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Male-On-Male Sexual Violence and Intimate Partner Violence Victimization & Perpetration: Social and Behavioral Determinants & Health Implications among South African Men

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M.P.H., University of Michigan, Ann Arbor, 2010

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An abstract of

A dissertation submitted to the Faculty of the

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Abstract

Male-On-Male Sexual Violence and Intimate Partner Violence Victimization & Perpetration: Social and Behavioral Determinants & Health Implications among South African Men

By Daniel Wade Murdock

High rates of male-on-male sexual violence have been documented among South African men in the general population and disproportionally affect men who have sex with men (MSM). South African MSM also face high rates of physical intimate partner violence (PIPV). This dissertation applies a mixed-methods approach to identify social and behavioral correlates of male-on-male sexual violence and PIPV victimization and perpetration among MSM and non-MSM. The study also examines links between violence, depression, and HIV risk. Study findings revealed many parallels between male-on-female violence and male-on-male violence, and suggest that male-on-male sexual violence and PIPV are often associated with gendered norms and behaviors. The findings also indicate that both community homophobia and internalized homophobia are associated with violence victimization and perpetration. This research underscores the mental and sexual health implications of violence, examines novel theoretical approaches for understanding male-on-male violence, and supports evidence-based approaches to address male-on-male sexual violence and PIPV.

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Chapter 1: Introductory Literature Review

Significance

Sexual violence is a serious global public health concern. Although in many countries little research has been conducted on the issue, available data suggest that the prevalence of sexual violence victimization among women in some countries may be as high as 25% (Hakimi, Hayati, Marlinawati, Winkvist, & Ellsberg, 2001; Mooney, 1993). Figures such as these reflect a diverse range of victimization experiences that are considered acts of sexual violence. Sexual violence is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (R. Jewkes, Sen, & Garcia-Moreno, 2002). Applying this definition, sexually violent acts can be classified into five categories. These categories include (1) completed sex act without the victim's consent, or involving a victim who is unable to consent or refuse; (2) an attempted (non-completed) sex act without the victim's consent, or involving a victim who is unable to consent or refuse; (3) abusive sexual contact; (4) non-contact sexual abuse; and (5) sexual violence, type unspecified – inadequate information available to categorize into one of the other 4 categories (Basile & Saltzman, 2002).

In addition to being a serious violation of human rights, experiences of sexual violence victimization also have profound impacts on physical and mental health. Moreover, the range of possible health implications of sexually violent experiences reflects the diverse circumstances of sexual violence victimization. Experiences of sexual violence carry significant risks of physical injury and are associated with a wide range of

short- and long-term sexual and reproductive health problems, such as sexually transmitted infections, chronic pelvic pain, and urinary tract infections (Coker, Smith, Bethea, King, & McKeown, 2000; Collett, Cordle, Stewart, & Jagger, 1998; Eby, Campbell, Sullivan, & Davidson, 1995; R. Jewkes, Vundule, Maforah, & Jordaan, 2001; Letourneau, Holmes, & Chasedunn-Roark, 1999). Sexual violence victimization may also result in significant long-term mental health problems, including depression, suicidal ideation, and post-traumatic stress disorder (Cheasty, Clare, & Collins, 1998; Creamer, Burgess, & McFarlane, 2001; Darves-Bornoz, 1997). In addition to these health impacts, sexual violence also carries implications for individuals' social wellbeing. Following experiences of sexual violence many victims may be socially stigmatized or ostracized by family and peers (Mollica & Son, 1989; Omaar & De Waal, 1994).

South Africa is home to an endemic culture of sexual violence. According to a 2002 United Nations survey, the country ranks highest in the world in recorded incidence of rape per capita (*The eigth United Nations survey on crime trends and operations of criminal justice systems (2001 - 2002)*, 2005). The exact rate of sexual violence incidence remains unknown due to underreporting (Artz, 1999). Common barriers to reporting include lack of access to police (Artz, 1999), fear of retaliation by the perpetrator and fear of the legal process itself (C. Africa, 1998). Additionally, many instances of forced sex are not reported to legal systems because they do not align with popular understandings of rape (Stanton, 1993).

Despite these challenges in estimating the true incidence of sexual violence victimization and perpetration in South Africa, a recent population-based study found that more than one quarter of South African men report having perpetrated sexual violence

against a woman at least once in their lifetime (R. Jewkes, Sikweyiya, Morrell, & Dunkle, 2009). While a number of studies in the country have documented significant rates of sexual violence victimization reported by women (S. S. Africa, 2000; K. L. Dunkle et al., 2004; Health, 1999; R. Jewkes & Abrahams, 2002; R. Jewkes et al., 2009), new research has recently identified an unexpectedly high prevalence of sexual violence between men.

Drawing on data from the population-based household survey referenced above, Dunkle, Jewkes, Murdock et al. (2013) found that 11.2% of South African men report a history of nonconsensual sex with another man at least once during their lifetime, including male-on-male sexual violence victimization (8.3%), perpetration (2.3%) or both (0.6%). However, there are significant disparities in the sexual violence risks faced by different groups of South African men. Men who have ever had consensual sex with men (MSM) are over four times more likely than non-MSM to report male-on-male sexual violence victimization (34.4% versus 8.1%) as well as perpetration (10.9% versus 2.6%). (Kristin L Dunkle, Jewkes, Murdock, Sikweyiya, & Morrell, 2013)

The prevalence of male-on-male sexual violence victimization in South Africa, particularly among MSM, is significantly higher than that seen in countries such as the United States, where 1.4% of men report having been sexually assaulted in their lifetime (Black et al., 2011). These numbers highlight a need to investigate the social dynamics that promote sexual violence between men in this setting, particularly among MSM, in order to inform the development of relevant interventions. A paucity of empirical research has been conducted to study the social determinants or health consequences of male-on-male sexual violence in South Africa.

Sexual Violence and PIPV among MSM Globally

Despite the early state of the empirical literature examining sexual violence among MSM in South Africa, there is a larger body of research from around the world that has identified increased risks of physical intimate partner violence (PIPV) and sexual violence faced by MSM populations. Much of this research has been conducted with MSM in the United States and other Western countries. Among U.S. MSM, studies have consistently found an elevated lifetime prevalence of physical IPV and sexual violence victimization compared to heterosexual men, and in some cases even compared to heterosexual women (Braitstein et al., 2003; Greenwood et al., 2002; Houston & McKirnan, 2007; Mustanski, Garofalo, Herrick, & Donenberg, 2007; Nieves-Rosa, Carballo-Diéguez, & Dolezal, 2000; Ratner et al., 2003; Relf, Huang, Campbell, & Catania, 2004; Stall et al., 2003; Waldner-Haugrud & Gratch, 1997; Waldner-Haugrud, Gratch, & Magruder, 1997; Waterman, Dawson, & Bologna, 1989). One study with young MSM from Chicago found rates of violence victimization among MSM as high as those found by Dunkle et al. (2013) among South African MSM (Mustanski et al., 2007). Mustanksi et al. (2007) found that 34.4% of young MSM reported a history of PIPV victimization and 32.3% of MSM respondents reported a history of sexual violence victimization.

A significant limitation of international research on sexual violence among MSM is an overreliance on non-probability sampling methods. However, it is noteworthy that the few available studies that have used probability-sampling methods have consistently found rates of sexual violence victimization similar to those found in studies using non-probability methods. For example, one such study conducted with MSM in 4 urban U.S.

cities found a 22.0% prevalence rate of 5-year PIPV victimization and a 5.1% prevalence rate of 5-year sexual violence victimization (Greenwood et al., 2002). Further, a national probability-based survey in the United States found even higher rates of violence victimization among MSM in the longer term. The study found that 35.7% of MSM reported physical IPV victimization and 15.4% reported sexual violence victimization since adulthood (Tjaden, Thoennes, & Allison, 1999).

Another limitation of international studies of sexual violence among MSM is that research in this area has overwhelmingly focused solely on victimization experiences. Moreover, among the few international studies that are known to have examined PIPV and sexual violence perpetration among MSM, only one has been conducted in South Africa (Stephenson, de Voux, & Sullivan, 2011). Despite the limited availability of empirical research on this topic, existing evidence suggests that rates of PIPV and sexual violence perpetration among U.S. MSM may be higher than corresponding rates documented among men in the general population. One venue-based study with gay- and bisexual-identified men in San Francisco found that 26.1% of men in the study reported perpetrating at least one act of PIPV or sexual violence directed at a partner in their current or most recent relationship (Harms, 1995). More work is needed to examine the prevalence of sexual violence perpetration among diverse populations of MSM and corresponding social determinants. This work is particularly needed in low- and middle-income countries where all research on MSM health remains scant.

Social Determinants of PIPV and Sexual Violence among MSM

Given the absence of data specific to this topic, we must draw on international studies of male-on-male sexual violence and South African studies of male-on-female

sexual violence to gather preliminary indications of likely causal and contributory factors of male-on-male sexual violence risks in South Africa. Although studies of the social determinants of male-on-male sexual violence remain notably limited worldwide, existing international research on the topic has overwhelmingly emphasized the influence of social-contextual constructions of masculinities that promote the normative use of interpersonal violence, often in male-dominated social environments. In particular, prior studies have focused on the elevated risks of sexual violence faced by male civilians and combatants in armed conflict situations (Carpenter, 2006; Del Zotto & Jones, 2002; Gingerich, Leaning, & Rights, 2004; Oosterhoff, Zwanikken, & Ketting, 2004), incarcerated men in prisons and jails (Zawati, 2007), and specific groups of men and boys who are socially vulnerable in relation to other men (Gordon, Crehan, & Programme, 2000).

Within South Africa, a number of recent studies have identified key social and behavioral factors that contribute to female sexual violence victimization, including gender power inequalities (Abrahams, Jewkes, Laubscher, & Hoffman, 2006; K. L. Dunkle et al., 2004; R. Jewkes, Penn-Kekana, Levin, Ratsaka, & Schrieber, 1999; R. K. Jewkes, Dunkle, Nduna, & Shai, 2010), poverty (K.L. Dunkle et al., 2006; R. Jewkes & Abrahams, 2002; Kim et al., 2007; Petersen, Bhana, & McKay, 2005), alcohol and drug use (Abrahams et al., 2006; K.L. Dunkle et al., 2006; Parry, Pluddemann, Louw, & Leggett, 2004), and the occupation of subordinate social statuses relative to men (R. Jewkes & Abrahams, 2002; Kim et al., 2007). Local research with female sexual violence victims has also found that perpetration by strangers is rare (R. Jewkes & Abrahams, 2002), and suggests that local patterns of sexual violence reflect a societal climate of rape

tolerance and the normative use of violence as a first line strategy for conflict resolution (Abrahams et al., 2006; Abrahams, Jewkes, Laubsher, & Africa, 1999; Petersen et al., 2005; Simpson, 1991; Wood & Jewkes, 2001).

Similar to data regarding male-on-female sexual violence perpetration, local evidence suggests that male-on-male sexual violence perpetrators and victims alike report higher levels of alcohol abuse, and a number of sexual risk behaviors that include unprotected sex, increased overall sexual partner frequency, and increased frequency of sex with transactional sexual partners (Kristin L Dunkle et al., 2013). In addition, this research points to a significant overlap between the South African male-on-female sexual violence epidemic and the male-on-male sexual violence epidemic. Dunkle, Jewkes, Murdock et al. (2013) have found that 88% of men who report perpetrating an act of sexual violence against another man also report perpetrating an act of sexual violence against a woman. Moreover, 51% of men who report experiences of male-on-male sexual violence victimization also report perpetrating an act of sexual violence against a woman.

Although the study from which these figures were identified did not ask respondents about their sexual identities explicitly, respondents were asked about their primary sexual attraction (with the response options ‘women,’ ‘men,’ ‘both,’ and ‘unsure’). Among men reporting a history of consensual sex with other men, those who reported a primary sexual attraction to men faced the highest odds of having been sexually assaulted by another man (43%) (Kristin L Dunkle et al., 2013). To the extent that this measure can be considered a proxy measure of sexual identity, this finding seems to suggest that gay identity may be a significant risk factor for male-on-male sexual violence victimization above and beyond the already elevated risks faced by men

reporting a history of consensual sex with other men, but targeted research is needed to confirm and explain this finding.

Violence & Masculine Gender Constructions

South African research regarding the social determinants of male-on-female sexual violence perpetration (discussed above) support an emerging theoretical framework which asserts that the endemic nature of male-on-female sexual violence perpetration represents a response to recent shifts in gender roles and a corresponding crisis of masculinity (Campbell, 1992; Morrell, 2001; Walker, 2005). Specifically, the framework suggests that there is a crisis of masculinity among working-class black South African men and that responses to this crisis are directly responsible for the endemic use of various forms of violence in contemporary South Africa. Scholars who promote this framework, which draws on social identity theory, argue that a crisis of masculinity has resulted from new threats to male dominance in material and decision-making fronts at the household level brought on by democratic changes in post-Apartheid South Africa.

Moreover, such scholars suggest that there is a generational divide in the construction of new masculinities that often include violent masculinities. Young men are argued to often be better educated and more politicized than their fathers, but often face greater risks of unemployment and consequently fewer opportunities for marriage in a culture that requires men to pay a bride price. Scholars argue that it is because of these limited opportunities that many young men face a loss of a respected form of masculine identity, and that violence is often used as a strategy to regain this status. Finally, this framework holds that the increased use of violence in interpersonal and social situations as a reassertion of masculinity also reflects the embedded nature of violence within

family structures to maintain order and control, and as a first-line strategy for conflict resolution in a wide variety of relationships.

More work is needed to examine whether responses to the 'crisis of masculinity' described above extend to perpetration of sexual violence against other men as well as women. This framework suggests that sexual violence perpetrated against men may be used as a means to structure and assert hierarchies of masculinities in a general social context of limited opportunities to achieve traditional forms of respected manhood. This application of the framework is supported by documented examples of male-on-male sexual relationships among heterosexual men being used to structure power in environments that lack opportunities to achieve traits associated with hegemonic masculinity. Particularly informative to this application of the framework is research exploring how power and vulnerability are constructed and experienced in the context of 'mine marriages' among workers in the South African gold mines (Moodie, 1988) and 'prison marriages' among inmates in South African prisons (Gear & Ngubeni, 2002). In both cases sexuality is fundamentally linked with the exercise of masculine power and reconstructions of gender.

The author of the latter work argues that vulnerability to being made into a prison 'wife' can be equated to vulnerability to unwanted sex in general. Factors related to such vulnerability included lack of familiarity with inmate subculture, lack of material resources, and a lack of physical strength. Also relevant is how gender reconstruction into a 'woman' in the prison environment was associated with shame, while being a 'man' who has a prison 'wife' was associated with higher status and pride. Additionally, while men who had previously been prison wives were able to achieve a promotion in social

status to manhood, this transition almost always involved such men perpetrating acts of violence themselves in order to demonstrate masculine prowess and occurred within gang-related institutional contexts (Gear & Ngubeni, 2002).

Although these examples come from all-male environments, they provide evidence of how nonconsensual male-on-male sex has been used among groups of South African men to structure power, gender, and social status in contexts of limited opportunities for achieving a respected form of manhood. These examples may have direct and indirect connections to the sexual violence risks faced by South African MSM. The relevance of these examples is supported by evidence suggesting that men in the general population who hold less socially respected forms of masculinity, such as gay-identified men, may experience an increased risk of male-on-male sexual violence victimization (Kristin L Dunkle et al., 2013). Such victimization experiences may reflect acts of sexual violence that are perpetrated against a man holding a subordinate masculinity as a means to assert the perpetrator's masculine superiority, achieve either social status or self-esteem, or alleviate anxiety.

There is evidence that recent gender reconstructions among same-sex practicing men in South Africa may actually contribute to perceptions of a crisis of masculinity that promote such acts of sexual violence. For example, ethnographic work from the gay male community in Mkhumbane, South Africa describes how the community has historically been divided into the gendered stereotypes of *iqenge* and *isikhesana* (Louw, 2001). *Iqenge* was initially used (in the 1950s) to refer to men who adopt a male homosexual gender and are typically the 'active' partner in sexual relationships. *Isikhesana* initially referred to men who a adopted a female homosexual gender. While the construction of

iqenge has remained intact, the meaning of *isikhesana* has changed to become gender neutral. The author argues that the emergence of a democratic South Africa in the 1990s "produced political and social space for new expressions of sexuality and constructions of masculinity" that is apparent in the reconstruction of *isikhesana* identities. The notion that an individual who previously held a feminine gender identity now occupies a masculine gender identity in the new South Africa may contribute to a crisis of masculinity in a similar way to which changing gender roles for women have done so. New empirical research is needed to evaluate the extension of the theoretical framework presented here to explain sexual violence risks among MSM and identify possible alternative explanations.

