

## 'Clinics aren't meant for men': Sexual health care access and seeking behaviours among men in Gauteng province, South Africa

Jami S Leichter, Gabriela Paz-Bailey, Allison L Friedman, Melissa A Habel, Alex Vezi, Martha Sello, Thato Farirai, David A Lewis

### Abstract

Men may be key players in the transmission of sexually transmitted infections (STI), and it is important that STI/HIV health services reach men. The objective of this study was to explore sexual health care access and seeking behaviours in men. This study used focus groups to examine sexual health care access and seeking behaviours in men 5 years after implementation of free antiretroviral therapy (ART) in the South African public sector. Six focus groups ( $N=58$ ) were conducted with men  $\geq 18$  years in an urban area of Gauteng province. Men were recruited from various locations throughout the community. Men reported several barriers and facilitators to the use of public and private clinics for sexual health services including HIV testing, and many men reported seeking care from traditional healers. Men often viewed public clinics as a place for women and reported experiences with some female nurses who were rude or judgmental of the men. Additionally, some men reported that they sought sexual health care services at public clinics; however, they were not given physical examinations by health care providers to diagnose their STI syndrome. Most men lacked knowledge about ART and avoided HIV testing because of fear of death or being abandoned by their families or friends. Study findings suggest that men still require better access to high-quality, non-judgmental sexual health care services. Future research is needed to determine the most effective method to increase men's access to sexual health care services.

**Keywords:** sexual health care access, men.

### Résumé

Les hommes peuvent être des responsables dans la transmission des infections sexuellement transmissibles (IST), et il est important que les services de santé des IST/VIH les sensibilisent (les hommes). Les objectifs de cette étude étaient d'examiner l'accès aux soins de santé et les comportements sexuels des hommes pendant 5 ans après la mise en œuvre de la thérapie antirétrovirale (ART) gratuite dans le secteur public Sud-Africain. Six groupes d'hommes âgés  $\geq 18$  ans ( $N=58$ ) ont menés des discussions dans la zone urbaine de la province de Gauteng. Ces hommes sont recrutés dans divers endroits dans toute la communauté. Ils ont déclaré rencontrés des obstacles et facilitateurs à l'accès des cliniques publiques et privées des services de santé sexuelle, y compris le test du VIH, et beaucoup d'hommes déclarent être à la recherche de soins vers des guérisseurs traditionnels. Les hommes ont souvent vu les cliniques publiques comme des endroits pour les femmes et se sont souvent plaint des expériences qu'ils ont eues par rapport aux infirmières qui ont un mauvais jugement sur eux. Certains d'entre eux ont déclaré qu'ils cherchaient des soins de santé dans les cliniques publiques, mais qu'ils n'étaient pas soumis à des examens physiques pour diagnostiquer leurs syndrome d'IST. La plupart d'entre eux n'avaient pas de connaissances de l'ART et évitent le test du VIH parce qu'ils ont peur de la mort ou d'être abandonné par leurs familles ou leurs amis. Cette étude suggère que les hommes doivent exiger de meilleures qualités de soins, un non-jugement des services de santé sexuelle. Les recherches futures sont nécessaires pour déterminer la méthode la plus efficace d'accroître l'accès des hommes aux services de santé sexuelle.

**Mots clés:** l'accès aux soins sexuels, les hommes, VIH.

**Jami S Leichter**, PhD, is a research behavioural scientist in the Division of STD Prevention at the US Centers for Disease Control & Prevention, Atlanta, GA. Her research interests include high-risk or marginalised populations, such as persons repeatedly infected with STDs and impoverished communities, the role of sexual networks, and national surveys of sexual behaviour.

**Gabriela Paz-Bailey**, MD, MSc, PhD, is a medical epidemiologist working at Del Valle University and Tephinet Inc. on HIV-related research and programmes in Central America. She also worked in South Africa on herpes simplex type 2 and syndromic management of genital ulcer disease. Her research interests include the epidemiology of HIV and STI among high-risk groups, HIV and STI interactions, and STI management strategies.

**Allison L Friedman**, MS, is a health communication specialist in the Behavioral Interventions & Research Branch in the Division of STD Prevention at the US Centers for Disease Control & Prevention. She has focused her efforts directing national campaigns to raise awareness of STDs, reduce STD-associated stigma, and promote STD testing and prevention.

