International Journal of Innovative Research and Scientific Studies, 7(2) 2024, pages: 420-428

IJIRSS
International Journal of Innovative Research & Scientific Studies

ISSN: 2617-6548

URL: www.ijirss.com

Receptivity of referral letters and partner notification practices for sexually transmitted infections among a population of men who have sex with men in South Africa: A qualitative study

Matshidiso Adelaide Malefo[1*], Olalekan Abdulwahab Ayo-Yusuf[2], Mathildah Mpata Mokgatle[3]

[1,3]*Department of Public Health, School of Healthcare Sciences, Sefako Makgatho Health Sciences University. Pretoria 0204, South Africa.*
[2]*School of Health systems and Public Health, University of Pretoria, Pretoria, South Africa.*

Corresponding author: Matshidiso Adelaide. Malefo (*Email: gomolemokarabo98@gmail.com*)

Abstract

Although an effective public health strategy to control transmission of sexually transmitted infection (STI) and promote linkage to care exists, little is known about the receptivity of patient referral letters and partner notification (PN) among men who have sex with men (MSM). A qualitative study was conducted involving MSM enrolled in a clinical trial. Individual exit interviews were done with purposefully sampled participants (n = 23) at month 12 from baseline. The study was conducted at a research institute located in a poorly resourced community in Gauteng Province, South Africa. The themes that emerged from the data during thematic content analysis were reaction to STI diagnosis on receiving a referral letter, receptivity of the referral letter and partner notification, STI treatment and usefulness of a referral letter, experiences of accessing healthcare services, nurses' attitudes towards the MSM, and the MSM's recommendations for improving health services. The findings suggest that the MSM were receptive to referral letters, which they believed allowed for earlier and easier access to treatment and provided the opportunity to embrace safer sexual practices. Nevertheless, many felt it was challenging to inform their sexual partners due to some being in casual or multiple sexual relationships. Some reported experiencing discrimination from nurses while seeking treatment. This study anticipated that it would be of importance to policymakers when designing and implementing policies on patient referral letters and partner notifications.

Keywords: Men who have sex with men, Partner notification, Qualitative study, Receptivity, Referral letter, Sexually transmitted infections, Tshwane North.

DOI: 10.53894/ijirss.v7i2.2646
Funding: This research is supported by the National Research Funding and Flemish government (Grant number: ZIUS2015AP021).
History: Received: 23 August 2023/**Revised:** 20 October 2023/**Accepted:** 9 January 2024/**Published:** 29 January 2024

Authors' Contributions: All authors contributed equally to the conception and design of the study. All authors have read and agreed to the published version of the manuscript.
Competing Interests: The authors declare that they have no competing interests.
Transparency: The authors confirm that the manuscript is an honest, accurate, and transparent account of the study; that no vital features of the study have been omitted; and that any discrepancies from the study as planned have been explained. This study followed all ethical practices during writing.
Institutional Review Board Statement: The Ethical Committee of the Sefako Makgatho Health Sciences University, South Africa has granted approval for this study on 6 June 2019 (Ref. No. SMUREC/H/168/2019: PG).
Publisher: Innovative Research Publishing

1. Introduction

In sub-Saharan Africa, the management of sexually transmitted infections (STIs) in men who have sex with men (MSM) is generally syndromic, with urethritis as the most common clinical presentation [1, 2]. Sexual behaviours, including the type of sexual partnership(s) and the force of infection in the sexual network, influence the risk of STI transmission [3]. Many STIs remain untreated because a huge proportion of infections are asymptomatic, in particular rectal and oropharyngeal infections [4, 5]. Despite the wide range of behavioural and biomedical interventions applied to interrupt the STI transmission chain, the prevalence of STIs remains high worldwide, with more than one million people being newly infected with STIs per day [6].

Partner notification (PN) is most effective in reducing STI transmission if it reaches individuals whose sexual behaviours and partnerships increase their STI risk. There are three different approaches to PN. These are: (i) patient referral, where the tested patient notifies his sexual partner(s) of a possible STI exposure and refers them to sexual health care services for screening; (ii) provider referral, where the health care professional notifies the sexual partner(s) of the tested patient; and (iii) contract referral, where the health care professional notifies the sexual partner(s) within an agreed time period in the event that the tested patient fails to do so [7]. PN involves the disclosure of private and often secret information that could impact a partnership [8].

Numerous studies have demonstrated that the type of partnership, the length of the relationship, the standards of communication between partners, and the availability of contact information all affect notification and communication about potential STI exposures [9, 10]. When applied successfully, PN helps end the transmission chain by decreasing the morbidity and mortality rates and reducing the societal and financial burden of STIs. Previous research has found that individuals are more likely to notify their main sexual partners of a possible STI diagnosis than partners who are seen as transmitters, casual, or one-time sexual partners before the onset of symptoms [11]. Although PN has become a common and effective practice in the worldwide control of STIs, research in this field is limited, especially among MSM [12]. Most of the existing evidence on the role of PN in behaviours related to STIs still focuses almost entirely on the Human Immunodeficiency Virus (HIV) without including other STIs [13]. The findings of this study will contribute vastly to the body of knowledge on the importance of the use of referral letters and partner notification in reducing STI infections and increasing STI treatment uptake among MSM. Moreover, this study enables health workers to facilitate effective service delivery when dealing with MSM. By offering insight into real-world implementation, this study contributes to obtaining a better perspective on STI referral letters and partner notifications among MSM. Hence, the objective of the present study was to assess the receptivity and views on the usage of referral letters and partner notification practices for sexually transmitted infections among a population of Men who have Sex with Men (MSM) in South Africa.