Gender & Power

The Theory of Gender and Power, developed by Raewyn Connell, is among the most prominent theories applied in studies of sexual violence and other gender-based sexual health risks (Connell, 1987). The theory posits that three major structures characterize gendered relationships between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis. Conventional applications of the theory of gender and power in public health research examine the influence of gender relations associated with these structures in the context of masculine subordination of femininities (Connell, 1987; G. M. Wingood & DiClemente, 2000). Such approaches examine how structural power, labor asymmetries, and gender hierarchies interact to contribute to the systematic subordination of women relative to men, which, in turn, constrains women's agency, health and wellbeing.

To apply this theory to an investigation of male-on-male sexual violence requires an examination of gender relations associated with power and labor structures in a context of hierarchies among different masculinities. Central to such hierarchies is the concept of hegemonic masculinity, which is the form of idealized masculinity that is culturally dominant in a given setting and represents power and authority (Connell & Messerschmidt, 2005). This socially dominant gender masculinity subordinates not only femininities, but also other masculinities that are less culturally valued. Prior studies of hegemonic masculinity in southern Africa have emphasized that manhood is not constructed as biologically inherent; rather it must be achieved via social performance (Conell, 2003; Gilmore, 1990; Pollack, 1999). Research in this area stresses the role of financial independence, employment, and providing for a family as the primary social requirements for achieving hegemonic versions of African manhood. Research suggests that young men who do not achieve a sense of socially respected manhood are more likely to engage in violence (Barker & Ricardo, 2005).

While there is no known research of the normative use of sexual violence against men specifically to achieve or affirm one's manhood, prior research has identified a common perception of sex as performance, specifically as a means by which to demonstrate masculine prowess. For example, ethnographic research in South Africa by Wood and Jewkes suggests that a lack of economic and recreational opportunities for youth often lead to sexual relations being used as a means for gaining respect and social status (Wood & Jewkes, 2001). They assert that notions of male sexual entitlement and control of women are embedded in locally dominant constructions of masculinity, and that perpetration of sexual violence is a means to position one's social status among male

peer groups. New research is needed to identify how local constructions of masculinities may promote the use of male-on-male sexual violence as a means to structure and assert social hierarchies in relation to other men.

Research suggests that patterns of sexual violence reflect context-specific gender relations, as well as gender-based social structures and norms (Abrahams et al., 2006; Petersen et al., 2005; Walker, 2005; Wood, 2005; Wood & Jewkes, 1997). Yet, gender-based theoretical frameworks in studies of sexual violence have almost exclusively been applied to the social vulnerabilities faced by women relative to men. This conception of gender relations ignores the potential role of violence in the hegemonic and heteronormative gender socialization of men and boys. The notably high prevalence of male-on-male sexual violence in South Africa, and the elevated risks of such violence faced by MSM, highlights a need to develop new perspectives for understanding relationships between sexual violence and social constructions of gender and sexuality. This need is further highlighted by research showing a disturbing relationship between gay-bashing and sexual assault in South Africa (Reid & Dirsuweit, 2002). Research suggests that up to 22% of gay hate crimes in South Africa involve the rape of the victim (Theron, 1994). More work is needed to investigate how experiences of homophobia exist within broader structures of gender and power and contribute to sexual violence victimization among MSM.

Gay Identities & Homophobia in South Africa

Given the significant role that social constructions of identity often play in contexts of gender-based violence, it is critical to examine the social constructions of gay identities in South Africa and the role that they may play in promoting sexual violence

risks among MSM. Central to such an examination is an understanding of the distinctions between sexual identity, sexual behavior, and sexual attraction. Since the term Men Who Have Sex with Men is a behaviorally defined designation, individuals for whom this label applies have diverse sexual identities. Considering this, there is initial evidence suggesting that MSM with sexual identities that challenge the heterosexual status quo may face greater risk of violent victimization.

The South African government does not keep specific statistics on homophobic crime. However, homophobic victimization is endemic in violent, masculine cultures and has extensive implications for gay men and lesbians (Reid & Dirsuweit, 2002). It profoundly affects individuals' freedom of movement and their use of social spaces. However, few research efforts exist around these issues in South Africa and those that do deal primarily with gay white men, who may face less risk of violent homophobic victimization. Beginning in 1996 when South Africa adopted a constitution that outlawed discrimination on the basis of sexual orientation, the country experienced a major political and legal mobilization of queer groups that served to increase the social visibility of gay men and lesbians (Tucker, 2011). However, the effects of increased social visibility of queer identities have often had different implications for white gay men and gay men of color.

Among black African township men, an increase in homophobic violence emerged most strongly as a result of a sudden visibility of queer sexuality, not possible during apartheid (Tucker, 2011). In these instances, violent homophobic manifestations have themselves been shaped by the particular racialized histories of different groups. Indeed, qualitative research examining how black gay men view themselves in relation to

white gay men suggests that black gay men perceive an increased risk of being sexually or physically assaulted for challenging the heterosexual status quo (Graziano, 2004). More work is needed to examine the sexual violence risks faced by MSM with marginalized sexual identities and the interactive effects of other forms of social marginalization.

Sexual Violence & STIs

While the study of social causes of male-on-male sexual violence is critical, it is also important to understand the consequences of these experiences. One significant public health consequence of sexual violence pertains to sexual health. Research from South Africa and around the world has consistently identified increased risks of HIV and other sexually transmitted infections (STIs) among both victims and perpetrators of sexual violence and other forms of gender-based violence (Braitstein et al., 2003; K. L. Dunkle et al., 2004; Eby et al., 1995; Garcia-Moreno & Watts, 2000; Maman et al., 2002; Van der Straten et al., 1998). One such study in Soweto, South Africa found that after adjustment for age, current relationship status, and women's own risk behavior, intimate partner violence victimization was significantly associated with HIV seropositivity among women (OR 1.48, 95% CI 1.15 – 1.89) (K. L. Dunkle et al., 2004).

More recent longitudinal research from South Africa also provides temporal evidence in support of recognizing causality in the relationship between gender-based violence and HIV incidence among young women. A 2010 study found a relative HIV incidence rate ratio for women who experienced more than one incident of physical or sexual IPV victimization of 1.65 (95% CI 1.13 – 2.40), compared to those with one or no physical or sexual IPV victimization experiences (R. K. Jewkes et al., 2010). Research on

gender-based violence perpetration among South African men has also found that men who report perpetration of physical violence against a female partner on more than one occasion are significantly more likely to have HIV (OR 1.48, 95% CI 1.01 – 2.17) (R. Jewkes et al., 2009).

Similarly, South African men who report a history of sexual violence perpetration against another man are significantly more likely to have HIV, compared to those who do not (OR 2.55, 95% CI 1.02 – 6.38) (Kristin L Dunkle et al., 2013). Although there is currently a lack of empirical evidence from South Africa identifying increased HIV/STI risks among victims of male-on-male sexual violence, research with MSM in nearby Botswana has identified such an association. Researchers found that Botswana MSM who reported having been raped were significantly more likely to have HIV compared to other MSM (OR 6.3, 95% CI 1.5 – 25.6) (Baral et al., 2009). Similarly, data from the United States suggests that battering victimization among MSM is significantly associated with increased HIV risk behaviors (Relf et al., 2004), and MSM with a history of sexual assault are significantly more likely to have HIV compared to other MSM (OR 2.05, 95% CI 1.06 – 3.94) (Mustanski et al., 2007).

However, international literature examining relationships between sexual violence and HIV/STIs among MSM remains limited in scope and methodology. For example, many studies in this area have not differentiated the risks associated with physical IPV and sexual violence victimization. Further, even among those that do make such a distinction, non-partner sexual violence is rarely examined separately from sexual violence perpetrated by a consensual sexual partner. Finally, few studies have sought to

examine risks of acquiring other STIs besides HIV that may be associated with sexual violence among MSM.

In addition to the work that has identified these increased HIV/STI risks, a growing body of empirical research has examined the mechanisms by which experiences of sexual coercion and violence increase an individual's risk of acquiring HIV and other STIs. First, sexual violence victimization influences HIV/STI risks directly when it interferes with an individual's ability to negotiate condom use (Heise, Ellsberg, & Gottmoeller, 2002). Consequently, that individual's biological susceptibility to HIV and other STIs is increased during the incident of sexual violence itself when the perpetrator(s) is infected with HIV and/or another STI. Additionally, any abrasions and tears experienced by the victim during the experience will facilitate entry of the virus into the bloodstream (Slaughter, Brown, Crowley, & Peck, 1997; Sommers et al., 2012). Victims of forced anal sex also face increased direct HIV/STI risks. Specifically, victims of forced anal sex are much more susceptible to HIV since anal tissues are easily damaged, allowing the virus easier entry into the bloodstream (Draughon, 2012). This direct HIV/STI risk factor may be of particular importance in contexts of male-on-male sexual violence.

Indirect links between sexual violence and HIV/STIs are also well established in empirical literature, and include several distinct pathways. Studies have found that physically violent men are more likely to have HIV and to impose risky sexual practices on their partners (Chuang, Liebschutz, Cheng, Raj, & Samet, 2007; Gilbert, El-Bassel, Wu, & Chang, 2007; R. Jewkes et al., 2006). Such men are more likely to have multiple partners, to have sex more frequently, to practice transactional sex, to practice anal sex

and to report symptoms of sexually transmitted infections. Also, being a victim of sexual violence can make individuals more likely to engage in high-risk behaviors, which can increase risks of HIV infection (Gellert & Durfee, 1989; González-Guarda, Peragallo, Urrutia, Vasquez, & Mitrani, 2008; Koblin et al., 2006; Ravi, Blankenship, & Altice, 2007; G.M. Wingood & DiClemente, 1997; Wyatt, 1985; Zierler et al., 1991). Finally, victims of sexual violence in intimate relationships may have difficulty negotiating condom use even in contexts of consensual sex, and proposing the use of a condom may increase the risk of violence (Bogart et al., 2005; Chuang, Liebschutz, Horton, & Samet, 2006; Lang, Salazar, Wingood, DiClemente, & Mikhail, 2007; Sales et al., 2008).

Demonstrating these indirect links, research from South Africa has shown that women with abusive or controlling male partners are more likely to be HIV-positive after controlling for their own HIV risk behavior (K. L. Dunkle et al., 2004). These findings suggest that having a violent male partner may be an independent risk factor for prevalent HIV infection among women, lending support to the hypothesis that abuse and controlling men may be more likely to be HIV-positive. Research with South African men has also provided evidence of indirect links between sexual violence and HIV/STI risks. For example, data from an HIV risk reduction intervention with young men suggests that men who perpetrate IPV engage in significantly higher levels of HIV risk behavior than non-perpetrators (K.L. Dunkle et al., 2006). Moreover, results from the same study suggest that more severe, frequent, and long-standing violence is associated with higher levels of risky behavior.

More work is needed to understand the pathways through which sexual violence perpetration may increase an individual's STI risks. Similarly, further research is needed

to examine whether the pattern of mechanisms that promote STI risks among MSM victims of sexual violence is similar to that among female sexual violence victims. The findings from this type of research would have significant implications for the development of STI prevention interventions for South African MSM, who already face a greater risk of acquiring HIV and other STIs compared to men in the general population (Kristin L Dunkle et al., 2013).

Conclusions

The evidence presented here suggests that male-on-male sexual violence and PIPV represents a poorly understood but highly prevalent public health issue that disproportionately affects a highly vulnerable population. Given the early state of the literature on this topic, more work is needed to examine social patterns of male-on-male violence risks and specifically explore how interactions between social structures and social norms may contribute to PIPV and sexual violence between men. Further, considering the evidence linking sexual violence and HIV/STIs among perpetrators and victims of male-on-female sexual violence, research is needed to explore connections between male-on-male violence and sexually transmitted infections. The findings from this research will inform clinical and community practice to reach male-on-male violence victims in South Africa and link them to appropriate health and psychosocial support services. Given the paucity of research and intervention efforts on this topic, this work is urgently needed. This dissertation study applied a mixed-methods approach to study the social determinants of male-on-male sexual violence and PIPV among South African men, including MSM, and associations with mental and sexual health.

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Chapter 2: Gender presentation, sexual identity, and partnership dynamics among South African MSM and MSM/W: Implications for violence and HIV prevention

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Abstract

Background: Research from South Africa has consistently identified an increased risk of HIV among both victims and perpetrators of physical intimate partner violence (PIPV) and sexual violence. Yet the mechanisms that drive the association between PIPV and sexual violence perpetration and HIV/STI risk among South African men who have sex with men (MSM) and men who have sex with men and women (MSM/W) are not clearly understood.

Method: To describe the social patterns of male-on-male violence, and to identify implications for HIV risk, we conducted a qualitative study that consisted of 20 in-depth interviews (IDIs) with10 MSM and 10 MSM/W. IDI topics included masculinity, social status, violence norms, sexuality, and relationships. We used descriptive and comparative analyses to examine how gender presentations and sexual identities influenced men's relationships, experiences of violence, and HIV risk behaviors. Three primary thematic categories emerged: homophobia and sexual identities; partner concurrency; and PIPV and sexual violence.

Results: Participants described homophobic violence and harassment that they felt was common in their communities, and suggested that MSM and MSM/W victims of violence may not report these experiences due to social stigma and perceived institutional homophobia. Bisexual partner concurrency was common among MSM/W, many of whom indicated that their sexual relationships with men were restricted to short-term partners and partners who would not disclose their same-sex sexual activity. Many participants reported experiences of sexual violence, and some

suggested that relationship violence was often considered justifiable when perpetrated by a loving partner.

Conclusions: Expectations to perform normative/hegemonic masculinity and community homophobia influence MSM and MSM/W health. Men who must conceal their same-sex relationships for their own safety may be more likely to engage in behaviors that promote violence and carry increased HIV risks. MSM-focused violence prevention and HIV prevention strategies should address community and institutionalized homophobia and develop targeted strategies to reach MSM and MSM/W who may not associate with known gay venues or openly gay or bisexual men.

Keywords: Violence, MSM, South Africa, homophobia, gender, HIV

Introduction

Violence among South African MSM

Nearly 1 in 10 South African men report having been sexually assaulted by another man during their lifetime (Kristin L Dunkle, Jewkes, Murdock, Sikweyiya, & Morrell, 2013). Men who report a history of consensual sex with men (MSM) are over four times more likely than non-MSM to report male-on-male sexual violence victimization and perpetration (Kristin L Dunkle et al., 2013). The prevalence of male-on-male sexual violence victimization in South Africa, particularly among MSM, is significantly higher than that seen in countries such as the United States, where 1.4% of men report having been raped in their lifetime (Black et al., 2011).

Violence and HIV

Research from South Africa and around the world has consistently identified increased risks of HIV and other sexually transmitted infections (STIs) among both victims and perpetrators of sexual violence and physical intimate partner violence (PIPV) (Braitstein et al., 2003; K. L. Dunkle et al., 2004; Eby, Campbell, Sullivan, & Davidson, 1995; Garcia-Moreno & Watts, 2000; Maman et al., 2002; Van der Straten et al., 1998). South African men who report a history of sexual violence perpetration against another man are significantly more likely to have HIV, compared to those who have not (Kristin L Dunkle et al., 2013). Research from Botswana has also found that MSM who reported having been raped were significantly more likely to have HIV compared to other MSM (Baral et al., 2009). Similarly, data from the United States reveals that MSM with a history of sexual assault are significantly more likely to report unprotected receptive and

insertive anal intercourse (Relf, Huang, Campbell, & Catania, 2004) and HIV infection (Mustanski, Garofalo, Herrick, & Donenberg, 2007).

A growing body of research has examined the mechanisms by which experiences of sexual coercion and violence can increase women's risk of acquiring HIV and other STIs. First, violent victimization influences HIV/STI risks directly when it interferes with a woman's ability to negotiate condom use and the perpetrator(s) is infected with HIV and/or another STI. (Heise, Ellsberg, & Gottmoeller, 2002). Victims of violence in intimate relationships may also have difficulty negotiating condom use even in contexts of consensual sex, and proposing the use of a condom may increase the risk of violence (Bogart et al., 2005; Chuang, Liebschutz, Horton, & Samet, 2006; Lang, Salazar, Wingood, DiClemente, & Mikhail, 2007; Sales et al., 2008). Yet it remains unclear whether these same mechanisms influence HIV risks among victims of male-on-male violence.

Studies have also found that physically abusive men are more likely to impose risky sexual practices on their partners (Chuang, Liebschutz, Cheng, Raj, & Samet, 2007; Gilbert, El-Bassel, Wu, & Chang, 2007; Jewkes et al., 2006). Men who perpetrate violence are also more likely to have multiple partners, to have sex more frequently, to participate in transactional sex, and to report symptoms of STIs (Kristin L Dunkle et al., 2006; Jewkes et al., 2006; Simbayi et al., 2006). Being a victim of violence may also make individuals more likely to engage in sexual risk behaviors, which can increase risks of HIV infection (Gellert & Durfee, 1989; González-Guarda, Peragallo, Urrutia, Vasquez, & Mitrani, 2008; Koblin et al., 2006; Ravi, Blankenship, & Altice, 2007; Wingood & DiClemente, 1997; Wyatt, 1985; Zierler et al., 1991).

