Chapter 15
Layered Stigma and HIV/AIDS: Experiences of Men Who Have Sex with Men (MSM) in South Africa

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1 Introduction

While HIV emerged in central Africa and spread southward, the first HIV/AIDS cases in the Republic of South Africa were diagnosed in men who have sex with men (MSM) in the mid-1980s.[1] Unlike the primarily homosexually spread HIV epidemics of North America and Western Europe, the modern South African AIDS crisis has been primarily driven by heterosexuals. In fact, the heterosexual HIV/AIDS epidemic in South Africa has completely eclipsed AIDS among MSM. Nevertheless, HIV continues to spread among South African MSM (Burrell et al. 2010; Lane et al. 2011; Rispel et al. 2011). Not unlike other marginalized and disenfranchised populations, South African MSM have limited access to HIV/AIDS prevention programs and health resources, including targeted education programs, HIV testing and counseling, care services, and antiretroviral therapy. Given the generalized AIDS epidemic and limited health resources in South Africa, it is understandable that any one group may not be singled out for prevention and treatment

[1]Note that we use the behavioral term MSM which encompasses gay and bisexual men as well as heterosexual men who may on occasion engage in same-sex acts. When referring to sexual identities, we use the terms gay, bisexual, and heterosexual, but we acknowledge that gay, bisexual, and heterosexual are Western conceptualizations of same-sex desires and are not indicative of localized categories of same-sex desire between men.

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services. However, MSM may be the most difficult to reach population because they remain invisible and unattended in South Africa's HIV/AIDS prevention and treatment services.

A history of homophobia and criminalization of same-sex behavior in many southern African countries including South Africa undoubtedly plays a critical role in the absence of HIV/AIDS services for MSM. It is well established that MSM conceal their sexual orientation and engage in clandestine sexual relations. Secrecy is also maintained when MSM test HIV-positive, concealing their HIV status from sex partners. Failure to disclose ones HIV-positive status to sex partners can place them at risk, further propelling the HIV epidemic (see also Chaps. 16, 17, and 18 in this volume). With little research until recently conducted on the HIV risks facing MSM in South Africa, there remains an urgent need to take stock in what we do know and to identify our gaps in knowledge. Examining where we are at the present time of the epidemic and what we know is critical to developing a research agenda as well as to inform prevention programming and treatment services. The purpose of this chapter is to examine the current state of research on MSM and HIV/AIDS in South Africa. In this chapter, we briefly discuss same-sex behavior and sexual identities in southern Africa more broadly and then we review HIV/AIDS in reference to MSM in South Africa in particular. We also describe research findings from a qualitative study of HIV-positive MSM and examine layering of stigmas experienced by HIV-positive MSM. We conclude with recommendations for advancing HIV prevention targeted to South African MSM within the framework of a human rights perspective.

2 Same-Sex Sexualities in Southern Africa

There is a growing body of research on same-sex relationships in southern Africa. Gay and bisexual men are unlikely to come forward to participate in research given the degree of risk for negative social consequences that they face. In parallel to gay men's reclusiveness, there is also considerable reluctance to focus on MSM among researchers and service providers. A sense of denial regarding homosexuality contributes to the continued lack of attention to this population (Johnson 2007). Another factor that significantly contributes to the lack of research on MSM in southern Africa stems from stereotyping the masculinity of African men and denial of homosexuality in African culture (Constantine-Simms 2000). Myths of African sexuality and beliefs about inherent differences in sexualities between Africans and Western populations have also contributed to a general ignorance of diversity in sexual orientations (Reid and Walker 2005). Still, others have pointed to traditional customs among indigenous populations for the suppression of homosexuality (Epprecht 2006).

Anthropological research has provided insights into the long-standing history of homosexuality in African cultures. For example, Teunis (2001) investigated homosexual relationships between truck drivers and adolescent boys in Dakar Senegal and found these practises well established. Adolescent homosexuality is also described by Lockhart (2002) who studied the sexual behavior of street boys in Tanzania. In both cases, power differentials between older men and adolescents

were obvious in the sexual dynamics and directly tied to HIV risks. The history of homosexuality in countries such as Lesotho and Nigeria is also well documented, with sexual relationships reflecting stereotypical male-female gender roles in traditional marriage (Epprecht 2002; Allman et al. 2007). Culturally defined heterosexual roles also characterize homosexual relationships in South African culture, such as the "male wife" role characteristic of sexual encounters which were found in some South African mining townships (Halperin 1999). These power differentials have human rights implications that extend from those that occur in the same gender-power dynamics of heterosexual relationships.