2. Methodology

2.1. Study Design

A qualitative, descriptive method was utilized to explore the understanding of the use of partner notification to address curable sexually transmitted infections in a population of Men who have Sex with Men in South Africa.

2.2. Study Population and Setting

The study population consisted of MSM who resided in Ga-Rankuwa, Tshwane North, Gauteng Province, South Africa. The study was conducted at the Medunsa Clinical Research Unit (MeCRU). MeCRU is a well-established and nationally recognized research unit appropriate to assist with recruiting MSM from communities and testing them. The site was also established for research that involves tests for HIV and STI's (rectal, genital, and oral swabs). The study population consisted of MSM who had completed their twelfth-month study visit as part of a clinical trial.

2.3. Sampling Technique and Size

Purposive sampling was used to select the MSM who had completed their 12th month follow-up visits in the longitudinal clinical trial. The sample size was n=23, following a previously suggested guideline [14] and informed by the principle of data saturation, where no new ideas emerged during the performance of the research.

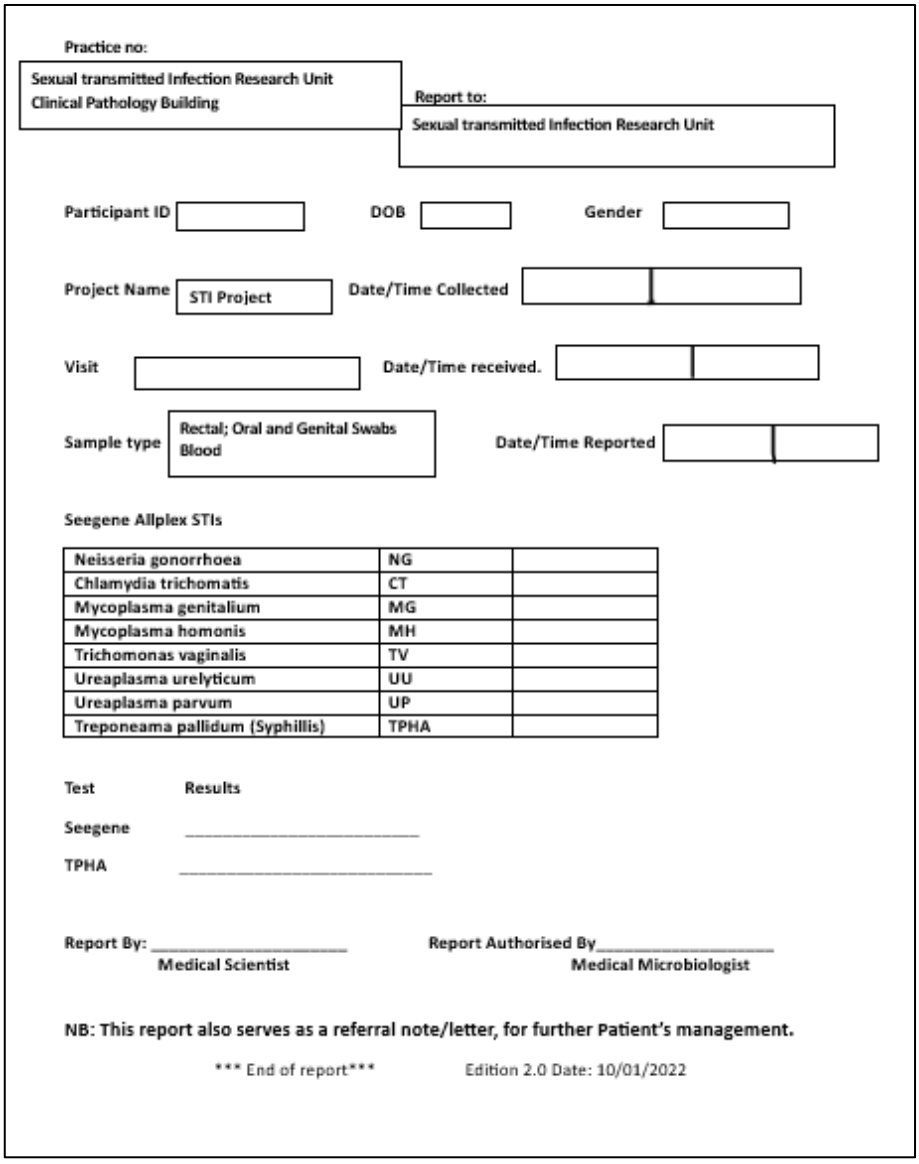
2.4. Recruitment, Data Collection Methods, and Tools