Gender and power

Research suggests that patterns of sexual violence and PIPV reflect context-specific gender relations, as well as gender-based social structures and norms (Abrahams, Jewkes, Laubscher, & Hoffman, 2006; Petersen, Bhana, & McKay, 2005; Walker, 2005; Wood, 2005; Wood & Jewkes, 1997). Gender-based theoretical frameworks in studies of violence have almost exclusively been applied to social factors, such as gendered poverty and relationship power dynamics (K. L. Dunkle et al., 2004; Petersen et al., 2005), faced by women relative to men. This conception of gendered violence risk factors can usefully be expanded to examine ways in which hegemonic and heteronormative gender socialization of men and boys contributes to male-on-male violence, including sexual violence, PIPV, and homophobic violence.

This is highlighted by research showing a relationship between gay-bashing and sexual assault in South Africa (Reid & Dirsuweit, 2002): Up to 22% of gay hate crimes in South Africa involve the rape of the victim (Theron, 1994). What is not currently understood is how gay men's exposures to homophobia exist within broader structures of gender and power and contribute to violent victimization and HIV risk among MSM and men who have sex with men and women (MSM/W). This information is critical for the development of evidence-based violence and HIV prevention programs targeting MSM and MSM/W in South Africa.

The current study

This qualitative study was designed to provide an in-depth understanding of the processes through which gender presentation, sexual identities, and gendered relationship norms contribute to experiences of violence and HIV risk among South African MSM

and MSM/W. We conducted in-depth interviews with men who had diverse sexual identities and behaviors to describe and compare gendered social patterns of male-on-male sexual violence, PIPV, and homophobic violence.

Methods

This research was one component of an existing/ongoing program that was designed to to develop and evaluate community based HIV prevention for MSM in rural South Africa (Lane et al., 2014). The parent study used ethnographic field methods to inform the adaptation of a community-level MSM behavior change intervention to the South African township setting. Key informants from the parent study were used to identify participants recruited into this study.

Participants

We used purposive sampling to recruit 20 Black African men - 10 MSM and 10 MSM/W. Participants were between the ages of 22-40 and resided in the Mpumalanga and Gauteng provinces of South Africa. Participants were recruited by their sexual identities as disclosed to key informants. Pseudonyms are used to refer to participants throughout the manuscript.

Procedures

The Emory University Institutional Review Board and the University of the Witwatersrand Human Research Ethics Committee granted ethics approval for this study. Key informants asked participants if they were interested in participating in an approximately 60 minute, digitally recorded in-depth interview. Written informed consent was provided by each participant before the start of each Interview. The

interviews were primarily conducted in personal residences to protect participants' confidentiality. Interviewers were trained ethnographers and used the same semi-structured interview guide. The guide was developed from a literature review and covered topics including: masculinity, social status, violence norms, sexuality, and relationships, although interviews were conversational and participants were encouraged to elaborate on themes that were particularly important to their own experiences. Interviews were conducted in a language of the participant's choice, including English, isiZulu, Sotho, and Swati. Digital interview recordings were translated into English and transcribed by interviewers.

Data analysis

We used a mixture of inductive and deductive coding. Inductive codes were allowed to emerge from the data using open coding and then grouped into thematic concepts. DM and RFM discussed these emergent and a priori codes, as well as the data corpus as a whole, throughout the analysis process. Major codes included "sexual violence," "physical violence," "stigma," "substance use". These codes were categorized into overarching themes (e.g. "relationship power" and "gender norms"), and we compared how these themes manifested differently for MSM and MSM/W. Based on our theoretical framework, we made these comparisons through the lens of gender presentation and sexual identities to better understand how gender and power manifest differently or similarly in the lives of MSM and MSM/W, and how this influences their experiences of violence and HIV risk behaviors. We coded the transcripts using MAXQDA 10 software.

Results

The mean age of MSM participants was 28.7 and the mean age of MSM/W participants was 26.6. Most participants resided in the Mpumalanga province (90% of MSM and 70% of MSM/W), and the remaining participants resided in the Gauteng province. Zulu was the most common ethnic group (70% of MSM and 80% of MSM/W), followed by Swati (30% of MSM and 10% of MSM/W) and Sotho (10% of MSM/W). Three primary thematic categories emerged from the analysis: homophobia and sexual identities; partner concurrency; and sexual violence and PIPV

Homophobia and sexual identities

Several participants identified community homophobia as widespread and a common barrier preventing them from publicly disclosing their sexual identity. Men who lacked financial independence faced added pressure to conceal their sexual identity.

> I would say that gay men who are working are more independent than those who are not and they are more open about their sexuality than those who are not working. – Unathi, 39, MSM

Many men described homophobic violence as common in their community. Some participants also suggested that gay and bisexual men who are victims of violence, including sexual violence and PIPV, often do not report these experiences due to community stigma and institutional homophobia.

> Even if you go and report gay bashing, the police do not care and you become the joke at the police station because they will keep on calling the other officers to come in and listen to your story, so in such a situation instead of going to the police you end up being physical in order to defend yourself. – Unathi, 39, MSM

The interviews also revealed a discernable relationship between community homophobia and internalized homophobia. This relationship was particularly well illustrated by several interviews with MSM/W in which participants characterized their same-sex relationships as less legitimate than their opposite-sex relationships. These men typically distinguished their same-sex relationships as strictly sexual encounters, rather than intimate relationships. In two interviews with MSM/W, participants specifically stated that they perceived gay-identified men as wealthy, and that their sexual encounters with such men were exclusively transactional. Another MSM/W participant indicated that his first same-sex encounter was solely intended as transactional but later developed into a more intimate relationship.

> By then I had an impression that gay men have lots of money and I expected that they will buy me alcohol and everything. One day these gay men came through and took me and some of my friends to go drink and I didn't even think that one day I will sleep with them. It happened that I was drunk and I got a blackout and he took me to his place and when I woke up in his place the house was beautiful and he drives a beautiful car, and he has everything. I decided that I must have sex with him. Maybe I might become fortunate as well. That's how it started. I started developing feelings for him, and I got used to it. With this one I ensure that I use a condom, but with my girlfriend I don't use it sometimes. – Themba, 25, MSM/W

In each of these scenarios participants downplayed the significance of their same-sex relationships due to a deliberate avoidance of intimacy. All of the men who described their same-sex relationships in this way self-identified as straight or heterosexual. These scenarios appeared to reflect strategies used by some men to rationalize same-sex behavior and combat internalized stigma. However, this rationale was not expressed by

participants explicitly. This theme was also linked with HIV risk behaviors, as several participants reported inconsistencies in condom use across intimate and non-intimate partnerships.

Partner concurrency

There was a consensus among participants that men must have female partners in order achieve a socially respected manhood. For men who had not publicly disclosed their same-sex sexual activity, adhering to this norm often promoted bisexual partner concurrency. Some MSM/W also identified public disclosure of their same-sex behavior as a barrier to forming relationships with women, and others cited rumors or suspicions around their sexuality as a source of conflict with female partners. While infidelity and suspicions of infidelity were the most commonly cited sources of partner conflict across all types of relationships, some men suggested that bisexual partner concurrency was tolerated within their same-sex relationships.

> There are a lot of challenges because I tend to be suspected, especially by my wife. She confronted me before and said that she heard that there are rumors about me sleeping with other men. However, I was able to defend myself and I told her that she has never come home and seen me with another man. …The biggest challenges for me are those rumors. – Thando, 22, MSM/W

> What I like about gay men is that they don't have a problem with the fact that I have a girlfriend on the side. …I can't tell my girlfriend that I'm dating someone else on the side because she will freak out. – Themba, 25, MMS/W

Many MSM/W who had not publicly disclosed their sexuality indicated that their sexual relationships with men were often restricted to short-term partners and partners who would not disclose their sexual activity to avoid being stigmatized.

> I broke it off with him because I found that he was also sleeping with gay men that are out and gay and I didn't like that. …It is not that I discriminate against gay people who are out of the closet but it's just that I can't be associated with them because I have a family and a child. – Thando, 22, MSM/W

Sometimes, these types of short-term undisclosed relationships were associated with violence perpetrated by straight identified men against those who were more closely identified as gay.

> Let's say this [straight] guy has slept with this [gay] guy on the previous night. And then he probably comes in a pub or something and finds the very same guy that he slept with in the pub. And then he will say, "I'm leaving with you now." And the gay guy will say, "no we're not leaving." And then he would force him, like "let's go." – Sizwe, 29, MSM/W

A consistent pattern that emerged across the themes in this category was overlapping influences of masculine gender norms and community homophobia on participants' relationship dynamics and HIV risk behaviors. The most salient influences were masculinity norms requiring some men to maintain heterosexual relationships in order to preserve social respectability, and contexts of homophobia that required some men to keep their same-sex relationships hidden to avoid stigma. Many participants – particularly MSM/W – cited these social influences as contributing factors to increased partner concurrency, more frequent and shorter-term partnerships, inconsistent condom use across partnerships, and sources of conflict with both male and female partners.

Sexual violence and PIPV

In several interviews, participants recalled personal histories of sexual violence or identified sexual violence as a significant problem facing their community. Although none of the participants explicitly identified experiences in which sexual violence was perpetrated as a form of homophobic violence, some MSM participants stated that having a stereotypically masculine partner was often protective against physical homophobic violence and verbal harassment when such partners were willing to publicly disclose their relationship. When discussing personal experiences with sexual violence, participants most often described acts of sexual violence perpetrated by non-partners or non-main partners. These experiences included encounters with prior once-off partners, known friends and acquaintances, and violent transactional sexual encounters.

> Say, for instance, you have an agreement with a guy that you will fetch him at a certain time, next thing when you get there he is not ready to leave because he is busy with his friends and you feel as though he is wasting your time and ignoring you. I would then grab this guy and take him into the car and go home and then when we get home I'll try to get into the mood to have sex, and he may no longer be in the mood, and under these circumstances I may end up forcing myself onto this guy. – Wandile, 23, MSM

> It actually did happen to me. I was sleeping with my family friend. …We were sleeping, and then suddenly I felt him holding tight onto me, penetrating me, and I confronted him asking him what it is that he is doing, and he said to me, "no my brother, I am almost finished." Then I let him do what he wanted to do, but I was not there emotionally and I had not given my consent to this, it was forced. …You know even afterwards I had to go around looking for towels, because he didn't even use a condom, he just did as he pleased with me. – Thando, 22, MSM/W

> Something like that once happened in my neighborhood. A certain guy raped my friend who is gay because he believes that when he has sex with a male he gets luck. Most of the guys in my neighborhood share the same belief. This guy raped my gay friend more than once and he told him that after the day he raped him he went to do crime and he thrived and he wanted to rape him again. They raped my gay friend when he was drunk. Every time when he is drunk they rape him. – Themba, 25, MSM/W

When asked about forced sex within relationships, many participants – most of whom were MSM – indicated that this was a common occurrence. However, these men often suggested that in certain situations this was considered justifiable when perpetrated by a loving partner. Experiences with PIPV were also reported by a small number of participants, many of whom also stated that such acts were often justifiable in the context of a loving relationship.

> I think if you really love that person and it's been a while since you have sex together I think that can make your partner force you to have sex, if they really love you a lot it could lead them to forcing sex. – Bongani, 26, MSM/W

> Some people forgive and they love being loved and they think that their partner beats them because they love them. – Mphafane, 40, MSM

Participants were most likely to report experiences of sexual violence occurring outside of a primary relationship. However, participants expressed a wide range of views regarding definitions of sexual violence, which may have influenced these reports. One significant difference between MSM and MSM/W, for example, was that MSM were much less likely to consider forced sex within a primary relationship to be an act of sexual violence, compared to non-partner forced sex. It is unclear the extent to which

varying definitions of sexual violence held by participants impacted their likelihood of reporting non-consensual sexual experiences.

Discussion

The purpose of this study was to provide an in-depth understanding of how gender norms and sexual identities contribute to violence and HIV risks among South African MSM and MSM/W. The theory of gender and power offers a useful lens to understand how gender norms and sexual identities contribute to violence and HIV risk among South African MSM and MSM/W. Homophobic discrimination and violence were common experiences, often rooted in the fact that men who could not or did not pass as straight were not seen as sufficiently masculine, or because MSM/W felt a need to use violence or sexual dominance to assert their masculinity. For many participants, fear of stigma, discrimination, and potentially violent harassment were prominent barriers to disclosing their sexual identity. Some felt that disclosure could result in the loss of social and economic support. Violent incidents were rarely reported to police due to expectations that cases would go unresolved and due to fear of being mocked or ridiculed by police. These findings demonstrate a need for institutionalized cultural sensitivity training for law enforcement officers tasked with responding to reports of violence.

Gender norms and homophobia also influenced participants' relationship dynamics in ways that may drive violence and HIV risks. Many MSM/W who characterized their same-sex sexual encounters as less legitimate than their opposite-sex relationships often restricted their same-sex encounters to short-term undisclosed relationships and transactional encounters, which were frequently described in violent contexts. This

dynamic was also associated with partner concurrency and inconsistent condom use across different types of partnerships, which were often characterized by perceptions of intimacy. These results indicate that MSM-focused violence and HIV prevention efforts must tackle both community homophobia and internalized homophobia. These issues directly influence men's gendered perceptions of relationship intimacy and their ability to disclose concurrent relationships, both of which shape situational contexts of violence and HIV risk behaviors.

Although experiences of sexual violence were most often reported outside of primary relationships, all participants who reported a personal experience with sexual violence had previously known the perpetrator or victim. This mirrors findings from previous studies in which most female sexual violence victims knew their assailant (Adefolalu, 2014; Merchant, Keshavarz, & Low, 2004). Forced sex was reported in the context of longer-term relationships by several participants, however, most participants did not consider this to be an act of sexual violence. Additionally, experiences of forced sex and physical intimate partner violence with primary relationship partners were often considered justifiable if they occurred in the context of a loving relationship. These findings highlight a need for more explicit discussion around issues of sexual consent and physical safety in MSM-tailored violence prevention efforts.

Several participants identified a stereotype that gay men were wealthy and that transactional relationships with these men would bring good luck or good fortunes. This perception appeared to reflect an environment in which men who lack financial independence face added pressure to conceal their sexual identity. In two interviews, participants identified scenarios in which this belief led to sexual violence perpetrated

against gay-identified men. In instances of forced sex perpetrated by a prior once-off partner, perpetrators were most often described as men seeking to conceal their same-sex encounters.

This suggests that current intervention efforts targeting MSM and MSM/W via gay-identified venues may fail to reach a significant proportion of such men who do not associate with openly gay/bisexual social environments, yet who also face elevated risks of violence and HIV. This underscores the need for broad community-based intervention strategies and collaboration with health practitioners to elicit detailed sexual histories of all patients and screen for exposure to violence in order to better understand patients' HIV risk behaviors and employ tailored HIV prevention strategies.

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Chapter 3: Disparities in violence, mental health, and HIV risks among South African men with socially marginalized masculinities: An application of the Theory of Gender & Power

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Abstract

Background: Gender-based power imbalances have consistently been found to place women at significant risk for violence and HIV. However, little empirical research has examined whether power dynamics associated with different expressions of masculinity influence men's health in similar ways. This study tested an application of the Theory of Gender and Power (TGP) to examine pathways between gender-based constructs and South African men's self-reported history of violence victimization, depressive symptoms, and HIV serostatus.

Methods: We collected cross-sectional survey data and HIV test results from 713 men seeking HIV testing at two sexual health clinics in metropolitan Cape Town. The sample was comprised of men with diverse sexual identities and behaviors, including 201 men who have sex with men (MSM). We used structural equation modeling (SEM) to examine whether two indicators of marginalized masculinities – non-heterosexual identity and effeminate gender presentation – were associated with TGP constructs and adverse health outcomes.

Results: SEM analyses indicated good fit for the specified model (RMSEA = 0.046; CFI = 0.977; TLI = 0.971) and most hypothesized relationships were supported. The final model demonstrated a direct association between marginalized masculinities and violence victimization, and indirect associations between marginalized masculinities and depressive symptoms and HIV status via TGP constructs.

Conclusions: The findings provide evidence that marginalized gender identities put men at direct risk for violence victimization and are indirectly associated with men's mental health and HIV status. The findings suggest that gender hierarchies contribute to gender-

based health disparities not only between men and women, but also among men. Public health interventions should seek to address masculine gender norms that contribute to poor health outcomes among socially marginalized men.