**Melissa A Habel**, MPH, is a health scientist at the Centers for Disease Control & Prevention in the Division of STD Prevention, Behavioral Interventions and Research Branch, Atlanta, GA. Her primary research focuses on the sexual behaviour of adolescents and young adults, specifically exploring how new media and technology influence behaviour and can be used for STD prevention.

**Alex Vezi** is a sexual health counsellor at the Sexually Transmitted Infections Reference Centre at the National Institute for Communicable Diseases, National Health Laboratory Service, South Africa. He is a medical recruiting officer and facilitator for several behavioural research studies and holds a Project Management certificate.

**Martha Sello**, RN midwife, RNE, BCur is a clinical nurse manager at the STI Reference Centre of the National Institute for Communicable diseases in Johannesburg, South Africa. Her research interest is in varying projects investigating sexually transmitted infections epidemiology. She was previously a senior nurse clinician in the genitourinary medicine (GUM) clinic at St Thomas Hospital, Central London, UK.

**Thato Farirai** is currently working as the HIV counseling and testing Lead for CDC GAP South Africa. Her research interests are in behaviour change communication and in models of HIV testing and counselling.

**David A Lewis**, FRCP (UK), PhD, is Head of the Sexually Transmitted Infections Reference Centre at the National Institute for Communicable Diseases, National Health Laboratory Service, South Africa. He is also the Director of the African Region of the International Union against Sexually Transmitted Infections (IUSTI). His research interests include men's sexual health, gonorrhoea resistance, genital ulceration and STI surveillance.

Correspondence to: Jami S Leichter (jleichter@cdc.gov)

## Introduction

South Africa has one of the largest HIV/AIDS epidemics (UNAIDS, 2007; AVERT, 2007) and other sexually transmitted infections (STIs) are common (Johnson, Coetzee, & Dorrington, 2005). For men attending sentinel surveillance primary health care clinics in South Africa's Gauteng province from 2000 to 2006, the most common STI presentations were urethral discharge (60%), genital ulcer syndrome (19%) and genital warts (5%) (Lewis, Tshelane, Khanyile & Pillay, 2007). During the same time frame, the three most common STIs in women were vaginal discharge syndrome (68%), lower abdominal pain syndrome (13%) and genital ulcer syndrome (Lewis, Tshelane, Khanyile *et al.*, 2007). Additionally, the seroprevalence of herpes simplex virus type 2 (HSV-2) was 17% in men and 53% in women in a general population study (Auvert, Ballard, Campbell *et al.*, 2001) and 71% in male STI patients with genital ulcers (Paz-Bailey, Sternberg, Puren *et al.*, 2009).

Given the high STI/HIV rates in South Africa, research has examined STI/HIV knowledge and stigma and their role in sexual health care access and seeking behaviours. Findings suggest that STI knowledge is often inadequate, with some believing that STI/HIV can be acquired through non-sexual contact (e.g. bewitchment, taxi seats) (Shefer, Strebel, Wilson *et al.*, 2002; Campbell, Nair, Maimane & Nicholson, 2007). Inaccurate beliefs about STI/HIV transmission were more common in male STI patients as compared to female STI patients (Reddy, Meyer-Weitz, Van den Borne & Kok, 1999). Accordingly, inadequate knowledge has been associated with stigmatising attitudes toward STI/HIV in multiple studies (Shefer, Strebel, Wilson *et al.*, 2002; Campbell, Nair, Maimane, & Nicholson, 2007; Kalichman & Simbayi, 2004; Kalichman, Simbayi, Cain, Jooste, Skinner & Cherry, 2006). Additionally, the combination of lack of knowledge and stigmatising attitudes have been associated with men having multiple sex partners (Meyer-Weitz, Reddy, Van den Borne, Kok & Pietersen, 2003) and poorer access to STI/HIV health care including HIV testing (Kalichman & Simbayi, 2004; Holzemer, Uys, Makoe, Stewart, Phetlhu & Dlamini, 2007). It was thought that availability of antiretroviral therapy (ART) would increase HIV testing and decrease stigma (Levy, Miksad, & Feim, 2005); however, early findings from South Africa and Tanzania suggest that stigma and health care access issues remain (Roura, Urassa, Busza, Mbata, Wringe & Zaba, 2009; Chopra, Kendall, Hill, Schaay, Nkonki & Doherty, 2006).