Upon recruitment, the informed consent process included the introduction of the researcher to the participants, a description of the goals and assumptions of the researcher, a description of the study's aims and objectives, and an explanation of the intended use of the results of the study. The researcher used an individual interview guide containing open-ended questions during face-to-face interviews that were 15-30 minutes long. All study participants were offered STI testing at screening. A clinician used direct swabbing to obtain samples for testing from rectal, oral, and genital swabs. Participants who received an STI diagnosis were referred to a local clinic based on their laboratory results. The referral letter consisted of the following: participant's participation number, gender, age, date of birth, participant visit, and sample type (See Figure 1). Tests were done on the participants to look for Neisseria gonorrhoea (NG), Chlamydia trachomatis (CT), Mycoplasma genitalium and homonis (MG&MH), Trichomonas vaginalis (TV), Ureaplasma urelyticum and parvum (UU&UP), Treponema pallidum (TPHA), and syphilis. The following questions were asked:

- Did you receive an STI referral letter? If so, tell me more about it.
- How did you use the referral letter and treatment?
- Did you make your partner aware of the referral letter? If you did or did not, why?

- What are the benefits of the referral letter and treatment?
- How did you feel about the services at the health care facilities?
- What services do you normally use at health care facilities?
- What can be done to improve health care facilities?

A digital tape recorder was used to record all interviews. and the interviews were transcribed verbatim [15].



Practice no:

Sexual transmitted Infection Research Unit
Clinical Pathology Building

Report to:
Sexual transmitted Infection Research Unit

Participant ID | DOB | Gender

Project Name: STI Project | Date/Time Collected

Visit | Date/Time received.

Sample type: Rectal; Oral and Genital Swabs, Blood | Date/Time Reported

Seegene Allplex STIs

Neisseria gonorrhoea	NG	
Chlamydia trichomatis	CT	
Mycoplasma genitalium	MG	
Mycoplasma homonis	MH	
Trichomonas vaginalis	TV	
Ureaplasma urelyticum	UU	
Ureaplasma parvum	UP	
Treponeama pallidum (Syphillis)	TPHA	

Test Results

Seegene _____

TPHA _____

Report By: _____ Medical Scientist

Report Authorised By_____ Medical Microbiologist

NB: This report also serves as a referral note/letter, for further Patient's management.

*** End of report*** Edition 2.0 Date: 10/01/2022

Figure 1.
Participant's referral letter.

2.5. Data Analysis and Coding

The first step was transcribing the audio recording verbatim and translating the Setswana audio into English. Two of the authors of this report are Setswana-speaking, and the co-author is English-speaking. Data were loaded into Microsoft Office 365 to be translated into English. Thematic content analysis was employed, and initial common codes were identified, categorized into groups, and labels assigned to them in the form of themes. Further relations and subgroups that emerged were placed under the umbrella themes to form subthemes. The organized data resulted in a codebook, which, together with the 23 transcripts, was uploaded into qualitative research software (QSR) NVivo version 12 software for analysis.

2.6. Trustworthiness of the Data

Trustworthiness was ensured throughout this study, as described by Lincoln and Guba [16]. Credibility was promoted by engaging in recorded, in-depth discussions with participants. To increase the study's transparency, the provision of a research methodology and a description of the findings ensured transferability. Using the approved methodology based on ethics and empirical research ensured reliability.

2.7. Ethical Approval

Ethical approval for the study was obtained from the Sefako Makgatho Health Sciences University Research Ethics Committee (Ref: SMUREC/H/168/2019: PG (Postgraduate), and the study was conducted in accordance with the Helsinki Declaration.

3. Results

3.1. Demographic Characteristics of Participants

The mean age of the MSM was n= 15; they were in the age range of 20 and 30 years; n=15 had completed high school; n=7 had completed tertiary education; n=8 were in a steady relationship; and n=15 were in a causal relationship. Of the n=23 participants, only n=4 were employed, n=10 reported practicing anal sex. The other characteristics of the participants are displayed in Table 1.

Table 1.
Profile of study participants.

Demographic information of the twenty-three (n=23) participants who were interviewed	
Age	**n (%)**
20-30	15 (65.2)
31-40	7 (30.4)
Highest level of schooling	
Tertiary	8 (34.7)
High school	15 (65.2)
Employment status	
Employed	4 (17.3)
Unemployed	19 (82.6)
Marital status	
Single	23 (100)
Type of relationship	
Casual	15 (65.2)
Stable	8 (34.7)
Sexual orientation	
Gay	21 (91.3)
Bisexual	2 (8.6)
Number of sexual partners	
One	6 (26.0)
Two	5 (21.7)
Three or more	12 (52.1)
Prevention method during sex	
Condoms	12 (52.1)
Both condoms and lubricant	8 (34.7)
None	3 (13.0)
Sexual practices	
Anal sex	10 (43.4)
Anal sex and oral sex	8 (34.7)
Anal sex and rimming	3 (13.0)
Anal and vaginal sex	2 (8.6)

Source: Malefo, et al. [17].

Thematic Content analysis for qualitative research was used, and Table 2 presents the themes and sub-themes that emerged from the data during data analysis.

Table 2.
Themes and subthemes of partner notification among MSM participants.

