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"They see you as a different thing": The Experiences of Men Who Have Sex with Men with Health Care Workers in South African Township Communities

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Abstract

Objectives—To describe interactions between men who have sex with men (MSM) and health care workers (HCWs) in peri-urban township communities in South Africa.

Method—Qualitative study using semistructured in-depth interviews and focus group discussions in the Gauteng province townships of Soweto and Mamelodi. We purposively sampled 32 MSM for in-depth interviews and 15 for focus group discussions. Topics explored included identity, sexuality, community life, use of health services, and experiences of stigma and discrimination.

Results—MSM felt their options for non-stigmatizing sexual health care services were limited by homophobic verbal harassment by HCWs. Gay-identified men sought out clinics with reputations for employing HCWs who respected their privacy and their sexuality, and challenged those HCWs who mistreated them. Non-gay identified MSM presented masculine, heterosexual identities when presenting for sexual health problems, and avoided discussing their sexuality with HCWs.

Conclusions—The strategies MSM employ to confront or avoid homophobia from HCWs may not be conducive to sexual health promotion in this population. Interventions that increase the capacity of public sector HCWs to provide appropriate sexual health services to MSM are urgently needed.

Keywords

Africa; *HIV*; *homosexual men*; *health care seeking*; *sexually transmitted diseases*

Introduction

South Africa is unique among African nations for its explicit constitutional prohibition of discrimination on the basis of sexual orientation. Its major cities, including Cape Town, Durban, Johannesburg, and Pretoria, are home to visible gay and lesbian communities and lesbian-gay-bisexual-transgender (LGBT) community-based organizations (CBOs). South Africa is also unique among African nations in that the HIV epidemic was first recognized

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among primarily white, gay-identified men who have sex with men (MSM) in the 1980s; only after 1990 did a second, heterosexually-transmitted epidemic emerge among South Africa's black population.[1-3] The national mobilization to combat HIV has addressed heterosexual and mother-to-child transmission, while targeted sexual health information and services for MSM have been undertaken largely by the country's few LGBT CBOs. In 2007, the South African Department of Health signaled its intention to mobilize resources to address the needs of MSM for HIV and sexual health services. The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP) recognizes MSM as a specific vulnerable group, noting that 'there is very little currently known about the HIV epidemic amongst MSM,' and that 'MSM who practice receptive anal intercourse have an elevated risk for HIV infection.'[4]

The low-income, peri-urban "township" communities on the periphery of South Africa's major urban areas are home to visible, emerging communities of black MSM. In the Gauteng province townships of metropolitan Johannesburg and Tshwane (Pretoria), the population of MSM includes individuals who self-identify as "gay" or "bisexual," as well as "straight."[5] Gay men are the most visible of MSM sub-groups. The emergence of township gay communities in the years since the end of apartheid has been the subject of several studies.[6-9] Bisexual and straight-identified MSM, or non-gay identified (NGI) MSM, are often less visible, choosing to self-identify by terms that allow them to blend into the general population and that do not necessarily preclude having female sexual partners.

Despite its constitution, homosexuality remains stigmatized in South Africa, as it does in much of sub-Saharan Africa, as "un-African" behavior.[10] The emergence of gay communities in townships may in turn be rendering homophobia increasingly visible in these communities. We define homophobia loosely as enacted hostility to same-sex sexuality[11] and same-sex practicing individuals.[12]This broad definition includes overt forms of physical assault, including rape and murder, and less lethal practices, such as verbal harassment. Studies have shown that homophobia is associated with indicators of poor mental health,[13] and increased risk behavior for HIV and other STIs.[14-16]

In light of South Africa's unique legal framework, its severe HIV epidemic, and the goals of the NSP, it is important to understand the experiences of MSM who currently access sexual health services in the public sector. Studies of sexual health seeking behavior among men and women in sub-Saharan Africa have observed more pronounced patterns of delayed treatment-seeking among women [17-19], and the stigmatization of female patients' sexuality by public sector health care workers (HCWs) [20-22]. However, given the persistence of stigma against homosexuality in South African society, it is worth exploring whether hostility towards same-sex practicing men exists and how it impacts their sexual health seeking strategies. In this paper we describe the experiences of Gauteng township MSM who seek public sector sexual health services.