Keywords: Gender, Power, Masculinity, Violence, HIV

Introduction

A long-standing priority of violence and HIV research and prevention efforts in heterosexual epidemics has been to identify and confront gender-based health disparities. Consequently, there is a substantial body of empirical literature examining the mechanisms by which hetero/sexist disparities in gender and power influence women's risks of gender-based violence and HIV infection. One of the most prominent theoretical frameworks that has been applied across this literature is Connell's sociological theory of gender and power (TGP) (Connell, 1987). Connell's TGP identifies three overlapping yet distinct social structures that characterize gendered relationships and contribute to gender-based health disparities. These structures include: (1) the sexual division of labor, which examines gender-based economic inequalities; (2) the sexual division of power, which examines gender-based inequities in authority and control; and (3) cathexis, which examines gendered social norms and affective attachments (Connell, 1987).

Conventional applications of the theory of gender and power in public health research have examined the influence of gender relations associated with these structures in the context of masculine subordination of femininities (Wingood & DiClemente, 2000). Such approaches have demonstrated how structural power, labor asymmetries, and gender hierarchies interact to contribute to the systematic subordination of women relative to men, which, in turn, constrains women's agency, health and wellbeing.

Recently, a growing body of research has documented high levels of male-on-male sexual violence (Dunkle et al., 2013), physical intimate partner violence (Stephenson, de Voux & Sullivan, 2011), and homophobic violence (Reid & Dirsuweit, 2002) among men in South Africa. Among this research, a population-based study conducted by Dunkle et

al. (2013) found that 9.5% of all South African men reported a history sexual victimization by another man. The same study also found that men who have consensual sex with men (MSM) were over seven times more likely than non-MSM to report a history of male sexual violence victimization (aOR=7.34; 95% CI 4.30–12.5). Research from Southern Africa has also found that MSM who report a history of male rape victimization are more likely to be HIV-positive than other MSM (Baral et al., 2009).

These figures highlight an urgent need to identify the social determinants of male-on-male violence in South Africa and associated HIV risk. In particular, the high levels of male-on-male violence reported by both MSM and non-MSM in South Africa suggests that men's risk of violence victimization is not determined by men's sexual behavior alone, and may therefore reflect similar social disadvantages that have been found to increase women's risk of violence victimization and associated HIV infection. This study sought to test an extension of the theory of gender and power to examine disparities in men's risks of violence victimization and HIV infection in South Africa.

The Theory of Gender & Power and Women's Violence & HIV Risks

The utility of the TGP framework for examining the influence of male-female gender hierarchies on women's violence and HIV risks is well established in empirical literature. A notable study by DePadilla et al. (2011) applied the TGP framework to examine condom use among young African-American women and found that the model provided evidence to support both direct and indirect associations between TGP constructs and condom use. Also consistent with the theoretical propositions presented in the TGP framework, violence research from South Africa has revealed that men who hold more gender inequitable beliefs are more likely to perpetrate violence against women, as are

men who engage in gender inequitable practices such as transactional sex (Jewkes et al., 2011).

HIV research has shown that South African women with low relationship power equity and women with a history of intimate partner violence have increased risk of HIV infection (Jewkes et al., 2010; Dunkle et al., 2004). Economic disadvantage, which has been found to be associated with participation in transactional sex and less knowledge about HIV/AIDS, has also been well-documented as a risk factor for both gender-based violence (Jewkes & Abrahams, 2002; Kim et al., 2007; Petersen, Bhana, & McKay, 2005) and HIV risk (le R. Booysen & Summerton, 2002; Dunkle et al., 2004) among South African women.

Applying the Theory of Gender & Power to Hierarchies of Masculinities

Previous applications of the theory of gender and power in public health research have most often employed the theory to examine gender-based health disparities between men and women. However, Connell & Messerschmidt (2005) suggest that TGP concepts also extend to more nuanced gender hierarchies, including hierarchies of masculinities, and associated health inequities. Central to understanding these hierarchies is the concept of hegemonic masculinity, which is the form of idealized masculinity that is culturally dominant in a given setting and represents power and authority. Connell & Messerschmidt contend that socially dominant masculinities subordinate not only femininities, but also other masculinities that are less culturally valued. They argue that different dynamics of masculine hegemony characterize different types of gendered relationships that may contribute to gender-based inequities. These dynamics include *external hegemony*, which refers to the institutionalization of men's dominance over

women and *internal hegemony*, which refers to the social ascendancy of one group of men over other men.

This view of masculine gender hierarchies implies that the social mechanisms contributing to disparate violence and HIV risks among women relative to men via external hegemony may similarly contribute to disparate violence and HIV risks among men with socially marginalized masculinities – such as men with effeminate gender presentations and men with non-heterosexual identities – via internal hegemony. To date no known studies have applied the TGP framework to examine the ways in which masculine gender hierarchies influence violence and HIV risks among men with socially marginalized masculinities.

There is emerging evidence, however, which suggests that men with marginalized masculinities often face social and health-related disadvantages relative to other men. A study with Black South African gay and bisexual men found that gender nonconforming men experienced a greater amount of discrimination compared to their gender conforming counterparts (Cook et al., 2013). Research also suggests that openly gay and bisexual men in South Africa face an increased risk of non-partner sexual violence victimization. A study by Theron (1994) found that as many as 22% of gay hate crimes in South Africa involve the rape of the victim. Research with MSM in Soweto found that gay-identified MSM were at significantly higher risk for HIV infection than non-gay-identified MSM (Lane et al., 2011). In-depth interviews with MSM in South African township communities have also revealed that gay-identified men who describe their gender identity as feminine often face homophobic verbal harassment from healthcare workers when accessing sexual health services (Lane et al., 2008).

Limitations of Existing Literature

A notable limitation of the existing literature on this topic has been a narrow focus on the socially marginalized masculinities of certain groups of MSM relative to other MSM. While the findings from previous studies demonstrate a consistent pattern of social and health-related risks associated with marginalized gender presentations and sexual identities, the high rate of male-on-male violence among the general population of South African men and the limited application of theory-driven research on this topic warrant further examination of the phenomenon. More work is needed to investigate how men's gender presentations and sexual identities operate within broader structures of gender and power and how they may contribute to violence victimization and HIV risk.

The Present Study

This study sought to address these concerns by testing an application of the theory of gender and power to examine gender- and sexuality-related disparities in violence and HIV risks among a sample of men with diverse sexual identities, attractions, and behaviors. We proposed a conceptual model (Figure 1) to test a set of relationships between two indicators of marginalized masculinities, three major TGP constructs, and two indicators of health status. Indicators of marginalized masculinities included non-heterosexual sexual identities and nonconforming or 'effeminate' gender presentations. The sexual division of labor was measured with indicators of socioeconomic status, including education, food security, and housing security. The structure of cathexis was measured using indicators of beliefs regarding gendered social norms. The sexual division of power was measured using indicators of male-on-male sexual violence victimization, physical intimate partner violence (PIPV), and experiences of homophobic

violence and harassment. Finally, two indicators of health status were represented in the model, including measures of depressive symptoms and HIV status.

In accordance with the theoretical propositions of the TGP, we hypothesized four sets of relationships among the model constructs. First we predicted relationships between marginalized masculinities and the constructs representing the three TGP social structures:

H1: Men with more marginalized (a) sexual identities and (b) gender presentations experience greater socioeconomic disadvantage (division of labor).

H2: Men with more marginalized (a) sexual identities and (b) gender presentations experience increased violence victimization (division of power).

H3: Men with more marginalized (a) sexual identities and (b) gender presentations believe in less conservative gender norms (cathexis).

Next, we hypothesized a set of relationships among the three TGP constructs:

H4: Men with greater socioeconomic disadvantage (division of labor) experience increased violence victimization (division of power).

H5: Men with greater socioeconomic disadvantage (division of labor) believe in more conservative gender norms (cathexis).

We also hypothesized relationships between the TGP constructs and mental health and HIV status:

H6: Men with greater socioeconomic disadvantage (division of labor) report more depressive symptoms.

H7: Men with greater socioeconomic disadvantage (division of labor) are at increased risk of HIV infection.

H8: Men with more violence exposures (division of power) report more depressive symptoms.

H9: Men with more violence exposures (division of power) are at increased risk of HIV infection.

H10: Men who believe in more conservative gender norms (cathexis) report fewer depressive symptoms.

Finally, we predicted indirect relationships between marginalized masculinities and health status:

H11: More marginalized (a) sexual identities and (b) gender presentations are indirectly associated with HIV seropositivity.

H12: More marginalized (a) sexual identities and (b) gender presentations are indirectly associated with greater depressive symptoms.

The model also predicted that the following indicators will covary based on theoretical rationale: gender presentation with sexual identity and depressive symptoms with HIV status.

Methods

Procedure

The data were collected from May – August 2014 from men seeking HIV testing at two men's sexual health clinics in metropolitan Cape Town. The recruitment sites included a clinic located near the Cape Town city center and a clinic located in a nearby partially informal township. The clinics were chosen in part because they offered targeted outreach to MSM and were known in their communities for providing MSM-friendly services. This ensured that men with non-heterosexual identities and behaviors would be

overrepresented in the study sample relative to the general population to address the research questions.

Clinic attendees were eligible to participate in the study if they were seeking voluntary HIV counseling and testing (VCT), were at least 18 years old, and had been sexually active with a man or woman within the last year. Men who met these conditions, as determined by a pre-screen assessment during patient check-in, were approached by a research staff member and invited to participate in the study. The men were provided an overview of the study procedures, which included completing a 45-minute questionnaire using an audio computer-assisted self-interview device prior to HIV testing, and linking their de-identified HIV test result with their de-identified questionnaire responses. Separate written informed consent was obtained from all men who agreed to participate for the questionnaire and for accessing HIV test results. The questionnaire was available in English and isiXhosa. Participants were compensated with an R80 (then about $8) grocery voucher for their time and R20 (then about $2) cash for transportation expenses.

All study protocols were approved by U.S. and South African research ethics committees, as well as local city and provincial health departments. Of the 750 men who consented to participate in the study, 726 (96.8%) completed the questionnaire, and 713 (95.1%) completed subsequent HIV testing.

Measures

Demographic, Sexual and Relationship Characteristics

Participants were asked to report on individual demographic characteristics including *age*, *race* and *employment* within the last year. *Relationship status* was measured with a question asking participants to identify the type of their current or most recent

relationship within the past 12 months. Participants who indicated that their current or most recent relationship was with permanent partner or a spouse were coded as 1= permanent/married or 0 = non-permanent/unmarried. *Sexual history with women* was assessed with the question "Over your whole life, how many women have you had vaginal, oral or anal sex with? Please think about all the women, including your wife, girlfriend, once-offs, and sex workers." *Sexual history with men* was assessed with the question "Over your whole life, how many men have you had, oral or anal sex with? Please think about all the men, including your husband, boyfriend, once-offs, and sex workers."

Gender Presentation & Sexual Identity

Three items were used to measure the latent construct of *gender presentation.* Participants were asked "In general, how feminine do you think you are?", "How feminine do you think you act and behave?", and "How feminine do you think you appear and come across to others?". Response options were arranged on a 5-point Likert scale and ranged from 1 = not at all to 5 = extremely. The three items had high internal consistency (α=.87). *Sexual identity* was measured using a single question and thus was treated as an observed variable rather than a latent construct. Participants were asked how they would describe their sexual identity and provided with response options including gay or homosexual, bisexual, straight or heterosexual, transgender or transsexual, and other. In order to compare marginalized and non-marginalized sexual identities, responses were collapsed such that straight or heterosexual = 1 and all others = 0.

Sexual Division of Labor

Three variables were used to measure acquired risks in this domain. *Education* was measured using the question "What is your level of education?" and response options ranged from 1 = no school to 7 = higher education degree completed. *Food security* was measured by summing 8 items that assessed how often participants did not have enough food or enough money for food over the last 12 months (α=.86). An example item is "In the last 12 months how often have you went a whole day without food because you did not have enough food or enough money for food?" with response options ranging from 1 = every day to 5 = never. *Housing security* was measured by summing 4 items with yes/no response options (α=.82). An example item is "In the last 12 months, has there been a time when you couldn't afford a place to stay or when you couldn't pay the rent?". Housing security questions were reverse coded such that higher scores across the SDL constructs indicated higher socioeconomic status.

Sexual Division of Power

The sexual division of power was measured using three variables: homophobic abuse and harassment, physical intimate partner violence, and male-male sexual violence. *Homophobic abuse and harassment* was measured by summing 6 items (α=.91) that assessed participants' experiences during adulthood in which they were harassed or victims of violence because of their gender presentation or perceived sexual orientation. An example item is "As an adult, how often have you been hit or beaten up because someone thought you were gay or attracted to other men?" Response options for these questions were placed on a 4-point scale ranging from 1 = many times to 4 = never. *Physical intimate partner violence (PIPV)* was measured by summing 5 items from the WHO Violence Against Women Instrument (WHO, 2005), which were revised to be

gender non-specific (α=.88). An example item is "How often has any man or woman you were involved with slapped you or threw something at you which could hurt you?" Participants were given three response options, which included "never," "once," and "more than once". *Male-male sexual violence* was measured using two items with yes/no response options. The items included "Has a man who was your sexual partner ever forced you to have sex or made you afraid to say no to sex?" and "Has a man who was not your sexual partner ever forced you to have sex or made you afraid to say no to sex?" The responses to these two question were consolidated to allow for comparison across MSM and non-MSM.

Affective Social Norms (Cathexis)

The Gender Equitable Men Scale (Pulerwitz & Barker, 2008) was used to measure gendered social norms. A subset of items from the original scale underwent minor revisions in order to make the questions more generalizable to heterosexual and non-heterosexual men alike. Following these revisions and subsequent data collection, the scale items were analyzed using exploratory factor analysis. The results of the analysis indicated the presence of three sub-scales, which were then used to identify three separate constructs measuring the affective social norms component of the structure of cathexis. These constructs included sexual beliefs, violence beliefs, and generalized masculinity beliefs. Each of the items across the three sub-scales were presented as statements and participants were asked to indicate their level of agreement using with each statement using a 4-point Likert scale ranging from 1= strongly agree to 4 = strongly disagree. *Sexual beliefs* were measured with 7 items (α=.78) and included items such as "I would be outraged if my main partner asked me to use a condom." *Violence beliefs* were

measured using 5 items (α=.83). An example item is "It is okay for a man to hit his partner for refusing sex." *Masculinity beliefs* were assessed with 6 items (α= .68), and included statements such as "It disgusts me when I see a man acting like a woman."

Mental Health Status

Depressive symptoms were assessed to measure mental health status using the 20-item Center for Epidemiologic Studies Depression (CESD) Scale (Radloff, 1977). The CESD Scale items (α=.94) were summed to calculate a depression score such that higher scores indicate more depressive symptoms. The depression score was treated as a single observed variable in analyses.

HIV Serotatus

HIV status was determined via rapid antibody testing of blood samples collected during VCT. Non-reactive samples were identified as HIV-negative. Reactive samples were re-tested with another rapid antibody test before being confirmed as HIV-positive. Indeterminate test results were sent to the National Health Laboratory Services (NHLS) lab in Johannesburg for confirmatory testing.

Statistical Analysis

First, we calculated descriptive statistics for demographic, sexual, and relationship characteristics of the total sample and each clinic sub-sample. Descriptive statistics were also calculated for all manifest indicator variables of the 4 latent variables as well as the 3 observed variables included in the model. Pearson correlation analysis was then conducted to examine the strength of associations between all variables included in subsequent analyses. The distributions of continuous variables were examined to verify normality.

Next, we employed structural equation modeling (SEM) using a two-step process. In the first step, confirmatory factor analysis was used to test a measurement model and examine the relationships between the latent variables and their manifest indicator variables. This procedure was used to calculate standardized factor loadings for each indicator variable. In the second step, a structural model was tested to examine the hypothesized relationships among the latent variables and with the observed variables included in the model. Following the test of the hypothesized model, a final revised (trimmed) model was tested in which non-significant pathways were removed.

We used Mplus version 7.31 software (Muthén & Muthén, 2012) to perform mean- and variance-adjusted weighted least squares (WLSMV) estimation, appropriate for structural equation models with categorical and continuous outcomes (Muthén & Muthén, 2012). Goodness of model fit was evaluated using the chi-square test, the Root Mean Square Error of Approximation (RMSEA, acceptable fit if <0.06), Bentler's Comparative Fit Index (CFI, acceptable fit if > 0.95), and the Tucker-Lewis Index (TLI, acceptable fit if >0.95). Full information maximum likelihood estimation was used to handle missing data. A power analysis indicated that the sample size was sufficiently powered to detect acceptable model fit using RMSEA. A minimum sample size of 159 participants was needed to detect acceptable fit for a model with 76 degrees of freedom (where null RMSEA = 0.05; alternative RMSEA = 0.08; power = 0.8; type 1 error rate = 0.05) (Preacher & Coffman, 2006).

