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EXPLORING THE NEEDS OF MEN WHO HAVE SEX WITH MEN (MSM) IN HIV SERVICES IN GABORONE CITY AND SELECTED SURROUNDING VILLAGES IN BOTSWANA

BY

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APPROVAL PAGE

This research essay has been examined and is approved as meeting the required standards of scholarship for partial fulfillment of the requirements for the degree of Master of Nursing Science.

Supervisor…….. Date……

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STATEMENT OF ORIGINALITY

The work contained in this Research Essay was carried out by Simon Mokgwathi from 2018 to 2019 in partial fulfillment of a degree of Master of Nursing Science at the University of Botswana. This is my own work and all the sources I have used or quoted have been indicated and acknowledged by means of complete reference. The work has not been submitted for the award of any degree of any university. No part of this work should be reproduced without authorized permission from the owner.

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Signature of student Date

DEDICATION

This project is dedicated to my son Christopher Mokgwathi who has stood by my side through some of the most difficult times in my life. I will always give a heartfelt ‘thank you’ to him. Thank you so much! God bless you for the good wishes and efforts and for having been there for me when I needed you most!

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Abstract

There is reliable evidence that men who have sex with men (MSM) are at an increased risk of HIV infection compared to other men of reproductive age. However, there is limited data on the proportion of MSM reached by HIV services globally. This may be compounded by the lack of explicit programmes to curb HIV among MSM. MSM still endure varied forms of stigma and discrimination worldwide, with some countries criminalizing their sexual orientation. In many countries including Botswana, research on MSM is also very low; and there is lack of data on the efforts, risks, challenges and successes in HIV prevention among MSM. The purpose of the proposed study is to explore HIV service needs for men who have sex with men (MSM) in Gaborone and selected surrounding villages in Botswana.

The study will use a qualitative descriptive approach. Data will be collected from MSM and HIV care providers to help explore the specific needs of MSM in HIV services. MSM participants will be sampled through purposive and snowball sampling techniques whereas HIV care providers (which include registered nurses, medical doctors, pharmacy personnel, psychologists and lay counselors) will be sampled using convenience sampling technique. The study will target a total of twenty (20) participants for each group.

The proposed study is guided by Kristen Swanson's Caring Model. Data will be analyzed using content analysis method. Findings of the study could provide empirical evidence to support advocacy among groups already putting pressure on policy makers to openly address MSM HIV prevention and care; inform health care curricula developers on the critical areas of need in HIV services for MSM, as well as inform organizations

providing HIV services on the needs of health care workers in providing quality HIV services for MSM in Botswana.

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTORY SECTIONS

Introduction

This chapter will address the background of the study, the statement of the problem, purpose of the study, the research questions, significance of the study, and definition of terms. A theoretical framework that guides the study which seeks to understand the needs of men who have sex with men (MSM) in HIV services in Gaborone city and selected surrounding villages in Botswana will also be discussed.

Background

Sex between men occurs in every culture and society; although its extent and public acknowledgement vary from region to region (Muraguri, Temmerman, & Geibel, 2012). Studies have shown that MSM are a high risk group for HIV infection; and HIV incidence and prevalence among MSM has not abated; despite HIV and AIDS having first been recognized among MSM in the 1980s (Beyrer, et al., 2012). Grossman et al. (2011) reported that in the USA, as of 2009, MSM accounted for 53% of the new HIV infection cases. Studies have also indicated high HIV incidence and prevalence among MSM in Western Europe, North America, Australia, Latin America, and Asia (Muraguri, Temmerman, & Geibel, 2012). For instance, Strömdahl et al. (2015) reported that in 2013, of the 29,157 men found to be HIV positive in the European Union, 42% were estimated to have acquired the infection through sex with other men. Researchers have also reported a 33% increase in MSM who tested HIV positive between 2004 and 2013 in Europe. The high incidence and prevalence rates of HIV among MSM may be in-part due to the unmet needs of MSM in HIV services.

In sub-Saharan Africa, MSM have been largely disregarded in most national and regional public health responses (Vu, et al., 2013). This is in spite of consistently high HIV rates in MSM populations across countries. Surveys in sub-Saharan Africa have reported MSM HIV prevalence ranging from 10.9% in South Africa to 24.5% in Kenya (Hakim, et al., 2015). High prevalence rates, poor HIV prevention, treatment and care programs for MSM in Africa are also generally thwarted by hostile attitudes toward homosexuality (van der Elst, et al., 2013). Studies have shown that in many African countries, MSM are vulnerable to HIV due to stigma, punitive laws against homosexuality, and limited access to services. Where homosexuality remains illegal and stigmatized, MSM will not readily disclose their sexual orientation; and this could hamper chances of instituting relevant prevention, education, and care. Kushwaha et al. (2017) reported that MSM in Ghana had expressed a wide range of concerns in HIV prevention. MSM reported poor quality of HIV services, stigma, and skill inadequacy amongst HIV care providers.

A study by Batist et al. (2013) revealed that, in South Africa, men who have sex with men (MSM) remain significantly affected by HIV, with reported HIV prevalence ranging between 10 and 50%. This is despite the efforts by the South African government and non-governmental organizations (NGOs) such as the Desmond Tutu HIV Foundation (DTHF) which have engaged MSM through both peer education and the use of safe spaces within township communities to provide HIV education, address stigma, address behavioral risks, and link individuals into HIV testing or care (Baral, et al., 2013). Baral et al. (2013) reported that in Eswatini, a country with the highest HIV prevalence in the world and where HIV is reported to be a generalized female predominant epidemic because of the cultural and social factors in the country, MSM are still at high risk for HIV infection. In their study, Baral et

al. (2013) found that there was lower condom use between male sexual partners than it was among heterosexual partners. Although MSM who enrolled in the study also admitted heterosexual activities, HIV acquisition risk for MSM was primarily related to sex with other men (Baral, et al., 2013). An association between MSM and heterosexual networks has been reported in countries such as Kenya. However, many African countries have not begun to address the needs of the population in their national HIV prevention and control programs (van der Elst, et al., 2013). The continued poor quality of HIV prevention and care for MSM is harmful to national HIV/AIDS responses, the consequence of which is endured not only by MSM, but by all (van der Elst, et al., 2013).

Like it is the case in many countries, the incidence of HIV amongst MSM in Botswana is relatively higher (3.6%) than the national incidence (0.84%) (NACA, 2015). The 2012 Botswana Sentinel Surveillance Survey revealed a trend similar to that seen in other African countries, whereby MSM engaged in heterosexual activities with 46.7% of the 454 MSM surveyed reporting having female sexual partners. More than 60% (65.9%) of the population reported "always using condoms" during anal sex. The survey also showed that 60% of MSM were not aware that anal sex is associated with higher risks of HIV acquisition; and only 49.4% of MSM surveyed had received HIV related information in the past year. Despite these observations, there were no HIV prevention packages (including specific health education) targeting MSM.

On the 11th of June 2019, several news outlets both locally and internationally reported that the High Court of Botswana had denounced and outlawed Sections 164, 165, and 167 of the penal code of Botswana which criminalized same-sex sexual practices. In passing judgment on a case brought to court to challenge these Sections of the penal code,

Justice Michael Leburu said, “any criminalization of love, of finding fulfillment in love, dilutes compassion and tolerance”. The court ruled that the existing law violated constitutional rights by denying Botswana citizens liberty, dignity, privacy and, equality. This is a significant step towards addressing the needs of MSM and reducing the risk of HIV infection in this population as it paves a way to openly addressing MSM. The court ruling may open avenues for researching on MSM and integrating MSM into the rest of the society. Currently in Botswana, a country in which HIV care is mainly funded by the government, MSM services are primarily provided by non-governmental organizations (NGOs). As the needs of MSM are belatedly beginning to be recognized, attention should be drawn to unmet needs of MSM in HIV prevention, treatment, and care (Beyrer, et al., 2012). There is therefore a need for research that could help in identification of specific HIV vulnerabilities and needs of MSM in Botswana.

Statement of the Problem

The unique needs of men who have sex with men have to be known and addressed in order to adequately manage the HIV scourge. This is because there is clear and consistent evidence that men who have sex with men (MSM) are at an increased risk of HIV infection compared to other reproductive-age men (Brown, et al., 2016). For instance, in Thailand in 2012, HIV prevalence in the general population was reported to be 1.6% whereas prevalence in MSM alone was 24.6% (Relay, 2012). Several factors contribute to this trend, including a greater biological risk of HIV transmission during anal intercourse, versatile sexual positioning that facilitates rapid HIV transmission within sexual networks, and limited access to prevention and care services due to stigma, discrimination and criminalization of same-sex sexual practices (Holland, et al., 2015). The search for factors influencing health

seeking behaviors among MSM has also brought into focus how HIV care providers interact and communicate with clients during the provision of services (Dapaah, 2016). Ledda et al. (2017) reported that some HIV care providers still behaved prejudicially towards MSM. There is therefore a likelihood that MSM might delay or avoid seeking health care when they need it because of discrimination or perceived homophobia within the health care system (Cele, Sibiya, & Sokhela, 2015).

There is limited data on the proportion of MSM reached by HIV service programmes worldwide. The mean coverage of prevention programmes reported by 20 countries in 2012 for all MSM was 54% (WHO, 2015). However, one international review concluded that globally, fewer than one in ten MSM receive a basic package of HIV prevention services (WHO, 2015). Holland et al. (2015) investigated access to HIV services for MSM at non-governmental organizations (NGOs) and community-based organizations (CBOs) in Cameroon cities and found that 33.4% of MSM in Yaoundé and 66.1% of MSM in Douala had been connected to NGO/CBO services in the past 12 months. Beyrer et al. (2012) reported that in many settings around the world in 2012, MSM did not have access to the most basic of HIV services and technologies such as affordable and accessible condoms, appropriate lubricants, and safe HIV testing and counseling. Even before the 11th of June 2019 when the High Court of Botswana outlawed punitive legislation against same-sex intimate relations, the government had to some extent yielded to pressure to recognize MSM as a significant group in HIV services. This is evidenced by the inclusion of MSM as beneficiaries of the HIV pre-exposure prophylaxis in the Botswana 2016 integrated HIV clinical care guidelines. The initiative was a response to the realization that MSM were at a

high risk of HIV infection. However, it is not clear as to how much of the MSM population is reached by this service and how adequately the service addresses MSM needs.

Hakim et al. (2015) and Kushwaha et al. (2017) carried out studies exploring HIV prevention among MSM in Cote d'Ivoire and Ghana respectively. Transactional sex, unprotected sex, heterosexual activities, HIV care provider skill inadequacy, legal and structural barriers wer implicated for increased HIV risk among MSM. Similar results were reported in the Botswana sentinel surveillance survey which reported risks such as inconsistent condom use, sexual intercourse with both men and women, lack of awareness of the high risk and poor access to HIV information. In a country like Botswana, where it may be assumed that HIV information is readily accessible to all (NACA, 2015), it is disturbing that MSM would be left behind.

Although Botswana government has recognized the importance of extending services to incarcerated men and similar populations (NACA, 2015), and recently legalized homosexuality, stigma and accessibility of HIV services may still remain a challenge to MSM due to societal and individuals' prejudice. It is important to find out if HIV care providers have the necessary competence in both skill and attitude to provide HIV services to MSM and if they have material resources for providing such services. This need is supported by the dearth of research in the country that could provide the necessary evidence to support government's efforts to contain the spread of HIV. Given MSM's high risk for HIV infection reported in empirical literature, this population needs to be given focused attention in HIV care, as ignoring that will retard progress in containing the spread of HIV infection.

Purpose of the Study

The purpose of this study is to explore the needs of men who have sex with men (MSM) in HIV services in Gaborone city and selected surrounding villages in Botswana.

Specific Research Questions

1. What are the perceptions of MSM regarding the accessibility and quality of HIV services due to them?
2. What are the perceptions of HIV care providers regarding the accessibility and quality of HIV services for MSM?
3. What factors determine the accessibility and quality of HIV services for MSM?

Significance of the Study

The study could provide empirical evidence to support advocacy amongst groups already putting pressure on policy makers to address MSM HIV prevention and care. Findings of this study may help inform health care curricula developers on the critical areas of need in HIV services for MSM. Findings of the study may also inform organizations providing HIV services about the needs of HIV care providers in providing quality HIV services for MSM in Botswana.

Theoretical Framework

Kristen M. Swanson's theory of 'Caring' will be used as a framework to guide the proposed study. Swanson is a nursing scholar who developed her theory in 1991 and 1993 inspired by the work of Jean Watson in her theory of Human Caring (Jansson & Adolfsson, 2011). In its development, the theory of 'Caring' focused on teaching and healing during pregnancy, giving insight on how families and health care providers deal with miscarriage as well as how to foster the healing process necessary to provide closure (Swanson, 1991).

Despite the theory being rooted in nursing care, it has shown versatility over the years, being used across different populations in different situations (Kalfoss & Owe, 2015).

Swanson's 'theory of Caring' posits that caring is expressed in five (5) processes that ultimately lead to the client wellbeing, namely (a) maintaining belief , (b)knowing, (c) being with, (d) doing for, and (e) enabling. Each process is explicitly defined to provide a caring roadmap (Kalfoss & Owe, 2015). The researcher found Swanson's theory ideal for the proposed study as provision of care to MSM is a delicate act that requires creation of a supportive and protective environment, in order to enable and maintain compassion, trust, and respect. The five processes of caring and their application to the study are discussed below:

Maintaining Belief. 'Maintaining belief' is sustaining faith in the other's capacity to get through an event or transition and face a future with meaning; believing in other's capacity and holding him or her in high esteem, maintaining a hope-filled attitude, offering realistic optimism, helping to find meaning, and standing by the one being cared for, no matter what the situation is (Swanson, 1991). In this study, maintaining belief is demonstrated by HIV service providers accepting MSM as they are and understanding the challenges they have in disclosing their sexual orientation, as well as accessing relevant HIV services. HIV care providers are welcoming to MSM, do not prejudice MSM based on their sexual orientation, and treat MSM with respect. Interaction with MSM occurs in the most comfortable areas, and ensuring privacy is upheld.

Knowing. 'Knowing' is striving to understand an event as it has meaning in the life of another person. A 'knowing' care provider avoids priori assumptions about the meaning of an event. She or he focuses on the one being cared for, conducting a thorough ongoing

cue-seeking assessment of the experience of the one being cared for (Swanson, 1993). In the proposed study, when knowing occurs, both HIV care providers and MSM become aware of the uniqueness of HIV susceptibility of MSM compared to other population groups. They know of the risks associated with insertive and receptive anal intercourse such as the fact that the anus may not produce enough lubricant during sexual intercourse, thus being prone to lacerating. Both HIV care providers and MSM are aware that anal sex provides an easy portal for HIV infection. HIV care providers respect individual differences and assess demographic data, age, gender, marital status, education, social influences from cultural backgrounds, and health care experiences for each of their clients. HIV care providers have the skills to collect sensitive history without being judgmental.