Methods

We conducted in-depth interviews with 32 MSM in two Gauteng township communities (Soweto and Mamelodi), and 3 focus group discussions with 15 MSM in one township community (Soweto) between April 2006 and March 2007. Eligibility criteria included being 18 or older, and ever having had sex with another man. Although racial identity was not an explicit inclusion criteria, all participants recruited were black South Africans. Sampling began with "out" gay-identified men known to the investigators. Other gay and NGI MSM were identified through ethnographic fieldwork by Mr. Mogale, who made repeated visits to MSM-friendly social venues in each township to establish rapport with members of MSM social networks associated with these sites. For individual interviews, we purposively sampled men based on their self-described sexual identity (e.g. gay, bisexual, straight, see Table 1), age, and

reported HIV status. For each focus group discussion, we purposively recruited 4 gay, 3 bisexual, and 8 straight MSM to participate in a discussion with others who shared their self-described sexual identity (one discussion per identity group). All potential participants voluntarily gave their contact information to Mr. Mogale, who arranged for study enrollment visits to take place within two weeks of initial contact.

Interviews took place either in a private interview room in the Perinatal HIV Research Unit (PHRU) at Chris Hani-Baragwanath Hospital in Soweto, or in a private community setting of the participant's choosing. Discussions took place in a private meeting space at the PHRU. Interviews and discussions followed an interview guide that explored identity, sexuality, community life, use of health services, and experiences of stigma and discrimination. Interviews lasted approximately 60 minutes, and discussions approximately 120 minutes. Interviews and discussions were conducted in the participants' choice of Zulu, Sotho, Tswana, or English. Written informed consent was obtained from all participants. Ethical approval was granted by the University of the Witwatersrand's Human Research Ethics Committee, and the University of California, San Francisco's Committee on Human Research.

All interviews and discussions were recorded on digital voice recorders, transcribed, and translated into English. Because very little research has been conducted specifically with South African MSM on the research topics, data analysis followed a grounded theory approach, allowing for in-depth exploration of emerging themes in the participants' narrative responses as research progressed.[23] All English transcripts were entered into Atlas.ti software for coding. Coding took place in two phases. Topical codes were applied first to allow quotations to be sorted according to interview guide topic areas. Then, open interpretive coding was utilized to identify and analyze emerging themes within and between topical areas.

Results

Participants were well-informed about their right to receive HIV testing and STI treatment, and where to access services. However, most participants' narratives portrayed public health clinics as places where HCWs constantly threatened MSM's rights to privacy and confidentiality by engaging in gossip and homophobic verbal harassment. All participants had either experienced or witnessed such harrassment from HCWs, and agreed that gay-identified men bore the brunt of HCWs' homophobia. This often took the form of HCWs' use of local derogatory slang words such as *stabane* (“hermaphrodite”) and *sgezo* (as well as its English equivalent “faggot”) to refer to openly gay patients. Indeed, those gay-identified men whose experiences of homophobia from HCW's was most extreme were those who described their gender identity as being “feminine” or “like a woman,” and whose speech, manners, and dress were recognized as feminine by the study's fieldworker.

MSM presenting for rectal STIs were particularly vulnerable to such treatment, because rectal STIs were evidence that men had engaged in a particularly taboo sexual behavior, and confirmed popular stereotypes of MSM as promiscuous vectors of disease. One NGI MSM recalled an incident he witnessed between an HCW and two gay men:

> I once went to the clinic and there were two gay men at the clinic, apparently one of them had an STD, then a nurse said to them she expected that, she wasn't expecting them to have flu but an STD, because they sleep around and God is punishing them.

One gay participant attributed these experiences of harassment to what he perceived as a norm of avoiding health care and poor sexual health among MSM generally:

> [S]ome of them don't treat us with respect. Sometimes, if you were having sex without a condom and maybe you get an STD, then you go to the clinic, the nurse will ask

> questions like "What was in here?"—she means in the anus. And that makes us afraid of going to the clinic to get treatment on time and that's why many gay men get sick.

The sexual health seeking strategies that gay men described were built around avoiding HCWs who were likely to harass them. Identifying sympathetic HCWs was a difficult process of trial and error. One focus group participant expressed a preference for clinics that employed younger health care workers, suggesting that homophobia was characteristic of the "ignorance" of an older generation: "We mustn't forget that most nurses are old people and they still have that mentality that a man is a man and a woman is a woman." But another disagreed, arguing that age was irrelevant, and what mattered was an HCW's capacity for acceptance, which was far more difficult to gauge from outward appearances:

> People are aware of gay and lesbian people but accepting those people like human beings is another story, because they don't understand what they are going through inside, so that causes a problem, in terms of when you need help from them, they see you as a different thing.