Also, research has identified additional barriers to sexual health care access and the associated delays in seeking sexual health care in South Africa. Factors associated with sexual health care access and delay in seeking care include the perceived seriousness of symptoms and whether or not self-treatment occurred (Meyer-Weitz, Reddy, Van den Borne, Kok & Pietersen, 2000). Additionally, for HIV-positive men, daytime clinic hours and a belief that clinics were for women, as they typically have mostly female staff, were barriers to care (Orner, Cooper, Myer, Zweigenthal, Bekker & Moodley, 2008).

Findings from studies on sexual health care access in other countries have been consistent with those from South Africa. A review of studies on health care seeking for STI/HIV provided a framework for health care seeking that included factors such as

symptom duration and seriousness, socio-demographic variation, self-treatment, health literacy, and perceived stigma (Hogben & Shrier, 2007). A population-based study conducted in Nairobi, Kenya found that the majority of respondents who have STI-related complaints did not seek care (Voeten, O'Hara, Kusimba, Otido, Ndinya-Achola, Bwayo *et al.*, 2004). Of those who sought care, delays in care-seeking were related to the perceived seriousness of symptoms and a lack of financial resources (Voeten, O'Hara, Kusimba, Otido, Ndinya-Achola, Bwayo, *et al.*, 2004). Additionally, most respondents chose to seek care in the private sector; women were more likely to report seeking sexual health care at government facilities than men (Voeten, O'Hara, Kusimba, Otido, Ndinya-Achola, Bwayo, *et al.*, 2004). One study in Uganda compared those seeking care for STIs in public and private clinics and found that age, perceptions of care and staff at public and private clinics as well as other psychosocial variables were associated with seeking care from different types of health care providers (Nuwaha, 2006).

In 2007 the World Health Organization (WHO) published a global strategy for STI control and prevention (WHO, 2007). One recommendation was 'male involvement, male motivation, and services for men' (WHO, 2007). In some societies, men may be the 'key players' in STI transmission (Hawkes & Hart, 2000) as they often migrate for employment, marry later and are more likely to purchase sex. To encourage men to access sexual health care services and receive appropriate treatment, health services must reflect and respond to men's needs (Pearson, 2003). Given that both a 'Western' and traditional approach to sexual health care services are present in South Africa, allowing patients a choice, this study uses a cognitive anthropological approach to health care decision making (Young & Garro, 1981). Thus, the objective of this study was to explore sexual health care access and seeking behaviours in men 5 years after implementation of free ART in the public sector in South Africa. Specifically, this exploratory study examined the sexual health care-seeking practices of South African men and sought to understand the factors (including STI/HIV knowledge and attitudes) that may drive men's health-seeking decisions in a culture with a pluralistic health care system.

## Methods

### Research design and study setting

This exploratory qualitative study used focus groups ( $N=6$ ) to collect information about cultural or group norms, attitudes and beliefs regarding access to sexual health care in men. The study was conducted in a largely economically depressed urban area of Gauteng province (Johannesburg metropolitan area) with approximately 350 000 residents. The community consisted of a combination of informal settlements (where dwellings were built from improvised materials) and formal settlements (where dwellings were built with standard construction materials of single dwelling houses). Residents include Johannesburg natives and migrant workers from rural South Africa and neighbouring African countries. During data collection the streets of the community were filled with people as public workers were on strike.

### Participant selection

A convenience sample was used for this study. Men who appeared to be age 18 years or older were recruited from various public

settings throughout the community such as taxi ranks, street corners or outside of public institutions. Recruiters consisted of men who were similar to potential participants in ethnicity and age. Recruiters were from a local non-governmental organisation and from the STI Reference Centre, National Institute for Communicable Diseases (NICD) of the National Health Laboratory Service (NHLS). Participants were eligible for the study if they were male, 18 years or older, willing to provide informed consent, and able to converse in English, Zulu or Sotho. A schedule for focus groups was determined in advance, and eligible participants were assigned to a group. This study was approved by the ethics review boards at the University of Witwatersrand and the Centres for Disease Control and Prevention and by the Gauteng Department of Health. All participants were given a copy of the consent form, provided informed consent, and received R20 (2.75 USD) as reimbursement.