Themes	**Sub-themes**
1. Reaction to being diagnosed with STIs and receiving a STI referral letter.	• Acceptance of a positive STI diagnosis • Disappointed, shocked, and sad after receiving a STI referral letter.
2. Participants views on the referral letter and partner notification.	• Challenge of notifying multiple and casual partners • Perceived doubt and blame for the STI diagnosis led to no notification. • Disclosure of STI diagnosis, issuing a referral letter to the partner, and partner usage of the referral.
3. STI treatment and usefulness of a referral letter	• Treatment receipt and completion

Themes	Sub-themes
	• Usefulness of receiving an STI referral letter and treatment
4. Experiences of accessing health care services.	• Healthcare providers offered support and good, acceptable service. • Challenge of long queues and waiting time in clinics
5. Nurses' attitude towards the MSM	• Stigma, judgement, and discrimination from the nurses
6. Health service recommendations by the MSM	• Need for training healthcare providers. • Dedicated clinics for rendering services to the MSM • Improve the rendering of the general health service
7. Evidence of missed opportunity by the syndromic management approach to treating asymptomatic STIs among the MSM	

Theme 1: Reaction to being diagnosed with STIs and receiving a STI referral letter.

The participants reported that when they received a positive STI diagnosis and a STI referral letter, they did not have any problems because of their risky sexual lifestyle. They indicated that they would receive treatment earlier and that they were aware of their health status. "*Participants will be identified as PPT".*

Sub-theme 1: Acceptance of a STI-positive diagnosis.

"I was okay because I expected that I was reckless in my sexual behaviour. I was just sleeping around." PPT 18

"I was OK, because at least I know that I can get help earlier, and I now know where I stand health-wise." PPT 20

"I was OK. I only got diagnosed with one type of STI, and I managed to go to the clinic to get treatment." PPT 21

Sub-theme 2: Disappointed or shocked after receiving the STI referral letter.

Some of the participants reported their disappointment and stress when they were given a STI referral letter. They did not expect a positive STI diagnosis because they were asymptomatic.

"Firstly, I was disappointed with myself. I was once treated for STI before syphilis, and now I have three STI's: anal and oral infections and syphilis. I took a week before I went to the clinic to take my treatment." PPT 02

"I was like OK…. I had a little stress. I was surprised; I didn't expect that I had STIs that I was not even aware of, but I accepted afterwards." PPT 03

"I was sad; I did not believe it because it was the first time I was told that I have STIs. So, I went to the clinic, and they gave me treatment." PPT 15

Theme 2: Participants' views on the referral letter and partner notification.

The participants were asked if they made their partners aware of the referral letters. In response, the participants stated that notifying their partners about receiving the STI referral letters was not easy. The participants thought that their partners might blame them as if they were the ones who infected them or brought STIs to them. Others were in casual relationships, and it was not easy for them to reach those partners.

Sub-theme 1: Challenge of Notifying Multiple and Casual Partners.

"No, I had multiple partners, so who was I supposed to tell? Some are one-night stands. When you tell someone you had sex with that you have STIs, they will no longer communicate with you. They will block you. Because they do not have any STI signs, they will not listen to you, so I do not want to lose them." PPT 02

"No, I had a lot of partners, so who was I supposed to tell?" PPT 18

"No, where am I going to start because I have casual partners, you know, a one-time thing, so I did not see them again." PPT 19

Sub-theme 2: Perceived doubt and blame for STI diagnosis led to no notification.

"No, I did not. To be honest with you, I do not know why I did not make him aware of this." PPT 09

"No, this person is not a person that I am serious about, so I did not see the importance of telling him." PPT 11

"They will not believe me because now, when I tell them that I am HIV-positive, they do not believe me. They always say I am lying. So, you see, they will not believe me. Sometimes they will blame me, saying I am the one who infected them, so that was also a challenge on my side." PPT 16

Sub-theme 3: Disclosure of STI diagnosis, issuing a referral letter to the partner, and partner usage of the referral.

The participants reported that they had disclosed their STI status and issued a referral letter to their partners, but they had not made a follow-up to check if they had gone to the clinic to be treated. Some partners refused to go to the clinic to receive treatment.

"Yes, I did, but he refused to go to the clinic because he is always at work." PPT 04

"Yes, I did. At first, he was not OK, but he went to the clinic to be treated." PPT 05

"Yes, I did, but he did not go to the clinic, so I did not talk much about it." PPT 07

"Yes, I tried, but he did not go." PPT 10

"Yes, I told him, but I did not follow up with him if he went to the clinic to be treated." PPT 12

Theme 3: STI treatment and the usefulness of a referral letter.

Some participants mentioned that they had gone to clinics and received treatment. Additionally, they reported that they had completed their treatment in accordance with the doctor's instructions. They were glad they had received the letter and that it stipulated the diagnosis.

Sub-theme 1: Treatment receipt and completion.

"If you do not treat STIs, they will stay, and they will continue. I took my pills on time, and now I am fine treated." PPT 03

"Yes, they gave me treatment (pills), and I completed the treatment." PPT 18

"If I did not receive a referral letter, I was not going to be aware of these STIs and would not be treated. They gave me pills …antibiotics." PPT 22

Sub-theme 2: Usefulness of receiving the STI referral letter and the treatment.

Some participants reported that receiving the STI referral letter and treatment was beneficial because they were treated, and they were now taking precautions. They also reported that it was easy to receive treatment because they had been able to produce the referral letters.

