Original Article

You become afraid to tell them that you are gay: Health service utilization by men who have sex with men in South African cities

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Abstract We describe the utilization of health services by men who have sex with men (MSM) in South African cities, their perceptions of available health services, and their service preferences. We triangulated data from 32 key informant interviews (KIIs), 18 focus group discussions (FGDs) with MSM in four cities, and a survey of 285 MSM in two cities, recruited through respondent-driven sampling in 2008. FGDs and KIIs revealed that targeted public health sector programs for MSM were limited, and that MSM experienced stigma, discrimination, and negative health worker attitudes. Fifty-seven per cent of the survey participants had used public health services in the previous 12 months, and 69 per cent had no private health insurance, with no difference by HIV status. Despite these findings, South Africa is well placed to take the lead in sub-Saharan Africa in providing responsive and appropriate HIV services for MSM.
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Introduction

Worldwide, men who have sex with men (MSM) are disproportionately affected by the HIV epidemic.[1,2] They remain a highly vulnerable group in the southern African region, where there are high HIV prevalence rates among the general population.[1] This vulnerability is exacerbated by continuing stigmatization of same-sex relationships and criminalization in several African countries, both of which act as barriers to HIV prevention programs.[3,4] Globally, HIV prevention services reach less than 10 per cent of MSM.[2,5]

In South Africa, although the HIV epidemic among MSM preceded the onset of the generalized HIV epidemic by several years, current policies and public health programs are largely unresponsive to the needs of MSM.[6,7] The exceptions are innovative, albeit small-scale programs by Lesbian, Gay, Bisexual, and Transgender (LGBT) organizations that play important roles in responding to the HIV epidemic among MSM.[8–10] The South African *National Strategic Plan* (NSP) *on HIV & AIDS and STIs*, approved in March 2007, contains HIV program targets for MSM and other vulnerable groups.[11] However, there has been little, if any, progress on the implementation of actions pertaining to MSM.[7,12]

We describe the availability and utilization of HIV programs and health services by MSM in South African cities in order to recommend service improvements in line with the NSP objectives. The study findings are part of a larger study, the Johannesburg-eThekwini Men's Study, conducted in 2008 to provide information on HIV among MSM in Johannesburg and Durban.[13]

Methods

We used a combination of qualitative and quantitative methods: key informant interviews (KIIs), focus group discussions (FGDs), and a survey. KIIs and FGDs took place concurrently in the first half of 2008, followed by the survey in the latter half of the year. We have described the survey methods elsewhere.[13]

Study setting

We selected key informants purposively from around South Africa and conducted FGDs in four cities: Johannesburg, Durban, Pietermaritzburg,

and Cape Town. We conducted the survey in Johannesburg, because it is the largest city in South Africa, and in Durban, because it is the largest city in KwaZulu-Natal, the province with the highest HIV prevalence in the country.

Study population

The study focused on MSM, a term that refers to biological males who have sex with other biological males, regardless of sexual orientation or gender, and includes men who identify themselves as gay and those who do not.[14] We selected key informants with expertise related to MSM, health policy and programs, or HIV, but they were not required to be MSM. FGD and most survey participants identified themselves as MSM.

Research design and methods

We identified 32 key informants through snowball sampling. They included 17 people working for LGBT organizations; eight government policymakers or HIV program managers; and seven researchers, all with expertise in HIV and MSM. Interview topics included: health service challenges faced by MSM in South Africa and HIV-related services for MSM. Each digitally recorded interview lasted about an hour, after which the study team transcribed it verbatim. Interviewers also took detailed notes during each interview and wrote a synopsis.

We held 18 FGDs with a total of 152 men, having recruited participants through civil society organizations and personal contacts. We recruited groups to include a range of characteristics in terms of age, race, geographic location, religious affiliation, and HIV-positive status. Discussion topics included: perceived HIV-related service needs; barriers to accessing HIV-related services; and suggestions for policy and programs to address MSM's HIV prevention and care needs. The co-facilitator took detailed field notes and the team digitally recorded each session; these lasted 2–3 hours. The study team gave each participant R50 (US$7; $1 = R7) to cover travel costs.

We recruited MSM living in the municipal areas of Johannesburg and Durban for the survey using respondent-driven sampling (RDS).[15–17] Each participant completed a self-administered questionnaire that contained sections on sexually transmitted infections (STIs)

and health-seeking behavior; HIV testing; health service utilization and preferred providers. Participants also provided finger-prick blood specimens for anonymous HIV testing in a laboratory.[13]

The Research Ethics Committees of the South African Human Sciences Research Council and the University of the Witwatersrand approved the study. All participants provided written, informed consent to participate.