Results

Characteristics of the Study Sample

The age range of the sample was 18 – 89 years (M=28.42 years; SD=8.89). 72.59% of participants identified as Black, 19.42% as Coloured, 5.37% as White, 1.65% as Indian, and 0.96% as other. 48.90% of participants were employed within the last year. 27.76% of men reported any history of consensual sex with another man and 20.72% reported consensual sex with a man within the last year. MSM most frequently reported their sexual identity as straight / heterosexual (42.00%), followed by bisexual (28.00%), gay / homosexual (18.00%) and other (12.00%). The HIV prevalence rate among participants was 7.57%. The full set of sample characteristics are presented in Table 1 along with site-specific sample characteristics for each recruitment clinic.

Bivariate Correlations among Manifest Indicators and Observed Variables

The bivariate correlations for all manifest indicators and the observed variables included in the model are presented in Table 2. Most of the correlation coefficients were highly significant ($p<.01$), particularly among indicators of the same latent construct.

Confirmatory Factor Analysis: Measurement Model

The measurement model consisted of 4 latent constructs and 12 indicator variables. Each of the 4 latent constructs was measured by 3 manifest indicator variables. The results of the measurement model indicated good model fit (χ^2 (df, p) = 119.899 (48, $p<0.000$); RMSEA = 0.045; CFI = 0.987; TLI = 0.982). All factor loadings were substantial and significant ($p<0.000$). Standardized factor loadings are presented in Figure 2.

Structural Equation Modeling: Hypothesized Model

The initial hypothesized model presented in Figure 1 includes the indicator variables for each latent construct and predicted structural paths among latent constructs and the three observed variables also included in the model. SEM analysis of the hypothesized model indicated acceptable model fit (χ^2 (df, p) = 232.705 (76, p<0.000); RMSEA = 0.052; CFI = 0.972; TLI = 0.962). Standardized coefficients for all hypothesized model pathways are presented in Figure 3. Six of the hypothesized pathways were statistically significant (p<0.05) and four were not significant. The four hypotheses that were not supported were: H1(b): gender presentation was not associated with socioeconomic disadvantage; H3(a): sexual identity was not associated with conservative gender norms; H3(b): gender presentation was not associated with conservative gender norms; H6: socioeconomic disadvantage was not directly associated with depression; and H9: violent exposures were not associated with HIV status. Additionally, HIV status did not significantly covary with depression.

Structural Equation Modeling: Final Model

The final structural model with standardized path coefficients is presented in Figure 4 and unstandardized and standardized parameter estimates and significance levels for the model are presented in Table 3. The findings for the final model indicated good model fit (Chi2 (df, p) = 208.228 (83, p<0.000); RMSEA = 0.046; CFI = 0.977; TLI = 0.971). We found significant (p<0.05) direct effects supporting the following study hypotheses:

H1: Men with more marginalized (a) sexual identities experienced greater socioeconomic disadvantage.

H2: Men with more marginalized (a) sexual identities and (b) gender presentations experienced increased violence victimization.

H4: Men with greater socioeconomic disadvantage experienced increased violence victimization.

H5: Men with greater socioeconomic disadvantage believed in more conservative gender norms.

H7: Men with greater socioeconomic disadvantage were at increased risk of HIV infection.

H9: Men with more violence exposures reported more depressive symptoms.

H10: Men who believed in more conservative gender norms reported fewer depressive symptoms.

We also found significant ($p<0.05$) indirect effects supporting the following study hypotheses:

H6: Socioeconomic disadvantage was indirectly associated with greater depressive symptoms.

H11: Marginalized (a) sexual identities were indirectly associated with HIV seropositivity.

H12: Marginalized (a) sexual identities and (b) gender presentations were indirectly associated with greater depressive symptoms.

Discussion

This study tested an application of the Theory of Gender and Power to examine pathways between gender-based constructs and South African men's self-reported history of violence victimization, depressive symptoms, and HIV serostatus. We specifically examined whether two indicators of marginalized masculinities – sexual identity and gender presentation – were directly related to socioeconomic disadvantage, history of

victimization, and beliefs in gendered social norms. We also examined whether those factors were associated with men's mental health and HIV status.

We found consistent and significant associations between both indicators of marginalized masculinities and men's history of violence victimization. Men with more feminine gender presentations and non-heterosexual identities were more likely to report violent experiences, including PIPV, sexual violence, and homophobic harassment. This violence was, in turn, associated with more depressive symptoms among the men in our study.

While both feminine gender presentations and non-heterosexual identities were associated with a greater risk of violence, only non-heterosexual identities were associated with socioeconomic disadvantage. This finding may reflect a phenomenon documented in previous research, which has shown that men who publicly disclose non-heterosexual identities often risk losing financial support from social and familial networks (Murdock et al., 2016). This finding is particularly notable since we found socioeconomic disadvantage to be significantly associated with HIV infection. However, due to the cross-sectional nature of the data, we were unable to establish the directionality of this relationship.

We were surprised to find that neither indicator of marginalized masculinities was associated with beliefs in gendered social norms. In fact, gender normative beliefs were only significantly associated with socioeconomic status. This finding suggests that men with marginalized masculinities are similarly influenced by hegemonic gender norms as other men, and are therefore just as likely to hold beliefs that adhere to gender hierarchies. This finding may also reflect a theory that many marginalized men often

align themselves with hegemonic gender norms as a passing behavior that distracts from the stigma associated with their marginalization (Cheng, 1999). The significant relationship we found between socioeconomic disadvantage and belief in conservative gender norms also supports this premise. Since hegemonic masculinity is associated with power, men with limited socioeconomic power might seek to gain patriarchal privileges through performance of hegemonic masculinity (Coston & Kimmel, 2012).

We also found that beliefs in gendered social norms were significantly associated with depressive symptoms, such that men with more conservative gender beliefs were significantly less likely to report depressive symptoms. There are a number of possible interpretations of the nature of this relationship. For instance, depression may be exacerbated when men's beliefs about how men should think, feel, and behave do not align with restrictive gender norms (Mahalik & Cournoyer, 2000). Another interpretation of this phenomenon is that men's beliefs about gender norms, which often emphasize masculine traits such as emotional stoicism and self-reliance, may contribute to a form of masked depression among men who strongly adhere to such views (Addis, 2008).

While most of our study hypotheses were supported with statistically significant findings, notably we did not find a significant relationship between violence victimization and HIV status. Other research on this topic has shown mixed results (Baral et al., 2009; Dunkle et al., 2013) There have been a number of studies, however, that have demonstrated an increased risk of HIV among female victims of violence (Dunkle et al., 2004; Jewkes et al., 2010). One possible explanation for this discrepancy may be that gender norms influence men's and women's responses to violence victimization in different ways. Research has shown that women who experience violence have less

power to negotiate condom use (Fox et al., 2007; Maman et al., 2000) and are more likely to engage in coping behaviors, such as alcohol use, which increases their likelihood of engaging in unprotected sex (Kaysen et al., 2007). Men who experience violence may experience different condom negotiation power dynamics and may engage in a different set of coping mechanisms in response to violence victimization. More research is needed to understand gender differences in the relationship between violence victimization and HIV status.

Overall, our SEM indicated good model fit and most hypotheses stemming from the theory of gender power were supported. The findings suggest that the utility of gender-based theoretical frameworks not only applies to our understanding of health disparities among women, but also among men, i.e., such frameworks can also contribute to our understanding of gender-based influences on men's health and well-being. This study has demonstrated that men who do not adhere to hegemonic ideals of masculinity face an elevated risk of violence and experience indirect constraints on their HIV and mental health status. In practice, these findings suggest that violence prevention efforts should not only seek to create more gender equitable norms between men and women, but should also address perceptions of what constitutes reputable expressions of masculinity. Such efforts would not only be valuable in response to the high rates of violence victimization experienced by South African men, but would also serve as strategies to confront gendered social influences on men's HIV risk and mental health status.

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Appendix: Tables & Figures

Table 1: Characteristics of the Study Sample

Characteristic	*Overall*	*City Center*	*Township*
	% (N) Unless otherwise stated		
Sample Size (% of total sample)	726	221 (30.44%)	505 (69.56%)
Mean Age (SD)	28.42 (8.89)	34.69 (9.81)	25.67 (6.84)
18-25 years	47.25% (343)	17.65% (39)	60.20% (304)
>25 years	52.75% (383)	82.35% (182)	39.80% (201)
Employed within Last 12 Months	48.9% (355)	47.1% (104)	49.7% (251)
Race			
Black	72.59% (527)	20.81% (46)	95.25% (481)
Coloured	19.42% (141)	57.92% (128)	2.57% (13)
White	5.37% (39)	15.38% (34)	0.99% (5)
Indian	1.65% (12)	4.52% (10)	0.40% (2)
Other	0.96% (7)	1.36% (3)	0.79% (4)
Married / Permanent Relationship	42.15% (306)	35.75% (79)	44.95% (227)
Sexual History			
Sex with Women Only	72.24% (523)	43.64% (96)	84.72% (427)
Sex with Men Only	2.76% (20)	5.91% (13)	1.39% (7)
Sex with Women & Men	25.00% (181)	50.45% (220)	13.89% (70)
HIV-Positive	7.57% (54)	7.69% (16)	7.52% (38)

SD = Standard deviation

Table 2: Correlation Coefficients of Observed Indicator Variables

Variables	*1*	*2*	*3*	*4*	*5*	*6*	*7*
1. Sexual Identity	1						
Gender Presentation							
2. General Fem.	-0.11**	1					
3. Fem. Behavior	-0.12**	0.79**	1				
4. Fem. Appearance	-0.11**	0.73**	0.78**	1			
Division of Labor							
5. Education	0.10**	-0.01*	-0.01*	-0.01*	1		
6. Food Security	0.25**	-0.03**	-0.03**	-0.03**	0.21**	1	
7. Housing Security	0.16**	-0.02*	-0.02*	-0.02**	0.14**	0.36**	1
Division of Power							
8. Harassment	-0.28**	0.15**	0.16**	0.15**	-0.12**	-0.32**	-0.21**
9. PIPV	-0.12**	0.07**	0.07**	0.06**	-0.05**	-0.14**	-0.25**
10. Sexual Violence	-0.38**	0.20**	0.21**	0.20**	-0.16**	-0.43**	-0.28**
Normative beliefs							
11. Sexual Beliefs	0.14**	-0.02*	-0.02*	-0.02*	0.12**	0.30**	0.20*
12. Viol. Beliefs	0.13**	-0.01*	-0.02*	-0.01*	0.11**	0.28**	0.18**
13. Masc. Beliefs	0.07**	-0.01*	-0.01*	-0.01*	0.06**	0.16**	0.10*
Health Status							
14. CESD	-0.14**	0.09**	0.09**	0.08**	-0.05**	-0.14**	-0.09**
15. HIV	-0.07*	0/01	0.01	0.01	-0.06*	-0.16**	-0.10*

Variables	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*
8. Harassment	1							
9. PIPV	0.17**	1						
10. Sexual Violence	0.52**	0.23**	1					
Normative beliefs								
11. Sexual Beliefs	-0.18**	-0.08**	-0.24**	1				
12. Viol. Beliefs	-0.16**	-0.07**	-0.21**	0.48**	1			
13. Masc. Beliefs	-0.09**	-0.04**	-0.12**	0.27**	0.24**	1		
Health Status								
14. CESD	0.20**	0.09**	0.27**	-0.02	-0.01	-0.01	1	
15. HIV	0.09*	0.04*	0.12**	-0.09*	-0.08*	-0.04*	0.01	1

*p<.05; **P<.01

Table 3: Results of the Structural Equation Modeling Analysis

Parameter Estimate	*Unstandardized Coefficient (Standard Error)*	*Standardized Coefficient (Standard Error)*
Measurement Model		
Gender → General femininity	1.00	0.86 (0.01)**
Gender → Feminine behavior	1.07 (0.02)**	0.92 (0.01)**
Gender → Feminine appearance	0.99 (0.02)**	0.85 (0.01)**
Labor → Education	1.00	0.28 (0.04)**
Labor → Food security	20.02 (3.38)**	0.74 (0.04)**
Labor → Housing security	2.98 (0.62)**	0.50 (0.05)**
Power → Homophobic harassment	1.00	0.62 (0.04)**
Power → PIPV	0.22 (0.04)**	0.29 (0.04)**
Power → Sexual violence	0.25 (0.03)**	0.82 (0.04)**
Norms → Sex beliefs	1.00	0.73 (0.04)**
Norms → Violence beliefs	0.63 (0.08)**	0.65 (0.04)**
Norms → Masculinity beliefs	0.42 (0.06)**	0.37 (0.04)**
Direct Effects		
Sex ID → Labor	0.22 (0.04)**	0.34 (0.05)**
Sex ID → Power	-1.60 (0.41)**	-0.21 (0.05)**
Gender → Power	0.85 (0.21)**	0.22 (0.05)**
Labor → Power	-7.49 (1.53)**	-0.63 (0.06)**
Labor → Norms	5.14 (0.87)**	0.56 (0.05)**
Labor → HIV	-0.74 (0.30)*	-0.21 (0.08)**
Power → CESD	0.46 (0.09)**	0.37 (0.05)**

Norms → CESD	0.21 (0.09)*	0.13 (0.06)*
Covariance: Gender & Sex ID	-0.05 (0.02)**	-0.13 (0.04)**
Indirect Effects		
Sex ID → HIV	-0.16 (0.07)*	-0.07 (0.03)*
Sex ID → CESD	-1.26 (0.22)**	-0.13 (0.02)**
Gender → CESD	0.39 (0.11)**	0.08 (0.02)**
Labor →CESD	-2.39 (0.64)**	-0.16 (0.04)**

*p<.05; **P<.01

Figure 1: Hypothesized Model

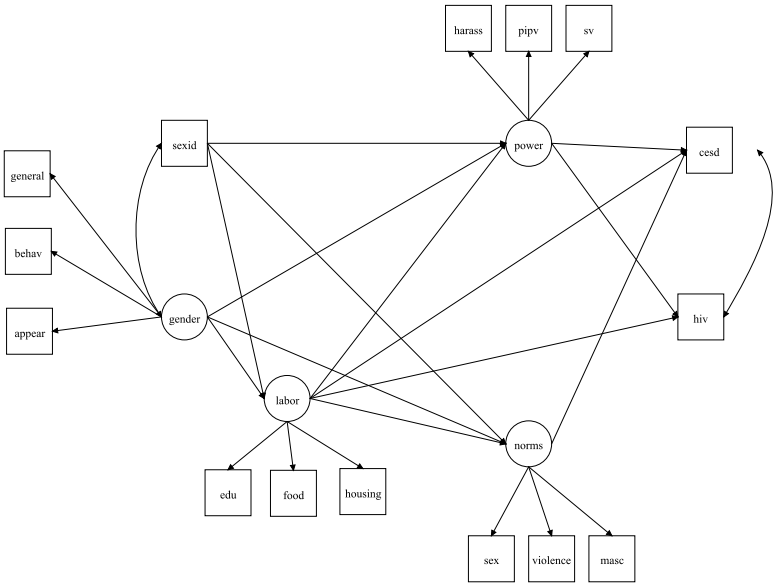


Figure 2: Standardized Measurement Model Results

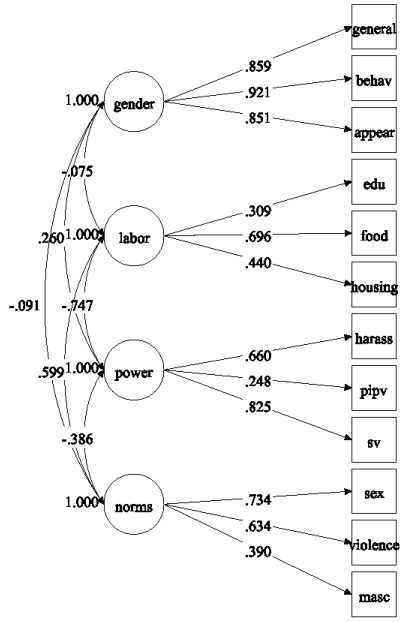


Figure 3: Standardized SEM Results: Hypothesized Model

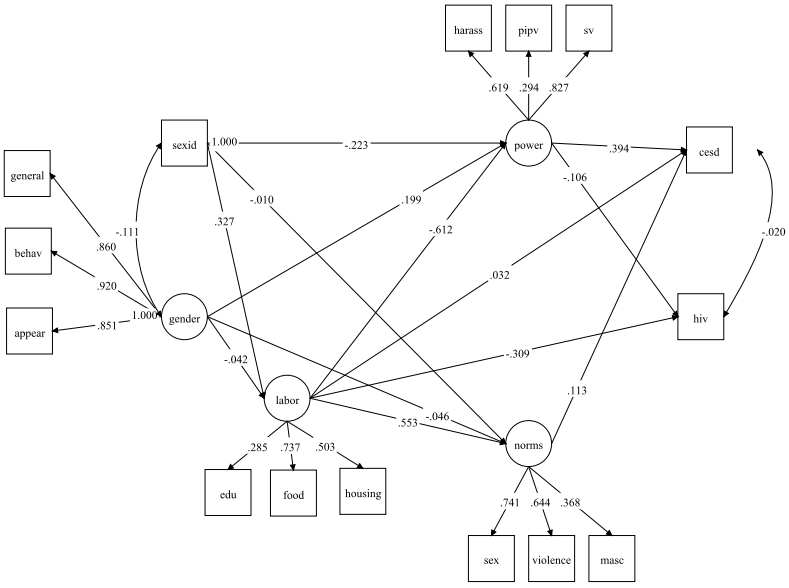
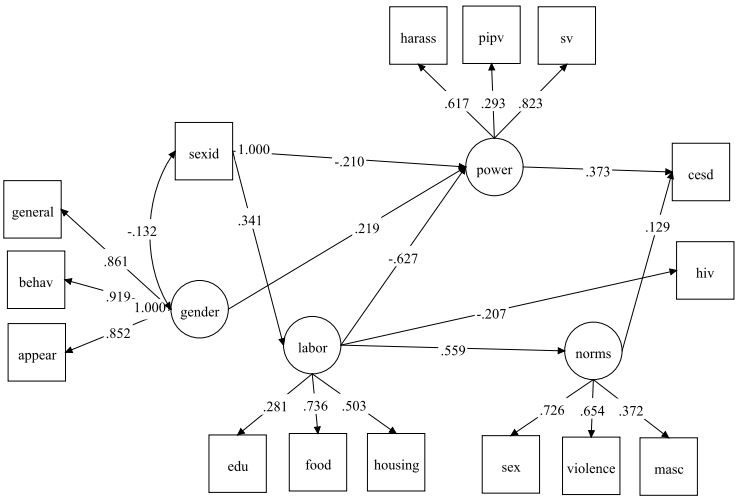