### Data collection

Data collection occurred from 19 - 22 June 2007 and was conducted by two research teams. Each team consisted of one male sexual health counsellor (from South Africa) who facilitated the groups and took notes and one female scientist (from USA) who took detailed notes. A semi-structured guide was developed for the focus groups. The guides allowed interviewers to ask follow-up questions when appropriate. The topics that were included on the guide consisted of STI/HIV knowledge, the importance of STI/HIV, and access to STI services including HIV testing. On average, the focus groups were approximately 1.5 hours in length and were conducted in English, Zulu or Sotho. As it was not possible to audio-record the focus groups, every attempt was made to capture quotes verbatim. Notes that were taken in Zulu or Sotho were translated into English. The two interview teams met daily during data collection to review and expand their notes and to discuss impressions and common or convergent themes from the focus groups. Focus group notes were kept in a locked file cabinet (hard copy) and in password- and security-protected computers (electronic copy).

### Data analyses

The focus group notes were analysed using a thematic content analysis to explore the men's sexual health-seeking decisions in a culture with a pluralistic health care system. As part of the thematic content analysis, three researchers independently reviewed the focus group transcripts and developed separate lists of the most common or recurrent codes (themes) in the data (Green & Thurgood, 2004). Subsequent to their individual reviews, the researchers met to reconcile their lists into one final list of common or recurrent codes. Using the final list of codes, one researcher coded transcripts based on the first five codes using NVivo7. Subsequently, a second researcher randomly selected 10% of the group transcripts to verify these codes. The overall agreement in coding between the two researchers was 96.7%; thus, the first researcher coded all transcripts for the remaining codes.

### Study limitations

Our study has some limitations. It is qualitative and was not designed to be generalisable to other populations or settings. Rather, we sought to obtain more detailed information on the relationship between STI/HIV knowledge and sexual health care seeking and access among men in one area of South Africa.

## Results

### Demographics

Six focus groups were conducted that included a total of 58 men with a range of 6 - 12 men per focus group. Men ranged in age from 18 to 50 years (mean = 25 years) and over 80% had at least attended high school (standard 6 - 10) (Table 1). Half of participants were Zulu, followed by 14% who were Tswana and 10% who were Sotho. The overwhelming majority of participants had never been married (88%), and only 10% of men reported being currently married. Two-thirds of men were currently unemployed. Approximately one-third of men reported that they either were not affiliated with a religion or were non-practising, with most of the remaining men reporting an affiliation with a form of Christianity.

### Facilitators to use of public clinics for STI care

Some men had positive comments about public primary health care clinics. Specifically, they reported reasons why they would choose a public clinic as opposed to a private clinic or a traditional healer if they thought they had an STI. The most frequently cited facilitators to receiving STI care at a public clinic included having competent nurses, a convenient location and free services. Some men stated they would visit a public clinic over a traditional healer as they thought the quality of STI care provided by the public clinic was higher than the care provided by traditional healers.

*'I (would) go to the clinic because (I) want something that is proven. Herbs from the traditional healers are not proven.'*  
*'At the traditional healer, they won't test (for STI or HIV). So, I wouldn't go to one.'*

### Barriers to use of public clinics for sexual health services

Conversely, many men reported mixed experiences with public clinics, and most men cited reasons why they would avoid public clinics for sexual health care services. The most frequently cited barriers included long queues, displeasure with health care providers, limited information given by providers and a lack of confidentiality. Men thought that it was too time-consuming to seek sexual health care at public clinics and cited waiting in queues as long as 4 - 5 hours to see a provider.

*'The waiting time is too long. They [nurses] take their time, talk among themselves while you wait. Then, they won't even take 5 minutes with you in the exam room. You might get there at 8:00 and you're there until 16:00.'*

One man offered a potential solution to the long queues: *'They need shifts, to substitute for the staff when they go to lunch and take [tea] breaks — so the wait is not so long.'*

Men reported a perception that men avoid public clinics because they do not feel welcome at these clinics. In most public clinics in our study location, the health care providers are mostly female nurses, and clinic waiting rooms are full of female patients.