Data management and analysis

We analyzed the KIIs and FGDs using thematic content analysis[18] and the survey data using Stata version 11.[19] We used standard logistic regression, combining data from both cities, to calculate odds ratios (ORs) associated with being HIV positive. We decided not to adjust the results for the sampling method as is usually done in RDS studies[16] because we recruited only 81 out of a target sample size of 200 in Durban, and because survey participants lacked demographic diversity (two-thirds were under 25 years of age and 88 per cent were Black African). We triangulated the data from the three components to arrive at the findings reported in this article.

Results

Availability of HIV prevention, treatment, and care services for MSM

The scarcity of targeted HIV prevention and treatment services for MSM was the dominant concern in the KIIs and FGDs. Key informants and FGD participants could not identify any government health services for MSM, but only non-governmental organizations that provided MSM-targeted services. The following comments are illustrative:

> In Johannesburg I do not know where to go. I must go to many places in order to know where bisexuals or gays can get help. I must seek around until I get the direction where to go. What they [government] can do is to ensure that the [services] are known and near to the people. (FGD 1, Johannesburg)

> Health care services are not friendly towards MSM and [HIV] programs are not strong enough and they [MSM] have difficulty accessing services. The materials produced for awareness and behavior change and access to care do not target this sector. (Key informant 9, provincial government HIV program manager, Johannesburg)

> Gay-identified people face challenges in terms of service provision – both the availability and appropriateness of health services. (Key informant 19, senior staff member, LGBT service organization)

Major national HIV prevention campaigns target the heterosexual population and do not mention homosexual HIV transmission, whereas targeted health services for bisexual and transgender people are even scarcer, leaving them particularly vulnerable to HIV infection.

Health service utilization

The majority of survey participants (74 per cent) reported having been tested for HIV in the past, but only 48 per cent said they had been tested and given the results in the previous 12 months. Compared with men who tested HIV negative as part of this study, HIV-positive men were significantly more likely to have been tested for HIV in the past (OR: 2.0; 95 per cent confidence interval [CI]: 1.1 – 3.6); however, testing in the previous year was not associated with HIV status as measured in this study.

Overall, 14 per cent of survey participants reported an STI diagnosis in the previous 12 months. HIV-positive participants were significantly more likely to report an STI diagnosis in the previous 12 months than those who tested HIV negative (OR: 2.1; 95 per cent CI: 1.0 – 4.3). Only 49 per cent of participants with an STI diagnosis or symptoms in the previous 12 months said they had sought treatment from a doctor or nurse.

Fifty-seven per cent of survey participants reported using a public sector health service, 45 per cent reported using a private health service, and 5 per cent reported seeing a traditional healer in the previous 12 months (Table 1). Only 30 per cent of participants had private health insurance. Patterns of health service utilization, and private health insurance coverage reported, did not differ by measured HIV status.

Table 1: Survey participants' utilization of health services in the previous year

Characteristic	*All participants (%) (n=276)*	*HIV-negative participants (%) (n=147)*	*HIV-positive participants (%) (n=113)*	*Odds ratio (OR) (HIV positive versus HIV negative)*	*95% confidence interval OR*
Used a government health service in the previous 12 months (%)	56.9	59.2	56.6	0.90	0.55–1.5
Used a private health service in the past 12 months (%)	45.4	45.1	41.6	0.87	0.53–1.4
Used a traditional healer in the past 12 months (%)	4.8	5.6	4.6	0.81	0.26–2.5
Private health insurance membership (%)	30.6	28.9	27.6	0.94	0.55–1.6

Provider preferences

Key informants differed with regard to whether health services for MSM should be mainstreamed within the public sector, or whether separate services were needed; overall, they agreed on the need for some specialized services for MSM. Almost all survey participants stated that they would be willing to use a health service run by a gay organization or one catering specifically to MSM, and expressed an interest in attending a workshop or individual counseling on how MSM could prevent themselves and their partners from getting HIV (Table 2).

