (Habermas & Blazek, 1987). Universities are not divorced from the politics, economics or civil influences of the country, as evidenced by the student movements that identified the increasing gap between the knowledge taught at university and the application thereof to current South African challenges. Ideally, students were calling for praxis, the ability to apply theory and/or knowledge to the very real challenges they experienced in society.

Certainly, the student movements articulated some of the discontent experienced by students. As part of the institutional response to self-identifying students, it was important for universities to begin clearly articulating the role of the university in its provision of services to students. I, therefore, return to the national legislation and the National Department of Higher Education and Training (hereafter referred to as DHET) transformation report, which defined the role of higher education. It stipulates two functions of the university, one of which includes the university's obligation to respond to issues of social justice within and beyond the university.

The DHET encourages universities to make their institutions accessible and inclusive to all students. The constitutional mandate reiterated by the DHET implies that the university has an obligation to create an institutional system that recognizes the effects of apartheid and supports redress for students. Akin to Habermas' writing about the role of the university in a democracy, DHET defines that one of the obligations of the university is to create social cohesion through inclusive practice and supportive institutional systems, the latter being

articulated in the White Paper 3A for Transformation. The obligation on the university to provide an environment that is representative and inclusive to all self-identifying students is particularly important from both a legal and a human rights standpoint.

However, universities often neglect their relationship to their student population, beyond the transfer of academic knowledge. In this research study, I contend that the university may be unintentionally privileging heterosexuality over other sexualities and that an inclusive culture should reflect and support the diversity of all self-identifying students. Similarly, academic spaces of teaching and learning should mirror the institutional ethos and discourse, lest universities be perceived as being too distant from current debates, realities and student needs.

With regard to the sexual diversity programme, only two programme coordinators were able to influence the academic space. Alex mentioned the development of a course related to "LGBQTIA+" discourse (Alex, 27y) and another programme coordinator was invited to "their lecture classes to come and speak to their students about this topic" (Sipho, 28y). In both instances, this knowledge was isolated to one faculty or one lecture period; therefore, exposure was limited.

There may be a number of reasons why the other programme coordinators were unable to access academic spaces in the university; the length of time of the programme may have been a factor that limited the reach of the programme within the academic space. For the future, it would be useful for educators to consider their responsibility in cultivating inclusion in the university. During such deliberations, it would be useful to understand what could be done differently; how they could contribute to the queering of the institutional space and what role the educator has in creating an inclusive educational environment to develop citizenship, identity and competencies beyond the confines of the lecture room.

The absence of praxis in the White Paper 3A furthers the gap in university responses that seek to frame the relationship between institutional student programmes and the role of academia (Department of Education, 1997). My research re-emphasizes the absence of academic engagement in programme work associated with student health and support on university campuses. By positioning the institutional ethos and culture within the framework of higher education curriculum and pedagogies, the academic project can begin to complement the institutions' social project. In this way, universities could attempt to develop

the praxis to generate new knowledge about the role of HEIs in developing students' awareness, political identity and citizenship.

5.3 Who is right?

In June 2016, the South African Minister of International Relations attended the United National Human Rights Council (UNHRC) meeting to establish the first Independent Expert on Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity. South Africa's ambassador abstained from voting on the formation of the Task Team to investigate violence against sexual minorities, citing an African proverb: "If you want to walk fast, walk alone; but if you want to walk far, walk together" (Unknown author: Origin Burkina Faso).

In essence, the Minister used this proverb to justify South Africa's abstention and called for consensus among all African countries, prior to the UNHRC establishing a task team against violence and discrimination based on sexual orientation and gender identity. The South African abstention was premised on the need for consensus among other African nations, many of whom use religion as the basis for prosecuting and persecuting sexual diversity. It was divisive and contentious. First, the abstention protected competing ideals over the very real concern for the rights and safety of self-identifying persons living in Africa. Secondly, the abstention contradicted the ethos of human rights enshrined in South Africa's Constitution. Despite the existence of South Africa's constitutional mandate to protect the right to sexual orientation and the right to physical security, the position taken at the UN exposes an archaic debate where the protection of rights to religion and culture trumps the implementation of the right to sexual orientation.

As evidenced in the findings of my PhD, there was the sense of acquiescence by executive management who, prior to the implementation of the 2014 programme, appeared to be unaware of challenges facing sexually diverse students in their universities. However, through the student movements, the gaps in practice and structural discrimination became evident and, in many ways, catalysed change in the landscape of higher education. Measures of redress that have been identified in my PhD include ensuring that the institutional environment does not exclude the representation of all identities in the university. Whilst, in policy, there seems to be a clearly defined obligation for inclusive health and support

services, the findings from my research show gaps in practice to relevant and accessible health services. As demonstrated by the programme coordinators, it is possible for a university to develop an institutional culture where mostly everyone could "walk together" (albeit it via different paths) towards the common goal of an inclusive and non-discriminatory environment.