*'Most men don't go (to a public clinic) because they are afraid. They don't feel comfortable going because all the docs and nurses are female and the clinics are full of women.'*

**Table 1. Demographics of focus group participants**

	Age (yrs)		Total N (%)
	18 - 24 N (%)	25 - 50 N (%)	
Age, yrs (mean (SD))	--	--	24.9 (5.6)
Ethnicity			
Xhosa	3 (11%)	2 (7%)	5 (9%)
Zulu	19 (63%)	11 (37%)	31 (53%)
Sotho	1 (4%)	5 (18%)	6 (10%)
Tsonga	1 (4%)	1 (4%)	3 (5%)
Tswana <sup>1</sup>	1 (4%)	7 (25%)	8 (14%)
Pedi <sup>1</sup>	2 (7%)	--	2 (3%)
Other			3 (5%)
Education			
Less than primary (std 1 - 2)	--	1 (4%)	1 (2%)
Primary (std 3 - 5)	--	2 (7%)	3 (5%)
High school (std 6 - 10)	26 (93%)	21 (78%)	48 (84%)
Tertiary <sup>2</sup>	2 (7%)	3 (11%)	5 (9%)
Religion			
None/not practising	8 (29%)	9 (33%)	17 (30%)
Protestant/Anglican/Lutheran	4 (14%)	2 (7%)	6 (11%)
Catholic	3 (11%)	4 (15%)	8 (14%)
Muslim	--	--	--
Traditional	3 (11%)	2 (7%)	6 (11%)
Zion Christian Church <sup>1</sup>	6 (21%)	6 (22%)	12 (21%)
Christian <sup>1</sup>	3 (11%)	3 (11%)	6 (11%)
Other	1 (4%)	1 (4%)	2 (4%)
Marital status			
Never married	28 (57%)	21 (75%)	51 (88%)
Married	--	6 (21%)	6 (10%)
Formerly married	--	--	--
Living with partner	--	1 (4%)	1 (2%)
Employment			
Employed	7 (25%)	2 (7%)	10 (17%)
Unemployed	14 (50%)	23 (82%)	38 (66%)
Student	6 (21%)	--	6 (10%)
Other	1 (4%)	3 (11%)	4 (7%)
N	28	28	58

<sup>1</sup> Responses were not listed as response options, but were provided by participants.

<sup>2</sup> College, technical or university.

Row and column Ns may not sum to total due to missing data.

Additionally, men thought that many public clinic staff lacked compassion or respect for them as a patient. In most of the focus groups, men reported unpleasant visits and discomfort interacting with female nurses. Additionally, some men thought that the health care providers at public clinics, who were typically female nurses, were disrespectful and even rude. This unfriendly behaviour on the part of clinic staff led to a perception that public clinics were inhospitable toward men.

*'You get discouraged. They [nurses] chastise you.'*  
*'I wouldn't go to the (public) clinic. It's embarrassing. The nurses make sure they humiliate you. They yell at you, tell you how stupid you are while the people [other patients] are waiting outside (and can hear everything). They strip you of your manhood.'*

When men who suspected they had an STI were seen by providers, they reported receiving limited information about their condition and were sometimes criticised by staff in front of other patients. Of the men who reported seeking sexual health care services at public clinics, most stated that they had not received a genital examination by a nurse despite this being an essential component of the STI syndromic management approach. Rather, men were simply asked about their symptoms and were given medication.

*'They just give you pills and never examine you. They never want to see what my penis looks like. Clinics aren't meant for men. They're not specialists. They don't know what they're doing.'*

### Alternatives to public clinics: the role of traditional healers and private doctors in sexual health care

Men discussed the use of providers other than those in the public sector for sexual health care. First, there was a diversity of opinion on the use of traditional healers. As previously noted, some men preferred public clinics to traditional healers because they thought that traditional healers did not provide STI/HIV testing or even treatments that would cure the STI. As South Africa uses syndromic management, STI testing is not routinely conducted at public health clinics either. During one focus group, most men said they would prefer to visit a public clinic and only a couple of men said they would seek sexual health care from a traditional healer. Conversely, in another group, many men stated they would use a traditional healer for sexual health care. Finally, a few men believed that receiving care from both a public clinic and a traditional healer was the best solution for an STI.