Gay men did have some success in identifying non-stigmatizing sexual health services, but they were not easily accessible. Among men in Soweto, two public health clinics in central Soweto and one in the Johannesburg city center (15 km away) were mentioned as the most desirable locations for sexual health services. Participants from Mamelodi relied on one clinic in the Pretoria city center, 25 km away.

However, when gay participants could not avoid homophobic HCWs, they felt empowered to challenge them. One described his response to such a situation:

> There was this one, she said to me why I am behaving like a girl and what must she write on my file, a male or a female? … I felt bad, but I asked her how can she say that because this is who I am and it is my life, what was she going to do if I was her child? And she said she will never have a child like me! So I said she must leave me alone and do what she is here for.

Gay men who challenged HCWs in this way were claiming the right to be socially visible, and asserting their right as South African citizens to non-discriminatory treatment. One participant believed that the ability of gay men to receive appropriate health care services was improving because discrimination on the basis of sexual orientation had been outlawed. Although his optimism was not shared by other gay-identified participants, like them he situated these struggles with HCWs as part of a larger, as yet incomplete struggle for full equality:

> We have cases where you find a person experiences such [negative] experiences but they are not like before. I think people are starting to have a sense of tolerance towards men of the minority groups or towards sexual orientations because of the laws of this country.

NGI MSM in our study did not express a similar urgency to locate MSM-friendly services, or to assert their rights to non-discrimination. Perhaps because they were more likely to witness ill-treatment of gay-identified men, their strategy was to deny their own same-sex behavior to HCWs. This was premised upon presenting a masculine gender identity to HCWs, and making plausible claims to heterosexual activity. As one self-identified bisexual man explained:

> I normally lie about it to them. I have a girlfriend, like if I had an STI I would tell them that my girlfriend wasn't around so I slept with somebody else and I got infected.

For NGI MSM, keeping sexuality private in health care settings was an extension of a larger social strategy of remaining invisible by keeping their same-sex behaviors hidden from family, friends, and female sexual partners. Most felt that it was inappropriate for HCWs to ask about "personal" information:

> I struggle with trusting people. Not unless I really trust that person am I able to be open about what I do and stuff like that, because I don't think you have to be asked if you have sexually transmitted disease are you straight or gay, whether you got this from a male or female. I think that would be invading my privacy, and if someone were to ask me that it wouldn't matter how much pain I'm in I would walk out. A person must ask about the STD and how to prevent it, not personal questions like my sexual identity.

In elaborating health-seeking strategies that promoted their invisibility, NGI MSM asserted a right to privacy in health care that was an alternative interpretation of their constitutional guarantee of equality. But protecting privacy through invisibility also prevents many NGI MSM from seeking sexual health information and services from sympathetic public sector HCWs or from LGBT CBOs. For some, this could have the unintended consequence of reinforcing erroneous beliefs about HIV or STI transmission. For example, one straight-identified participant seemed certain that his STIs could only be acquired heterosexually:

> I don't [disclose my same-sex behavior] … because when I go to the doctor is not for male sexual contact that I have contracted an STD.

Discussion

While the persistence of homophobia in South African society negatively impacts the ability of all MSM to access non-stigmatizing health services, the specific sexual health seeking strategies individual MSM employ to avoid homophobia depends on how they present their sexual and gender identities to HCWs, and how HCWs perceive them. Gay-identified men, many of whom are gender non-conforming, were more likely to confront HCW homophobia in the health care setting when they could not access non-stigmatizing health services. NGI MSM, who identified as bisexual or straight, were likely to emphasize a masculine gender identity and avoid disclosing same-sex sexual behavior when presenting for sexual health services. The split between gay and NGI MSM's experiences with HCWs appears to follow the gendered construction of STIs in South Africa described by Shefer et al., by which HCWs stigmatize the sexuality of women who contract STIs as “promiscuous”, but not men, who may sometimes receive positive reinforcement about their presumed multiple partnerships from HCWs as well as their peers.[21] With MSM in this study, the sexuality of openly gay-identified and gender non-conforming men was further stigmatized by HCWs' homophobia; knowing this, NGI MSM who were not open about their sexuality and were able to emphasize their masculinity could escape such degrading and “feminizing” treatment.