"The treatment helped me because I was cured, and I told myself that I was no longer going to have sex without any protection. This opened my eyes." PPT 02

"The treatment helped me because I was cured, and I am taking care of my sexual life." PPT 04

"I think because I had a referral letter, it was easier for me to be assisted as compared to if I did not have any referrals." PPT 12

"Having that referral letter made things simple. They asked where I got that letter, and I explained the study to them, and they gave me treatment." PPT 16

"The treatment helped me; I was cured, and now I use condoms." PPT 06

"I am happy that I got referred for treatment. Now I am cured." PPT 21

Theme 4: Experiences of Accessing Health Care Services.

Some participants reported that visiting the clinic was a challenge because you waited for long hours before being assisted. Others mentioned that they had received support and had a good relationship with the nurses, and that having a referral letter made it simple for them to access treatment.

Sub-theme 1: Healthcare providers offered support and good, acceptable services.

"It was difficult for me to tell my family members, so the person who supported me was from the clinic - a nurse and counsellor. They also referred me to the clinic psychologist - not sure - or a social worker because I thought it was a permanent thing. I was not going to be cured." PPT 01

"The service was OK. The nurses were friendly and welcoming." PPT 07

Sub-theme 2: Challenges of long queues and waiting time in clinics.

"I do not go to the clinic. It is a lot of work. You stand in a queue for longer hours before you can be attended to, so I hate to wait that long." PPT 03

"Nurses are just moving up and down and start to work late at around 9:00 a.m. You wait again two hours at the dispensary just to get medication." PPT 11

Theme 5: Nurses' attitude towards the MSM.

Some participants described the nurses' unpleasant behaviour towards them as being unapproachable, discriminating, and getting easily annoyed with them, and being judgmental.

Sub-theme 1: Stigma, judgment, and discrimination from nurses

"Like, why are you gay? So they always judge us. The nurse was asking stupid questions like why you decide to sleep with men, not women. The Bible is saying this, so you are doing opposite things to the Bible." PPT 02

"I think number one is discrimination and stigmatization, because when I went to the clinic, they discriminated against me because of language. The nurse who was assisting me was forcing me to speak the local language, Setswana, and number two is because I am gay. The nurse starts saying that I am careless. I do not take care of myself. And she injected me on the muscles because I had pain and bruises afterwards for almost five days. I was so frustrated with the way she treated me." PPT 10

"The nurses are not the same. They will tell us gays that we are problematic and that we do not take care of ourselves. The nurses talk too much and are rude, but not all of them." PPT 12

Theme 6: Health service recommendations by MSM.

Participants made recommendations that might assist or improve the health care facilities when dealing with MSM. This might also assist in granting access to health care to MSM without them being afraid of being judged or discriminated against.

Sub-theme 1: Need for training healthcare providers.

"They need to improve their services towards dealing with MSM. Maybe a doctor or nurse can be trained and test these STIs." PPT 05

"They need to improve their services towards dealing with MSM. They need training, and they must treat us the same because if you are MSM and sick, especially with STI, it is like you are irresponsible." PPT 06

Sub-theme 2: Dedicated clinics for rendering services to MSM

"Yes, I made him aware, but he wanted to come here and join the study, but because he is staying in Mamelodi, he did not even go to the clinic." PPT 13

"I think they can have gay-friendly clinics or staff, because not all nurses are that friendly to gays, but the service was good, maybe because I had a referral letter from you. They helped me fast, without any complaints. They even asked me about the study and what we were doing, so I explained to them." PPT 14

Sub-theme 3: Improve the rendering of the general health service.

"The nurses must be fast. The clinics are very slow. They must help people as they come in." PPT 15

"When we go to the clinic, we first do not want to be judged. As much as they are saying they practice batho-pele principles and they are not discriminating or stigmatization, it is a lie. Gay people are not being treated with respect at the clinic. They need to hire MSM, or gay health professionals, or train nurses on how to work with MSM." PPT 16

Theme 7: Evidence of a missed opportunity by the syndromic management approach to treating asymptomatic STIs among the MSM.

"I was surprised because I did not know that kind of STI existed." PPT 14

"I was bored. I always visit the clinic to collect my HIV medication, so I thought when they took my blood, they would see those STIs." PPT 16

4. Discussion

The study was conducted among MSM who were selected for exit interviews from a longitudinal study on the control, management, and treatment of STIs. Participants had been diagnosed with at least one or more STIs. All participants who had been diagnosed with STIs were given treatment referral letters.

The themes and subthemes identified in this study offer a comprehensive description of the importance of receiving STI referral letters, the benefits of treatment, and PN. The study revealed that the participants were disappointed and shocked when they received referral letters for treatment because they had not perceived themselves as having been infected with STIs due to the asymptomatic nature of the early stages of the infection. The findings also suggest that it was not easy for the MSM to inform their sexual partners about the referral letters that were issued post-diagnosis because some were in casual relationships and some wanted to avoid being blamed for STI acquisition and transmission in their relationships. Similar findings of a reluctance to disclose or deliver the referral letter to a sexual partner in fear of being blamed were cited in studies from South Africa and other countries such as Indonesia, Peru, and Mozambique [11, 18-20].