*'The clinic will just treat your symptoms; they won't cure you. Healers treat the root cause. You won't get (the STI) again. Everybody goes to the fathers. Sometimes it's your uncle, cousins. Healers treat the root cause. You won't get it again.'*

Some men thought that traditional healers, who were often called 'fathers', may be used because in some instances they offer expedited treatment, a closer, more convenient location, and more privacy than public clinics. Men who preferred seeking care at traditional healers often said that they would not go to a public clinic because staff are rude.

When asked about alternatives to traditional healers, some men said they would go to a public clinic, citing the convenience of a clinic's location and the availability of free medicine. Conversely, some participants thought private doctors provided the best type of sexual health care as they offered more confidentiality and a higher quality of care; however, most men noted that the high cost for these services was often prohibitive.

### Barriers to HIV testing remain

Men provided several reasons why men often do not get tested for HIV. The primary reason for not getting an HIV test was fear. Most men reported that they did not get tested because they knew that they were at risk for HIV. This fear was often born of a lack of knowledge about HIV, its transmission, and the effectiveness and availability of free ART. Many men reported that they viewed an HIV-positive test as a death sentence and that after a diagnosis with HIV 'you just wait to die'.

*'What you don't know won't kill you and what you do know will kill you. If you're feeling strong, you're fine. If you get an HIV test (and test positive), within 3 months, you're sick. You get skinny ... you die faster. You get sicker knowing. It's better not to know.'*

Some men were aware of treatments for HIV but did not know specifically about ART. Other men were aware of ART; however, they lacked confidence in the effectiveness of ART because it was not a 'cure' and believed that it was equivalent to treatments available from traditional healers or even a tea that is offered as

treatment for health conditions by some churches. Additionally, fear of HIV testing was related to HIV stigma, and men were concerned about abandonment by family and friends.

Some men were worried about the confidentiality of HIV test results. As HIV counsellors in public clinics are often from the men's communities, men thought that their friends and family would find out if they were HIV positive. Some men thought that the potential for a breach in confidentiality could be avoided by going to a private clinic or a chemist for a test; other men simply avoided getting an HIV test altogether.

*'The clinics are too stressful. If someone knows you, or if the staff knows you, they will tell others in the community. I wouldn't want to take the risk [of being seen]. I'd get a test kit from the chemist so I could do it in my own home.'*

Men also cited a lack of trust in the test kits from public clinics as a barrier to getting an HIV test. Specifically, a few men were afraid that they would receive a false positive test result, and one man thought that it was possible that dirty needles would be used during the test and that he would acquire HIV through testing. Additionally, in one focus group, some men believed that they were more knowledgeable about STI/HIV than the HIV voluntary counselling and testing (VCT) counsellors. 'They [HIV counsellors] don't even know that HIV is an STI.' Men also reported that the current VCT was too lengthy and judgmental. 'Counselling makes you not want to test. It discourages you and scares you.' Thus, some men simply avoided HIV testing.

### Potential facilitators for HIV testing

Men offered several suggestions to facilitate HIV testing that included providing: (i) client-centred counselling where the counsellor works with the man to talk about his options for lowering his risk for HIV; (ii) couples counselling and testing; and (iii) in-home testing. As compared to the current VCT approach which focuses on education and test readiness, most men believed that client-centred counselling sessions would be ideal. One man stated that he wanted someone to talk about *him* – personalised health information based on his own risk rather than general education. Some men wanted couples counselling to help with disclosure of test results to their partners, while others wanted to be able to have an HIV test at home to maintain their confidentiality.

### Lack of STI/HIV knowledge as a barrier to seeking sexual health care services

As with HIV, most men had heard of STIs in general; however, they admitted that they did not know much about the symptoms of STIs and that this was a barrier to seeking sexual health care services.