Furthermore, my study offers suggestive evidence that executive management and other institutional stakeholders may not have a clear understanding of how to implement the legal obligations conferred upon them by the Constitution. What became evident in the findings was that neither the programme coordinators nor the self-identifying students seem to access the legal remedies that are supported by the Constitution. This omission resulted in negotiating inclusion rather than articulating that such discrimination is subject to legal ramifications. One has to question why the application of the right to sexual orientation is perpetually dependent on the consensus (or acceptance) of persons who are not affected, harmed, and/or influenced by the right to sexual orientation.

Drawing on the findings, the tension between articulating the university's role in relation to the Constitution and its practical application within an institution becomes evident when relevant services and/or practices do not already form part of the institution's culture and system. As noted in this programme, the universities appeared to be dependent on external funding and resources to provide relevant health and support services to sexually diverse populations in university. The development of an inclusive and enabling environment, as called for by DHET, brings to the fore the many complex challenges that often face universities. However, it may be necessary to carefully articulate the responsibilities of a university and then institutionalise the necessary structures and related programmes so that such obligations can be fulfilled.

I conclude this chapter with the claim that there is a slippage in the application of the right to sexual orientation within the five universities. This allows for the universities' partial protection of the right to sexual orientation. The presence of this legal slippage begs the questions: Are universities "constitutional-free zones" (De Vos, 2015)? And will it take yet another *en masse* movement to teach universities that discrimination of any kind can no longer be tolerated? Until then, it is likely that the enforcement of the human rights framework and its related punitive measures may be necessary until sexual diversity (like

racial diversity) is as equally protected as other rights enshrined in the Constitution. In the interim, I focus on the opportunity available for leadership to proactively apply the law available to them via the Constitution to include and protect all persons who have been rendered invisible by discrimination and stigma.

5.4 Conclusion

In this chapter, I presented four overarching themes that were implicit in the research data. Drawing on the research findings, I conclude that leadership, in its most traditional sense, is not localised to the Vice Chancellor and Deputy Vice Chancellors, and that the programme coordinators identified devolved leadership within the university, which increased institutional receptivity and support for the inclusion of the programme and its related activities in university. Therefore, when considering leadership and power, one should not only think of a top-down approach, but also that there are other multi-level partnerships in the university that could be formed, by a coordinator and/or coordinating unit.

It is important to emphasize that all five institutions, regardless of their historical, financial and political positions, still delivered on the programmatic outcomes as required by the grant. Given that the institutions had various degrees of infrastructural development, there were, however, common institutional elements that promulgated the reach of the programme. These critical elements were a health clinic and the financial freedom to employ human resources that could provide relevant psychological services as well as a physical and virtual space in the university to cultivate unity and support among self-identifying students. I submit that, if these elements are already present, in addition to a central coordination unit or person, a minimal amount of resourcing is required to implement the programme at the HEIs.

Furthermore, where executive support was lacking, the institutionalization of a sexual diversity programme is still possible where other forms of support are offered by *consciousized* academics and administrative staff who were willing to adopt a human rights framework among students, self-identifying students and institutional staff members working in communication and media.

Secondly, I conclude that, in a university context, health and support services need to be accessible to self-identifying populations, not only in the way in which practitioners engage with students, but also in the time and location of the services that should be available

when students are most accessible. Institutions should consider innovations in work conditions for staff member who provide biopsychosocial support for students. Lastly, in order to monitor the efficacy of the biopsychosocial programme, monitoring and evaluation should accompany each aspect of the programme so that progress can be tracked and necessary improvements adopted.

Similarly, as part of the institutional response, I suggest that one of the ways in which the institution could reflect the institutional discourse is to encourage academic engagement with the human rights discourse conveyed by the programme. Such engagement would invite academics to increase their self-reflexivity and question how they engage with self-identifying students in the academic environment.

I conclude Chapter Five with the hope that universities begin to define the processes required to provide accessible and non-discriminatory health and support services to sexually diverse students. However, as evidenced in my PhD, the extent to which such services are supported and sustained is chiefly dependent on whether there is an enabling and non-discriminatory environment in the university.

Chapter Six: Conclusion

6.1 Introduction

Globally, the decline in new incidences of HIV is indicative of the successful progress in treatment, adherence and psychosocial support. However, for three key populations, increases in new incidences of HIV are still being evidenced. My PhD focuses on one of these key populations within the context of five South African universities.

The biomedical term for this key population is 'men who have sex with men' (MSM). In Chapter One, I grappled with the biomedical term 'MSM' and emphatically move away from the use of this term in my PhD. I only refer to MSM when quoting authors and/or discussing characteristics that are unique to MSM. I justify my rationale for shifting away from the biomedical term on the fact that South African sexually diverse populations do not identify with the majority of biomedical terms, the latter contributing to the pathologization of sexual practice and related sexual identities. In the absence of contextually relevant vocabulary, I use the generic terms 'students', 'sexually diverse' and 'self-identifying' interchangeably in an attempt to avoid an assertion of language that contributes to the stigma and marginalization experienced by sexually diverse populations.