Being With. Swanson (1993) defined 'Being with' as being emotionally present to the other, conveying ongoing availability and sharing feelings, whether joyful or painful (Swanson, 1993). Being with is based on connecting, bonding, and attachment (Kalfoss & Owe, 2015). In the proposed study, 'being with' is exhibited when HIV care providers build trusting relationships with MSM, being there when needed, empathizing, and being non-judgmental. MSM therefore feel that HIV care providers are emotionally present with them and are therefore open to their feelings and needs regardless of the beliefs that HIV care providers may hold.

Doing For. 'Doing for' means to do for others what one would do for self if it was possible, including anticipating needs, comforting, performing skillfully and competently, and protecting the one being cared for while preserving his or her dignity (Swanson, 1991). This is where HIV care providers exhibit professional competence including the right attitude, clinical knowledge, collective skill-mix and self confidence (Kalfoss & Owe,

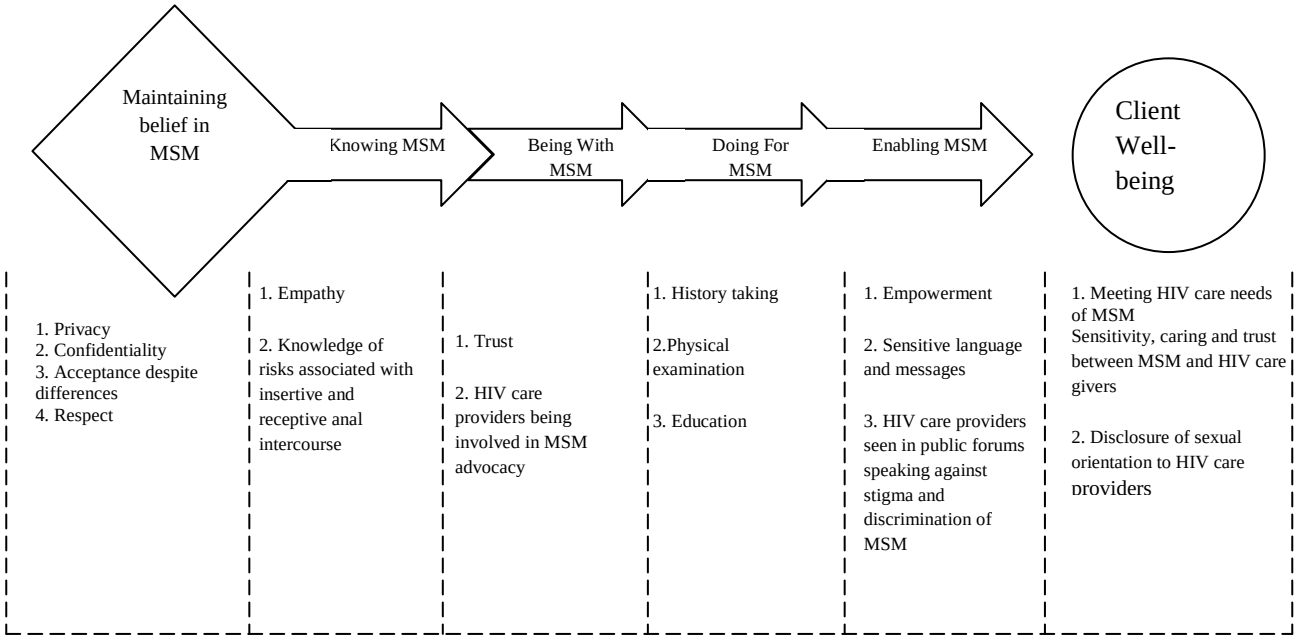
2015). HIV care providers possess the necessary skill for providing HIV care to MSM. They are cognizant of the environment where interactions with MSM take place, that is, they create a safe and non judgmental environment, ensuring confidentiality and respect for MSM at all times**.** History collected from MSM is relevant and includes sexual history. This involves exploring the number of partners, bi-sexuality, type of intercourse (e.g. oral, anal) and HIV prevention such as condom use and use of appropriate lubricants. On physical examination, providers assess the mouth; carefully inspect the oral cavity noting any evidence of trauma and sores as this could be a portal for HIV infection. The provider also performs an ano-rectal assessment doing direct visualization of the anal sphincter for tears and ulcerations. Digital rectal examination is also performed to check for discomfort, signs of bleeding (example, hemorrhoids) and sphincter tone.

Enabling. 'Enabling' is facilitating the other's passage through life transitions and unfamiliar events by focusing on the event, informing, explaining, supporting, validating feelings, generating alternatives, thinking things through, and giving feedback (Swanson, 1991). Enabling involves empowering the one being cared for (Kalfoss & Owe, 2015). In the proposed study 'enabling' is shown by HIV care providers being directly involved in dealing with stigma and discrimination. For example, HIV care providers being vocal against stigma and discrimination in public forums so as to improve MSM's confidence and trust. Persons who publicly identify as MSM are seen interacting with HIV care providers in dissemination of HIV prevention information and help identify peers who are still not forthcoming in seeking HIV care. Sensitive messages and language that is not prejudiced are used to sell the idea of disclosing sexual orientation to HIV care providers. Referral between health facilities is sensitive, that is, confidentiality is maintained at all levels, and the clients

are informed of the need to share certain privileged information in order for them to access relevant care.

Client well-being. When all the five processes of caring are successfully observed, client well-being is achieved. Care delivered represents mutual efforts of both the provider and the one being cared for; thus bringing fulfillment, satisfaction, respect, and empowerment. Client wellbeing in this study is demonstrated when there is commitment, caring, and trust between MSM and HIV care providers. MSM are encouraged to disclose their sexual orientation and therefore receive relevant interventions to curb the HIV scourge. Dedication of care providers to providing care to MSM also helps shape the latter's personal behaviors and attitudes. The essence being that continuous exposure to MSM mitigates previous negative attitudes and dispels misconceptions. Specific packages for HIV prevention targeting MSM are created to help meet their needs in HIV services.

Figure 1. Kristen Swanson's Caring Model in Exploring the Needs of MSM in HIV Services (Adapted from Swanson 1993).



Definitions of Terms

Accessibility to services: The ease at which HIV services can be obtained taking into account the barriers that may hinder access.

Care: Care provided by trained personnel offering a comprehensive HIV programme including health promotion, counseling, support, prevention, diagnostics, and treatment.

HIV care providers: Doctors, nurses, pharmacy personnel, psychologists, and lay counselors who provide HIV services to MSM.

LEGABIBO: LeGaBiBo (Lesbians, Gays and Bisexuals of Botswana) is an LGBTI (Lesbian, Gay, Bisexual, Transgender and Intersex) organization in Botswana.

MSM: Men who indulge in sexual intercourse with other men whether they identify as gay, bisexual or not. The term defines the sexual route through which men may be exposed to the risk of HIV, rather than the sexual orientation by which the individual may define themselves.

MSM HIV needs: HIV service recognizes the unique needs of MSM. Service covers HIV testing and antiretroviral treatment, STI screening, treatment for STIs, individual counseling, sexual health promotion, and support that MSM may require.

"Maintaining Belief" in MSM: A situation where MSM are given hope in HIV services. This is attained when HIV care providers address impediments such as stigma and discrimination, which can make MSM lose faith in the service (Swanson, 1993).

"Knowing" MSM: A situation where HIV care providers understand the sexual behaviors of MSM. In this way, HIV care providers will appreciate the vulnerabilities to HIV infection which MSM are at risk for (Swanson, 1993).

"Being With" MSM: This is when HIV care providers establish trusting relationships with their MSM clients to enhance sharing of ideas and understanding of each other (Swanson, 1993).

"Doing for" MSM: A situation whereby HIV care providers are competent in delivering HIV services to MSM (Swanson, 1993).

"Enabling" MSM: This is a situation whereby MSM get empowered through linkages and education and are enabled to face the challenges they meet in HIV services as well as to be able to care for self, motivate other MSM to do the same, and advocate for the rights of MSM in HIV services (Swanson, 1993).

Conclusion

The provision of HIV services to MSM remains a global challenge, despite the fact that MSM are at a high risk for contracting HIV. MSM's access to HIV services is hampered by the socio-cultural and legislative factors. For instance, stigma and discrimination based on sexual orientation that are prevalent in many countries including Botswana puts MSM at a disadvantaged position, in as far as prioritization and resourcing HIV services. There is lack of specialized resources for HIV prevention among MSM in health care facilities in many countries. In such countries, including Botswana, research on MSM is also very low, with the subsequent lack of data on the efforts, risks, challenges and successes in HIV prevention for MSM. The proposed study therefore investigates the needs, accessibility and quality of HIV services for MSM from the perspective of both MSM and HIV care providers in Greater Gaborone, Botswana. Findings of the study could inform policy and programme for improving HIV services for the MSM population.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents a review of literature on the needs of men who have sex with men (MSM) in HIV services. The review covers the global, regional and local situation. Literature acknowledges that MSM are a high risk group for HIV infection and that addressing their needs for HIV prevention is vital in controlling the spread of the epidemic. The literature review is organized by Kristen Swanson's 'Caring' Model, and therefore covers "maintaining belief" in MSM, "knowing" MSM, "being with" MSM, "doing for" MSM, and "enabling" MSM.

"Maintaining belief" in MSM

It is imperative that factors that hinder MSM from believing in the health care system and exploiting its available HIV services are removed. Stigma and discrimination have always been a constant hindrance to MSM's access to appropriate health care across different countries. Tackling stigma and healthcare inequalities are necessary for existing and new prevention methods to significantly decrease HIV incidence among MSM (Wheelock et al., 2017). Observations from developed countries, that one may assume have made advances in curtailing prejudice against MSM, show that stigma and discrimination are still prevalent. In Scotland, Flower et al. (2013) revealed that fear of seeking health care existed among MSM who would seek health care at distant clinics in an effort to retain anonymity at home; a practice that limited their access to convenient services. This observation was also made by Liu et al. (2016) when they reported that discrimination from healthcare workers was a common reason for failure to seek HIV care among MSM.

Similarly, in Sub Saharan countries MSM have been reported to be skeptical about disclosing their sexual orientation to HCP (Aho et al. 2019; Crowell et al. 2017; Stromdahl et al. 2014). This is especially true in countries where homosexuality is criminalized such as Nigeria and Kenya. In a study conducted by Matovu et al. in Uganda, none of the health care providers who participated in the study reported any experience in rendering care to MSM. In addition they reported that they would be uncomfortable rendering care to MSM because the latter were foreign to their culture.

In Botswana, prejudice in providing HIV care has not been studied. However, in their comparative study involving Botswana, Namibia, Malawi and South Africa, Zahn et al. (2016) found that, of the four countries, Botswana had the highest rates of fear to disclose sexual orientation to HIV care providers among MSM. Twenty one percent of Botswana participants reported that they were afraid to seek health care while 29% said they were afraid to walk in the community. The rest of the countries reported lower percentages. However, Botswana MSM reported the lowest rates of abuse related to their sexual orientation; and the highest disclosure rate to families was at 60.3%. A related study may explain the fear experienced by MSM in Botswana. In their study exploring attitudes towards homosexuality, Rakgoasi and Keetile (2016) noted that some men felt that MSM were not real men, weak, and always preoccupied with sex. One participant in the study even asserted that 'addressing the needs of homosexuals and MSM in public health forums would be dangerous as it may deem the behavior fashionable.' The authors also noted that attitudes towards MSM in Botswana were overly negative; with only a few participants holding a conservative view.

"Knowing" MSM

The definition of MSM is very broad in that it encompasses men with different sexual behaviors such as gays and bisexuals. This may present a challenge in the provision of HIV care because the diversity of the population may mean different needs. It is therefore important to explore the unique characteristics of MSM which make them at risk for HIV infection. Studies show that MSM indulge in risky sexual behaviors. Researchers believe that 'knowing' these characteristics of MSM can help in providing targeted interventions such as relevant health education on HIV prevention. Bourne et al. (2013) conducted an online survey in 38 European countries seeking to understand MSM's conceptions of 'what constitutes the best sex?' The researchers found that MSM had an array of sexual practices which they perceived as 'best sex' such as anal intercourse, oral intercourse and use of sexual accessories. The researchers then concluded that the findings had significant implications for HIV prevention as knowing the range of sexual desires held by MSM in delivery of holistic sexual health care can help MSM to have the 'best sex' with the least harm.

Crosby, Mena and Geter (2017) conducted a study in the southern states of the USA to compare selected sexual risk behaviors for young black MSM (YBMSM) who were HIV-positive and their HIV-negative counterparts. When asked about recent unprotected insertive anal intercourse, it was found that 29/422 (28.4%) of HIV negative participants had indulged in recent unprotected insertive anal intercourse compared to 29/120 (24.2 %) of those who were HIV positive. In addition, 114/316 (36%) of HIV negative participants affirmed to practicing unprotected receptive anal intercourse compared to 38/115 (33%) of HIV positive participants. Condomless anal intercourse in the last sexual contact was reported by 20/158

(12.7%) HIV negative participants and by 8/55 (14.5%) HIV positive participants. These differences were so insignificant that the researchers concluded that YBMSM in southern United States were experiencing high levels of HIV exposure risk or risk of exposing others to HIV, regardless of their HIV status.

Studies in Africa show similar sexual preferences and practices among MSM reported elsewhere. Aho et al. (2014) and Park et al. (2013) reported that in Cote d'Ivoire and Cameroon, MSM practiced unprotected anal intercourse, had inconsistent use of lubricants, had multiple sexual partners, and also engaged in heterosexual activities. Unprotected anal intercourse was at 64.1% in Cameroon and at 65.2% in Cote d'Ivoire while 62% of MSM in Cameroon identified as bisexual and 56.2% of MSM in Cote d'Ivoire admitted sex with women. Wirtz et al. (2017) found that a third of the 2453 MSM recruited in a study to evaluate geographical disparities in HIV prevalence and care among men who have sex with men in Malawi, had bisexual identities or history of marriage or cohabitation with women. There is dearth of studies exploring the characteristics of MSM in Botswana. Reviewed studies indicate an array of sexual preferences among MSM which must be known in HIV care in order to institute relevant care. It is important to acknowledge that given the different socio-cultural situations across countries, some MSM may choose to conceal their identities by indulging in heterosexual activities. Therefore, HIV care providers must be aware of this possibility and make proper assessments that enable the protection of both MSM clients and their partners.

"Being With" MSM

Studies have shown that trusting relationships between MSM and HIV care providers are essential to the realization of desirable health outcomes. Hubach et al. (2017) asserted

this view in their study assessing opinions of and barriers to accessing pre-exposure prophylaxis among MSM in Oklahoma, USA. One of the major themes in the study findings was that where MSM had to disclose their sexual orientation, the reaction of the provider dictated whether or not clients would be able to disclose again in the future. Given the sensitive nature of homosexuality related to the political, social, and cultural barriers, trust between health care providers and their MSM clients directly affects disclosure of sexual orientation (Levy, et al., 2014). In their study that sought to understand structural barriers to accessing HIV testing and prevention services among black men who have sex with men (BMSM) in the United States, Levy et al. (2014) argued that BMSM were not likely to disclose their sexual orientation to health care providers because of concerns over comfort and trust, among others. Lack of disclosure had consequences in that it led to inaccurate reporting of unprotected anal intercourse, which subsequently reduced the likelihood of obtaining HIV testing and education. Similar observations were noted by Qiao et al. (2018) when they reviewed studies published from different settings around the world between 2004 and 2016, which examined the relationship between client's disclosure of sexual orientation and uptake of HIV testing among MSM. In the review, disclosure rate had a median of 61%, with MSM who could not disclose their sexual orientation concerned about breach of confidentiality. This could be an indication that MSM lacked trust in health care providers. It is also worth noting that in the same study, disclosure of sexual orientation was directly linked to the health care provider recommending HIV testing.