Figure 4: Standardized SEM Results: Final Model



Chapter 4: A group-level path analysis comparing social and behavioral correlates of sexual violence perpetrated against men and women by MSM and non-MSM in South Africa

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Abstract

Background: There is a growing body of literature examining the drivers of sexual violence perpetrated by men against women in South Africa. Recent research has also documented high levels of male-on-male sexual violence in the region. Yet, no known studies have examined whether the correlates of sexual violence perpetration differ by the gender of the victim or the consensual sexual partnering of the perpetrator. This study seeks to compare the correlates of sexual violence perpetrated by men who have consensual sex with men (MSM) and non-MSM against men and against women.

Method: We collected cross-sectional survey data (N=724) from men seeking HIV testing at two public sexual health clinics in metropolitan Cape Town. We conducted a multiple group path analysis, comparing social and behavioral determinants of sexual violence perpetration against men and women by MSM and non-MSM.

Results: Path analysis revealed mostly overlapping drivers of sexual violence perpetrated against men and women by both groups, including hypermasculine attitudes, socioeconomic status, and physical intimate partner violence. Participation in crime was associated with sexual violence against men only among non-MSM, while transactional sex was associated with sexual violence against men only among MSM.

Conclusions: This study provides a systematic examination of how social and behavioral factors operate similarly and differently as drivers of sexual violence perpetrated again men and women by MSM and non-MSM. The findings suggest that relationship factors may be important drivers of male-on-male sexual violence among MSM and male-on-female sexual violence among both groups, while peer-related factors may be a unique

driver of male-on-male sexual violence among non-MSM. Programmatic and policy efforts to prevent sexual violence perpetration should reflect these distinctions.

Keywords: Sexual Violence, Rape; Forced Sex; Perpetration, Gender, MSM, Masculinity

Introduction

In response to high rates of male sexual violence against women in South Africa, a large body of research has identified social and behavioral factors associated with perpetration of such violence in the general population. While high rates of male-on-female sexual assault have long been established (Jewkes & Abrahams, 2002; Jewkes et al., 2009), recent research has also revealed a high prevalence of male-on-male sexual violence. Population-based estimates indicate that nearly 1 in 10 South African men have been sexually assaulted by another man during their lifetime, including 34.4% of men who have consensual sex with men (MSM) and 8.1% of non-MSM (Dunkle et al., 2013). Yet, little is known about the factors associated with men's sexual violence against men, and less is known about how factors associated with sexual violence may vary depending on the consensual sexual partnering of the perpetrator and the gender of the victim.

In the absence of extensive research on this topic, studies of male-on-female sexual assault point to several possible correlates of men's sexual violence against men. One of the most consistently identified correlates of male-on-female sexual violence is socioeconomic status (SES). Studies have shown that men who are socially marginalized by factors such as poor educational attainment and economic insecurity are more likely to perpetrate sexual violence against women (Jewkes et al., 2006; Jewkes et al., 2013). There is also a large body of evidence demonstrating that men who experience significant trauma during childhood, including physical and sexual abuse, are more likely to perpetrate sexual violence than other men (Dunkle et al., 2004; Jewkes et al., 2011a).

Gender norms heavily influence many attitudes and behaviors that are often associated with sexual assault. Research on attitudinal correlates of rape has consistently

demonstrated a link between sexual assault and hypermasculine attitudes that emphasize exaggerated hegemonic masculine traits such as strength, aggression, and sexuality (Johnson & Knight, 2000; Moore & Stuart, 2005; Santana et al., 2006). Additionally, gender inequitable constructions of masculinity have been found to be associated with rape supportive attitudes (Petersen, Bhana & McKay, 2005) and rape perpetration (Jewkes et al., 2011a) among South African men. Hegemonic constructions of masculinity also often promote many behavioral correlates of sexual assault. Men who engage in hypermasculine behaviors such as alcohol use (Abrahams et al., 2004; Dunkle et al., 2006), transactional sex (Dunkle et al., 2007; Simbayi et al., 2006), and physical intimate partner violence (PIPV) (Jewkes et al., 2012; Jewkes et al., 2016) have been found to be more likely to perpetrate sexual violence.

Although these social and behavioral factors are all well-established correlates of male-on-female sexual assault, the extent to which they also correlate to male-on-male sexual violence is unclear. Previous research suggests that some social and behavioral drivers of sexual assault may vary depending on the consensual sexual behavior of the perpetrator and their relationship to the victim. In particular, some studies have found important differences between factors associated with sexual violence perpetrated against intimate partners and non-partners. These studies suggest that PIPV perpetration may be a more reliable predictor of partner rape (Dartnall & Jewkes, 2013), while non-partner rape may be more strongly associated with peer-related factors, such as gang membership, peer pressure, and drug use (Jewkes et al., 2006; Jewkes et al., 2010). These findings indicate that some drivers of male-on-male sexual assault may differ for men with and without consensual male partners. For example, the high rate of sexual assault

perpetrated in gay hate crimes (Theron, 1994) may reflect a significant influence of peer-related factors on male rape perpetration by non-MSM.

Finally, there is evidence suggesting that gender norms and hierarchies may influence sexual violence perpetration in different ways depending on the degree of social marginalization associated with the perpetrator's masculine identity. Sociological research and theory has long recognized use of violence as a reassertion of masculinity by men facing a loss of respectable forms of masculine identity (Campbell, 1992; Connell, 2012; Messerschmidt, 1993; Morrell, 2001). This phenomenon has been well-documented in qualitative research, which has found that men facing a loss of respectable masculinity due to social and economic marginalization are often more likely to perpetrate violence, including sexual assault (Bourgois, 1996; Matthews, Jewkes & Abrahams, 2011; Niehaus, 2002). However, the nuances of this phenomenon have gone largely unexamined in quantitative research. It is unclear whether social or economic marginalization are similarly linked with sexual violence perpetration against women and men, and whether the marginalized masculinities often ascribed to consensual MSM play a role in sexually violent behavior.

The Present Study

This study examined whether correlates of sexual violence perpetration differ by the gender of the victim and the gender(s) of consensual sexual partners of the perpetrator. We conducted a group-level path analysis, comparing MSM and non-MSM, to examine whether SES, childhood trauma, and hypermasculine attitudes were associated with gender-specific sexual violence perpetration, either directly or indirectly

via a set of gendered behaviors commonly associated with sexual assault. The hypothesized path model is presented in Figure 1.

Methods

Procedure

We collected cross-sectional survey data from men seeking voluntary HIV counseling and testing (VCT) at two public sexual health clinics in metropolitan Cape Town. Men seeking VCT were eligible to participate in the study if they were at least 18 years old and if they were sexually active within the last 12 months. Patients were pre-screened during check-in and men who met our eligibility criteria were invited to participate in the study. Study participation involved completing a 45-minute questionnaire using an audio computer-assisted self-interview and providing consent to link participants' de-identified questionnaire responses with their de-identified HIV test results. 750 men consented to participate in the study, of whom 726 (96.8%) completed the questionnaire and 724 (96.5%) disclosed whether they had ever had male sexual partners. The questionnaire was available in English and isiXhosa.

Ethics

Ethics approval for all study protocols was given by the University of Cape Town Faculty of Health Sciences Human Research Ethics Committee, the Emory University Institutional Review Board, the Western Cape Department of Health, and the City Health Department of Cape Town. Participants received a grocery voucher worth R80 (then about $8) as compensation for their time and R20 (then about $2) cash to cover transportation expenses.

Measures

MSM Status

We identified men who have sex with men (MSM) using the question "Over your whole life, how many men have you had oral or anal sex with? Please think about all the men, including your husband, boyfriend, once-offs, and sex workers." Participants who reported one or more male oral/anal sexual partners were identified as MSM and coded as 1 and those reporting none were identified as non-MSM and coded as 0.

SES

We created an SES index using factor scores to weight four variables: education, food security, housing security, and employment. Response options for educational attainment ranged from 1 = no school to 7 = higher education degree completed. We measured food security by summing 8 items assessing how often participants did not have enough food or enough money for food over the last 12 months (α=.86). We measured housing security by summing 4 items assessing how often participants went without housing, had unreliable housing, or had difficulty paying for housing over the last 12 months (α=.82). We measured employment with the question "In the last 12 months have you had any paid work?" The index was scored such that higher scores corresponded to higher socioeconomic status.

Childhood Trauma

We measured traumatic experiences before age 18 using a 13-item version of the Childhood Trauma Scale (Bernstein et al., 2003; Jewkes et al., 2011b). The questions assessed emotional abuse and neglect (4 items), physical abuse (4 items), sexual abuse (3 items), and physical hardship (2 items) using 4-point Likert responses ranging from 1 =

never to 4 = very often. Scale sores ranged from 13 – 52 and the items had high internal consistency (α=.87).

Hypermasculinity

We measured hypermasculine attitudes using a revised version (Peters, Nason & Turner, 2007) of the Hypermasculinity Index (HMI) (Mosher & Sirkin, 1984). The HMI included 26 questions measuring perceptions of danger as exciting (8 items), fighting (8 items), and calloused sexual attitudes (10 items). Each question used a phrase-completion format in which participants were presented with the stem of a sentence along with two possible endings for that stem. The two opposing phrases were arranged along a continuum ranging from 1 to 10, allowing participants to indicate their level of agreement with that extreme.

A typical question stem was 'when I go to parties:' with response options ranging from 1 = 'I like wild parties' to 10 = 'I like quiet parties with good conversations.' Following focus group testing, we made minor revisions to the original wording of 4 HMI items to adapt the questions for cultural relevancy. Due to the large number of HMI items, we calculated mean HMI scores, rather than summative scores, to aid interpretation of the results. The HMI was scored such that higher scores corresponded to more hypermasculine attitudes. Possible values ranged from 1 – 10 and observed values ranged from 1 – 7.62 (α=.98).

Gendered Behaviors

Alcohol use was measured using the AUDIT-C (Bush et al., 1998) 3-item alcohol screening instrument. The items assessed how often participants drink alcohol, how many drinks they have on a typical day, and how often they have six or more drinks on one

occasion. The instrument is scored on a scale of 0 – 12, and each question has 5 answer choices ranging from 0 – 4. The 3 items had high internal consistency (α=.82).

We measured *participation in crime* using 5 yes/no questions. The questions assessed whether participants had ever been arrested, ever been sent to prison, owned a firearm, owned any other weapon, or ever been a member of a gang (Jewkes et al., 2011b). 'No responses were coded as 0 and 'yes' responses were coded as 1 and the items were summed to create a score ranging from 0 – 5 (α=.79).

We measured *transactional sex* by asking participants whether they had ever given or promised to give any of the following items to a woman or man to get them to have sex: clothes or cosmetics, a place to stay or a place to sleep, a cell phone or cell phone airtime, alcohol, drugs, cash, or transportation (Jewkes et al., 2011b). Participants who indicated that they had given one or more of these items in exchange for sex were coded as 1 and those who had not were coded as 0.

Physical intimate partner violence (PIPV) perpetration was measured using 5 gender-neutral questions adapted from the WHO Violence Against Women Instrument (WHO, 2005), which has been widely used in violence research (Jewkes et al., 2011b; Kim et al., 2009; Pronyk et al., 2006). The questions asked participants whether they had ever perpetrated different acts of physical violence towards a sexual or romantic partner. Response options included 'never,' 'once,' and 'more than once.' Responses were dichotomized such that men with a history of PIPV perpetration were coded as 1 and men with no such history were coded as 0.

Sexual Violence Perpetration

We measured sexual violence perpetration using 4 questions adapted from the WHO Violence Against Women Instrument (Jewkes et al., 2011b; Kim et al., 2009; Pronyk et al., 2006; WHO, 2005). The questions were asked separately with regard to female partners (when applicable), male partners (when applicable), female non-partners, and male non-partners. For each scenario, the questions asked whether participants had "physically forced someone to have sex when they did not want to,' 'forced someone to have sex when they were too drunk to say whether they wanted it or not,' 'forced someone to do something sexual that they found degrading or humiliating,' or 'forced someone to have sex without a condom when they wanted to use a condom.' Response options for each question included 'never,' 'once,' and 'more than once.'

Female sexual violence (FSV) perpetration was coded as 1 if participants answered 'once' or 'more than once' to any of the items assessing female partner and female non-partner perpetration and coded as 0 if participants had responded to all female perpetration items with 'never.' Male sexual violence (MSV) perpetration was coded as 1 if participants answered 'once' or 'more than once' to any of the items assessing male partner and male non-partner perpetration and coded as 0 if participants had responded to all male perpetration items with 'never.' While only non-partner MSV perpetration was measured among non-MSM, both partner and non-partner FSV perpetration was measured among a majority of MSM who reported ever having female partners.

Statistical Analysis

All analyses were conducted using STATA 13.0. First we carried out descriptive analyses to examine the distribution of socioeconomic variables, childhood trauma, hypermasculine attitudes, gendered behaviors, and sexual violence perpetration by MSM

status. Proportions were compared using Pearson's chi squared test and means of continuous variables were compared using t-tests. Next, we used Wald tests to examine group-level invariance across the parameters included in our hypothesized model. We determined that equality constraints were conceptually appropriate for two parameters with significant invariance across groups. These parameters included the direct pathway between hypermasculinity and crime, and the covariance between alcohol use and transactional. Sex. All other parameters were free to vary across MSM and non-MSM in model testing.

During a first stage of model testing, we tested our hypothesized model with the two parameter constraints mentioned above by conducting a multi-group path analysis using full information maximum likelihood estimation with missing values. We then tested a more parsimonious model in which paths that were non-significant across both groups were systematically removed. The trimmed model retained one non-significant path (between hypermasculinity and male sexual violence perpetration) that was approaching significance ($p = 0.060$).

We evaluated goodness of model fit using the chi-square test, the Root Mean Square Error of Approximation (RMSEA, acceptable fit if <0.06), Bentler's Comparative Fit Index (CFI, acceptable fit if > 0.95), and the Tucker-Lewis Index (TLI, acceptable fit if >0.95). A power analysis indicted that 167 participants were needed to detect acceptable fit for our hypothesized model, which had 66 degrees of freedom (where null RMSEA = 0.05; alternative RMSEA = 0.08; power = 0.8; type 1 error rate = 0.05) (Preacher & Coffman, 2006).