The use of the term 'sexually diverse' also served a technical purpose in my PhD. The reader will notice that one of the key findings identified a unity among MSM and sexually diverse students – a unity that did not distinguish between sexual identity or sexual behaviours. The unison among self-identifying students ultimately influenced the development and structure of the programme in the university.

In Chapter One, I foregrounded the tension between the university and the university's responsibility and role as asserted by the Constitution and the national government. Despite being understood as sites of academic freedom and expression, universities are often unable to protect students from heteronormative discrimination and its related oppressions. Therefore, my PhD sought to document the formation of a sexual diversity programme in five heterogeneous universities to determine what institutional conditions were developed for self-identifying students who were experiencing tangible and intangible forms of discrimination at university.

Through my PhD I attempt to identify a new praxis that offers university practitioners a structural framework for developing and/or adapting their institutional culture and programmes in order to create an enabling and inclusive environment that can better support sexually diverse populations in the university.

In Chapter One, I defined the scope of the challenge affecting self-identifying students at South African universities. I then presented the key findings of the systematic review conducted in Chapter Two. A systematic review is a useful method that can emphasize new avenues of research and/or gaps in knowledge about a particular topic. My systematic review articulates a current gap in knowledge that shows, strikingly, the lack of higher education responses for self-identifying students in university.

Initially, my systematic review sought to identify published research from combined prevention programmes for students in HEIs; however, none of the articles identified in the search strategy met this criterion. This was an important finding, as it means that, as of 15 January 2015, there were no publications about MSM and/or gay health and support services in HEIs.

It was, therefore, necessary to broaden the scope of the inclusion criteria, and place more emphasis on any combined prevention programmes (CPP) for MSM, with the view that elements of CPP could demonstrate best practice for MSM health support service in the higher education context.

A three-phase method was used in the systematic review. The first phase comprised a desktop review that identified all published research in three electronic journal databases, namely PubMed, SCOPUS and CINHAL. For the database searches, I used the MESH database to generate a variation of terms (see supplementary data) for the word search, using keywords and their synonyms relating to HIV prevention, programme, MSM, gay, and university. No limiters (for example, language, year, country, author) were applied. The search extracted twenty-nine articles from PubMed, thirteen from SCOPUS, and one from CINHAL. All forty-two articles that were identified in the database search were included in the systematic review after confirming that each article had been peer reviewed in accredited journals.

Following this process, I applied three limiters. The first was that the research study must focus on the MSM population. Secondly, that the study had to provide information on

psychosocial and/or biomedical prevention, care and support (combined prevention programming) to MSM. Lastly, the study needed to move beyond mere descriptions of the study to include recommendations and/or guidelines that could influence and/or improve MSM biopsychosocial programming.

In total, nineteen studies were excluded, as they were not focused on MSM populations and combined prevention programmes. Of the remaining studies, fifteen articles were excluded, as they focused on the biomedical HIV prevalence of MSM populations, but did not discuss psychosocial combined prevention studies. One study was excluded, as it was not written in English. Seven studies remained in the review, as they satisfied the criteria for research conducted on combined prevention programmes for MSM populations.

The final phase of the systematic review comprised the data analysis of the seven studies. Using the UNAIDS framework for combined prevention programming (CPP) to define the elements of CPP, I sought out components of CPP for MSM populations. Through preliminary synthesis, key findings and emerging themes were identified in the studies. I then synthesized these themes into categories to organize the key findings of each study. An overview of each of the seven articles is presented in Chapter Two, which documents the praxis used in combined prevention programmes for MSM.

The importance of this review was to establish current practices that could inform university-based programme responses for sexually diverse populations. Through the systematic review, I identified that, as of 15 January 2015, my PhD would be at the forefront of institutional practice, and that it would be the only knowledge contribution that responded to the formation of institutional programmes for sexually diverse populations in the context of higher education.

In Chapter Three, I discussed and critiqued my theoretical perspective. I emphasized the contestation about the use of critical theory, namely that a critical theorist has an omniscient advantage of which '*others*' are not aware. I attempted innovations in my research design and methodology in order to overcome the shortcomings of critical theory. I tried to destabilize my *'self'* as a researcher by using a personal narrative – an experience, which I describe to be a relinquishing of my sexuality, identity and power, in order to situate myself *with* the programme coordinators. In Chapter Three, I discussed how the programme coordinators perceived my destabilization.