MSM's health care issues including concern over 'trust' in the mainstream health system, has led to them mainly accessing HIV care through non-governmental organizations (NGOs) and community based organizations (CBOs) globally (Thomas, et al., 2011). NGOs

and CBOs have generally proven to be successful in the provision of HIV services to MSM because in such organizations, MSM find comfort and trust because they interact with other MSM. Wong et al. (2018) found that MSM testing for HIV at CBOs and voluntary counseling and testing (VCT) sites were more likely to be associated with linkage to HIV care than those testing at hospitals. Interacting with fellow MSM at NGOs/CBOs led to improved health outcomes among MSM. In evaluating the efficacy and effectiveness of HIV prevention interventions among MSM in Europe, Strömdahl et al. (2015) found that interactive group activities led by trained peer leaders reduced unprotected anal intercourse by 13% to 33% across European countries. This finding is consistent with those of a qualitative study carried out in China by Liu et al. (2016) to assess barriers and linkages to HIV care among MSM. One of the major messages revealed in Liu et al.'s study was that participants felt comfortable discussing HIV issues with an HIV positive peer, and were more likely to take suggestions from someone in a similar plight. Similar results were reported in Oregon and California, USA, where peer-led community projects decreased unprotected anal intercourse from 41% to 30% among a cohort of 300 MSM (Kegeles, Hayes, & Coates, 1996). The importance of trust in the provision of HIV services to MSM was also shown in a review conducted by Nyato et al. (2018) in sub-Saharan Africa. The study examined participants' accrual and delivery of HIV prevention interventions for MSM. Peer-led outreach services were found to be crucial to reaching out and delivering services to MSM.

The accessibility of NGOs and CBOs in HIV service provision for MSM has also been reported in Africa. Holland et al. (2015) discovered that MSM in Cameroon mainly accessed HIV care through non-governmental and community-based organizations

(NGOs/CBOs). It was noted that organizations which provided services to MSM improved access to HIV prevention, treatment, and care services. Otambo et al. (2016) concurred with this observation when they established that in Nairobi, Kenya, NGOs were at the forefront of offering HIV services to MSM. MSM expressed comfort and convenience in using NGOs compared to public health institutions. Despite studies just reported that indicate better performance of NGOs on accessibility of HIV services compared to mainstream care, in their study exploring determinants of retention in HIV care in Indonesia, Nugroho et al (2018) found that involvement with HIV-related organizations seemed to inhibit retention in care among MSM. This study finding that is contrary to findings of most studies around the world and demands further exploration. Although there are a few NGOs offering HIV services in Botswana, no study was found comparing NGOs and public health facilities on the accessibility of HIV services to MSM in the country.

"Doing for" MSM

Several studies in Africa have indicated lack of relevant skills among HIV care providers (HCP) in the provision of HIV services to MSM. The collective clinical skill-mix and the professional competence of HCP have been shown to be critical in providing quality HIV services. A study exploring MSM's experiences in using HIV prevention resources in three Ghanaian cities, revealed that MSM felt that health care providers were lacking compassion and the necessary skills to help them (Kushwaha et al., 2017). For instance, health care providers neglected to perform genital and anal physical examinations; thereby missing important clinical problems. In a similar study in South Africa, HIV care providers were reported to be lacking necessary knowledge and skills for providing care to MSM (Duby et al., 2018). In the same study, key populations which included MSM described their

encounters with HIV care providers and reported that providers in government facilities were not equipped with the knowledge and skills to provide them with appropriate services. For instance, one MSM participant said:

> The last time I went to the clinic there was this lady and she is very old. So she was busy writing and asking questions and stuff, then came the part where I had to take my clothes off. She was like "where are you sick" and then I had to tell her that my 'other vagina' (anus) is sick. She couldn't understand. "What are you talking about?" "My A-S-S is sick", and she was like "What happened? Did you have sex with your ...(anus)?" I am like "yes, I am gay."

The view that providers lacked the skills to effectively serve MSM reported in Kushwaha et al. (2017) and Duby et al. (2018) were affirmed by a Matovu et al. (2019)'s study in Uganda. The Matovu et al.'s study sought the views of health care providers on their competence in serving MSM. A majority of the health providers felt that they did not have adequate skills to effectively serve MSM, and called for specific training to improve their clinical skills. Micheni et al. (2017) also reported that the competence of HCP and their ability to provide high quality empathetic care was crucial for MSM's adherence to anti-retroviral therapy. They therefore recommended special training for providers in how to care for MSM. The importance of provider training was supported by Scheibe et al. (2017) in their study that evaluated health care providers' attitudinal shift towards MSM following sensitization training. The study revealed that training increased a sense of compassion and understanding as well as knowledge and awareness of the health risks, social vulnerabilities, and specific needs of MSM. The need for sensitization of healthcare workers through training and skills development is paramount to mitigating the discrimination of MSM and

improving HCP's ability to provide non-discriminatory, non-judgmental and appropriate health services (Duby 2018). No study was found evaluating the competence of HIV care providers' in rendering HIV services to MSM in Botswana. However, such studies are important as the population of MSM increases.

"Enabling" MSM

HIV care providers need to empower MSM so as to build their confidence in HIV services. They need to identify with MSM who have gone public with their sexual orientation and partner with them in providing education on HIV prevention and encouraging other MSM who are not forthcoming with their sexual orientation or HIV status to seek HIV care. A study by Herbst et al. (2007) supported this assertion when exploring the effectiveness of individual, group, and community-level HIV behavioral risk-reduction interventions for MSM in the United States. The results showed that compared to individual-level interventions, group-level HIV behavioral interventions for MSM, particularly those that included a skill-building component, were effective in reducing the odds of having unprotected anal sex and increasing the odds of condom use during anal sex. This was because of the support and empowerment that MSM got from the group. Another study by Liu et al. (2016) in China concurred with this view when exploring barriers and facilitators to engagement in HIV care among MSM. Several participants reported that they would be likely to initiate HIV care if a friend or partner introduced them to a hospital or a specific HCP.

Another study which showed the importance of empowerment for MSM was an online study carried out in Latin American countries by Magidson et al. (2015) exploring MSM engagement in HIV care. The study revealed that among all participating HIV-

infected MSM (n = 2,350) across Latin American countries, HIV-infected individuals not engaged in HIV care more often reported unprotected anal intercourse (UAI) than HIV-infected individuals in care at 42.7% and 36.2%, respectively. The study also showed that 100% adherence to ART was associated with protected anal intercourse. This was an indication that MSM who interacted more with HCP were empowered for both self-care and motivating other MSM. Micheni et al. (2017) argued that lack of interaction between HIV care providers and MSM was detrimental in that some MSM lacked the skills needed to interface with the healthcare system. It became apparent that the level of interaction between HCPs and MSM outside the health system was minimal, resulting in MSM being seen as strangers in health care system.

In their study in the townships of Cape Town, South Africa, Batist et al. (2013) found that engaging MSM in HIV prevention programmes improved their access to MSM-specific HIV-prevention information, condoms, and water-based lubricants. Still in South Africa, Duby et al. (2018) also found that HIV care providers' positive attitudes encouraged good uptake of services. For instance, one MSM was quoted saying:

> I have never had experiences like those, they are the friendliest towards gay people. Even when I am sick I go there and the service is okay unless they wait for me to leave and speak behind my back. People do that but I have not had such an experience.

A study by Kapanda et al. (2019) in Malawi also asserted the importance of empowering MSM. The study explored healthcare providers' attitudes towards care for MSM in Malawi. Providers suggested increased availability of MSM-centered and friendly health services, staffed by trained providers who are non-judgmental, non-discriminatory,

and who have respect for people's right to accessible health care. Such attitudes were said to be important for supporting and empowering MSM as well as increasing their access to health services.

Conclusion

All studies reviewed are in unison that MSM are a highly significant population in HIV prevention that cannot be ignored. MSM are a marginalized group with unique challenges and thereby needing specialized attention in the efforts to curb the HIV scourge. There is an abundance of literature on MSM and their needs in HIV care in developed countries. However, only a few of such studies have been in sub-Saharan Africa. The researcher also noted lack of interventions tailored to HIV prevention among MSM in many countries. Literature also suggests that MSM may not be as well equipped with HIV prevention information as their hetero-sexual counterparts.

In order to successfully combat HIV/AIDS among MSM, more research is needed that integrate behavioral, structural, and biomedical components. Studies reviewed from across the world address these components but there is not much research from Botswana. Studies are needed to explore MSM at the health systems level, the individual level, and policy making level that could shed light on how best to serve the MSM population and include them in the mainstream HIV care in Botswana.

The proposed study will explore the needs of MSM in HIV care. It is hoped that the study will increase insight into MSM and their needs in health care services in Botswana. The study explores the needs of MSM from the perspectives of both MSM and HIV care providers, which is a strength in that the researcher will be able to get perspectives from both parties for a deeper understanding of the HIV service needs of MSM.

CHAPTER THREE

STUDY METHODS

Introduction

This chapter presents procedures of how the study will be conducted. The chapter covers the research design, the study setting, the study population, the sampling technique, and, the sample size. The chapter will also address the research instrument, ethical considerations, pilot study, recruitment of the participants, data collection procedure, data storage, data analysis, study limitations, and conclusion.

The Study Design

A study design is a general plan for addressing the research question, including the specifications for enhancing the study's integrity (Polit & Beck, 2008). The purpose of a study design is to achieve greater control of the study and to improve the validity of its findings. The research design must be appropriate for the purpose of the study, feasible given realistic constraints, and effective in reducing threats to validity. The proposed study employs a qualitative descriptive approach in investigating the needs of MSM in HIV services. Qualitative Description follows the tradition of qualitative research, that is, an empirical method of investigation aiming at describing the participant's perception and experience of the world and its phenomena. However, qualitative description is less theoretical, and less interpretive than other qualitative methods (Neergaard et al., 2009). A qualitative description describes participants' experiences in a language similar to their own; involving low inference interpretation, and thereby staying closer to the data (Neergaard et al., 2009).

The goal of qualitative descriptive studies is a comprehensive summarization, in everyday terms, of specific events experienced by individuals or groups of individuals (Caelli, Ray, & Mill, 2003; Merriam, 1998). Qualitative descriptive design was therefore selected for studying the experiences of MSM because the researcher expects that MSM have experiences of how HIV services are rendered to them as a special population; they are able to identify specific needs which they feel might not be catered for or that need to be strengthened in service provision. In order to be representative of MSM's experiences, a description of MSM experiences needs to be as close to the information they provide as possible as well as have as fewer insinuations as possible.

The Study Setting

According to Grove, Burns and Gray (2013), a study setting is a place where participants are recruited and where the study is conducted. In qualitative research design, the study usually takes place in a naturalistic setting. Creswell (2013) described a natural setting as a site where participants experience the issue or problem under study. Unlike what usually happens in surveys, qualitative researchers do not bring participants into a lab (a contrived situation), nor send out instruments for them to complete. Instead, "qualitative researchers gather close information by talking directly to people and seeing them behave and act within their context" (p. 45).

The setting for the proposed study is Gaborone city and selected surrounding villages within a 20 kilometer radius from the city. These villages are Tlokweng, Mogoditshane, Mmopane, Metsimotlhabe, and Gabane. As the economic hub and the capital city of Botswana, Gaborone has the largest population in the country. According to Central Statistics Office (2016), Gaborone has a population of 231,626 people accounting for around

10% of the country's total population. Villages surrounding Gaborone also account for relatively higher populations compared to other villages of comparable sizes. This is because people who cannot find accommodation in the city commute from villages closer to the city. According to the Central Statistics Office (2016), the combined population in the named villages is 130,333. The total population of the setting is therefore 361,959, which makes about 16.1% of Botswana's total population. The selected setting is therefore more densely populated than the rest of the country; with a high likelihood of a higher proportion of MSM. Furthermore, MSM in the city and areas around the city may be easier to identify because societal dynamics of living in such areas can make sexual identity more overt compared to the more traditional communities far away from the city.

Accessing HIV care providers in Gaborone and selected surrounding villages may be easy to achieve because there are many health facilities offering HIV care within a smaller geographical radius because of the population density. The likelihood of a relatively higher population of MSM in the selected setting compared to other parts of Botswana increases the chances that HIV care providers in Gaborone and surrounding villages will have rendered services to MSM at some point in their practice.

The Study Population

A study population is the entire group of persons that is of interest to the researcher and that can be designated by specific criteria such as age, gender, and a health problem (Brockopp & Hastings-Tolsma, 2003). The target populations for the proposed study will be; Men who have sex with men (MSM), and HIV care providers in Gaborone and selected surrounding villages.

Sampling

A sample is a sub-set of a population, selected by the researcher to participate in a study. In qualitative research, information–rich participants are the ones to be considered, not their numbers (Polit & Beck 2006). Sampling is a process of selecting units (for example, people) from a population of interest to provide necessary information which is relevant to the enquiry (Polit & Beck, 2012). Speziale and Carpenter (2007) observed that in qualitative research, participants are chosen based on their first-hand experience with the phenomenon of interest. In the proposed study, MSM will be sampled using purposive and snowballing techniques. Purposive sampling is the selection of participants who have knowledge or experience of the area or phenomenon being studied (Polit & Beck, 2012). Snowball sampling, a variant of purposive sampling, also called network sampling or nominated sampling, is the selection of participants through previously chosen ones (Polit & Beck, 2012). Snowballing is suitable for the proposed study because MSM may not be forthcoming due to inhibiting social factors such as stigma and discrimination. It may therefore be helpful to utilize chain referral by the already identified participants.

HIV care providers, comprising medical doctors, nurses, pharmacy personnel, psychologists, and lay counselors will be selected using convenience sampling. Convenience sampling is a non-probability sampling technique whereby subjects are selected because of their convenient accessibility and proximity to the researcher (Polit & Beck, 2012). Convenience sampling technique is relevant for selecting HIV care providers because the researcher expects HIV care providers to work with diverse clients including MSM and to have the relevant information needed for the study. The researcher acknowledges that it may be difficult to sample HIV providers who identify as providing care to MSM. Therefore,

despite making efforts to recruit all cadres of HIV care providers, the researcher will not make any effort to balance the numbers of HIV care providers by cadre. The other fact hindering balancing the number of HIV care providers by cadre is that their numbers in the health facilities vary, with nurses being the most abundant and the rest being relatively few.