The MSM in this study indicated that their reasons for not disclosing the positive STI diagnosis were because they did not want to lose their partners or relationships, and because of the asymptomatic nature of the STIs, their partners would not believe them. Rejection and physical retaliation or social harm to the index person from those who were notified have been found in other studies where disclosure and partner notification are concerned [21-23].

The MSM reported that they benefited from receiving the referral letters and STI treatment. The referral letter contained information on the type of STIs they had, and data show that receiving the referral letter assisted them to become aware of their risky sexual behaviour and to adopt protective behaviours to reduce the risk of future infection. This finding is consistent with those from other similar studies where awareness of an infection aroused self-care and healthy choices to prevent sexually transmitted infections [24-26]. A study by Tomnay, et al. [26] reports an expression of gratitude for the information contained in the referral letter in the form of a partner notification slip and the statement that the notification made it possible for the participant to make good health care decisions.

The MSM in this study said that they had issued their partners with the STI referral letters; however, some of the partners opted not to take treatment. Some reported that they had not followed up with their partners to find out if they had gone to the clinic and taken STI treatment because they did not have control over their partner's decisions. In their study, Nearchou, et al. [7] indicate that where individuals believe their partner will refuse treatment, they may have lower PN intentions because they have less control over their partners' subsequent behaviour. Similarly, a study performed in Botswana showed that most young adult patients diagnosed with an STI notified their partners themselves and indicated that this would also be their future preference for partner notification [27]. In their study, Hansman, et al. [28] found that most participants (88.1%) indicated that they would prefer to notify their sexual partners themselves of their potential exposure to STIs (patient referral), with only 10.9% indicating that they would prefer a healthcare provider to perform this action (provider referral).

This study finds that barriers such as the negative attitudes of nurses, which include discrimination, prejudice, and judgement of gay men, made it difficult for some of the MSM to access services at the clinics. They confirmed that they experienced unfriendly behaviour from nurses during clinic visits and long queues. Furthermore, the MSM reported that the nurses are slow and take their own time when dealing with patients. This may be due to the few health care providers having to deal with a large volume of patients in a short time. Other studies report similarly [29-32]. Some of the reasons given for the unacceptable quality of services were that nurses experience a high patient load, staff absenteeism, and burnout [33].

Recommendations made by the MSM were that health care facilities should be improved and open user-friendly clinics that will provide appropriate services to the MSM population. They also indicated that nurses must be trained on how to work with MSM. This would assist MSM in accessing health care services freely without any fear. Similar findings show that MSM and Transgender Women themselves may be unwilling to access healthcare services due to fear of discrimination by health care workers, a lack of trust, and previous bad experiences in health care settings, including sexual health care services [34-36] Stigma and discrimination in healthcare settings remain a neglected issue, and a lack of sensitive and trained health care providers can limit access to care, which contributes to health inequalities. This behaviour of nurses could weaken the capability of the health system and compromise the quality of patient care. Reducing the stigma and discrimination encountered by men who have sex with men in healthcare settings is key to improving their health outcomes.

4.1. Contributions of the Study to the Body of Knowledge

The study contributes to the literature by describing the challenges influencing MSM access to health care services and the importance of referral letters to reduce STI infections and increase STI treatment uptake among the MSM population. The findings of the study have the possibility of paving the way for future studies that could further develop and intensify patient referral letters and partner notification in low- and middle-income countries.

4.2. Implications for Practice and Recommendations

It is anticipated that this study would be of value to policymakers when designing and implementing policies on STI's patient referral letter and partner notification. The suggestion for policy makers is to reflect on the development of particular guidelines that are relevant for MSM since they are a susceptible and high-risk population. The government should develop workshops to facilitate better communication regarding knowledge.

4.3. Limitations for the Study and Directions for Future Research

The participants in this study were chosen using purposeful sampling and may not be representative of all MSMs in South Africa. Another limitation is that the study did not recruit participants from all ethnic groups. Despite these limitations, the findings of the study should be transferable to similar settings in other provinces.

4.4. Future Research

The findings from this study might benefit other researchers in understanding the importance of patient referral letters and partner notifications. It provides insights into the challenges of access to health care services among sex MSM in Tshwane District. There is a chance of conducting a repetition of this study in other districts, municipalities, and provinces of South Africa. Such a repetition study could help to evaluate the similarities and differences in the usage of patient referral letters and partner notifications among MSM across different regions. Furthermore, it is expected that a similar study could be conducted using a quantitative methodology to gain a broader viewpoint on the occurrence within a larger population.

5. Conclusion

The study reveals that it is important to gain a deeper understanding of the interventions used to break the transmission train and how different beliefs and attitudes may affect them. The reactions to the referral letters and PN highlight the strength of the participants' awareness of the severity of the STIs and suggest they may have begun to act accountable for their actions in exposing the health of other people to potential risk. The findings suggest that there is a need to educate the public about the benefits of referral letters and PN practices, regardless of whether the diagnosis is for HIV/STIs. Our findings provide important information on the role of STI referral letters in the intention to notify a partner, but further research is needed to gain a better understanding across different population groups and inform future educational campaigns.