Other research methods that attempted to address the weakness of the critical theorist approach included increasing the number of opportunities for engagement and review by the five programme coordinators, who formed the sample group for my PhD. Increasing the opportunities for the review of my data analysis by each of the programme coordinators was an attempt to align my voice *with* those of the programme coordinators. However, during this process, I also tried to honour the purpose of critical theory, which I define to be the co-construction of new ways of thinking and acting through active listening, questioning and encouraging dialogue, in order to gain more clarity about *each other's* perspectives.

Chapter Three diverted from the traditional presentation of research methodology. Instead, the reader will find the voice of the programme coordinators inserted in the discussion about the research methods used. My justification for this diversion from the traditional structure of the PhD is based on the need to soften my subjective interpretation and replace the latter with the programme coordinators' experiences and views on the research design. As such, I also attempted to relinquish my power as the researcher in a further attempt to avoid interpreting the reality on behalf of the programme coordinators. The intention in Chapter Three was to highlight the attempts made to enhance existing research methods, by creatively addressing the weaknesses in my chosen theoretical perspective, with the hope of strengthening the associated research methods in the subject areas of sexual diversity and institutional programmes.

In Chapters Four and Five, I discussed the findings that emerged from the data. The axial codes that emerged in Chapter Four were contextually relevant to the university context and, from a micro-level, share important detail on the formation and implementation of a sexual diversity programme. Although related, the findings in Chapter Five differ from those in Chapter Four, as I purposefully strengthened the critical theorist lens to magnify the absences in the data that identify emerging ethical issues, from a macro-level, that affect relationships in leadership, power, government, universities and the application of the law. These relationships, if left unattended to, may perpetuate the oppressions experienced by students in the higher education system. I concluded my PhD with Chapter Six, where I provided recommendations that seek to advance new avenues of research for governance, evaluation and institutional programming in South African higher education.

In the ensuing sections, I provide a summary of each Chapter and conclude with recommendations that may be of use for the higher education sector.

6.2 Context

With four million young people living with HIV, 29% of whom are adolescents aged between 15-19 years, some members of this age group may possibly be studying at HEIs. The support provided by universities is, therefore, limited not only to academic training, but also to the provision of health and support services that enable students' academic progress. Failure to provide health and support services to any student in the university has a direct effect on a student's academic performance. However, these gaps in health and support services are exacerbated for self-identifying students who are not willing to access available health and support services.

I used five research questions to guide my research and identify the innovative strategies used at five universities in order to locate and retain self-identifying students into systems of care and support:

(1) What health and support services do HEIs provide?

(2) How are MSM students in HEIs targeted in seeking health and support services?

(3) How are internal stakeholders in HEIs organised to respond to, and support MSM students?

(4) How do internal stakeholders in HEIs respond to the needs of MSM students?

(5) What are the factors that facilitate and/or impede the development and implementation of health and support programmes for MSM students in HEIs?

Through the research, I suggest that the role of the university includes providing inclusive services and non-discriminatory engagement, both of which should be enjoyed by all students, but more so by students who experience oppression.

6.3 Literature review

From the systematic review process described earlier in this chapter, key findings for MSM combined prevention programming were identified. Beyrer *et al.* (2013) [Study ID 2]

identified two important facts. First, it is possible to determine the length of time it will take before new incidences of HIV will occur within a sexual network. This finding is important, as it allows practitioners to introduce health interventions at vulnerable points in the HIV transmission cycle.

Secondly, the study found that, in a specific MSM sexual network, new incidences of HIV occur within a 17-month time frame. The researchers suggest that tailored HIV prevention programmes should include education about substance use, mental health, serosorting, early treatment, use of pre-exposure prophylaxis, and periodic HIV testing. Evidence-based research by Fox *et al.* (2009) [Study ID 13] expands on Beyrer's research on HIV transmission in a MSM sexual network. Fox *et al.* (2009) claim that intensive and sustained HIV treatment and behaviour-change counselling, immediately after diagnosis, can reduce the onward transmission of HIV in an MSM sexual network. Fox *et al.*'s (2009) study is of importance, because the research demonstrates good practice in terms of the prevention of new incidences of HIV via a psychosocial programme, the latter possibly being an area that warrants further investigation for HEIs.

The second article in the systematic review by Conner *et al.* (2005) [Study ID 7] describes a community partnership that focused primarily on the development of a social marketing plan. Primary findings from this study emphasize the use of appropriate communication media that are accessible to MSM, in order to provide psychosocial support. It would be important for HEIs to review their media and messaging in a collaborative and representative manner, in order to articulate an inclusive response that is representative of all students.

The research by Elam *et al.* (2008) [Study ID 9] was the third article identified in the systematic review. The authors identify three key factors that influence decisions about condom use and risk among participants in the study. The first finding was that, when substances were used, two effects occurred, namely lowered inhibition and enhanced pleasure (Elam *et al.*, 2008: 475). Another influential finding identified in this research was the probable risk assessment discourse that was used to determine what type of sexual practice can be experienced with a partner prior to intercourse or after unprotected anal intercourse (UAI) and what recourse one should take if HIV is suspected (Elam *et al.*, 2008). The last important finding in this research includes pleasure discourse and how decisions related to

HIV risk are often blurred in favour of fulfilling sexual and emotional needs (Elam *et al.*, 2008).