Sample Size

According to Magilvy and Thomas (2009), qualitative descriptive studies typically have a small sample size compared to other qualitative approaches. With a sample size ranging from as few as three (3) participants (Magilvy &Thomas, 2009), qualitative descriptive design is appropriate for studying MSM as domineering circumstances such as stigma and discrimination may make it difficult for the representatives of the population to be readily forthcoming. That is, larger sample sizes may therefore be difficult to realize in studies targeting MSM. The targeted sample size for the proposed study is twenty (20) MSM, and twenty (20) HIV care providers. Although numbers are considered, another guiding principle for sample size in qualitative research is data saturation (Polit & Beck, 2012). Polit and Beck (2006) defined data saturation as the collection of data in a qualitative study to the point where closure is attained because new data yield redundant information. Though the researcher aims to enroll twenty (20) MSM and twenty (20) HIV care providers to participate in the study, the actual sample size may be a little more or a little less than twenty participants in each category depending on the number of participants at which data saturation is reached.

Criteria for Selection of MSM

Inclusion Criteria. Inclusion criteria are the characteristics that the participants must have in order to be included in the study (Burns & Grove 2001). The inclusion criteria for MSM in the proposed study are:

1) Men who identify as MSM

2) Age 18 years and above

3) Having sought HIV services at least five times in Gaborone and/or surrounding villages

4) Ability to communicate in English and/or Setswana

Men who identify as MSM are included because the researcher assumes that they have first-hand experience of what the proposed study needs, that is, they have undergone the experience of how they are treated in HIV service settings. In Botswana, age 18 years and above is the legal age where participants can give consent to participate in research. The study setting being Gaborone and the selected surrounding villages warrants that MSM in the study have accessed HIV services from the health facilities listed and therefore will have experiences to share with the researcher. Having sought care for at least five (5) times in the setting, allows MSM to have enough experience interacting with the system such that they have something that they can share on interviews. MSM in the study should be able to communicate in English and/or Setswana because these are the two official languages in Botswana.

Exclusion Criteria. Patino and Ferreira (2018) defined exclusion criteria as additional features of the potential study participants who meet the inclusion criteria that could interfere with the success of the study or increase the risk of an unfavorable outcome. For the proposed study, MSM who are mentally incapacitated such as those with psychosis

and dementia will be excluded. Mentally incapacitated participants may not be able to comprehend interview questions very well with the risk of compromising the trustworthiness of the study findings.

Criteria for Selection of HIV Care Providers

Inclusion Criteria. The inclusion criteria for HIV care providers in the proposed study are as follows;

1) Registered nurses, medical doctors, pharmacy personnel, psychologists and lay counselors who provide HIV services in Infectious Disease Control Centers (IDCCs) of health facilities in the selected study settings.

2) Age 18 years and above

3) Ability to communicate in English

4) Having worked in IDCC for a cumulative period of six months at any of the selected study settings.

HIV care providers who are 18 years of age are included in the study because they can legally give consent to participate in the study. HIV care providers should be able to communicate in English because English is the medium of communication in Botswana Health care. HIV care providers should have worked in IDCC because comprehensive HIV services in Botswana are primarily offered at such centers. The researcher anticipates that HIV care providers who have worked in IDCCs for at least six months have an increased chance of having encountered MSM seeking HIV service at some point during their practice.

Exclusion Criteria. Students will be excluded because they work under the guidance or mentorship of qualified staff, and therefore have limited ability to make independent decisions in HIV service provison.

Instrumentation

The researcher will develop separate interview guides for MSM and HIV care providers. An interview guide lists open questions or issues to be explored during the interview (Boyce & Neale, 2006). The interview guides will consist of sections A and B. Section A will solicit the socio-demographic data while section B will address the main study questions. The interview guides will be developed in English and that for MSM will later be translated into Setswana.

The Interview Guide for MSM. Section A will have questions on socio-demographic data; which will include age, marital status, duration of HIV service utilization, level of education, employment status, occupation, and monthly salary/income. It is essential to know the age of MSM participants in order to determine if the needs of MSM in HIV care services are the same across all ages. Marital status will help the researcher to know if the participant is exclusively MSM or is also involved in heterosexual activities, taking into consideration the fact that no gay marriages have ever been sanctioned in Botswana. The level of education, income, and occupation may influence HIV service literacy and health seeking behaviors of MSM. Employment status and monthly salary are important because literature has shown that some MSM engage in transactional sex. Crowell et al. (2017) reported that MSM who pay for sex usually have the final say on whether protection will be used or not during a sexual encounter. This suggests that MSM who sell sex may be more

vulnerable to HIV infection than those who buy it. Insight into the possibility of MSM indulging in transactional sex is therefore important.

Section B will start with a grand tour question which will open up the discussion. This question will be: "Attending to MSM in HIV care is a relatively new development in our health care settings. There is not much known about the specific needs of MSM in HIV prevention and management. Please describe to me your personal experiences as MSM interacting with HIV services. I am particularly interested in knowing the decisions that you have made in seeking services at the service centers, and your opinion about the services." The grand tour question will then be followed up using probes. The probes will be guided by concepts of Swanson's caring model which are: "Maintaining belief" in MSM, "Knowing" MSM, "Being With" MSM, "Doing for" MSM, and "Enabling" MSM. For example, under the concept of "Knowing" MSM, the question will be: To what extent do you think HIV care providers understand your sexual lifestyle and HIV service needs? (refer to Appendices D1 and D2 for the MSM interview guides).

The Interview Guide for HIV Care Providers. Section A will solicit information on the socio-demographic data of the HIV care providers including age, gender, marital status, cadre, HIV care training, and the time since the latest HIV training. The age of HIV care providers is important because the researcher anticipates that some MSM may feel free when attended to by younger HIV care providers while others may prefer older HIV care providers. The gender of HIV care providers may also influence their interaction with MSM in that some MSM may feel comfortable being attended to by female providers while others may prefer male providers. Marriage is a social support resource that may help one cope with a potentially challenging situation such as providing HIV services to MSM. The cadre

of HIV care providers will help the researcher understand which providers mainly provide services to MSM. This may also provide an understanding on which cadre MSM feel are most helpful when attending to them. The HIV care training of the HIV care providers is essential because the researcher expects that professionals who have training in HIV management would render relatively better service and be more accommodative of clients' diversities compared to those who are not trained. Time since the last training will inform the researcher about HIV care providers' continuing professional development in what they do, which is important in updating knowledge, attitudes, and skill related to emerging issues such as providing services to MSM.

Section B will start with a grand tour question which will be followed up with probes. The probes will also be guided by concepts of Swanson's caring model. The grand tour question will be: "Attending to MSM in HIV care is a relatively new development in our health care settings. There is not much known about the specific needs of MSM in HIV prevention and management. Please tell me your experiences in rendering HIV care to MSM focusing on the resources, personal feelings, competence and confidence in doing the job, training, legal framework, working conditions, frustrations, cooperation and responses of clients."

Just like with the MSM interview guide, probes for HIV care providers will also be guided by concepts of Kristen Swanson's Caring Model which are "Maintaining Belief" in MSM, "Knowing" MSM, "Being With" MSM, "Doing for" MSM, and "Enabling" MSM. An example of a question under the 'Knowing MSM' concept will be: What is your understanding of MSM in relation to HIV vulnerability and HIV care needs? (refer to Appendices D3 and D4 for the HIV Care Provider interview guides).

Ethical Considerations

Protection of human subjects is vital in any research (Arifin, 2018). Researchers should therefore adhere to protection of subjects from harm by observing ethical considerations throughout their study. In studying the needs of MSM in HIV services, the researcher will seek permission to carry out the study from the University of Botswana Research Ethics Committee, Ethics Review Board of the Ministry of Health and Wellness, Ethics Committees of District Health Management Team (DHMT) of Gaborone Health region, and the Ethics Committee of Princess Marina Hospital.

A written informed consent will be sought from potential study participants (both MSM and HIV care providers) (refer to Appendices C1, C2, C3, and C4 for the Participants' consent forms). The researcher will explain the purpose of the study, which is to explore the needs of men who have sex with men (MSM) in HIV services in Gaborone and surrounding villages. Potential participants will be assured that privacy and confidentiality will be maintained all the time. They will be informed that the information that they give will not be shared with anyone else except the supervisor, who will be assisting the researcher throughout the study, and the research assistant who will be helping during data collection. The researcher will also inform potential participants that their anonymity will be ensured. They will be informed that their names will not appear or be mentioned anywhere in the study. For instance, information obtained from the study participants will not be directly linked to any specific individual. Potential participants will be informed that the information they provide will not be used against them and that participation in the study is voluntary and that they have the right to change their minds and pull out of the study at any point. They will also be assured that they will not be penalized for pulling out of the study.

It is necessary to inform potential participants of the benefits that the intended study will have to themselves and the society as a whole. MSM will be informed of the benefits of the study, which ultimately is to address the specific needs of MSM in order to curb the spread of HIV infection. MSM will be made aware that they will not derive any direct benefits by participating in the study. Those expressing interest in participating in the study will be asked to provide a written informed consent for participation. They will also provide a written consent for being audio recorded.

Pilot Study

A pilot study is conducted as a prelude to the planned study, typically targeting a smaller number of participants but adhering to all planned procedures (Polit & Beck, 2008). Piloting the study evaluates the correctness of the instrument and instructions determined by whether or not the participants in the pilot sample are able to follow the directions as indicated and whether or not the logistics of the study work as intended. The pilot study will be conducted in one of the selected villages surrounding Gaborone. MSM participants for the pilot study will be purposively recruited through LEGABIBO. Two (2) MSM participants will be recruited for the pilot study. The village that is selected for pilot testing will not be used for the study. It is ideal to use one of the selected villages for piloting study tools because it curbs on costs.

HIV care providers will be conveniently recruited from any health facility in the selected villages, where MSM have reported to be recieving their HIV care. The health facility used in recruiting HIV care providers for piloting study tools will not be used for the main study. Two (2) HIV care providers will be recruited for participation in the pilot study.

Based on the results of the pilot study, the researcher will either maintain the interview guide and study protocol as they are or modify them as necessary.

Recruitment of the Study Participants

Recruitment of participants is soliciting participation by providing information to potential participants to generate their interest in the proposed study (Patel, Doku & Tennakoon, 2003). In Gaborone, MSM will be recruited from LEGABIBO drop-in center. The researcher will liaise with coordinators at LEGABIBO drop-in center and identify dates for planned group meetings at the center. The researcher would then use one of those days to be introduced to the group and to explain the purpose of the research as well as invite MSM to participate in the study. Interested MSM would then have the opportunity to meet the researcher one-on-one and make appointments for getting detailed information about the study and what participation will entail. Thereafter, appointment for written informed consent and data collection will be arranged.

Recruited MSM will also be asked to refer the researcher to their fellow MSM who could be willing to participate in the study. The researcher will develop flyers explaining the purpose of the study and will also show the contacts of the researcher. These flyers will be availed to recruited participants so that they can sell the study to potential participants even in the absence of the researcher. Interested potential participants will contact the researcher and make meeting appointments where the researcher will solicit their participation and arrange for data collection (refer to Appendices B1 and B2 for the MSM Information Sheets).

HIV care providers will be recruited from the selected health facilities based on the facilities identified to be the most frequented by MSM for health care services. For example,

if most recruited MSM reported that they use Nkaikela (Tlokweng) and Julia Molefhe (Gaborone) clinics for their health care services, HIV care providers from these facilities would be solicited to participate in the study. This therefore means that the researcher might end up not using all the health facilities in the setting, especially those that are seldom used by MSM. The researcher will build rapport by first establishing working relations with heads of departments (HODs) for the mentioned centers. The HODs will then introduce him to potential participants to whom he will explain the purpose of the study, and from whom he will solicit participation. Just like with MSM, flyers providing information on the study will be posted at selected health facilities (refer to Appendices B3 and B4 for the HIV Care Provider Information Sheets).

Data Collection Procedure

Once participants have been recruited and consent granted, the data collection process will follow. Interviews for MSM will take place at LEGABIBO drop-in center in a private space/room with the expectation that the center presents a safe environment at which MSM can be free to express themselves without feeling intimidated. The researcher will also extend an opportunity for MSM participants to suggest an alternative venue for interviews if they are not comfortable with the drop-in center. For HIV care providers, interviews will be conducted at their place of work during working hours, that is, between 0730 hours and 1630 hours. Interviews will be conducted in a private room.

All interviews will be conducted by the researcher face-to-face with the help of an interview guide. Participants will be informed that the interview will be tape recorded and their agreement will be solicited. Tape recording will be done by a trained research assistant so that the researcher can give full attention to the participants. The research assistant will

also take notes during the process. The researcher will not assume an expert position but will place himself at the same level with participants in order to understand MSM needs in HIV care without priori assumptions. Interviews are estimated to last for 30 to 45 minutes.

MSM Interview Procedure. Interviews will be conducted in either Setswana or English depending on the preference of the participants. The researcher will give MSM participants who can read and write section A of the data collection tool to fill-in their demographic information. Those who cannot read and write will be assisted by both the researcher and the research assistant to complete section A. The interviews will be conducted by the researcher face-to-face. The interviews will be tape recorded with the consent of the participants. The researcher will start by asking a grand tour question to allow participants to express their opinions about the phenomena of interest in their own words. The grand tour question will be followed up with probes guided by Kristen Swanson's Caring model. Some probes will emanate from the responses given by the participants. The researcher will employ strategies such as constant comparison, whereby he will reflect on some responses of participants interviewed earlier on in order to check if responses differ across contexts. One of the goals of constant comparison is to discover the patterns of information gathered (Boeije, 2002). The researcher will also paraphrase participants' responses in order to validate his interpretation of the responses.

HIV Care Provider Interview Procedure. The interviews will be conducted in English. The researcher will give HIV care provider participants section A of the interview guides to fill-in their demographic information. Interviews will be conducted by the researcher face-to-face. With the permission of the participants, they will be recorded. The researcher will start by asking a grand tour question. The grand tour question will be

followed up with probes guided by Kristen Swanson's Caring model. Some probes will emanate from the responses given by the participants. A trained research assistant will take notes and record proceedings. As will be done with MSM, constant comparison and validation of the researcher's interpretation will be employed. Interviews will last for 30 to 45 minutes.

Data Storage

Raw data for the proposed study will be kept for five (5) years. Though three years is the recommended minimum time to store data (Lin, 2009), research ethics committees in Botswana recommend a minimum of five years. Raw data in the study will include completed consent forms, completed demographic data collection tool, transcripts, field notes and audio tapes. All data documents will be kept locked up in a cabinet in a safe office with only the researcher having access to the cabinet. Consent forms will be kept separate from data in order to preserve anonymity of participants.

Data Preparation

Data preparation is the act of manipulating raw data which is usually unstructured into a form that is structured and that can be readily and accurately analyzed (Abdallah, Du & Webb, 2017). It is a process that may involve many different tasks including transcription and translation, which will be addressed in the proposed study.

Data transcription is a process by which an audio and/or video recording is translated into words that can then be studied and coded (Davidson, 2009). In the proposed study, verbatim transcription of audio taped interviews will be carried out by the researcher and the research assistant. Following each transcription, the tape will once again be played and checked against the transcript in order to confirm the accuracy of the transcriptions.

MSM interviews recorded in Setswana will be translated using the process of translation and back translation. Data translation and back translation will be conducted by the researcher and the research assistant who are fluent in both English and Setswana. The initial translation from Setswana to English will be done by the researcher; then the research assistant will back translate without having seen the original transcript. Behr (2016) described this process as the re-translation of translated text back into the original language, and the subsequent comparison of the original version and the back translation. This process ensures that the meaning of the responses is not lost during translation. Any distorted meanings will be discussed between the translators and modified accordingly.