Factors influencing utilization and health-seeking behavior

Participants in interviews and FGDs identified their health service utilization as being influenced by both structural (unresponsive

Table 2: HIV and STI service acceptance and service preference

	Percent
Service acceptance	
Willing to use a health service run by a gay organization or catering specifically for MSM	96.1
Interested in attending a workshop on how MSM can prevent themselves and their partners from getting STIs	96.4
Interested in attending a workshop on how MSM can prevent themselves and their partners from getting HIV	97.2
Interested in attending individual counseling on how MSM can prevent themselves and their partners from getting HIV	91.8
Service preference	
Preferred location of HIV prevention service	
Gay center	62.3
Community center	12.1
Youth center	10.3
Government clinic	6.8
Private clinic	4.3
Internet chat room	2.5
Workplace clinic	0.7
Preferred setting for a session on HIV prevention	
Men's group	47.7
Individual counseling	32.7
Seminar/workshop	15.0
Internet chat room	1.8

health system; lack of targeted health services; hetero-normative health services; unsympathetic/insufficiently trained health-care providers; stigma and discrimination) and individual factors (reluctance to test for HIV or utilize existing government services; non-disclosure of sexual identity or practices; lack of awareness and information).

Unresponsive health system

As illustrated below, the interviews and FGDs revealed that government health services have been generally geared toward the needs of heterosexual people, reflected in the provision of services; the wording of HIV guidelines; and the content of health education materials:

> There are hetero-normative questions regarding HIV and pregnancy, the kinds of questions that are asked and the assumptions made [by health workers]: There is either the fear of offending people, or simply not thinking about a different set of questions. (Key informant 2, human rights expert, Johannesburg)

> I think it would be nice for gay people to have their own particular place, because a lot of heterosexual people are working in those institutions. They ask you: 'Do you have a girlfriend?' and you say: 'No.'; and you become afraid to tell them that you are gay. (FGD 13, Durban)

This lack of responsiveness was attributed to health-care providers at public sector health facilities not being well versed with the health needs of MSM; homophobic attitudes; and a lack of training to provide services appropriate to MSM:

> When you go to a clinic being gay, you will be treated differently compared to being straight. They [MSM] are treated badly that is why some of them hide their sexual orientation. (FGD 6, Johannesburg)

> The [nursing] sisters in the clinic are very rude to us, especially to the HIV patients. They let you sit in very long queues and you get vitamin B tablets. You have to sit more than eight hours to get

> two packets of tablets. If you are HIV positive, they treat you like a dog. (FGD 7, Johannesburg)

> At the clinics, if you have an STI and tell the nurses that you have sex with a guy, it becomes a joke. I would really like to challenge the government to train these people [health care providers], because they [government] included us in the Bill of Rights. (FGD 13, Durban)

> We have tried to work on changing our staff's attitudes, but it is quite difficult. Religious staff often find it very hard to cope with [MSM], because their church is telling them that homosexuality is a sin. (Key informant 26, senior government manager, Cape Town)

Respondents also noted resource constraints as impediments to the utilization of health services:

> For MSM, when they know about their [HIV] status, the question is what will happen. There are issues around affordability of medicines; taking care of themselves; having to go to a public [government] clinic; and being put on a waiting list. (Key informant 1, LGBT activist, Johannesburg)

Stigma and discrimination

Sexual relationships between men remain unacceptable in many communities, particularly in Black African communities:

> I think the challenges faced by MSM are discrimination and being scared to come out – services are not very accessible and there is stigmatization. (Key informant 3, government manager, Johannesburg)

> For many working class [gay] people, they depend on their families, where there are still deeply embedded religious and cultural issues that are not being addressed. (Key informant 27, AIDS activist, Cape Town)

Owing to stigmatization of homosexuality, MSM may fear to disclose their sexual orientation and practices to health workers:

> People are scared of discrimination. I think the law might have changed a bit, but people are still discriminated against, even in the health services. (FGD 10, Johannesburg)

> I think MSM feel self-conscious and there is an inner fear of going to a public health facility; to say 'yes, I've engaged in this kind of behavior' because they are afraid of what the health worker will say. (Key informant 23, HIV surveillance expert, Pretoria)

> We go to clinics and hospitals, but most men having sex with other men do not reveal their sexual orientation, because they are afraid of discrimination. I know one guy who was asked by the counselor about his sexual orientation. She started giving him a lecture about how wrong it is to be homosexual, instead of counseling him. (FGD 12, Durban)

Key informants and FGD participants talked about the double discrimination that many HIV-positive MSM experience because of their sexual orientation and HIV status:

> Most HIV-positive gay men are scared to come out into the open. There is fear of rejection, and also self-blame. Being positive is often interpreted as the results of being gay. There is also the issue of one's own families and how they will react. (Key informant 1, LGBT activist, Johannesburg)

> They [communities] do not want to accept you. Especially when they find out that you are positive, then they reject you. You are nothing. They say your one foot is in the grave. (FGD 7, Johannesburg)

Fear of HIV testing

Key informants and FGDs identified widespread fear of HIV testing as being another impediment to health service utilization. Several

key informants pointed out that men in general are more reluctant to be tested for HIV than women, and tend to be more private about their HIV status, while many FGD participants expressed a fear of HIV testing:

> We all have a fear of that waiting period. It would all depend on the individual himself. If they are confident enough to go through it [HIV] testing they will probably do it. (FGD 11, Cape Town)

> People tend to be scared. In the gay community, there is this generalization that we all have HIV, which is a huge discouragement [for HIV testing]. (FGD 15, Durban)

Key informants and FGD participants identified a lack of information and awareness, particularly of prevention services, as influencing health service utilization:

> I think they [MSM] actually don't know much about HIV prevention. … gay people don't really understand how you could get HIV. (FGD 18, Cape Town)

Discussion

This study is one of the few studies to combine survey data with qualitative data to provide insights into factors influencing MSM's health service utilization in South African cities.

The majority of survey participants depended on the public health sector. However, except for a few externally funded NGO program initiatives, government services targeting MSM were scarce. Key informants and FGD participants pointed to both structural and individual factors that influence health service utilization. Key informants reported negative and judgmental health worker attitudes towards MSM, and discrimination against MSM in health-care settings. FGD participants were reluctant to use public sector health-care services and to disclose their sexual orientation to health workers because of past negative experiences. These findings are similar to those of other African studies that reported low rates of disclosure of sexual practices to health workers, driven by both fear and experience of

stigmatization and discrimination.[20–22] A Kenyan study found that MSM in Nairobi did not approach health-care providers for advice, for fear of exposure, and discrimination.[23] Another African study found that homophobia limited MSM's utilization of HIV and AIDS programs.[4] A South African study of MSM's experiences with health workers found that MSM avoided services where they felt stigmatized by health workers, and that many non-gay-identified MSM denied or avoided discussing their same-sex behavior with health workers.[20] When health workers do not consider the needs of MSM, or create barriers to care, it is difficult to ensure utilization of HIV prevention and treatment services.[21]

Given MSM's experiences of an unresponsive health system, and stigma and discrimination, it is not surprising that only 7 per cent of survey participants indicated a government clinic as a preferred health-care provider. This may have been shaped by previous negative experiences of government health services, as well as by general perceptions of sub-optimal quality of public sector facilities.[24,25] An even smaller percentage (4.3 per cent) of participants indicated that a private health-care provider was their preferred provider, suggesting the need for discussion and debate about increasing the supply of dedicated MSM services. The high percentage of respondents willing to attend a workshop or individual counseling on HIV prevention is encouraging, as both individual- and group-level interventions have been shown to be effective.[26]

Conclusion

Enhancing our understanding of MSM's health services utilization is critical in planning appropriate health services, as South African studies have confirmed a higher HIV prevalence among MSM compared with men in the general population.[13,27,28] Our study findings confirm the need for targeted HIV prevention and treatment services for MSM. Although the study suggests that MSM would prefer to attend facilities dedicated to their needs, this is unlikely to be achievable, given current resource constraints and health system challenges.[29] Government has a critical role in ensuring the provision of health services. As a first step, implementation of the NSP and the revision of HIV and AIDS guidelines and programs to meet the needs of MSM, would go a long way towards addressing service gaps, without incurring major

additional costs.[7] Existing continuing professional development and in-service training programs could be used to focus on sensitivity training for health-care providers. As many MSM feel more comfortable using dedicated services, support for LGBT organizations that provide health services should be increased, and lessons learned from these services should be incorporated into existing government services. The feasibility of establishing dedicated services or centers of excellence for MSM should also be investigated, and sustained civil society advocacy is needed to ensure implementation of NSP targets.

South Africa already has enabling legal and policy frameworks in place that emphasize equity, social justice, and non-discrimination. These frameworks are essential prerequisites for meeting the health needs of MSM. The country has the potential therefore to provide a leadership role in sub-Saharan Africa by improving service provision for MSM, thus providing important lessons for other low- and middle-income countries.

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