Results

Descriptive Statistics

201 study participants (27.76%) reported any history of consensual sex with another man, among whom 91.88% (n=181) also reported a history of consensual sex with a woman. The age range of the sample was 18 – 89 years (M=28.42 years SD=8.89). Most participants identified as Black (72.59%), followed by Coloured (19.42%), White (5.37%), Indian (1.65%), and other (0.96%). Bivariate associations between social and behavioral characteristics and MSM status are reported in Table 1. There were significant differences between MSM and non-MSM on all social and behavioral variables included in the model except for alcohol use. 3.67% (n=19) of non-MSM and 18.18% (n=36) of MSM reported non-partner male sexual violence (MSV) perpetration, and 32.83% (n=65) of MSM reported MSV perpetration against a partner. 6.76% (n=35) of non-MSM and 26.77% (n=53) of MSM reported non partner female sexual violence (FSV) perpetration, while 14.86% (n=77) of non-MSM and 37.37% (n=74) of MSM reported FSV perpetration against a partner.

Multiple Group Path Analysis

Group path analysis results for the hypothesized model (Figure 1) indicated poor fit of the data (χ^2 (2) = 11.026; RMSEA = 0.112; CFI = 0.989; TLI = 0.629). Four paths were highly non-significant across both groups and were removed from the model. These paths included SES → crime; crime → FSV; Trauma → FSV; and SES → PIPV. The pathway between hypermasculinity and male-on-sexual violence perpetration was approaching significance among non-MSM (p=0.060) and was therefore retained in the model. Group path analysis results for the trimmed model indicated good model fit (χ^2

(10) = 17.046; RMSEA = 0.044; CFI = 0.991; TLI = 0.942). Direct effects for all paths retained in the final model are reported in Table 2. Standardized coefficients for significant paths are presented for non-MSM in Figure 2 and for MSM in Figure 3.

The indirect effects between the SES, childhood trauma, and hypermasculinity variables and the two sexual violence perpetration variables are presented in Table 3 and total (direct + indirect) effects for all paths are reported in Table 4. Among the pathways with non-significant direct effects, we found significant ($p<0.05$) indirect and total effects for the following paths: Hypermasculinity → MSV (both groups); childhood trauma → FSV (non-MSM); and hypermasculinity → FSV (MSM).

Discussion

At the bivariate level, we found many important social and behavioral differences between MSM and non-MSM. MSM reported greater socioeconomic disadvantage, more traumatic experiences during childhood, and more hypermasculine attitudes. The lower socioeconomic status reported by MSM mirrors other study findings from South Africa (Dunkle et al., 2013) and may reflect losses of social and familial support experienced by many MSM who disclose their sexual behavior (Murdock et al., 2016). Disparities in childhood maltreatment by MSM status have also been documented in previous research (Balsam, Rothblum & Beauchaine, 2005; Corliss, Cochran & Mays, 2002; Saewyc et al., 2006). This research suggests that such disparities may reflect increased child abuse associated with disclosure of minority sexual attraction or performance of gender atypical behavior during childhood.

Our finding that MSM were more likely to report hypermasculine attitudes supports a prominent sociological theory, which posits that socially marginalized men

often over perform traits associated with hegemonic masculinity as a passing behavior and to distract from the stigma associated with their marginalization (Cheng, 1999; Coston & Kimmel, 2012). This theory may also help explain the higher levels of stereotypically masculine behaviors reported by MSM, including participation in crime and transactional sex, as well as high levels of violence perpetration, including physical intimate partner violence (PIPV) and sexual violence against both men and women. Empirical research suggests that internalized homophobia may be a possible driver of increased violence perpetration among MSM. Studies have shown a significant association between internalized homophobia and physical and sexual violence perpetration within same-sex relationships (Edwards & Sylaska, 2013; Murray et al., 2007). Further research is needed, however, to determine whether internalized homophobia among MSM is also associated with increased violence against women.

The path analysis results provide a nuanced examination of factors associated with four distinct contexts of sexual violence perpetration. These contexts include: (1) violence against women by non-MSM; (2) violence against women by MSM; (3) violence against men by MSM; and (4) violence against men by non-MSM. Our findings on the correlates of sexual violence against women by non-MSM largely mirror findings from previous studies. Each of the social and behavioral correlates included in the model was significantly associated with sexual violence against women, except for participation in crime.

However, there are two important caveats to these findings. First, we did not find a significant direct relationship between childhood trauma and male-on-female sexual violence (FSV). Yet, we did find a significant indirect relationship between these two

variables, which was mediated by alcohol use, transactional sex, and PIPV. Another important caveat is that the direction of the relationship between alcohol use and FSV among non-MSM was negative, and thus in contradiction with previous study findings. It should be noted that the effect size of this relationship was relatively small and the finding was not highly significant. Additionally, this relationship was not statistically significant at the bivariate level. Considering these factors and previous research findings, this relationship should be interpreted with caution and warrants further examination.

Among MSM, we found mostly overlapping correlates of sexual violence against women. The only exceptions were alcohol use and childhood trauma, which were not significantly associated with sexual violence against women by MSM. However, our results indicated an indirect relationship between childhood trauma and FSV that was approaching significance for MSM ($p=0.058$). Further research with a larger MSM sample size is needed to examine whether this relationship exists. A direct relationship between hypermasculine attitudes and FSV also approached significance among MSM ($p=0.053$), however, the indirect relationship between these two variables was statistically significant. Despite these minor differences, the results as a whole suggest that many of the same factors are associated with sexual violence against women by MSM and non-MSM alike.

While we found mostly overlapping correlates of sexual violence against women, the path analysis results revealed several important distinctions between factors associated with MSM and non-MSM perpetration of sexual violence against men. Among MSM, the same set of factors associated with sexual violence against women were also

associated with sexual violence against men, with an additional significant association found between childhood trauma and male-on-male sexual violence (MSV). Among non-MSM, there were two important differences between correlates of sexual violence against men and women. For this group, participation in crime was significantly associated with sexual violence against men, while transactional sex was not.

These differences likely reflect distinctions between partner and non-partner sexual violence perpetration. Across the four contexts of sexual violence that we examined, participation in crime was only associated with non-partner MSV perpetrated by non-MSM. This suggests that non-MSM may be more likely to perpetrate sexual violence against men in contexts of gang membership, incarceration, and gay hate crimes.

This was also the only context in which transactional sex was not associated with sexual violence perpetration. This finding suggests that transactional sex may be uniquely associated with sexual violence perpetration against consensual partners. Notably, SES was negatively associated with transactional sex among MSM. The direction of this relationship likely reflects a dynamic in which MSM who lack financial independence face increased social and familial pressures to conceal their sexual identity (Murdock et al., 2016). Low SES MSM may therefore be more reliant on transactional partnerships for undisclosed same-sex encounters.

In conclusion, our study findings are largely consistent with previous research examining the correlates of sexual violence against women and reveal mostly overlapping correlates for MSM and non-MSM perpetrators. Among MSM, the same set of factors were associated with sexual violence against both men and women, with an additional influence of childhood trauma on MSV perpetration. Among non-MSM,

participation in crime was uniquely associated with sexual violence against men, while transactional sex was uniquely associated with sexual violence against women.

These findings highlight the importance of addressing hypermasculine gender norms and sources of social marginalization in programmatic and policy efforts to prevent sexual violence against both men and women. Previous violence prevention programs have shown that promoting gender equitable norms and behaviors via community education and mobilization is an effective strategy to prevent violence against women (Hossain et al., 2014; Viitanen & Colvin, 2015). Our findings suggest that similar strategies may be effective for preventing male-on-male sexual violence. Community-based violence prevention programs should integrate efforts to challenge gender norms associated with homophobia and same-sex relationship power imbalances..

Our findings also indicate that efforts to prevent sexual violence against men by non-MSM should explicitly address violence that occurs in contexts related to crime. Violence prevention programs should adopt specific strategies targeting sexual violence in jails and prisons, gang rape, and homophobic violence. Community education, advocacy, and partnerships with criminal justice institutions are needed to promote social change and policy development addressing these concerns.

Finally, the significant relationships that we found between childhood trauma and sexual violence perpetration highlight a need for life-course approaches to violence prevention and programs that engage young men. Together, these recommendations address a critical need for evidence-based intervention strategies to prevent male-on-male sexual violence perpetration. The high prevalence of this violence highlights an urgent need for programmatic efforts to implement and evaluate these strategies.

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Appendix: Tables & Figures

Table 1: Social and Behavioral Characteristics of the Sample by MSM Status

	Non-MSM (n = 523)		**MSM** (n = 201)		
Characteristic (Range)	*% / Mean*	*95% CI*	*% / Mean*	*95% CI*	*p-value*
SES Index (5.15 – 25.00)	17.02	16.69 – 17.35	14.92	14.32 – 15.51	**0.000**
Childhood Trauma (13 – 52)	18.73	18.29 – 19.16	23.12	22.13 – 24.12	**0.000**
HMI (1 – 7.62)	4.02	3.90 – 4.14	4.70	4.52 – 4.89	**0.000**
Alcohol (0 – 12)	3.27	3.00 – 3.54	3.65	3.20 – 4.10	0.074
Crime (0 – 5)	0.77	0.66 – 0.88	1.79	1.54 – 2.03	**0.000**
Transactional Sex	43.59	39.39 – 47.89	68.16	61.37 – 74.25	**0.000**
PIPV	38.34	34.19 – 42.67	59.47	52.23 – 66.25	**0.000**
MSV	3.67	2.24 – 5.69	38.89	32.23 – 45.88	**0.000**
FSV	17.57	14.52 – 21.10	44.44	37.65 – 51.46	**0.000**

Table 2: Direct Effects

		Non-MSM		**MSM**	
		Unstandardized Coefficient (Standard Error)	*Standardized Coefficient (Standard Error)*	*Unstandardized Coefficient (Standard Error)*	*Standardized Coefficient (Standard Error)*
Alcohol	← SES	**0.101 (0.044)*** **	**0.124 (0.044)*** **	0.091 (0.056)	0.118 (0.073)
	← Trauma	**0.088 (0.033)*** **	**0.143 (0.045)*** **	0.032 (0.033)	0.069 (0.072)
	← HMI	0.153 (0.098)	0.070 (0.045)	**0.463 (0.189)** **	**0.185 (0.074)** **
TS	← SES	-0.002 (0.006)	-0.014 (0.044)	**-0.019 (0.008)** **	**-0.170 (0.068)** **
	← Trauma	**0.017 (0.004)*** **	**0.170 (0.044)*** **	0.003 (0.005)	0.038 (0.070)
	← HMI	**0.044 (0.015)*** **	**0.127 (0.044)*** **	**0.066 (0.026)*** **	**0.185 (0.071)*** **
Crime	← Trauma	**0.046 (0.011)*** **	**0.188 (0.043)*** **	**0.044 (0.017)*** **	**0.182 (0.068)*** **
	← HMI	**0.140 (0.036)*** **	**0.160 (0.040)*** **	**0.140 (0.036)*** **	**0.107 (0.028)*** **
PIPV	← Trauma	**0.026 (0.004)*** **	**0.269 (0.042)*** **	**0.010 (0.005)** **	**0.140 (0.069)** **
	← HMI	**0.045 (0.015)*** **	**0.132 (0.043)*** **	**0.108 (0.027)*** **	**0.290 (0.070)*** **
MSV	← Alcohol	**-0.006 (0.003)** **	**-0.096 (0.041)** **	-0.006 (0.009)	-0.039 (0.058)
	← TS	-0.015 (0.016)	-0.039 (0.041)	**0.315 (0.065)*** **	**0.303 (0.060)*** **
	← Crime	**0.045 (0.006)*** **	**0.302 (0.040)*** **	-0.001 (0.014)	-0.004 (0.049)
	←	**0.043 (0.017)*** **	**0.111 (0.043)*** **	**0.361 (0.062)*** **	**0.362 (0.059)*** **

	PIPV				
	← SES	**-0.004 (0.002)****	**-0.085 (0.041)****	**-0.017 (0.007)****	**-0.151 (0.061)****
	← Trauma	**0.004 (0.002)****	**0.097 (0.043)****	**0.007 (0.003)****	**0.096 (0.048)****
	← HMI	0.011 (0.006)*	0.082 (0.042)*	0.015 (0.024)	0.041 (0.066)
FSV	← Alcohol	**-0.012 (0.005)****	**-0.095 (0.040)****	0.010 (0.008)	0.063 (0.055)
	← TS	**0.102 (0.031)*****	**0.132 (0.039)*****	**0.297 (0.062)*****	**0.280 (0.057)*****
	← PIPV	**0.282 (0.032)*****	**0.359 (0.038)*****	**0.433 (0.060)*****	**0.425 (0.055)*****
	← SES	**-0.011 (0.004)*****	**-0.106 (0.039)*****	**-0.014 (0.007)****	**-0.118 (0.058)****
	← HMI	**0.042 (0.011)*****	**0.156 (0.040)*****	0.045 (0.024)*	0.120 (0.062)*

*p<0.10 **p<0.05 ***p<0.01

Table 3: Indirect Effects

		Non-MSM		**MSM**	
		Unstandardized Coefficient (Standard Error)	*Standardized Coefficient*	*Unstandardized Coefficient (Standard Error)*	*Standardized Coefficient*
MSV	← SES	-0.001 (0.00)	-0.011	**-0.006 (0.003)****	-0.056
	← Trauma	**0.002 (0.001)*****	0.066	0.004 (0.003)	0.059
	← HMI	**0.007 (0.002)*****	0.051	**0.057 (0.016)*****	0.154
FSV	← SES	-0.001 (0.001)	-0.014	-0.005 (0.003)*	-0.040
	← Trauma	**0.008 (0.002)*****	0.105	0.005 (0.003)*	0.075
	← HMI	**0.015 (0.005)*****	0.058	**0.071 (0.017)*****	0.187

*p<0.10 **p<0.05 ***p<0.01

Table 4: Total Effects

		Non-MSM		MSM	
		Unstandardized Coefficient (Standard Error)	*Standardized Coefficient (Standard Error)*	*Unstandardized Coefficient (Standard Error)*	*Standardized Coefficient (Standard Error)*
Alcohol	← SES	**0.101 (0.044)*** **	**0.124 (0.044)*** **	0.091 (0.056)	0.118 (0.073)
	← Trauma	**0.088 (0.033)*** **	**0.143 (0.045)*** **	0.032 (0.033)	0.069 (0.072)
	← HMI	0.153 (0.098)	0.070 (0.045)	**0.463 (0.189)** **	**0.185 (0.074)** **
TS	← SES	-0.002 (0.006)	-0.014 (0.044)	**-0.019 (0.008)** **	**-0.170 (0.068)** **
	← Trauma	**0.017 (0.004)*** **	**0.170 (0.044)*** **	0.003 (0.005)	0.038 (0.070)
	← HMI	**0.044 (0.015)*** **	**0.127 (0.044)*** **	**0.066 (0.026)*** **	**0.185 (0.071)*** **
Crime	← Trauma	**0.046 (0.011)*** **	**0.188 (0.043)*** **	**0.044 (0.017)*** **	**0.182 (0.068)*** **
	← HMI	**0.140 (0.036)*** **	**0.160 (0.040)*** **	**0.140 (0.036)*** **	**0.107 (0.028)*** **
PIPV	← Trauma	**0.026 (0.004)*** **	**0.269 (0.042)*** **	**0.010 (0.005)** **	**0.140 (0.069)** **
	← HMI	**0.045 (0.015)*** **	**0.132 (0.043)*** **	**0.108 (0.027)*** **	**0.290 (0.070)*** **
MSV	← Alcohol	**-0.006 (0.003)** **	**-0.096 (0.041)** **	-0.006 (0.009)	-0.039 (0.058)
	← TS	-0.015 (0.016)	-0.039 (0.041)	**0.315 (0.065)*** **	**0.303 (0.060)*** **
	← Crime	**0.045 (0.006)*** **	**0.302 (0.040)*** **	-0.001 (0.014)	-0.004 (0.049)
	←	**0.043 (0.017)*** **	**0.111 (0.043)*** **	**0.361 (0.062)*** **	**0.362 (0.059)*** **

	PIPV				
	← SES	**-0.005 (0.002)****	-0.096 (n/a)	**-0.024 (0.007)*****	-0.207 (n/a)
	← Trauma	**0.006 (0.002)*****	0.163 (n/a)	**0.011 (0.004)*****	0.155 (n/a)
	← HMI	**0.018 (0.006)*****	0.133 (n/a)	**0.072 (0.026)*****	0.195 (n/a)
FSV	← Alcohol	**-0.012 (0.005)****	**-0.095 (0.040)****	0.010 (0.008)	0.063 (0.055)
	← TS	**0.102 (0.031)*****	**0.132 (0.039)*****	**0.297 (0.062)*****	**0.280 (0.057)*****
	← PIPV	**0.282 (0.032)*****	**0.359 (0.038)*****	**0.433 (0.060)*****	**0.425 (0.055)*****
	← SES	**-0.012 (0.004)*****	-0.120 (n/a)	**-0.019 (0.007)*****	-0.158 (n/a)
	← Trauma	**0.008 (0.002)*****	0.106 (n/a)	0.005 (0.003)*	0.075 (n/a)
	← HMI	**0.057 (0.011)*****	0.214 (n/a)	**0.116 (0.026)*****	0.306 (n/a)