Data Analysis Procedure

Data analysis is a means of organizing data and reducing it to produce findings that are interpreted and communicated by the researcher (Grove & Burns, 2003). In the proposed study, the researcher will analyze data using content analysis method. Content analysis is a method for summarizing qualitative data by systematically sorting and comparing words and phrases (Elo & Kyngas, 2008). Content analysis is aimed at providing knowledge and understanding of the phenomenon under study (Bengtsson, 2016).

Qualitative content analysis has three (3) main approaches, namely: conventional, directed, and summative. Conventional content analysis involves inductive reasoning where participants have been allowed to express themselves as much as possible and the researchers immerse themselves in the data without any preconceived structure imposed on the data (Hsieh & Shannon 2005). Potter and Levine-Donnerstein (1999) described directed content analysis as a deductive use of a theory with the key tenets of the naturalistic paradigm forming the foundation of the researcher's general approach to the study design,

data collection, and analysis; while Hsieh and Shannon (2005) described summative approach as a process whereby the researcher identifies and quantifies certain words or phrases in the text in order to understand the contextual use of those words or phrases. With the quantification, the researcher does not infer meaning but attempts to understand the usage of such words or phrases.

The researcher will use all the three (3) approaches to content analysis in the proposed study. Conventional content analysis will be used in the proposed study because interview guides have grand tour questions which allow participants to express themselves as much as possible, without the researcher imposing any structure on how to respond to questions. This will allow for free inductive inferences. Directed content analysis will be used in the proposed study because the study is guided by Kristen Swanson's Caring model, with the researcher using the main concepts of the model to categorize data in order to identify themes and their interpretations. Despite the use of probes informed by the Swanson's Caring model, participants will be allowed to direct the flow of the discussion, thus still incorporating the inductive approach. The researcher will employ the summative approach by paying attention to repetitive use of some words and/or phrases. The researcher will note the frequency of the use of words and phrases; and explore the contexts in which those words and phrases are used. This will help in identifying meanings and implication of the words and phrases.

Data from MSM and HIV care provider participants will be analyzed separately, but the findings will thereafter be reviewed for consistency. The analysis process will start with the researcher reading through all the transcripts so as to get a general impression and understanding of the data at hand. He will then code the data, which involves assigning

identification codes to the data. A code is a descriptive construct designed by the researcher to capture the primary content or essence of the data (Theron, 2015). In the proposed study, the unit of analysis will be sentences. The researcher will undertake this process with the help of the research supervisor. The researcher will use the first transcript to assign different codes to different sentences that appear in the transcript. For example, a sentence may be coded "001," and be subsequently followed by a sentence coded "002." Sentences that have similar meaning will be assigned the same code. The supervisor will independently code a copy of the same transcript. Both the researcher and the supervisor will then compare their coding to check for consistency or agreement. If there are differences in their coding, the two parties will discuss the identified differences and reach a consensus.

Following data coding, the researcher will categorize data. Categorization is a process whereby data is reduced and converted to smaller manageable units (Polit & Beck, 2008). Codes with related text will be grouped together to form categories. The grouping or category will then assigned a label.

Development of themes will follow data categorization. Graneheim and Lundman (2004) described themes as 'meanings' deduced from codes or categories on an interpretative level. For the proposed study, themes will emerge from the categories and their contexts. The researcher will use inductive reasoning, deductive reasoning, and summative content analysis to identify themes that emerge from the data. Theme patterning will be noted. Theme patterning concerns the way the themes relate and fit together to give a logical and compelling meaning of the data.

Trustworthiness

Streubert and Carpenter (2011) described trustworthiness as establishing the validity and reliability of qualitative research. The authors further stated that findings of a qualitative research are trustworthy when they accurately give a true representation of the views and experiences of study participants. Four criteria used to measure trustworthiness are credibility, dependability, transferability and confirmability (Streubert & Carpenter 2011).

Credibility. Credibility is established when participants identify with reported research findings as reflecting their own experiences (Streubert & Carpenter 2011; Polit & Beck 2012). Some approaches for increasing the probability of producing credible findings are peer debriefing and member checking (Streubert & Carpenter 2011).

Peer debriefing is a process where one allows others with expertise to analyze his/her data (Streubert & Carpenter 2011). In the proposed study, the researcher will expose the preliminary findings of the study to the supervisor who is experienced in qualitative research to invite her constructive criticism. The researcher will be open to the views that build and enrich the undertaking. Since the researcher is a student, the supervisor will be responsible for examining the findings, interpretations, and recommendations and attest that they are supported by the data collected.

Member checking, whereby data, analytical categories, interpretations and conclusions are tested with members of those stake-holding groups from whom the data were originally collected (Streubert & Carpenter, 2011), is the most crucial technique for establishing credibility. In the proposed study, the researcher will do member checking with members of the LEGABIBO community for their feedback. The researcher will organize a meeting at which he will share and discuss the interpretations and conclusions made from

the collected data with participants to establish that they are representative of their experiences.

Transferability. Transferability refers to the probability that the study findings have meaning to others in similar situations. Transferability is also called "fittingness" for it determines whether the findings fit in or are transferable to similar situations (Streubert & Carpenter, 2011). It is the extent to which the findings from the data can be transferred to other settings. The researcher will comprehensively describe the study setting, characteristics of the study sample and sampling methods, the data collection strategies, and data analysis in the proposed study so as to enhance transferability of the findings.

Dependability. According to Polit and Beck (2012), dependability is related to the consistency of findings. This means that if the study were repeated in a similar context with the same participants, the findings would be consistent. In qualitative research the instruments to be assessed for consistency are the researcher and the participants (Streubert & Carpenter 2011; Polit & Beck 2012). For the findings of a research project to be dependable they should be checked and audited by means of external checks. The researcher intends to enhance dependability by involving experts in the area of study. Processes and analysis in the proposed study will be examined by the research supervisor. The extent of consistency of the responses of MSM and those of HIV care providers will also be used as a dependability measure.

Confirmability. Confirmability is a neutral criterion for measuring the trustworthiness of qualitative research. If a study demonstrates credibility and fittingness, the study is also said to possess confirmability (Streubert & Carpenter 2011). According to Polit and Beck (2012), confirmability refers to the objectivity of the data collected. This can

be achieved by engaging other independent people to evaluate the accuracy, relevance and meaning of the data. The researcher will involve the research supervisor in auditing the raw data, which includes the audio tapes and field notes in order to enhance confirmability of the study findings.

Authenticity. In addition to the four criteria already discussed, authenticity has also been recommended as a measure for establishing trustworthiness in a qualitative study (Fade, 2003; Polit & Beck, 2012). Fade (2003) defined authenticity as the extent to which the research reflects the true experiences of the participants. In the proposed study, member checks and peer debriefing will be used to determine and ensure authenticity of the findings. Participants will be given the opportunity to check that the data are representative of their own experiences. The researcher will also invite the input of the supervisor to review the findings and evaluate the researcher's logic and conclusions in order to determine if they are consistent with the data and can be attributed to the experiences and views of participants.

Limitations of the Study

Due to the sensitive nature of the topic under study and the lack of specialized HIV service packages targeting MSM, HIV care providers may not be aware of who, among their clients, is MSM. They therefore may not be able to articulate their experiences in rendering care to MSM. A small sample size of a qualitative research and a narrow geographical coverage of the study may limit the transferability of study findings to other geographical regions of Botswana. Future studies should therefore consider sampling over a wider geographical area as well as bringing in quantitative methods in order to recruit a larger sample size.

Conclusion

There has been significant research on the needs of MSM in HIV services globally, especially in developed countries, such that some of the MSM needs in health services are known. However, there is still lack of universally accepted MSM targeted packages in HIV services. There is also notable dearth of studies targeting MSM in Botswana. The few Botswana studies seen did not address HIV service needs for MSM.

The proposed study explores HIV service needs of MSM in Gaborone and selected surrounding villages of Botswana. The study uses qualitative descriptive design. It is guided by Swanson's Caring model and garners the perspectives of both MSM and HIV care providers. The study will be one of only a few studies targeting MSM in Botswana. The findings of the study will provide empirical evidence to support advocacy amongst groups already putting pressure on policy makers to address MSM HIV prevention and care as well as inform health care curricula developers on the critical areas of need in HIV services for MSM. The findings will also inform organizations providing HIV services about the needs of HIV care providers in providing quality HIV services for MSM in Botswana.

REFERENCES

Abdallah, Z. S., Du, L., & Webb, G. I. (2017). Data preparation. *Encyclopedia of Machine Learning and Data Mining*: 318-327

Aho, J., Hakim, A., Vuylsteke, B., Semde, G., Gbais, H. G., Diarrassouba, M.,… Laga, M. (2014) Exploring risk behaviors and vulnerability for HIV among men who have sex with men in Abidjan, Cote d'Ivoire: Poor knowledge, homophobia and sexual violence. *PLoS ONE* 9(6): e99591.doi:10.1371/journal.pone.0099591

Arifin, S. (2018). Ethical considerations in qualitative study. *International Journal of Care Scholars, 1*(2), 30-33.

Baral, S., Ketende, S., Mnisi, Z., Mabuza, X., Grosso, A., Sithole, B., . . . Adams, D. (2013). A cross-sectional assessment of the burden of HIV and associated individual- and structural-level characteristics among men who have sex with men in Swaziland. *Journal of the International AIDS Society*, *16*(3), 1-10.

Batist, E., Brown, B., Scheibe, A., Baral, S., & Bekker, L-G. (2013). Outcomes of a community-based HIV-prevention pilot programme for township men who have sex with men in Cape Town, South Africa. *Journal of the International AIDS Society, 16*(3), 1-7.

Behr, D. (2016). Assessing the use of back translation: The shortcomings of back translation as a quality testing method. *International Journal of Social Research Methodology, 20*(6), 1-12.

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *Nursing Plus*, 8-14.

Beyrer, C., Sullivan, P., Sanchez, J., Dowdy, D., Altman, D., Trapence, G., . . . Mayer, K. (2012). A call to action for comprehensive HIV services for men who have sex with men. *Lancet, 380*, 424–438.

Boeijie, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality & Quantity*, 391–409.

Bourne, A., Hammond, G., Hickson, F., Reid, D., Schmidt, A. J., Weatherburn, P. (2013). What constitutes the best sex life for gay and bisexual men? Implications for HIV prevention. *BMC Public Health* 13:1083 http://www.biomedcentral.com/1471-2458/13/1083

Boyce, C., & Neale, P. (2006). Conducting in-depth interviews*: A guide for designing and conducting in-depth interviews for evaluation input*: Watertown, MA: Pathfinder International

Brockopp, D. Y., & Hastings-Tolsma, M. T. (2003). Fundamentals of nursing research (3rd ed.). Boston: Jones and Bartlett Publishers, Inc.

Brown, C., Grosso, A., Adams, D., Sithole, B., Ketende, S., Greene, J., . . . Baral, S. (2016). Characterizing the individual, social, and structural determinants of condom use among men who have sex with men in Swaziland. *AIDS Research And Human Retroviruses, 32*(6), 539-546.

Burns, N., & Grove, S. K. (2001). The Practice of Nursing Research, Conduct, Critique, and Utilization. (4th ed.). Philadelphia. W. B. Saunders Company, Philadelphia.

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud:' Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods, 2*(2), 1-13.

Cele, N., Sibiya, M., & Sokhela, D. (2015). Experiences of homosexual patients' access to primary health care services in Umlazi, KwaZulu-Natal. *Curationis, 38*(2), 1-9.

Central Statistics Office. (2016). Population & housing 2011 census: Administrative and techinical report . Gaborone: Statistics Botswana.

Coia, N., Milne, D., McAdams, R., Morrison, C., Winter, A., Clutterbuck, D., . . . Baker, G. (2014). *HIV Prevention Needs Assessment of Men Who Have Sex with Men Year of Publication: 2014.* Glasgow: Scottish Government.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Crosby, R., Mena, L., & Geter, A. (2017). Are HIV-positive young black MSM having safer sex than those who are HIV-negative? *Int J STD AIDS, 28*(5), 441–446.

Crowell, T. A., Keshinro, B., Baral, S. D., Schwartz, S. R., Stahlman, S., Nowak, R. G.,… Ake, J. A. (2017). Stigma, access to healthcare, and HIV risks among men who sell sex to men in Nigeria. *Journal of the International AIDS Society*, 20:21489. http://www.jiasociety.org/index.php/jias/article/view/21489

Dapaah, J. (2016). Attitudes and behaviours of health workers and the use of HIV/AIDS health care services. *Nursing Research and Practice*, 1-9.

Davidson, C. (2009). Transcripiton: Imperatives for qualitative research . *International Journal of Qualitative Methods, 8*(2), 35-52.

Duby, Z., Nkosi, B., Scheibe, A., Brown, B., Bekker, L-G. (2018). 'Scared of going to the clinic:' Contextualising healthcare access for men who have sex with men, female sex workers and people who use drugs in two South African cities. *S Afr J HIV Med., 19*(1), a701.https://doi.org/10.4102/ sajhivmed.v19i1.701

Elo, S., & Kyngas, H. (2008).The qualitative content analysis process. *Journal of Advanced Nursing*, 62, 107-115. http://dx.doi.org/10.1111/j.1365-2648.2007.04569.x

Fade, S. (2003). Communicating and judging the quality of qualitative research: The need for a new language. *J Hum Nutr Dietet*, 139–149.

Flowers, P., Knussen, C., Li, J., & McDaid, L. (2013). Has testing been normalized? An analysis of changes in barriers to HIV testing among men who have sex with men between 2000 and 2010 in Scotland, UK. *HIV Medicine, 14*, 92–98.

Flowers, P., Riddell, J., Park, C., Ahmed, B., Young, I., Frankis, J., . . . McDaid, L. (2016). Preparedness for use of the rapid result HIV self-test by gay men and other men who have sex with men (MSM): A mixed-methods exploratory study among MSM and those involved in HIV prevention and care. *HIV Medicine*, 245-255.

Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today,24*, 105–112.

Grossman, C., Forsyth, A., Purcell, D., Allison, S., Toledo, C., & Gordon, C. (2011). Advancing novel HIV prevention intervention research with MSM - meeting report. Bethesda, Maryland, United States of America.

Grove, S., Burns, N., & Gray, J. (2012). *The Practice of Nursing Research: Appraisal, Synthesis, and Generation of Evidence.* Philadelphia: Elsevier/Saunders.

Hakim, A., Aho, J., Semde, G., Diarrassouba, M., Ehoussou, K., Vuylsteke, B., . . . Group, S. S.(2015). The epidemiology of HIV and prevention needs of men who have sex with men in Abidjan, Cote d'Ivoire. *PLoS ONE*, 1-13.

Herbst, J., Beeker, C., Mathew, A., McNally, T., Passin, W., Kay, L., . . . Johnson, R. (2007). The effectiveness of individual, group, and community-level HIV behavioral risk-reduction interventions for adult men who have sex with men: A systematic review. *American Journal of Preventive Medicine*, 38–67.