Elam *et al.*'s research signals important shifts in current HIV prevention education and programming for MSM in HEIs. These shifts alter the current landscape of HIV education by questioning what content is currently being taught and its relevance to all students.

The fourth article in the systematic review by Landovitz *et al.* (2012) [Study ID 24] identified that drug use limited the ability of MSM to adhere to medical protocol. Landovitz *et al.*'s (2012) research may influence South Africa's HIV programming and interventions for MSM who are on antiretroviral treatment. Once again, this stresses the importance of including substance use education under the ambit of pleasure discourse and risk assessment.

From Landovitz *et al.*'s (2012) research, an emerging concern emphasizes a disconnection between current HIV education and sexual practice, which may possibly render HIV prevention methods irrelevant to some of the student population. This latter claim is supported by the research identified in the fifth article in the systematic review where Braine *et al.* (2011) [Study ID 4] found that current HIV prevention education continues to treat risk behaviour as a product of ignorance and psychological difficulties and that current HIV prevention education does not account for MSM practices where risk becomes a calculated aspect of conscious sexual engagement. Sexual pleasure and fulfilment are prioritized, with HIV risk being a consequence.

In light of Landovitz *et al.*'s (2012) and Braine *et al.*'s (2011) research, it would be important for university biopsychosocial programmes to review the healthcare service and prevention education provided by the institution. The intention of the review would be to reframe HIV education and to ensure that it is relevant to all sexual practices.

The key findings that emerged from Carter *et al.*'s (2014) [Study ID 5] study were that the patient's perceptions of the health provider had an influential role in obtaining a complete and accurate sexual history and assessment. The authors also found that medical providers experience some discomfort when asking patients about sexual practice and behaviour, thus limiting the sexual assessment and STD screening process. The authors advocate that it is the responsibility of the healthcare provider to foster trust and create an enabling environment to assist patients in disclosing relevant information. Carter *et al.* (2014)

suggest that diversity training should be incorporated into health provider education to help health practitioners foster an environment that is perceived as non-judgemental and culturally sensitive. For higher education, it would be equally important for the primary healthcare clinic staff to be aware of this research and perhaps seek appropriate organizations that can assist with diversity training, if such skills are deemed to be lacking.

From the seven articles identified in the systematic review, it was found that innovations in biomedical and psychosocial responses are required for MSM, and that current medical training, including HIV prevention and education, may not be relevant to all sexual practices. The systematic review was, therefore, a useful mechanism to identify key gaps in biopsychosocial programming for MSM. This can assist in informing the development and content of MSM health and support programmes in the higher education context.

6.4 Theoretical position and research methodology

Positioning myself as a critical theorist who oscillates between modern and postmodern views not only influenced the way in which I analyzed the data, but also influenced both my engagement with the programme coordinators and my research methods.

Critical theory focuses on the influential relationship between the researcher and the participant. This relationship asserts, by its very nature, a power dynamic. In Chapter Three, I emphasized the methods used to overcome the shortcomings of critical theory by increasing dialogical opportunities for the programme coordinators to engage with my data analysis and effect any variations in interpretation.

Using a qualitative research method, I conducted a total of ten (2- to 3-hour) interviews with the five programme coordinators. Prior to the interviews, I conducted a pilot study with two other programme coordinators from different universities, in order to check the validity and reliability of the interview questions. Findings from the pilot study helped me refine seemingly ambiguous or repetitive questions. Following the analysis of the data, each participant was given his/her interview transcription and my analysis of the interview. The programme coordinator then had an opportunity to rectify my analysis. Further opportunities for validation then occurred via a focus group with all fourteen programme coordinators. In the ensuing section, I identify key knowledge contributions in my PhD.

6.5 Findings

6.5.1 Developing a psychosocial programme

Chapter Four identified four key findings relating to psychosocial programming. The first was that there is a synergistic relationship between the psychosocial and the biomedical elements of the programme. Without the psychosocial support of the peers and the programme coordinators, it was likely that there would have been a minimal uptake of biomedical services by MSM. This finding emphasizes the important role of psychosocial work in terms of attaining biomedical indicators. However, it is equally important that practitioners, grant funders and universities need to develop psychosocial indicators for biopsychosocial programmes, in order to avoid establishing a programme that emphasizes only biomedical indicators. The establishment of psychosocial indicators will also ensure that a similar approach is integrated within healthcare services.

A second finding during the formation of the biopsychosocial programmes was the innovation used to locate MSM students. This innovation saw the inclusion of all sexually diverse students into the programme, as a method of locating only MSM students. Characteristically, MSM are often difficult to locate and retain within systems of healthcare, due to the discrimination and stigma of being associated with the sexual behaviour and the assertion of cultural, religious and heteronormative views about men and masculinity.