*p<0.10 **p<0.05 ***p<0.01

Figure 1: Hypothesized Model

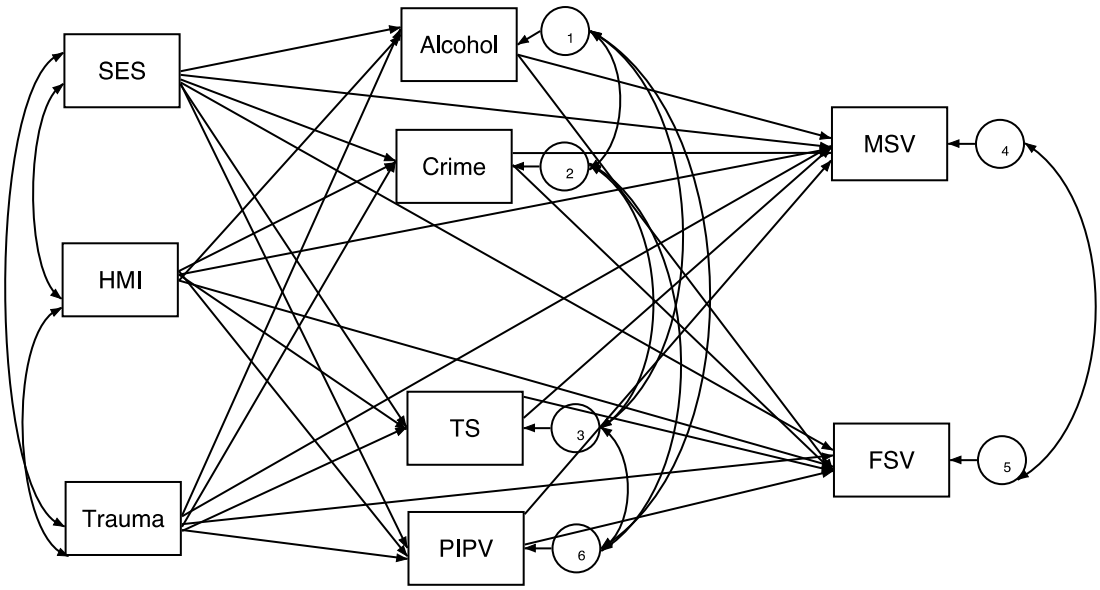


Figure 2: Standardized Coefficients for Paths Significant at *p<0.06 among Non-MSM

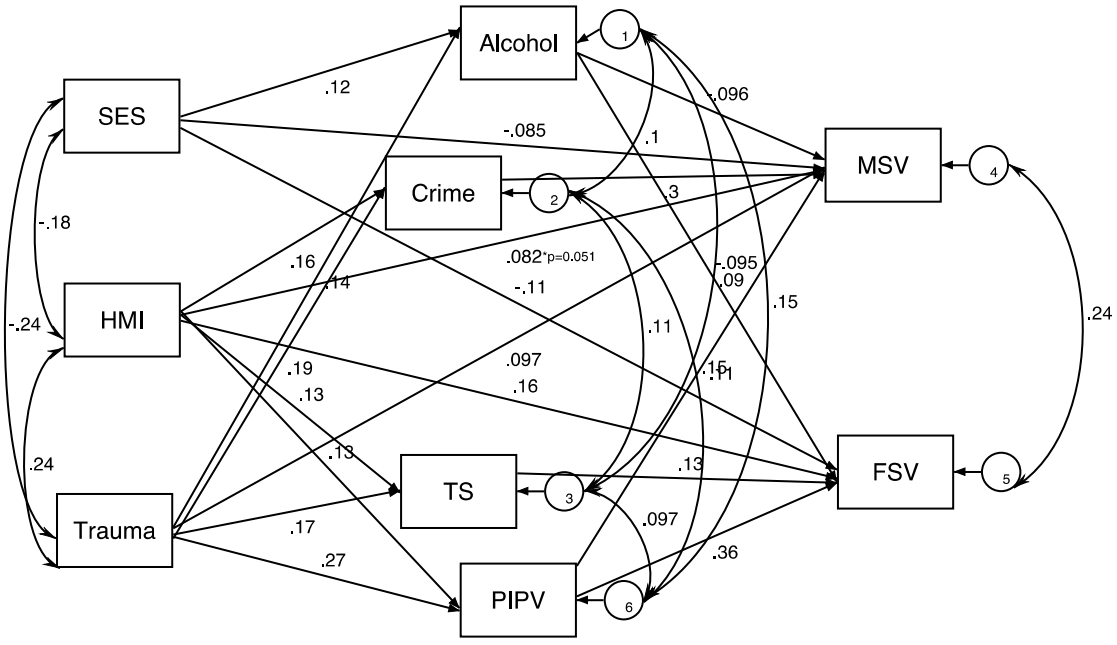
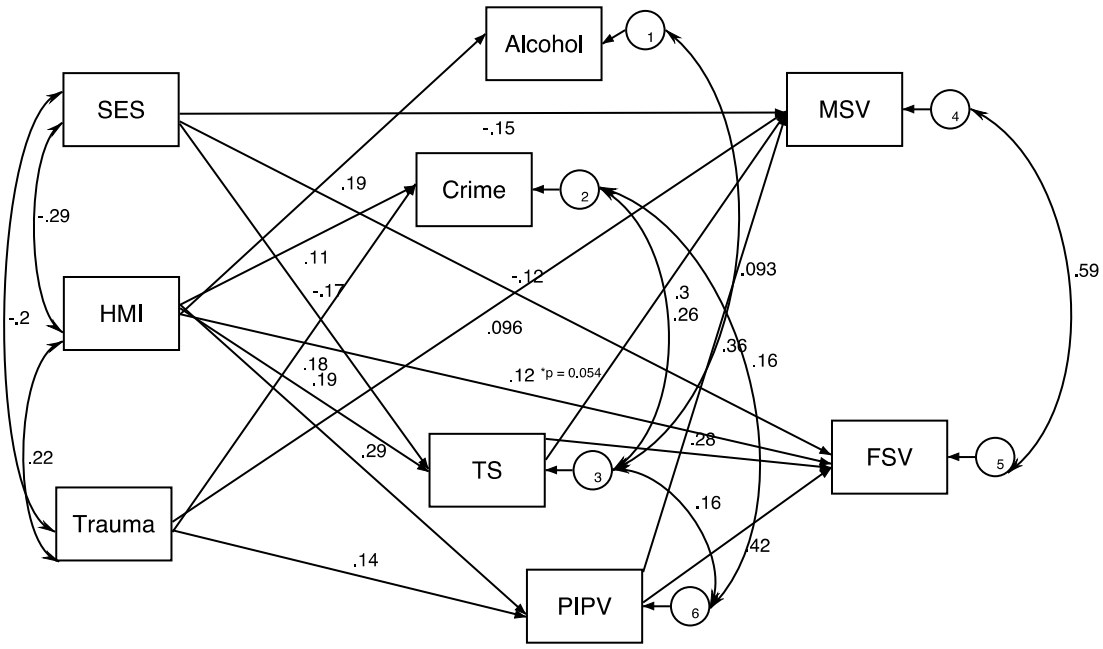


Figure 3: Standardized Coefficients for Paths Significant at *p<0.06 among MSM



Chapter 5: Conclusion

This mixed-methods dissertation study provides an in-depth examination of male-on-male physical intimate partner violence (PIPV) and sexual violence in South Africa. It identifies social and behavioral factors associated with both violence victimization and perpetration, and examines relationships between this violence and mental and sexual health outcomes. The study applies sociological gender theory to examine parallels between male-on-male violence and male-on-female violence, and identifies unique factors associated with male-on-male violence. The most significant study findings, their limitations, and their implications for future public health research and practice are described below.

Male-On-Male PIPV and Sexual Violence Victimization

Addressing a lack of theory-driven research on this topic, we tested an application of the Theory of Gender and Power (Connell, 1987) to examine whether gender theory can be applied to identify factors associated with male-on-male violence victimization. Previous research has shown that power imbalances associated with male-female gender hierarchies contribute to social disadvantages and violence victimization among women (Jewkes & Abrahams, 2002; Petersen, Bhana, & McKay, 2005). This study tested an extension of this theoretical framework to examine whether masculine gender hierarchies contribute to social disadvantages and violence victimization among socially marginalized men in similar ways.

Using structural equation modeling (SEM), we found that two indicators of marginalized masculinities– non-heterosexual identity and feminine gender presentation - were directly associated with male-on-male violence victimization. We also found an

indirect relationship between non-heterosexual identity and violence victimization that was mediated by socioeconomic disadvantage. These relationships also emerged in our qualitative study findings. In-depth interviews revealed that gender non-conforming men, as well as gay and bisexual identified men, were often targets of homophobic violence, including sexual assault. Our qualitative results also indicated that men who lacked financial independence, which was a marker of respected manhood, faced increased risks of violence within same-sex relationships.

These findings demonstrate how gender theory provides a useful framework for understanding male-on-male PIPV and sexual violence. Men who are socially marginalized for not meeting hegemonic masculine ideals face elevated risks of violence victimization, both directly and indirectly through socioeconomic disadvantage associated with their gender marginalization. Notably, we also found indirect relationships between indicators of marginalized masculinities and depression and HIV status. This suggests that the utility of gender-based frameworks for understanding health disparities among men extends beyond examinations of violence.

Our findings suggest that male-on-male PIPV and sexual violence may too be understood through a lens of gender-based violence, which is commonly applied to examine male-on-female violence. This carries significant implications for violence prevention efforts. Policies and programs that aim to prevent violence against women often seek to do so by challenging inequitable gender norms that marginalize women. Based on these findings, efforts to prevent violence against men should adopt similar strategies that seek to challenge gender norms that marginalize many men.

Male-On-Male Sexual Violence Perpetration

This study addressed a paucity of research identifying social and behavioral factors associated with male-on-male sexual violence perpetration. In particular, no known studies had previously examined whether correlates of sexual violence perpetration differ by the gender of the victim or the consensual sexual partnering of the perpetrator. Using multiple group path analysis, we examined whether a set of factors commonly associated with male-on-female sexual violence perpetration were also associated with male-on-male sexual violence perpetration. We examined these relationships by the MSM status of the perpetrator to determine whether factors associated with sexual violence against men differ among perpetrators who have had consensual sex with men and those who have not.

The results of our path analysis revealed mostly overlapping correlates of sexual violence perpetrated against men and women by both MSM and non-MSM. We found that hypermasculine attitudes, socioeconomic status, and physical intimate partner violence were significant correlates of sexual violence against both men and women perpetrated by both MSM and non-MSM. Our finding that hypermasculine attitudes were associated with each context of sexual violence perpetration provides further evidence demonstrating how gender norms influence male-on-male violence and male-on-female violence in similar ways.

We also identified differences between factors associated with sexual violence against men perpetrated by MSM and non-MSM. In particular, we found that transactional sex was associated with sexual violence against men only among MSM perpetrators, while participation in crime was associated with sexual violence

against men only among non-MSM perpetrators. These findings suggest that transactional sex may be uniquely associated with sexual violence perpetration against consensual partners. The significant association we found between participation in crime and male-on-male sexual violence perpetration among non-MSM may reflect previously documented sexual violence perpetrated against men in contexts of gang membership, incarceration, and gay hate crimes (Gear, 2007; Niehaus, 2002; Theron, 1994).

In-depth interviews also pointed to a relationship between internalized homophobia and male-on-male sexual violence perpetration, particularly among men who have sex with both men and women (MSM/W). We found that many MSM/W who had not publicly disclosed their sexuality indicated that their sexual relationships with men were often restricted to short-term partners and partners who would not disclose their same-sex sexual activity. These men often characterized their same-sex relationships as less legitimate than their opposite-sex relationships and downplayed their intimacy, possibly reflecting efforts to rationalize internal stigma. Sometimes, these types of short-term undisclosed relationships were associated with violence perpetrated by straight identified men against those who were more closely identified as gay.

Taken together, these findings reaffirm a significant influence of masculine gender norms and hierarchies on male-on-male violence. Study results establishing a relationship between participation in crime and male-on-male sexual assault by non-MSM, and results suggesting a relationship between internalized homophobia and male-on-male sexual assault by MSM/W each seem to demonstrate how male-on-male sexual violence is often used as a strategy to assert masculine dominance.

These findings are consistent with our study findings regarding male-on-male violence victimization.

Overlapping Violence Victimization and Perpetration

The study findings revealed a shared commonality of risk factors for both male-on-male violence victimization and perpetration. Specifically, various forms social marginalization influenced both violence victimization risks and violence perpetration risks. We found that socioeconomic disadvantage was associated with male-on-male violence victimization and sexual violence perpetration against both men and women. Other indicators of marginalization, including non-heterosexual identities and effeminate gender presentations were associated with men's risk of violence victimization in both qualitative and quantitative study findings. The qualitative results also revealed that, among straight-identified MSM/W, suspicions of homosexuality were often sources of conflict with female partners, and feelings of internalized homophobia were associated with male-on-male violence perpetration.

Although it was not a primary focus of the study, important patterns of overlapping victimization and perpetration also emerged from the results. In particular, men who were victims of childhood trauma, including physical and sexual violence, were more likely to perpetrate sexual violence against both men and women. Taken together, these findings indicate a need for further research examining whether adult victims of male-on-male sexual violence and PIPV are subsequently more likely to perpetrate violence against men and violence against women, and whether such relationships are moderated by indicators of social marginalization.

Mental and Sexual Health Implications

Male-on-male PIPV and sexual violence carry significant implications for mental and sexual health. We found a direct association between violence victimization and depressive symptoms in structural equation modeling. Although we did not find a significant association between violence and HIV status in SEM analyses, our qualitative study findings revealed situational contexts of male-on-male sexual violence that may carry increased HIV risks. Specifically, our qualitative results suggest that condoms are rarely used by non-partner perpetrators of male-on-male sexual violence. Qualitative interviews also revealed that many men who are victims of male-on-male PIPV and sexual violence often do not report these experiences due to fear of being mocked by police.

Such institutional stigma leaves the mental and sexual health needs of many victims of violence unaddressed. Victims in need of therapy for depression may not seek help due to fear of being stigmatized. Institutional stigma also has important implications for HIV risk. First, stigma may limit men's access to post-exposure prophylaxis (PEP) following a violent sexual encounter. Additionally, many MSM, who face an increased risk of HIV infection (Dunkle et al., 2013), may benefit from pre-exposure prophylaxis PrEP. Yet, stigma around male-on-male violence may restrict access to PrEP among MSM with violent partners. Violence prevention efforts must address institutional stigma associated with male-on-male IPV and sexual violence in law enforcement and healthcare. Changing social expectations about the consequences of violence perpetration may be an effective strategy to prevent violence, and changing expectations about the

consequences of violence victimization may help prevent HIV and empower victims to seek needed care.

Study Limitations

This dissertation study addressed a lack of theory-driven and qualitative research examining male-on-male PIPV and sexual violence in South Africa. However, our study findings are limited by several important factors. First, the cross-sectional nature of our data prevents us from making any causal inferences about factors associated with violence or about relationships between violence and mental and sexual health outcomes. Additionally, our reliance on a clinic-based study sample may have contributed to bias. Specifically, men who present for health services may be qualitatively different from those who do not with regard to violent experiences. Men with a history of violence may either be overrepresented in clinic-based samples due to the health complications associated with violence or perhaps even underrepresented due to healthcare barriers posed by stigma associated with violence. Despite these limitations, this study fills an important gap in research on this topic and provides initial evidence for future studies to build upon.

Future Recommendations

Considering the methodological limitations of this study, longitudinal research is needed to establish temporal relationships between male-on-male violence and factors associated with such violence. Longitudinal research would also allow for causal examinations of relationships between male-on-male violence and mental and sexual health outcomes. Population-based research is also needed to address the limitations of our clinic-based sample. Such research would help determine the representativeness of

this clinic-based sample, and establish whether sexual violence victims and perpetrators are over- or under-represented in clinical populations. This information is particularly important for estimating the impact of potential violence prevention and treatment strategies implemented by health service providers.

Despite these methodological limitations, our findings consistently demonstrated that masculine gender hierarchies and related social stigma influence male-on-male PIPV and sexual violence. The findings indicate a need for MSM-focused HIV prevention programs to integrate violence prevention strategies within new and existing efforts. The findings also suggest that efforts to challenge masculine gender stereotypes may be an effective strategy to prevent male-on-male violence and should be integrated within ongoing efforts to prevent violence against women. This study provides much needed empirical research examining factors associated with male-on-male PIPV and sexual violence victimization and perpetration in South Africa. The findings support the development of evidence-based policy and programmatic efforts to address this issue, and establish initial evidence, upon which future studies may build.

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