Holland, C., Papworth, E., Billong, S., Kassegne, S., Petitbon, F., Mondoleba, V., . . . Baral, S. (2015). Access to HIV services at non-governmental and community-based organizations among men who have sex with men (MSM) in Cameroon: an integrated biological and behavioral surveillance analysis. *PLoS ONE, 10*(4), 1-14.

Hsieh, H.-F., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288.

Hubach, R., Currin, J., Sanders, C., Durham, A., Kavanaugh, K., Wheeler, D., & Croff, J. (2017). Barriers to access and adoption of pre-exposure prophylaxis for the prevention of HIV among men who have sex with men (MSM) in a relatively rural state. *AIDS Education and Prevention, 29*(4), 315–329.

Jansson, C., & Adolfsson, A. (2011). Application of "Swanson's middle range caring theory" in Sweden after miscarriage. *International Journal of Clinical Medicine, 2*, 102-109.

Kalfoss, M., & Owe, J. (2015). Empirical verification of Swanson's caring processes found in nursing actions: Systematic review . *Open Journal of Nursing, 5*, 976-986.

Kapanda, L., Jumbe, V., Izugbara, C., & Muula, A. S. (2019). Healthcare providers' attitudes towards care for men who have sex with men (MSM) in Malawi. *BMC Health Services Research* 19:316. https://doi.org/10.1186/s12913-019-4104-3

Kegeles, S., Hayes, R., & Coates, T. (1996). The Mpowerment project: A community-level HIV prevention intervention for young gay men. *American Journal of Public Health, 86*(8), 1129-1136.

Kushwaha, S., Lalani, Y., Maina, G., Ogunbajo, A., Wilton, L., Agyarko-Poku, T., . . . Nelson, L. (2017). "But the moment they find out that you are MSM…": A qualitative investigation of HIV prevention experiences among men who have sex with men (MSM) in Ghana's health care system. *BMC Public Health,* 1-18.

Ledda, C., Cicciù, F., Puglisi, B., Ramaci, T., Nunnari, G. & Rapisarda, V. (2017). Attitude of healthcare workers (HCWs) toward patients affected by HIV/AIDS and drug users: A cross-sectional study. *International Journal of Environmental Research and Public Health,*14, 284;doi:10.3390/ijerph14030284 www.mdpi.com/journal/ijerph

Levy, M., Wilton, L., Phillips-II, G., Glick, S., Kuo, I., Brewer, R., & Magnus, M. (2014). Understanding structural barriers to accessing HIV testing and prevention services among black men who have sex with men (BMSM) in the United States. *AIDS Behav., 18*(5), 972–996.

Lin, L-C. (2009). Data management and security in qualitative research. *Dimensions of Critical Care Nursing, 28*(3), 132-137.

Liu, Y., Osborn, C., Qian, H.-Z., Yin, L., Xiao, D., Ruan, Y., . . . Amico, K. (2016). Barriers and facilitators of linkage to and engagement in HIV care among HIV-positive men who have sex with men in China: A qualitative study. *AIDS PATIENT CARE and STDs,30*(2),70-77.

Magidson, J., Biello, K., Safren, S., Rosenberger, J., Novak, D., Mayer, K., & Mimiaga, M. (2015). Engagement in HIV care and sexual transmission risk behavior among MSM using online social/sexual networking in Latin America. *AIDS Care, 27*(8), 1055–1062.

Magilvy, J., & Thomas, E. (2009). A first qualitative project: Qualitative descriptive design for novice researchers. *JSPN, 14*(4), 298-300.

Matovu, J. K. B.,Musinguzi, G., Kiguli, J., Nuwaha, F., Mujisha, G., Musinguzi, J.,…Wanyenze, R. K. (2019). Health providers' experiences, perceptions and readiness to provide HIV services to men who have sex with men and female sex workers in Uganda – a qualitative study. *BMC Infectious Diseases, 19*, 214. https://doi.org/10.1186/s12879-019-3713-0

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education.* San Francisco: Jossey-Bass Publishers.

Micheni, M., Kombo, B., Secor, A., Simoni, J., Operario, D., van der Elst, E., . . . Graham, S. (2017). Health provider views on improving antiretroviral therapy adherence among men who have sex with men in Coastal Kenya. *AIDS PATIENT CARE and STDs,31*(3), 113-121.

Ministry of Health. (2013). 2012 Mapping, Size Estimation & Behavioral and Biological Surveillance Survey (BBSS) of HIV/STI Among Select High-Risk Sub-Populations in Botswana. Gaborone: Ministry of Health.

Muraguri, N., Temmerman, M., & Geibel, S. (2012). A decade of research involving men who have sex with men in sub-Saharan Africa: Current knowledge and future directions. *Journal of Social Aspects of HIV/AIDS: An Open Access Journal, 9*(3), 137-147.

NACA. (2015). Progress report of the national response to the 2011 declaration of commitments on HIV and AIDS. Gaborone: National AIDS Coordinating Agency.

Neergaard, M. A., Olesen, F., Andersen, R. S., Sondergaard, J. (2009). Qualitative description–the poor cousin of health research? *BMC Medical Research Methodology*, 9, 52 doi:10.1186/1471-2288-9-52. http://www.biomedcentral.com/1471-2288/9/52

Nugroho, A., Erasmus, V., Coulter, R. W. S., Koirala, S., Nampaisan, O., Pamungkas, W.,… Richardus, J. H. (2018). Driving factors of retention in care among HIV-positive MSM and transwomen in Indonesia: A cross-sectional study. *PLoS ONE 13*(1): e0191255. https://doi.org/10.1371/journal.pone.0191255

Nyato, D., Kuringe, E., Drake, M., Casalini, C., Nnko, S., Shao, A.,…Changalucha, J. (2018). Participants' accrual and delivery of HIV prevention interventions among men who have sex with men in sub-Saharan Africa: A systematic review. *BMC Public Health* 18:370. https://doi.org/10.1186/s12889-018-5303-2

Otambo, P. C. N., Makokha, A., Karama, M., Mwangi M. (2016). Accessibility to, acceptability of, and adherence to HIV/AIDS prevention services by men who have sex with men: Challenges encountered at facility level. *Advances in Public Health.* Article ID 5157984, http://dx.doi.org/10.1155/2016/5157984

Park, J. N., Papworth, E., Kassegne, S., Moukam, L., Billong, S. C., Macauley, I.,...Baral, S.D. (2013). HIV prevalence and factors associated with HIV infection among men who have sex with men in Cameroon. *Journal of the International AIDS Society*,16(3),18752 http://www.jiasociety.org/index.php/jias/article/view/18752

Patel, M. X., Doku, V., & Tennakoon, L. (2003). Challenges in recruitment of research participants. *Advances in Psychiatric Treatment*, *9*(3), 229 - 238. https://doi.org/10.1192/apt.9.3.229

Patino, C. M., & Ferreira, J. C. (2018). Inclusion and exclusion criteria in research studies: definitions and why they matter. *J Bras Pneumol*. *44*(2), 84. doi: 10.1590/s1806-37562018000000088

Polit, D. F., & Beck, C. T. (2008). *Nursing Research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia. Lippincott Williams & Wilkins.

Polit, D.F., & Beck, C.T. (2012). *Nursing Research, Generating and Assessing Evidence for Nursing Practice* (9th ed.). Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Potter, W. J., & Levine-Donnerstein, D. (1999).Rethinking validity and reliability in content analysis. *Journal of Applied Communication Research, 27*, 258-284. doi:10.1080/00909889909365539

Qiao, S., Zhou, G., & Li, X. (2018). Disclosure of same-sex behaviors to health-care providers and uptake of HIV testing for men who have sex with men: A systematic review. *American Journal of Men's Health, 12*(5), 1197– 1214.

Rakgoasi, S., & Keetile, M. (2016). "They are less worthy than us, but they are better than women...." Attitudes towards homosexuality and men who have sex with men (MSM) in Botswana. *African Population Studies, 30*(2), 2910 - 2919.

Relay (2012). Men who have sex with men and HIV policies in developing countries. London: Panos London Illuminating Voices.

Scheibe, A. P., Duby, Z., Brown, B., Sanders, E. J., Bekker L-G. (2017). Attitude shifts and knowledge gains: Evaluating men who have sex with men sensitisation training for healthcare workers in the Western Cape, South Africa. *S Afr J HIV Med. 18*(1), a673. https://doi.org/10.4102/ sajhivmed.v18i1.673

Siegler, A., de Voux, A., Phaswana-Mafuya, N., Bekker, L-G., Sullivan, P., Baral, S., . . . Stephenson, R. (2014). Elements of condom use decision-making among MSM in South Africa. *J Int Assoc Provid AIDS Care, 13*(5), 414–423.

Speziale, H. J. S., & Carpenter. D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Streubert, H. J., & Carpenter, D. R. (2011). Q*ualitative Research in Nursing: Advancing the Humanistic Imperative.* Philadelphia: Wolters Kluwer.

Strömdahl, S., Hickson, F., Pharris, A., Sabido, M., Baral, S., Thorson, A. (2015). A systematic review of evidence to inform HIV prevention interventions among men who have sex with men in Europe. *Euro Surveill. 20*(15), pii=21096. Available online: http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=21096

Strömdahl, S., Williams, A. O., Eziefule, B., Emmanuel, G., Iwuagwu, S., Anene, O.,…Baral, S. (2019). An assessment of stigma and human right violations among men who have sex with men in Abuja, Nigeria. *BMC International Health and Human Rights*, 19,7 https://doi.org/10.1186/s12914-019-0190-x

Swanson, K. (1991). Empirical develoment of a middle range theory of caring. *Nursing Research, 40*(3), 161 - 166.

Swanson, K. (1993). Nursing as informed caring for the well-being of others. *Journal of Nursing Scholarship, 23*(4), 352-357.

Theron, P.M. (2015). 'Coding and data analysis during qualitative empirical research in PracticalTheology,' *In die Skriflig 49*(3), Art. #1880, 9 pages. http://dx.doi. org/10.4102/ids.v49i3.1880

Thomas, B., Mimiaga, M., Kumar, S., Swaminathan, S., Safren, S., & Mayer, K. (2011). HIV in Indian MSM: Reasons for a concentrated epidemic & strategies for prevention. *Indian J Med Res*, 920-929.

van der Elst, E., Smith, A., Gichuru, E., Wahome, E., Musyoki, H., Muraguri, N., . . . Sanders, E. (2013). Men who have sex with men sensitivity training reduceshomoprejudice and increases knowledge among Kenyan healthcare providers in coastal Kenya. *Journal of the International AIDS Society, 16*(3), 1-9.

Vu, L., Adebajo, S., Tun, W., Sheehy, M., Karlyn, A., Njab, J., . . . Ahonsi, B. (2013). High HIV prevalence among men who have sex with men in Nigeria: Implications for combination prevention. *Journal of Acquired Immune Deficiency Syndrome, 63*(2), 221–227.

Wheelock, A., Eisingerich, A.B., Ananworanich ,J., Gomez, G.B., Hallett, T.B., Dybul, M. R.,… Piot, P. (2013) Are Thai MSM willing to take PrEP for HIV prevention? An analysis of attitudes, preferences and acceptance. *PLoS ONE 8*(1), e54288. doi:10.1371/journal.pone.0054288

WHO. (2015). A technical brief: HIV and young men who have sex with men. Geneva: WHO.

Wirtz, A. L.,Trapence, G., Kamba, D.,Gama, V., Chalera, R., Jumbe, V.,…Baral, S. (2017). Geographical disparities in HIV prevalence and care among men who have sex with men in Malawi: Results from a multisite cross-sectional survey. *Lancet HIV*. http://dx.doi.org/10.1016/ S2352-3018(17)30042-5

Wong, N., Mao, J., Cheng, W., Tang, W., Cohen, M., Tucker, J., & Xu, H. (2018). HIV linkage to care and retention in care rate among MSM in Guangzhou, China. *AIDS Behav*,*22*(3), 701-710.

Zahn, R., Grosso, A., Scheibe, A., Bekker, L-G., Ketende, S., Dausab, F.,…Baral, S. (2016). Human rights violations among men who have sex with men in Southern Africa: Comparisons between legal contexts. *PLoS ONE 11*(1): e0147156. doi:10.1371/ journal.pone.0147156

APPENDIX A

Letters seeking Permission

P. O. Box 11037
Kanye

04th December 2019

The Principal Research Officer
Health Research Unit
Ministry of Health and Wellness
Private Bag 0038
Gaborone

u.f.s. Head of Department, School of Nursing

Dear Sir/ Madam

RE: PERMISSION TO CARRYOUT THE RESEARCH PROJECT

This letter serves to request for permission to conduct a research study in Gaborone and some villages lying within a 20 kilometer radius of Gaborone.

I am a Master of Nursing Science student at the University of Botswana. I am carrying out the research as a partial fulfillment of my Masters Degree program. The study is intended to explore the needs of men who have sex with men (MSM) in HIV services. The research topic is: "Exploring the needs of men who have sex with men (MSM) in HIV services in Gaborone and selected surrounding villages."

It is hoped that the results of the study will provide empirical evidence to improve HIV prevention and care among MSM. The request is to conduct the study from January to June, 2020.

Your cooperation and support will be highly appreciated.

Thanking you in advance,

Yours Faithfully,

……
Simon Mokgwathi – MNSc student, School of Nursing

Cc: Coordinator MNSc programme – School of nursing

P. O. Box 11037
Kanye

04th December 2019

The Director
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University of Botswana
Private Bag UB00708
Gaborone

u.f.s. Head of Department, School of Nursing

Dear Sir/ Madam

RE: PERMISSION TO CARRYOUT THE RESEARCH PROJECT

This letter serves to request for permission to conduct a research study in Gaborone and some villages lying within a 20 kilometer radius of Gaborone.

I am a Master of Nursing Science student at the University of Botswana. I am carrying out the research as a partial fulfillment of my Masters Degree program. The study is intended to explore the needs of men who have sex with men (MSM) in HIV services. The research topic is: "Exploring the needs of men who have sex with men (MSM) in HIV services in Gaborone and selected surrounding villages."

It is hoped that the results of the study will provide empirical evidence to improve HIV prevention and care among MSM. The request is to conduct the study from January to June, 2020.

Your cooperation and support will be highly appreciated.

Thanking you in advance,

Yours Faithfully,

……
Simon Mokgwathi – MNSc student, School of Nursing

Cc: Coordinator MNSc programme – School of nursing

P. O. Box 11037
Kanye

04th December 2019

The Chairperson,
Princess Marina Hospital Research and Ethics Committee
P. O. Box 258
Gaborone

u.f.s. Head of Department, School of Nursing

Dear Sir/ Madam

RE: PERMISSION TO CARRYOUT THE RESEARCH PROJECT

This letter serves to request for permission to conduct a research study in your facility. I need to utilize the Infectious Disease Control Center (IDCC) to recruit and interview study participants.

I am a Master of Nursing Science student at the University of Botswana. I am carrying out the research as a partial fulfillment of my Masters Degree program. The study is intended to explore the needs of men who have sex with men (MSM) in HIV services. The research topic is: "Exploring the needs of men who have sex with men (MSM) in HIV services in Gaborone and selected surrounding villages."