A related finding further identified that the peer social network is a contributing factor in the location, retention and support of self-identifying students. For some programme coordinators, the reliance on the social network to locate and retain MSM was absolute. Therefore, universities that are considering the implementation of a sexual diversity programme would need to establish and/or enhance their existing peer networks, in order to become responsive and relevant to self-identifying students in university.

A third notable finding was the use of an online platform in the peer network of self-identifying students. The programme coordinator administrated the online platform to share risk-reduction methods, psychosocial care, lay counselling, and/or prevention education among sexually diverse student groups. For practitioners, the use of online methods of engagement may fast become a modality for prevention education and psychological support, which necessitates new avenues of research for this medium of communication.

6.5.2 Reframing healthcare

Health services in the programme were strengthened by the wider campus dialogues, sensitization training and peer networks. In conjunction with the health and support services, some programme coordinators introduced health innovations, using the waiting room in the clinic to conduct prevention education that was relevant to all sexual practices. In addition, information, education and communication (IEC) materials in the form of posters were distributed in each university and their health clinics. These posters sought to reframe visual perceptions of relationship norms and promote values of inclusion and representations of sexual diversity.

In addition to reframing the environment in healthcare services, the programme coordinators worked with medical health practitioners to ensure that their engagement with students was non-discriminatory and inclusive. This was achieved through workshops, conversations and sensitization that were offered to university stakeholders. The majority of the programme coordinators found that the engagement with health practitioners was necessary and highlighted two assumptions. The first assumption is that medical practitioners are already equipped with the necessary skills and training to provide inclusive healthcare. The second assumption concerns current medical education, which is meant to prepare healthcare practitioners in their delivery of inclusive care. Both assumptions may require further investigation, particularly if the South African National Strategic Plan calls upon medical professionals to provide inclusive care.

6.5.3 Leadership and perceptions of power

Drawing on some of the key findings presented in Chapters Four and Five, I identified that the programme co-ordinators became the fulcrum point that determined the extent to which the programme would be sustained in the university.

The findings show that the function of the programme coordinators extended beyond merely coordinating the programme to include critical skills of mediation (between disgruntled stakeholders); negotiation (for access and inclusion); lay counselling (for affected students); sustaining peer efforts; integrating prevention education within healthcare settings, and providing strategic guidance for executive management. All the programme coordinators are, therefore, viewed as linking agents between university structures. They are also identified as the key role players within the university setting.

It is also noteworthy that three programme coordinators found that the psychosocial programme was easier to implement at the university with the support of executive management. However, it is interesting to note that the two universities that did not have explicit support from executive management, were able to implement the programme and achieve the programme indicators required by the grant.

My PhD, therefore, suggests that the efficacy (or implementation) of the programme is seemingly not dependent on the support of executive management, because all programme coordinators were able to achieve similar outcomes. As a critical theorist, I am aware of my inclination to question systems and power; however, in this instance, I am merely interpreting the findings of the research, which interrogates where leadership and power are located within a university. The data suggests that it may be possible to decentralize power and leadership within a university structure at various levels of the institution.

With regard to the sexual diversity programme, I return to the programme coordinators, who, with the support of a coordination unit, middle-management stakeholders, health staff and/or allies, were able to implement a sexual diversity programme and create an enabling university environment. Such a finding is further supported by the student movements that were also able to influence and effect institutional change. Therefore, I conclude that executive management within an institution may not be the only source of power and leadership for practitioners who intend to implement institutional sexual diversity programmes in HEIs.

6.5.4 Magnifying the absences

In Chapter One, I emphasised that there is a tension between the role of the university and the mandate conferred by the national government. This claim was magnified by the legal slippage in the application of the law and the National Department of Health Strategic Plan within the higher education setting; the latter requiring that health and support services be inclusive and non-discriminatory. In the wake of this legal slippage, I suggest that there may have been an unequal weighting towards heterosexual health and support services in the university setting, which was further influenced by a heteronormative institutional culture. This finding suggests that, unless sexual diversity programmes become incorporated as part of the institutional programmes, the university and its stakeholders may intentionally and/or

unintentionally not provide relevant health and support services for self-identifying students, thus perpetuating discrimination and its related oppressions.

6.6 Recommendations

There are four main recommendations for practitioners who are considering whether to implement an institutional programme that reframes the university culture and provides relevant biopsychosocial services to self-identifying students. The recommendations are presented with the view that there are additional nuances and complexities that may prevent, hinder and/or influence the implementation of the four interdependent recommendations listed below. I therefore remain aware that the extent and success to which these recommendations may be implemented, are highly dependent on whether the unique contextual challenges are addressed in each of the higher education institutions.