*'I've heard about cauliflower [genital warts], but I don't know anything about it.'*

*'Most men don't know (the symptoms of an STI). Sometimes you never know because when you go to the clinic, they don't explain to you what the problem is so you don't know how to not get it... they don't tell you what you have.'*

Although a few men identified painful or frequent urination or penile discharge as signs of a STI, most men in focus groups were unaware of STI symptoms. Often, men cited inaccurate symptoms; some thought one would feel 'cold' or 'changes' in the body and 'just know' if they had an STI. Most men commented on the lack of available information or places they can go to seek more information about STIs. Additionally, many men knew little about STI transmission and consequences. Men asked so many questions about STIs (e.g. 'Can they kill you? How do you become infected? How can you prevent them?') that the STI counsellors held voluntary educational sessions after all focus groups and most men stayed for these sessions.

## Discussion

Over a decade into the South African HIV epidemic and 5 years after free ART availability, men still require essential STI/HIV information and better access to high-quality, non-judgmental sexual health services. Our findings support previous research that found that inadequate STI/HIV knowledge persists (Shefer, Strebel, Wilson *et al.*, 2002; Campbell, Nair, Maimane & Nicholson, 2007; Reddy, Meyer-Weitz, Van den Borne & Kok, 1999) and STI/HIV remain stigmatised and feared (Shefer, Strebel, Wilson *et al.*, 2002; Campbell, Nair, Maimane & Nicholson, 2007; Kalichman & Simbayi, 2004; Kalichman, Simbayi, Cain, Jooste, Skinner & Cherry, 2006), even after several years of HIV educational efforts. Additionally, our findings support initial research that found that awareness and knowledge of ART was lacking and that ART was often equated with alternative therapies as they do not cure the infection (Chopra, Kendall, Hill, Schaay, Nkonki & Doherty, 2006). In our study, men often believed that ARTs were equivalent to treatments offered by traditional healers and churches.

Men's overall lack of knowledge about STI/HIV and ART appeared to be related to their decision not to seek HIV testing, and their lack of awareness of STI symptoms may influence their sexual health care-seeking behaviours. Additionally, several men avoided HIV testing because they found the current VCT process to be lengthy and judgmental; therefore, it is possible that a streamlined, non-judgmental and more client-centred approach to VCT would be more acceptable to men. Provider-initiated testing could also be a useful approach to increasing testing.

Perhaps the most important finding from this study is related to the quality of available sexual health care and its role in sexual health care seeking among men. Similar to findings from a study in Uganda (Nuwaha, 2006), several men believed that they could receive a higher quality of sexual health care services at private doctors; however, this contention would not appear to be supported in the literature. Studies of STI care offered in the private sector in South Africa have demonstrated that STIs are not always appropriately managed or treated in the private sector (Schneider, Blaauw, Dartnall, Coetzee & Ballard, 2001; Connolly, Wilkinson, Harrison, Lurie & Karim, 1999; Chabikuli, Schneider, Blaauw, Zwi & Brugha, 2002). It should be noted that our findings suggest problems with the quality of care in the public sector as well. Specifically, we found that at some men who reported STI symptoms were not given a physical examination by the health care provider. As described by WHO, a physical examination is an essential component of appropriate STI syndromic management

(WHO, 2003). Coupled with men's poor knowledge of STI symptoms, it is possible that some men could have had an STI that was not appropriately treated. These findings suggest that a wider examination of STI care in public health care clinics could be beneficial.

## Conclusion

In order to increase sexual health care-seeking behaviours among men, it may be important to make public clinics a more comfortable place for men to seek care. Men perceived clinics as a place for women given the large number of female patients and female staff. Additionally, there was a perception that female nurses in public clinics were rude and judgemental toward men. Current nurses and health care providers could be trained to more effectively communicate with male patients in a sensitive, non-judgmental way and to develop a rapport prior to a physical exam. It is also possible that having some male sexual health care providers, in addition to female providers, may aid in making clinics a more comfortable place for men. Finally, future research is needed to determine which STI/HIV interventions would be most effective in increasing sexual health care seeking and access in this population of men.

## Acknowledgment

This study was supported by Cooperative Agreement Number U62/CCU022901 from the Centers for Disease Control and Prevention (CDC), Atlanta, USA and by internal funding from the National Institute for Communicable Diseases of the National Health Laboratory Service, Johannesburg, South Africa. The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the US Centers for Disease Control and Prevention.

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