It is hoped that the results of the study will provide empirical evidence to improve HIV prevention and care among MSM. The request is to conduct the study from January to June, 2020.

Your cooperation and support will be highly appreciated.

Thanking you in advance,

Yours Faithfully,

……
Simon Mokgwathi – MNSc student, School of Nursing

Cc: Coordinator MNSc programme – School of nursing

P. O. Box 11037
Kanye

04th December 2019

The Director,
LEGABIBO
P.O. Box 550430
Gaborone

u.f.s. Head of Department, School of Nursing

Dear Sir/ Madam

RE: PERMISSION TO CARRYOUT THE RESEARCH PROJECT

This letter serves to request for permission to conduct a research study in your facility. I need to utilize the facility to recruit and interview study participants.

I am a Master of Nursing Science student at the University of Botswana. I am carrying out the research as a partial fulfillment of my Masters Degree program. The study is intended to explore the needs of men who have sex with men (MSM) in HIV services. The research topic is: "Exploring the needs of men who have sex with men (MSM) in HIV services in Gaborone and selected surrounding villages."

It is hoped that the results of the study will provide empirical evidence to improve HIV prevention and care among MSM. The request is to conduct the study from January to June, 2020.

Your cooperation and support will be highly appreciated.

Thanking you in advance,

Yours Faithfully,

……
Simon Mokgwathi – MNSc student, School of Nursing

Cc: Coordinator MNSc programme – School of nursing

P. O. Box 11037
Kanye

04th December 2019

The Coordinator,
Gaborone District Health Management Team
P.O. Box
Gaborone

u.f.s. Head of Department, School of Nursing

Dear Sir/ Madam

RE: PERMISSION TO CARRYOUT THE RESEARCH PROJECT

This letter serves to request for permission to conduct a research study at Julia Molefhe and Old Naledi clinics in your health district. I need to utilize the facilities to recruit and interview study participants.

I am a Master of Nursing Science student at the University of Botswana. I am carrying out the research as a partial fulfillment of my Masters Degree program. The study is intended to explore the needs of men who have sex with men (MSM) in HIV services. The research topic is: "Exploring the needs of men who have sex with men (MSM) in HIV services in Gaborone and selected surrounding villages."

It is hoped that the results of the study will provide empirical evidence to improve HIV prevention and care among MSM. The request is to conduct the study from January to June, 2020.

Your cooperation and support will be highly appreciated.

Thanking you in advance,

Yours Faithfully,

……
Simon Mokgwathi – MNSc student, School of Nursing

Cc: Coordinator MNSc programme – School of nursing

APPENDIX B (1)

Information for MSM Participants

(English version)

Title of the Study: Exploring the Needs of Men Who Have Sex with Men (MSM) In HIV Services in Gaborone city and Selected Surrounding Villages in Botswana.

Researcher's Name: Simon Mokgwathi

Date: …….

I am looking for men aged 18 years and above who identify as men who have sex with men (MSM) who are willing to give their views on the needs of MSM in HIV services. The study is to be conducted by a Master of Nursing Science student from the University of Botswana. The proposed study explores the needs of men who have sex with men (MSM) in HIV services in Gaborone city and selected surrounding villages, from the perspectives of MSM and HIV care providers. Participation in the study involves being interviewed face to face. It is estimated that the interviews will last for the duration of 45 minutes. The study has been given ethical clearance by the relevant authorities.

It is hoped that the results of the study will help improve HIV services to MSM. If you are interested in participating, please feel free to contact the researcher for more details on the study at the following contact details: Cell Numbers; 71465923, 75107843. Email: smn.mokgwathi@gmail.com

Thank you.

APPENDIX B (2)

Molaetsa go Batsaya Karolo (Borre ba ba Ratanang le Borre ba Bangwe)

(Setswana version)

Setlhogo sa Patlisiso: Patlisiso ka dithuso tse di tlhokwang ke boRre ba ba tlhakanelang dikobo le boRre ba bangwe mo ditirelong tsa mogare wa HIV mo Gaborone le metse mengwe e e mabapi mo Botswana.

Leina la mmatlisisi: Simon Mokgwathi

Letsatsi: …….

Ke laletsa boRre ba ba supileng ha ba na le bakapelo ba boRre, ba le dingwaga tse di lesome le boferabobedi le go feta, go tsaya karolo mo patlisisong. Patlisiso e e tla bo e dirwa ke moithuti wa dithuto tse dikgolwane tsa booki ko Unibesithing ya Botswana. Patlisiso e tla bo e itebagantse le tshekatsheko ya dithuso tse di tlhokwang ke borre ba ba tlhakanelang dikobo le boRre ba bangwe mo ditirelong tsa mogare wa HIV mo Gaborone le metse mengwe e e mabapi**.** Batsaya karolo ba tla kopiwa go araba dipotso tse di tla botswang ke mmatlisisi le mothusi wa gagwe. Go tla botsolotswa boRre le bangwe mo bodireding jwa botsogo. Dipotsolotso di tla tsaya metsotso e e ka nnang masome a mane le botlhano. Patlisiso e e rebotswe ka fa molaong ke dikomiti tsa melawana ya dipatlisiso e e maleba.

Tsholofelo ke gore maduo a patlisiso e a tla thusa go tokafatsa ditirelo tse di fiwang borre ba ba nang le bakapelo ba borre tsa go kganela le go alafa mogare wa HIV. Fa o na le kgatlhego ya go tsaya karolo, o ka ikgolaganya le mmatlisisi mo nomorong tse di latelang go tlhalosediwa ka botlalo ka patlisiso e. Nomoro tsa mogala; 71465923, 75107843. Email: smn.mokgwathi@gmail.com

Ke a leboga

APPENDIX B (3)

Information for HIV Care Provider Participants

(English version)

Title of the Study: Exploring the Needs of Men Who Have Sex with Men (MSM) In HIV Services in Gaborone city and Selected Surrounding Villages in Botswana.

Researcher's Name: Simon Mokgwathi

Date: …….

I am looking for nurses, doctors, pharmacy personnel, psychologists and lay counselors who have worked with MSM and willing to give their views on the needs of MSM in HIV care. The study is to be conducted by a Master of Nursing Science student from the University of Botswana .The proposed study explores the needs of men who have sex with men (MSM) in HIV services in Gaborone city and selected surrounding villages, from the perspectives of MSM and HIV care providers. Participation in the study involves being interviewed face to face. It is estimated that the interviews will last for 45 minutes. The study has been given ethical clearance by the relevant authorities.

It is hoped that the results of the study will help improve HIV services to MSM. If you are interested in participating, please feel free to contact the researcher for more details on the study at the following contact details: Cell Numbers; 71465923, 75107843. Email: smn.mokgwathi@gmail.com

Thank you.

APPENDIX B (4)

Molaetsa go Batsaya Karolo (Bodiredi)

(Setswana version)

Setlhogo sa Patlisiso: Patlisiso ka dithuso tse di tlhokwang ke boRre ba ba tlhakanelang dikobo le boRre ba bangwe mo ditirelong tsa mogare wa HIV mo Gaborone le metse mengwe e e mabapi mo Botswana.

Leina la mmatlisisi: Simon Mokgwathi

Letsatsi: …….

Ke laletsa baoki, dingaka, bodiredi jwa ko melemomg le ba ba sidilang maikutlo, ba ba thusitseng kgotsa ba ba thusang boRre ba banang le bakapelo ba boRre ka ditlamelo tsa HIV go tsaya karolo mo patlisisong e. Patlisiso e e tla bo e dirwa ke moithuti wa dithuto tse dikgolwane tsa booki ko Unibesithing ya Botswana. Patlisiso e tla bo e itebagantse le tshekatsheko ya dithuso tse di tlhokwang ke borre ba ba tlhakanelang dikobo le borre ba bangwe mo ditirelong tsa mogare wa HIV mo Gaborone le metse e e mabapi**.** Batsaya karolo ba tla kopiwa go araba dipotso tse di tla botswang ke mmatlisisi le mothusi wa gagwe. Dipotsolotso di tla tsaya metsotso e e ka nnang masome a mane le botlhano. Patlisiso e, e rebotswe ka fa molaong ke dikomiti tsa melawana ya dipatlisiso e e maleba.

Tsholofelo ke gore maduo a patlisiso e a tla thusa go tokafatsa ditirelo tse di fiwang borre ba ba nang le bakapelo ba borre tsa go kganela le go alafa mogare wa HIV. Fa o na le kgatlhego ya go tsaya karolo, o ka ikgolaganya le mmatlisisi mo nomorong tse di latelang go tlhalosediwa ka botlalo ka patlisiso e. Nomoro tsa mogala; 71465923, 75107843. Email: smn.mokgwathi@gmail.com

Ke a leboga.

APPENDIX C (1)

Consent Form for MSM

(English Version)

Consent to Serve as a Participant in a Research Study

Title of Study: Exploring the Needs of Men Who Have Sex with Men (MSM) In HIV Services in Gaborone and Selected Surrounding Villages

Name of Researcher: Simon Mokgwathi

You are being asked to participate in a study to explore the needs of men who have sex with men (MSM) in HIV services. Participation involves responding to a set of questions in a face-to-face interview forum. Taking part in the study is completely voluntary and you can withdraw at any time without any consequences. Information obtained from you will be kept confidential; any publications from the study will not have your name. Your recorded responses will be coded and the code will be used instead of your name.

There are no major risks anticipated in participating in this study. There will be no direct benefits due to you for participating in the study. However, findings of the study will help inform organizations providing HIV services about the needs of MSM in provision of quality HIV services.

Participant Declaration

I have read/ it was read to me and I understood the content of this form. I have been informed that taking part in this study is voluntary. I understand that I am free to withdraw from the study at any time if I no longer want to participate. I have been informed that the information that I share with the researcher will be kept with strict confidentiality.

My signature below shows that I freely agree to participate in the study.

Participant's Name……..... Signature……..
Date……

Study explained by……...Signature……..
Date……

I agree that my interview be audio recorded ☐ Yes ☐ No (*Tick what applies*)

Participant's Name……..... Signature……..
Date……

Study explained by……...Signature……..
Date……

APPENDIX C (2)

Tumalano ya go nna Motsaya Karolo mo Patlisisong (Borre ba ba Ratanang le Borre ba Bangwe)

(Setswana Version)

Setlhogo sa Patlisiso: Patlisiso ka dithuso tse di tlhokwang ke boRre ba ba tlhakanelang dikobo le boRre ba bangwe mo ditirelong tsa mogare wa HIV mo Gaborone le metse mengwe e e mabapi mo Botswana.

Leina la mmatlisisi: Simon Mokgwathi

O kopiwa go nna motsaya karolo mo patlisisong e e itebagantseng le tshekatsheko ya dithuso tse di tlhokwang ke boRre ba ba tlhakanelang dikobo le boRre ba bangwe mo ditirelong tsa mogare wa HIV mo Gaborone le metse e e mabapi**.** Fa o tsaya karolo mo patlisisong e, o tla botsolotswa dipotso ke mmatlisisi le mothusi wa gagwe. Go tsaya karolo ke boitlhaopi mme o ka ikgogela morago ka nako epe fa o bona o sena kgatlhego ya go tswelela ka patlisiso, ntleng ga ditlamorago dipe fela. Dikarabo tsa gago ga dina go amanngwa le leina la gago ka gope, mme ebile dikarabo tsa gago ditla babalelwa go itsa go ka bonwa ke ba ba sa amegeng mo patlisisong e. Kanamiso ya molaetsa wa patlisiso ga e ye go nna le maina a batsaya karolo.

Ga go solofelwe gore go ka nna le botlhabetsi mo go tseeng karolo mo patlisisong e. Ga o solofediwe go atswiwa ka sepe go tsaya karolo; mme hela go dumelwa fa maduo a patlisiso e a tla thusa go tokafatsa ditirelo tse di fiwang borre ba ba nang le bakapelo ba borre tsa go kganela le go alafa mogare wa HIV.

Maitlamo

Ke badile/baletswe mme e bile ke tlhalogantse diteng tsa maitlamo a. Ke tlhaloseditswe gore botsaya karolo ke boithaopi. Ke tlhaloganya gore ke gololesegile go ikgogela morago ka nako epe fela ha ke sa tlhole ke batla go tswelela le botsaya karolo. Ke tlhaloseditswe gore dikarabo tse ke di neelang mmatlisisi di tla babalelwa mme ga dina go amanngwa le leina lame ka gope.

Go baa monwana/go saena game go supa go gololesega le go dumalana go tsaya karolo mo patlisisong e.

Leina la motsaya karolo ……..... Monwana ……..

Letsatsi……

Karolo ka patlisiso e dirilwe ke ……. Monwana……..

Letsatsi……

Ke dumala gore potsolotso yame e gatisiwe ka sekapa mantswe ☐ Ee ☐ Nnya (*Tshwaya karabo ya gago*)

Leina la motsaya karolo ……..**.....** Monwana ……..

Letsatsi……

Karolo ka patlisiso e dirilwe ke …….. Monwana……..

Letsatsi……

APPENDIX C (3)

Consent Form for HIV Care Provider Participants

(English Version)

Consent to Serve as a Participant in a Research Study

Title of Study: Exploring the Needs of Men Who Have Sex with Men (MSM) In HIV Services in Gaborone and Selected Surrounding Villages

Name of Researcher: Simon Mokgwathi

You are being asked to participate in a study to explore the needs of men who have sex with men (MSM) in HIV services. Participation involves responding to a set of questions in a face to face interview forum. Taking part in the study is completely voluntary and you can withdraw at any time without any consequences. Information obtained from you will be kept confidential; any publications from the study will not have your name. Your recorded responses will be coded and the code will be used instead of your name.

There are no major risks anticipated in participating in this study. There will be no direct benefits due to you for participating in the study. However, findings of the study will help inform organizations providing HIV services about the needs of MSM in provision of quality HIV services.

Participant Declaration

I have read and I understood the content of this form. I have been informed that taking part in this study is voluntary. I understand that I am free to withdraw from the study at any time if I no longer want to participate. I have been informed that the information that I share with the researcher will be kept with strict confidentiality.

My signature below shows that I freely agree to participate in the study.

Participant's Name……..... Signature……..
Date……

Study explained by……...Signature……..
Date……

I agree that my interview be audio recorded ☐ Yes ☐ No (*Tick what applies*)

Participant's Name……..... Signature……..
Date……

Study explained by……...Signature……..
Date……

APPENDIX C (4)

Tumalano ya go nna Motsaya Karolo mo Patlisisong (Bodiredi)

(Setswana Version)

Setlhogo sa Patlisiso: Patlisiso ka dithuso tse di tlhokwang ke boRre ba ba tlhakanelang dikobo le boRre ba bangwe mo ditirelong tsa mogare wa HIV mo Gaborone le metse mengwe e e mabapi mo Botswana.