References

[1] K. Rees *et al.*, "Utilization of sexually transmitted infection services at 2 health facilities targeting men who have sex with men in South Africa," *Sexually Transmitted Diseases,* vol. 44, no. 12, pp. 768-773, 2017. https://doi.org/10.1097/olq.0000000000000679

[2] Department of Health, "Sexually transmitted infections management guidelines," Retrieved: http://www.kznhealth.gov.za/family/STI-guidelines-2015.pdf. [Accessed 19 February 2019], 2019.

[3] C. Mercer *et al.*, "How can we objectively categorise partnership type? A novel classification of population survey data to inform epidemiological research and clinical practice," *Sexually Transmitted Infections,* vol. 93, no. 2, pp. 129-136, 2017. https://doi.org/10.1136/sextrans-2016-052646

[4] D. A. Lewis *et al.*, "The burden of asymptomatic sexually transmitted infections among men in Carletonville, South Africa: Implications for syndromic management," *Sexually Transmitted Infections,* vol. 84, no. 5, pp. 371-376, 2008. https://doi.org/10.1136/sti.2008.029751

[5] K. Rebe *et al.*, "A cross sectional analysis of gonococcal and chlamydial infections among men-who-have-sex-with-men in Cape Town, South Africa," *PloS One,* vol. 10, no. 9, p. e0138315, 2015. https://doi.org/10.1371/journal.pone.0138315

[6] World Health Organisation, "Sexually transmitted infections (STIs) key facts," Retrieved: https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis). [Accessed 9 April 2022], 2020.

[7] F. Nearchou, D. Mc Laughlin, and R. Niland, "Sexual health behaviours and partner notification practices for sexually transmitted infections in young adults in Ireland [Internet]," *PsyArXiv,* 2023. https://osf.io/preprints/psyarxiv/jhq63/

[8] J. L. Clark, A. Perez-Brumer, and X. Salazar, "'"Manejar la Situacion": Partner notification, partner management, and conceptual frameworks for HIV/STI control among MSM in Peru," *AIDS and Behavior,* vol. 19, no. 12, pp. 2245-2254, 2015. https://doi.org/10.1007/s10461-015-1049-3

[9] N. B. Knoble and D. Linville, "Outness and relationship satisfaction in same-gender couples," *Journal of Marital and Family Therapy,* vol. 38, no. 2, pp. 330-339, 2012. https://doi.org/10.1111/j.1752-0606.2010.00206.x

[10] U. Marcus *et al.*, "Association of internalised homonegativity with partner notification after diagnosis of syphilis or gonorrhoea among men having sex with men in 49 countries across four continents," *BMC Public Health,* vol. 23, no. 1, pp. 1-12, 2023. https://doi.org/10.1186/s12889-022-14891-2

[11] C. Mathews *et al.*, "Sexual relationships, intimate partner violence and STI partner notification in Cape Town, South Africa: An observational study," *Sexually Transmitted Infections,* vol. 94, no. 2, pp. 144-150, 2018. https://doi.org/10.1136/sextrans-2017-053434

[12] G. Arthur, C. Lowndes, J. Blackham, and K. Fenton, "Divergent approaches to partner notification for sexually transmitted infections across the European Union," *Sexually Transmitted Diseases,* vol. 32, no. 12, pp. 734-741, 2005. https://doi.org/10.1097/01.olq.0000175376.62297.73

[13] L. Bull *et al.*, "BASHH 2018 UK national audit of HIV partner notification," *International Journal of STD & AIDS,* vol. 32, no. 9, pp. 872-877, 2021. https://doi.org/10.1177/0956462421990281

[14] G. A. Bowen, "Naturalistic inquiry and the saturation concept: A research note," *Qualitative Research,* vol. 8, no. 1, pp. 137-152, 2008. https://doi.org/10.1177/1468794107085301

[15] M. A. Constas, "Qualitative analysis as a public event: The documentation of category development procedures," *American Educational Research Journal,* vol. 29, no. 2, pp. 253-266, 1992. https://doi.org/10.3102/00028312029002253