Goal 16.3 of South Africa's NSP is to “Ensure a supportive legal environment for the provision of HIV and AIDS services to marginalized groups,” and to “Develop and distribute information and materials on rights to HIV prevention, treatment and support that responds to the special needs of … MSM.”[4] This is an important goal that must be pursued in light of South Africa's constitutional guarantees of non-discrimination. However, the experience of MSM in this study was not simply a lack of information about the right to health care; rather, that access to sexual health care in the public sector was complicated by the perception, based on actual experience, that they are likely to encounter homophobic verbal harrassment from HCWs. As one participant suggested, HCW homophobia may lead MSM to delay or avoid treatment for STIs or HIV. It may also be the case that only exceptionally self-confident gay-identified men who are knowledgeable about the larger struggle for LGBT equality in South Africa are able to confront homophobia in health care settings. Yet the enmity gay men incur by defending themselves is not conducive to forming patient-provider relationships that encourage adoption of health-promoting behaviors. Further research should explore these hypotheses.

Although experiences of homophobia among NGI MSM were less direct or severe than gay men's, their strategy of not discussing same-sex behavior with HCWs may place them at a greater disadvantage than “out” gay men in their ability to access appropriate advice on STI and HIV prevention and treatment. LGBT CBOs reach out to openly gay-identified men, and many NGI MSM may feel uncomfortable accessing services that are associated with gay men. Therefore, NGI MSM who avoid these services and act on the assumption that public sector HCWs are hostile to same-sex sexuality effectively deny themselves any source of appropriate HIV and STI prevention information. It is uncertain how widespread these experiences are, but it may be the case that NGI MSM's strategy of avoiding homophobia in health care settings inadvertently causes these MSM to continue to compromise their own sexual health as well as the health of their male and female partners.

These findings have important implications for intervention. Promoting awareness of sexual health services for MSM must be accompanied, at a minimum, by sensitization training for public sector HCWs. This training needs to increase HCW awareness of the sexual health challenges that all same-sex practicing men face. HCWs will need to build skills that encourage and enable them to offer non-stigmatizing sexual health and HIV services to gender non-conforming MSM. In addition, it should increase HCW awareness that not all MSM identify as gay, or are gender non-conforming, and that NGI MSM may be reluctant to discuss their same-sex behaviors. Such an intervention would not by itself remove homophobia from public health services, but by affirming a commitment to non-discrimination on the basis of sexual orientation, it would be an important step towards ensuring a supportive environment for all South Africans seeking sexual health services. South Africa's LGBT CBOs and health professionals can provide valuable assistance to these efforts. In addition, the efforts of LGBT CBOs to provide sexual health services for MSM, and to identify and develop networks of “gay-friendly” health service providers, should be strengthened and expanded.

This study has several limitations. This research was explicitly focused on the experiences of MSM in two communities in a single South African province, and may not be generalizable to the entire country. However, Gauteng is the wealthiest, most urban, and most cosmopolitan of South Africa's provinces, where an LGBT CBO is active in promoting LGBT rights in township communities, including rights to sexual health care and HIV prevention and treatment. It is possible that the visibility and assertiveness of LGBT persons in Gauteng elicits strong homophobic reactions among a minority of HCWs; but it is also possible that these experiences may represent the best-case scenario for South African township MSM at present. While the research team made every effort to recruit MSM from all known MSM sub-groups, our sampling methodology favored the recruitment of gay men, and a smaller number of bisexual and straight MSM who were comfortable discussing their sexuality and social lives. All participants were likely more knowledgeable about accessing health services and comfortable with the risks of participating in socially sensitive research than others in their communities or in South Africa more generally. Nonetheless, the evidence presented here suggests that MSM who are less socially visible or comfortable discussing sexuality would have particular difficulty accessing appropriate health care. Finally, this research did not directly address the experiences of HCWs in meeting the sexual health care needs of MSM, which would be an important component of the development of a comprehensive and effective strategy to combat homophobia in the health services.

The South African constitution's prohibition of discrimination on the basis of sexual orientation provides a necessary precondition for realizing the NSP's goal of increasing awareness of the rights of all South Africans to HIV and STI prevention and treatment. However, these findings suggest that a focus solely on increasing awareness is insufficient. Gay-identified men seem well aware of their rights—and that their rights are being violated—while few NGI MSM seem inclined to claim or enforce their rights. MSM's collective experiences suggest an urgent need

for HCWs to be made aware of the rights of all MSM to non-stigmatizing sexual health services, and receive training that more appropriately equips them to care for all same-sex practicing individuals.

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Table 1

In-Depth Interview Participant Characteristics

Township	Self-described sexual identity		
	Gay	Bisexual	Straight
Soweto (Johannesburg)	10	3	5
Mamelodi (Tshwane)	13	1	0