Leina la mmatlisisi: Simon Mokgwathi

O kopiwa go nna motsaya karolo mo patlisisong e e itebagantseng le tshekatsheko ya dithuso tse di tlhokwang ke boRre ba ba tlhakanelang dikobo le boRre ba bangwe mo ditirelong tsa mogare wa HIV mo Gaborone le metse e e mabapi**.** Fa o tsaya karolo mo patlisisong e, o tla botsolotswa dipotso ke mmatlisisi le mothusi wa gagwe. Go tsaya karolo ke boithaopi mme o ka ikgogela morago ka nako epe fa o bona o sena kgatlhego ya go tswelela ka patlisiso, ntleng ga ditlamorago dipe fela. Dikarabo tsa gago ga dina go amanngwa le leina la gago ka gope, mme ebile dikarabo tsa gago ditla babalelwa go itsa go ka bonwa ke ba ba sa amegeng mo patlisisong e. Kanamiso ya molaetsa wa patlisiso ga e ye go nna le maina a batsaya karolo.

Ga go solofelwe gore go ka nna le botlhabetsi mo go tseeng karolo mo patlisisong e. Ga o solofediwe go atswiwa ka sepe go tsaya karolo mme hela go dumelwa fa maduo a patlisiso e a tla thusa go tokafatsa ditirelo tse di fiwang borre ba ba nang le bakapelo ba borre tsa go kganela le go alafa mogare wa HIV.

Maitlamo

Ke badile mme e bile ke tlhalogantse diteng tsa maitlamo a. Ke tlhaloseditswe gore botsaya karolo ke boithaopi. Ke tlhaloganya gore ke gololesegile go ikgogela morago ka nako epe fela fa ke sa tlhole ke batla go tswelela le botsaya karolo. Ke tlhaloseditswe gore dikarabo tse ke di neelang mmatlisisi di tla babalelwa mme ga dina go amanngwa le leina lame ka gope.

Go baa monwana/go saena game go supa go gololesega le go dumalana go tsaya karolo mo patlisisong e.

Leina la motsaya karolo ……..... Monwana ……..

Letsatsi……

Karolo ka patlisiso e dirilwe ke …….. Monwana……..

Letsatsi……

Ke dumala gore potsolotso yame e gatisiwe ka sekapa mantswe ☐ Ee ☐ Nnya
(*Tshwaya karabo ya gago*)

Leina la motsaya karolo ……..**.....** Monwana ……..

Letsatsi……

Karolo ka patlisiso e dirilwe ke …… Monwana……..

Letsatsi……

Participant code.....

APPENDIX D (1)

INTERVIEW GUIDE FOR MSM

SECTION A

SOCIO-DEMOGRAPHIC DATA

Please respond to the questions below by a tick on the box, or filling appropriate responses.

1. What is your age? ……..
2. What is your highest level of education?

   ☐ Primary

   ☐ Secondary

   ☐ Tertiary

   ☐ No formal education

3. What is your marital status?

   ☐ Married

   ☐ Divorced

   ☐ Separated

   ☐ Single

4. What is your employment status?

   ☐ Unemployed

   ☐ Self-employed

   ☐ Employed full time

   ☐ Employed part-time

   ☐ Piece-jobs

   Other (Specify)……

Participant code.....

5. Occupation ……..
6. What is your monthly Salary/income? (in Pula)

☐ Below P2500

☐ P2500 – P5000

☐ P5000 – P10000

☐ Above P10000

Participant code.....

SECTION B

Grand Tour Statement/Question

Attending to MSM in HIV care is a relatively new development in our health care settings. There is not much known about the specific needs of MSM in HIV prevention and management. Please describe to me your personal experiences as MSM interacting with HIV services. I am particularly interested in knowing the decisions that you have made in seeking services at the service centers, and your opinion about the services.

(Please feel free to share as much as you can. There is no right or wrong answer/response).

Probes:

1. To what extent do you think HIV care providers understand your sexual lifestyle and HIV service needs?
2. To what extent do HIV care providers welcome you and establish trusting relationships with you when you seek HIV care?
3. How would you describe the competency of the HIV care providers serving you?
4. To what extent do you think getting HIV services empowers you to become comfortable in self care?
5. What is your expectation about the services you receive as MSM in HIV care?

(N.B. Some probes will be deduced from the responses given by the participants.)

Participant code.....

APPENDIX D (2)

KAEDI YA POTSOLOTSO YA BORRE BA BA RATANANG LE BORRE BA BANGWE

(SETSWANA VERSION)

KAROLO YA NTLHA

TSHEDIMOSO KA MOTSAYA KAROLO

Araba dipotso tse di latelang ka go tshwaya '√' mo lebokosong kgotsa o kwale karabo ya gago ka bokhutshwane fa moleng.

1. O dingwaga tse kae? ……..
2. O tsene sekolo go ema fa kae?

    ☐ Sekolo se se botlana

    ☐ Sekolo se segolwane

    ☐ Sekolo sa thuto tse dikgolo

    ☐ Gake a tsena sekolo

3. Seemo sa gago sa nyalo ke sefe?

    ☐ Ke mo nyalong

    ☐ Ke kgaogane le monna/mosadi

    ☐ Ga kena tirisano le monna/mosadi le etswa re sa kgaogana

    ☐ Ga ke mo nyalong

4. Seemo sa gago sa khiro ke sefe?

    ☐ Ga ke bereke

    ☐ Ke a ipereka

    ☐ Ke bereka tiro e e tletseng

☐ Ke bereka tiro ya nakwana mo tsatsing

☐ Ke bereka tsa nakwana

Sengwe se se farologanang le tse di boditsweng

(tlhalosa)……

5. Tlhalosa mohuta wa tiro e o e dirang ……..
6. Kaya moputso kgotsa madi a o nnang nao kgwedi le kgwedi (ka dipula)

☐ Kotlase ga P2500

☐ P2500 – P5000

☐ P5000 – P10000

☐ Go feta P10000

Participant code.....

KAROLO YA BOBEDI

Moalo wa kgang

Go neela borre ba ba tlhakanelang dikobo le borre ke selo se se sa tlwaelesegang thata mo bookelong ba rona. Ga gona kitso e kalo kalo ka tse di tlhokang go dirwa go ba thusa go thibela le go ba tlhokomela mo mogareng wa HIV. Ke kopa o tlhalose maitemogelo a gago fa o ntse o kopa dithuso mabapi le mogare wa HIV. Ke ka rata thata gore o ame gore o bona dithuso ko kae, o amogelwa jang, o thuswa jang, le gore ke mang a go neelang ditlamelo tse o a bong o di tlhoka.

(Gololesega go itlhalosa ka boleele jo o ka bo batlang. Ga gona karabo e go ka tweng e siame kgotsa ga e a siama).

Thokotso:

1. O itemogela eng ka fa bodiredi jwa botsogo (ba ba go thusang) bo tlhaloganyang botshelo jwa gago (mo go tsa tlhakanelo dikobo) le dithuso tse o di tlhokang mabapi le HIV?
2. Fa o kopa dithuso tsa HIV, bodiredi bo dira go le kae go go amogela le go aga botsalano le wena?
3. Maikutlo a gago ke afe ka bokgoni jwa bodiredi jo bo go fang dithuso tsa HIV?
4. O akanya gore dithuso tse o di neelwang di go thusa gole kae gore o ikemele mo go tsa botsogo?
5. Tsholofelo ya gago ke eng mo ditlamelong tsa HIV tse di fiwang borre ba ba nang le bakapelo ba borre?

(ela tlhoko: dipotso tse dingwe tsa thokotso di tla tswa di latedisa ka fa motsaya karolo a arabang)

Participant code.....

APPENDIX D (3)

INTERVIEW GUIDE FOR HIV CARE PROVIDERS

SECTION A

SOCIO-DEMOGRAPHIC DATA

Please respond to the questions below by a tick on the box, or filling appropriate responses.

1. What is your age? ……..
2. What is your gender?

   ☐ Male

   ☐ Female
3. What is your marital status?

   ☐ Married

   ☐ Divorced

   ☐ Separated

   ☐ Single
4. What is your Cadre?

   ☐ Nurse

   ☐ Doctor

   ☐ Lay counselor

   ☐ Psychologist

   ☐ Pharmacy personnel
5. How long is your total work experience in IDCC?.....(in months or years)

Participant code.....

6. Have you had any HIV training/qualification?

   ☐ Yes

   ☐ No

   If 'Yes' please

   specify……

7. How soon was the latest training

   (weeks/months/years)…….

Participant code.....

SECTION B

Grand Tour Statement/Question

Attending to MSM in HIV care is a relatively new development in our health care settings. There is not much known about the specific needs of MSM in HIV prevention and management. Please tell me your experiences in rendering HIV care to MSM focusing on the resources, personal feelings, competence and confidence in doing the job, training, legal framework, working conditions, frustrations, cooperation and responses of clients.

(Please feel free to share as much as you can. There is no right or wrong answer/response).

Probes:

1. What is your understanding of MSM in relation to HIV vulnerability and HIV service needs?
2. What do you do as an HIV care provider to ensure that MSM feel welcome and included in HIV services?
3. How is your competence in providing HIV services to MSM?
4. To what extent do you think you empower MSM to become comfortable in self care and advocacy for the rights of MSM?
5. What do think characterizes the best HIV care services to MSM?

(N.B. Some probes will be deduced from the responses given by the participants.)

Participant code.....

APPENDIX D (4)

KAEDI YA POTSOLOTSO YA BODIREDI

(SETSWANA VERSION)

KAROLO YA NTLHA

TSHEDIMOSO KA MOTSAYA KAROLO

Araba dipotso tse di latelang ka go tshwaya '√' mo lebokosong kgotsa o kwale karabo ya gago ka bokhutshwane fa moleng.

1. O dingwaga tse kae? ……..
2. O mong?

   ☐ Rre

   ☐ Mme

3. Seemo sa gago sa nyalo ke sefe?

   ☐ Ke mo nyalong

   ☐ Ke kgaogane le monna/mosadi

   ☐ Ga kena tirisano le monna/mosadi le etswa re sa kgaogana

   ☐ Ga ke mo nyalong

4. O dira o le eng?

   ☐ Mooki

   ☐ Ngaka

   ☐ Mosidila Maikutlo yo mmotlana

   ☐ Mosidila Maikutlo yo mogolo

   ☐ Modiri wa ko melemong

5. Fa o goboka, o diretse mo IDCC lebaka le le kae?.....(ka dikgwedi kgotsa dingwaga)
6. A o na le dithuto tse di faphegileng tsa mogare wa HIV?

   ☐ Ee

   ☐ Nnya

   Fa karabo e le 'Ee' tlhalosa dithuto ka

   botlalo……
7. E setse e le sebaka se se kae o sena go tsenelela dithuto tsa bofelo tse di amanang le tiro ya gago……. (araba ka dibeke, dikgwedi kgotsa dingwaga)

Participant code.....

KAROLO YA BOBEDI

Moalo wa kgang

Go neela borre ba ba tlhakanelang dikobo le borre ke selo se se sa tlwaelesegang thata mo bookelong ba rona. Ga gona kitso e kalo kalo ka tse di tlhokang go dirwa go ba thusa go thibela le go ba tlhokomela mo mogareng wa HIV. Ke kopa o tlhalose maitemogelo a gago fa o neela borre ba ba tlhakanelang dikobo le borre ditlamelo tsa HIV. O ka tlhalosa ka maikutlo a gago mo go ba neeleng dithuso, bokgoni jwa gago, tsa molao, tirisano mmogo le borre ba, le ka fa ba amogelang dithuso ka teng.

(Gololesega go itlhalosa ka boleele jo o ka bo batlang. Ga gona karabo e go ka tweng e siame kgotsa ga e a siama).

Dithokotso:

1. O tlhaloganya go le kae ka go tshabelelwa ke mogare wa HIV ga borre ba ba tlhakanelang dikobo le borre, le ditlamelo tse ba di tlhokang?
2. Ke eng se o se dirang o le modiredi go dira gore borre ba ba tlhakanelang dikobo le borre ba amogelesege mo bookelong?
3. O na le bokgoni le itemogelo e e kae go ka thusa borre ba ba tlhakanelang dikobo le borre ba bangwe?
4. O dumela gore o dira go le kae go rotloetsa borre ba ba tlhakanelang dikobo le borre go ikemela le go buelela ba ba tshwanang le bone?
5. O dumela gore borre ba ba tlhakanelang dikobo le borre ba bangwe ba tshwanelwa ke eng mo ditlamelong tsa HIV?

(ela tlhoko: dipotso tse dingwe tsa thokotso di tla tswa di latedisa ka fa motsaya karolo a arabang)

APPENDIX E

Research Timeline

ACTIVITY	DATE	DURATION (WEEKS)
Human subject protocol	6th January 2020 to 28th February 2020	8
Recruitment and training of Research Assistant	2nd March 2020 to 6th March 2020	1
Pilot Study	9th March 2020 to 20th March 2020	2
Recruitment of Study Participants	23rd March 2020 to 17th April 2020	4
Data Collection	20th April 2020 to 26th June 2020	10
Transcription of Interviews	29th June 2020 to 17th July 2020	3
Data Analysis	20th July 2020 to 11th September 2020	8
Report Writing	14th September 2020 to 9th October 2020	4
Overall Duration		**40**

APPENDIX F

Research Budget

BUDGET CATEGORY	UNIT COST	TOTAL COST
HUMAN RESOURCES		
Research assistant	P108.00/session *20	**P2160.00**
PHOTOCOPYING		
Permission letters	10 pages@ P0.50/page	P5.00
Consent forms	44 pages @ P0.50/page	P22.00
Flyers	4 pages @ P0.50/page	P2.00
Interview guides	44 guides (2 pages each) @ P0.50/page	P44.00
Final research proposal	5*100 pages @ P0.50/page	P250.00
TOTAL FOR PHOTOCOPYING		**P323.00**
TRAVEL, MEALS & ACCOMMODATION		
Return trip from Gaborone to Tlokweng*2 people	P10/person Meals@ P60/meal * 1 for 2 people	P130
Return trip from Gaborone to Kumakwane* 2 people	P10/person Meals@ P60/meal * 1 for 2 people	P130
Return trip from Gaborone to Gabane* 2 people	P10/person Meals@ P60/meal * 1 for 2 people	P130
Return trip from Gaborone to Oodi* 2 people	P10/person Meals@ P60/meal * 1 for 2 people	P130
Return trip from Gaborone to Metsimotlhabe* 2 people	P10/person Meals@ P60/meal * 1 for 2 people	P130
Return trip from Gaborone to Mogoditshane* 2 people	P10/person Meals@ P60/meal * 1 for 2 people	P130
TOTAL FOR TRAVEL, MEALS & ACCOMMODATION		**P780.00**
STATIONERY AND SUPPLIES		
Pens	4*P3.50 each	P14.00
Pencils	2*P2.50 each	P5.00
Rubber	1*P1.50 each	P3.00
Note book	2*P12.50	P25.00
Audio recorder	1*P400.00	P400.00
Cell phone airtime		P400
TOTAL FOR STATIONERY AND SUPPLIES		**P847.00**
BINDING		
Research proposal	5 copies @ P75.00	P400.00
Final research project	5 copies @ P75.00	P400.00
TOTAL COST OF BINDING		**P800.00**
TOTAL		**P4910.00**
10% EXIGENCIES		**P491.00**
GRAND TOTAL		**P5401.00**