[16] Y. S. Lincoln and E. G. Guba, *Naturalistic inquiry*. Newbury Park, CA: Sage, 1985.
[17] M. A. Malefo, O. A. Ayo-Yusuf, and M. M. Mokgatle, "A qualitative study of the benefits and utility of brief motivational interviewing to reduce sexually transmitted infections among men who have sex with men," *Behavioral Sciences,* vol. 13, no. 8, p. 654, 2023. https://doi.org/10.3390/bs13080654
[18] W. Cheng *et al.*, "HIV partner notification across different sexual partner types among men who have sex with men in Guangzhou, China," *AIDS Patient Care and STDs,* vol. 33, no. 7, pp. 295-298, 2019. https://doi.org/10.1089/apc.2019.0059
[19] J. A. Levy, V. A. Earnshaw, A. Milanti, A. Waluyo, and G. J. Culbert, "A qualitative study of healthcare providers' attitudes toward assisted partner notification for people with HIV in Indonesia," *BMC Health Services Research,* vol. 23, no. 1, p. 71, 2023. https://doi.org/10.1186/s12913-022-08943-x
[20] R. S. Myers *et al.*, "Acceptability and effectiveness of assisted human immunodeficiency virus partner services in Mozambique," *Sexually Transmitted Diseases,* vol. 43, no. 11, pp. 690-695, 2016. https://doi.org/10.1097/olq.0000000000000529
[21] S. Dalal *et al.*, "Improving HIV test uptake and case finding with assisted partner notification services," *Acquired Immunodeficiency Syndrome,* vol. 31, no. 13, pp. 1867-1876, 2017. https://doi.org/10.1097/qad.0000000000001555
[22] Q.-H. Hu *et al.*, "Assisted partner notification and uptake of HIV testing among men who have sex with men: A randomized controlled trial in China," *The Lancet Regional Health - Western Pacifi,* vol. 12, p. 100171, 2021. https://doi.org/10.1016/j.lanwpc.2021.100171
[23] M. Sharma *et al.*, "High acceptability of assisted partner notification services among HIV-positive females in Kenya: Results from an ongoing implementation study," *Journal of Acquired Immune Deficiency Syndromes,* vol. 86, no. 1, pp. 56-61, 2021. https://doi.org/10.1097/qai.0000000000002527
[24] G. J. Culbert, A. Waluyo, and V. A. Earnshaw, "Exploring the acceptability of HIV partner notification in prisons: Findings from a survey of incarcerated people living with HIV in Indonesia," *Plos One,* vol. 15, no. 6, p. e0234697, 2020. https://doi.org/10.1371/journal.pone.0234697
[25] M. Grande *et al.*, "Intensified assisted partner notification implementation in Botswana increased partner identification but not HIV case-finding: Findings highlight the need for improved data monitoring," *Journal of Acquired Immune Deficiency Syndromes,* vol. 87, no. 3, pp. 951-958, 2021. https://doi.org/10.1097/qai.0000000000002673
[26] J. E. Tomnay, A. Hulme-Chambers, J. Bilardi, C. K. Fairley, S. Huffam, and M. Y. Chen, "A qualitative study of means to improve partner notification after an HIV diagnosis among men who have sex with men in Australia," *AIDS Patient Care and STDs,* vol. 31, no. 6, pp. 269-274, 2017. https://doi.org/10.1089/apc.2017.0080
[27] M. M. Mokgatle, S. Madiba, and L. Cele, "A comparative analysis of risky sexual behaviors, self-reported sexually transmitted infections, knowledge of symptoms and partner notification practices among male and female university students in Pretoria, South Africa," *International Journal of Environmental Research and Public Health,* vol. 18, no. 11, p. 5660, 2021. https://doi.org/10.3390/ijerph18115660
[28] E. Hansman *et al.*, "Experiences and preferences with sexually transmitted infection care and partner notification in Gaborone, Botswana," *International Journal of STD & AIDS,* vol. 32, no. 13, pp. 1250-1256, 2021. https://doi.org/10.1177/09564624211033231
[29] R. A. Babel, P. Wang, E. J. Alessi, H. F. Raymond, and C. Wei, "Stigma, HIV risk, and access to HIV prevention and treatment services among men who have sex with men (MSM) in the United States: A scoping review," *AIDS and Behavior,* vol. 25, no. 11, pp. 3574-3604, 2021. https://doi.org/10.1007/s10461-021-03262-4
[30] A. Kigombola *et al.*, "Low engagement of key populations in HIV health services in Tanzania: Analysis of community, legal and policy factors," *The Pan African Medical Journal,* vol. 45, no. Suppl 1, p. 8, 2023. https://doi.org/10.11604/pamj.supp.2023.45.1.39591
[31] R. Roomaney, J. Steenkamp, and A. Kagee, "Predictors of burnout among HIV nurses in the Western Cape," *Curationis,* vol. 40, no. 1, pp. 1-9, 2017. https://doi.org/10.4102/curationis.v40i1.1695
[32] T. Tsele-Tebakang, H. Morris-Eyton, and E. Pretorius, "Concurrent use of herbal and prescribed medicine by patients in primary health care clinics, South Africa," *African Journal of Primary Health Care & Family Medicine,* vol. 15, no. 1, p. 3829, 2023. https://doi.org/10.4102/phcfm.v15i1.3829
[33] A. Payne, L. Koen, D. J. Niehaus, and I.-M. Smit, "Burnout and job satisfaction of nursing staff in a South African acute mental health setting," *South African Journal of Psychiatry,* vol. 26, no. 1, pp. 1-6, 2020. https://doi.org/10.4102/sajpsychiatry.v26i0.1454
[34] V. Chakrapani, P. A. Newman, M. Shunmugam, and R. Dubrow, "Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India," *AIDS Care,* vol. 23, no. 12, pp. 1687-1694, 2011. https://doi.org/10.1080/09540121.2011.582076
[35] V. Chakrapani *et al.*, "Efficacy of a multi-level pilot intervention ("Harmony") to reduce discrimination faced by men who have sex with men and transgender women in public hospitals in India: Findings from a pre-and post-test quasi-experimental trial among healthcare workers," *Venereology,* vol. 2, no. 3, pp. 86-107, 2023. https://doi.org/10.3390/venereology2030009
[36] M. R. Woodford, V. Chakrapani, P. A. Newman, and M. Shunmugam, "Barriers and facilitators to voluntary HIV testing uptake among communities at high risk of HIV exposure in Chennai, India," *Global Public Health,* vol. 11, no. 3, pp. 363-379, 2016. https://doi.org/10.1080/17441692.2015.1057757