Recommendation 1: Developing a psychosocial programme

Based on the findings of my research, a psychosocial programme for self-identifying students is dependent on the formation and support of a social network, which is strengthened by peer educators who are critical stakeholders and who are likely to provide first respondent support for students. It is evident from the literature review that current HIV prevention education programmes will need to be reviewed, in order to ensure that the education is inclusive and relevant to self-identifying students. Further avenues for research that could be considered are the establishment of online care and support services for students. This seems to be an emerging medium of communication upon which the students rely. Peer educators will also need to be equipped with lay counselling knowledge and training, to enable them to assist students.

Recommendation 2: Reframing healthcare

Francis (2017) argues that basic education policy, curriculum and professional development are referenced within hegemonic heterosexuality. Francis (2017) further states, educators are working under a culture and practice of compulsory heterosexuality. I argue, that healthcare like education, also operates within a culture of compulsory heterosexuality. This claim points to further research in health care practice, policy and curriculum reform, with a view to equip health practitioners with relevant knowledge to better support self-identifying students.

This includes inclusivity skills and training so that the healthcare provider can create an enabling and non-discriminatory environment. I recommend a review of the health administration documentation, staff engagement practices, and health professional curricula to ensure that students are accurately diagnosed and assessed.

Recommendation 3: Leadership and perceptions of power

The third recommendation articulates a strategy for practitioners, which suggests that there, needs to be both a top-down and a bottom-up approach that garners the institutional support within various tiers of the institution. It must be emphasized that the implementation of the programme was not solely dependent on executive support, although the latter was useful in promulgating the programme through the administrative and academic echelons. It is however, important to reflect on the many divergent views held by stakeholders within the institution. This third recommendation requires the university to take a position – which is difficult and uncomfortable. Therefore, in addition to devolving leadership and power to enable inclusion in the university, it will be equally important to develop support and cultural change mechanisms to facilitate the shifts in position with regard to sexuality and sexual diversity.

Recommendation 4: Magnifying the absences

The final recommendation seeks to narrow the gap between the transformation mandate conferred upon HEIs by government and the practical application of this mandate by the university. Further research on governance, institutional planning and programmes could be conducted to help HEIs structure their institutional responses, in order to better support and provide services to their students. This recommendation also points to further contributions to knowledge and scholarship, by establishing academic outputs that can capture the complexity and related challenges that hinder and promulgate inclusive practice in university environments. Such academic output can enhance, inform and measure institutional change that seeks to include self-identifying students.

6.7 Conclusion

Chapter Four established that the sexual diversity programme necessitated the creation of an enabling and inclusive culture on each of the five universities. Certainly, the student protests

called for a change in institutional culture to one that promoted inclusion, equality and non-discrimination.

The study found that, among other benefits, the sexual diversity programme also improved the institutional health and support services for self-identifying students in university. However, despite producing similar outcomes, the limitations of the study are that the successes of the programme are unique to the five universities. Nevertheless, such a result warrants further consideration by other universities who intend to implement an institutional programme for self-identifying students.

In conclusion, in the absence of institutional accountability which ensures that services are inclusive and non-discriminatory, it is of notable concern that institutional practices may continue to subtly and/or explicitly reinforce heterosexuality as the one form of sexual identity. In order for universities to demonstrate their commitment to an inclusive institutional culture, and sustain the important work initiated by the five programme coordinators; university management will need to set aside funding that will support relevant and accessible services for self-identifying students within the university setting.

ABSTRACT

The need for university support of self-identifying students has received recent attention with the introduction of global funding and directives from the National Department of Health through the National Strategic Plan (2012-2016). Previous HIV prevention programmes funding provided hardly any to no support for self-identifying populations in specific HIV prevention programmes, with the result that structural discrimination reinforced hegemonic norms that constrained the "health, opportunities and resources of [already] socially stigmatized individuals" (Storholm *et al*., 2013 p.8).

Being the only study, as at 15 January 2015, to focus on institutional programmes for men who have sex with men students (MSM) in higher education, my PhD contributes to a gap in knowledge and HIV prevention responses within the university setting.

The research reviews five university programmes that were developed to provide biopsychosocial responses for self-identifying students at university. The findings contribute towards praxis that seeks to serve and support populations that experience more than one form of oppression.

Applying a critical theorist approach, I conducted ten two hour qualitative interviews with programme coordinators working at five South African universities, to identify the methods they used to locate and retain MSM students within systems of health and support. Furthermore, through the analysis of the data, I analyse the unique approaches that are used in their combined prevention programmes for MSM students in higher education institutions. These approaches include innovations for locating MSM; social media use; structural change; health innovations; and psychosocial changes that focus on creating an enabling environment for sexually diverse students in the higher education setting.

As a critical theorist, I question the location of power and how the five programme coordinators navigated the university terrain in order to seek support and establish a contentious programme for self-identifying students in university. The results demonstrate that institutional support can be located within the various echelons of the university, which ultimately contests the power held by the executive management. Further findings question the role of academia in institutional programmes and calls for equality in the provision of health and related services for self-identifying students in higher education institutions.

Despite South Africa having an advanced Constitution and higher education system, there is much more work to be done, in the training of health care practitioners who are mandated through National policy, to create an inclusive health care environment. Similarly, universities as sites of academic freedom, seemingly fail to uphold the equal protection and implementation of students' right to sexual orientation and in so doing reinforce heteronormative practices that further discriminate and alienate self-identifying students in university - which results in the limited uptake of HIV prevention and support services in university. My PhD research contributes towards the gap in knowledge that articulates the changes required in higher education institutions that would enhance combined prevention programmes for MSM and sexually diverse populations at university.

Key Words

University, men-who-have-sex-with-men, inclusive, institutional-programmes; sexual-diversity; health; support services; higher education; transformation

OORSIG

Self-geïdentifiseerde studente se behoefte aan ondersteuning vanaf die universiteit het onlangs aandag gekry met die instelling van globale befondsing en die Nasionale Departement van Gesondheid se riglyne soos vervat in die Nasionale Strategiese Plan (2012 – 2016). Vorige MIV-voorkomingsprogramme se befondsing het weinig of geen ondersteuning gebied aan self-geïdentifiseerde populasies van spesifieke MIV-voorkomingsprogramme, met die gevolg dat strukturele diskriminasie heersende norms versterk het met betrekking tot die "gesondheid, geleenthede en bronne van individue wat [alreeds] 'n sosiale stigma het." (Storholm *et al*., 2013 p.8).

Tot op 15 Januarie 2015 is hierdie die enigste studie in hoër onderwys wat gerig is op institusionele programme vir mans wat seks het met mansstudente (MSM) en my PhD lewer 'n bydrae tot die leemte in MIV-voorkomingsresponse binne die universiteitsopset.

Die navorsing beoordeel vyf universiteitsprogramme wat ontwikkel is om op biopsigesosiale vlak antwoorde vir self-geïdentifiseerde studente op die kampus te bied. Die bevindinge dra by tot praktyke wat daarop ingestel is om populasies wat meer as een vorm van onderdrukking ondervind, te bedien en ondersteun.

Deur 'n kritiese teoretikusbenadering het ek tien twee-uur kwalitatiewe onderhoude gelei met programkoördineerders by vyf Suid-Afrikaanse universiteite om die metodes te identifiseer wat hulle gebruik het om MSM-studente op te spoor en binne die gesondheid- en ondersteuningstelsels te behou. Verder het ek deur die analise van die data die unieke benaderings geanaliseer wat gebruik is in hulle gekombineerde voorkomingsprogramme vir MSM-studente op kampus. Hierdie benaderings sluit in innoverings om MSM-studente op te spoor; die gebruik van sosiale media; strukturele verandering, gesondheid innoverings en sielkundig-sosiale verandering wat fokus op die skep van 'n gunstige klimaat vir seksuele diversiteit van studente in die hoër onderwysopset.

As kritiese teoretikus bevraagteken ek die magsetel en hoe die vyf programkoördineerders deur die universiteitsterrein beweeg het om ondersteuning te soek en omstrede programme te skep vir self-geïdentifiseerde studente op kampus. Die resultate toon dat institusionele ondersteuning gevind kan word binne die verskillende vlakke van die

universiteit, wat uiteindelik die mag betwis van die uitvoerende bestuur. Verdere bevindings bevraagteken ook die rol van akademici in institusionele programme en vra vir gelykheid in die voorsiening van gesondheid en verwante dienste wat aan self-geïdentifiseerde studente in hoër opvoedkundige instansies gebied word.

Ondanks die feit dat Suid-Afrika ’n gevorderde Konstitusie en hoër onderwysstelsel het is daar heelwat meer werk om te doen in die opleiding van gesondheidsorgpraktisyns wat deur die Nasionale beleid ’n mandaat het om ’n insluitende gesondheidsorg omgewing te skep. Enersyds blyk dit asof universiteite wat plekke van akademiese vryheid is faal in die handhawing van gelyke beskerming en implementering van studente se regte tot seksuele oriëntasie. Hierdeur word heteronormatiewe praktyke versterk wat lei tot verdere diskriminasie en vervreemding van self-geïdentifiseerde studente op kampus – wat weer ’n beperkte deelname aan MIV-voorkoming op kampus tot gevolg het. My PhD-navorsing dra by tot die leemte in kennis wat die veranderinge verwoord wat nodig is in hoër onderwysinstansies en wat gekombineerde voorkomingsprogramme sal versterk vir MSM en seksuele diversiteit van populasies op universiteit.

Sleutelwoorde

Universiteit, mans-wat-seks-het-met-mans, insluitend, institusionele programme, seksuele diversiteit, gesondheid, ondersteuningsdienste, hoër onderwys, transformasie.

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