With the rise of HIV/AIDS, there has been greater attention to homosexuality in some African countries such as Burkina Faso, Gambia, and Senegal (Niang et al. 2004). Although the increased attention to MSM in the context of HIV/AIDS has brought benefits of increased knowledge and awareness of needs, there has also been a price paid for blaming MSM for the AIDS crisis, further increasing the social stigmatization of MSM (Van Kesteren et al. 2005). The layering of AIDS stigma and homophobia is a common social phenomenon that may even be enhanced in countries where homosexuality is denied and AIDS is highly stigmatized. Same-sex relations are often seen as unAfrican and homosexuality is considered a European perversion or "White thing" among some Black South Africans (Lillah-Chiki 1999; Isaacs and Miller, 1985; Grundlingh 1999; Stein 2001; Graziano 2004).

There are also exaggerations of homosexuality in southern Africa along with unfounded beliefs that HIV epidemics are primarily attributable to the practise of anal intercourse, both among homosexuals and heterosexuals (Brody and Potterat 2003). The myth that HIV is not transmitted via vaginal intercourse is used to suggest that homosexuality and heterosexually practised anal sex are far more prevalent than ever before considered given the extent of AIDS in Africa. While the risk for HIV transmission is substantially greater for anal intercourse than vaginal intercourse, there is no credible evidence that anal intercourse is practised frequently enough to account for the HIV epidemic in southern Africa. In the absence of empirical evidence, exaggerated accounts of anal sex have caused backlash by falsely suggesting that vaginal intercourse is safe. In summary, research in southern Africa suggests that homosexuality is highly stigmatized and when layered with AIDS stigmas, poses serious challenges to HIV/AIDS prevention, testing, and treatment. Masculinity perceptions and misinformation about the relative efficiency of modes of HIV transmission have also served to further marginalize MSM.

3 HIV/AIDS and South African Men Who Have Sex with Men

Beginning in the early 1980s in the Western Cape of South Africa, HIV infection was characterized by male homosexual transmission, similar to patterns identified among gay men in the northern hemisphere (Ras et al. 1983; van Hermelen et al. 1997 cited in Burrell et al. 2010). Following this time, there was a considerable amount of attention given to redefining gay identities and gay communities in South Africa. Pegge (1995), for example, described the lives of gay men and lesbians with specific attention to gay men living in Cape Town. In this account, when the HIV

epidemic amplified in South African gay communities, there was still considerable secrecy about homosexuality and AIDS which acted to drive these communities even further underground. The early association between HIV/AIDS and gay communities in South Africa acted to further stigmatize homosexuality, defining AIDS as a gay disease, particularly with white South Africans, much as it did in the USA during that time. Also in parallel to the history of AIDS in other countries, the public's early failed response to AIDS in South Africa, particularly between 1983 and 1994, led to a further rejection of homosexuality and blame for HIV/AIDS that added to homophobia and the stigmatization of same-sex relationships.

The early association of AIDS to gay communities did, however, lead to behavior changes among some gay men in the face of the rising HIV/AIDS epidemic. The "AIDS scare" influenced some gay men in South Africa to practise safer sex, to cease their involvement in commercial sex establishments, and to change their partnering patterns, becoming more monogamous or serially monogamous. Although it is apparent that some gay men changed their behavior in South Africa in response to AIDS, there is no reliable estimate for current sexual risks and protective practises in male homosexual relations. The lack of information about gay men and their risk for HIV fuels denial and even avoidance of studying homosexuality, further contributing to the lack of public health attention to this population. The lack of HIV/AIDS surveillance among MSM in South Africa contrasts with other countries suffering generalized AIDS epidemics such as Thailand, where there is evidence for widespread HIV/AIDS among MSM and the need for prevention and care interventions targeted to MSM (Van Griensven et al. 2005). In the absence of active monitoring and surveillance, however, we are only left to guess the true extent of HIV/AIDS in South African MSM. We also do not know which needs among HIV-positive MSM are unmet since MSM remain hidden in the HIV/AIDS epidemic (Botha and Mtetwa 1995; Potgieter 2006; Pugh 2007).

Lane et al. (2006) confirmed that stigmatization and fear produce barriers to accessing HIV counseling and testing, as well as other prevention programming, among South African MSM (see also Chap. 6 in this volume). He also found that black South African MSM engage in considerable high-risk behaviors, with as many as one in four black MSM infected with HIV, a level of HIV prevalence that creates a particularly high-risk situation for HIV transmission. Nevertheless, South African MSM remain marginalized and unattended in HIV prevention and care. South Africa's inattention to a relatively small number of persons who are at great risk within a larger and more diffuse generalized AIDS epidemic creates an obvious inequity, and this human rights neglect translates to further spread of HIV. In addition, social stigmas attached to both homosexuality and HIV/AIDS likely combine to further complicate HIV prevention efforts.

4 Experiences of Layered Stigma Among MSM Living with HIV/AIDS

Layered stigma refers to multiple stigmatized identities, such as those ascribed to race, gender, and HIV status, existing within a single individual. In the present case, we are referring to the stigmas ascribed to homosexuality and HIV-positive status.

The adversities of each stigmatized identity are thought to multiply when layered, the degree to which is determined by culture. Stigmatization is also the basis for concealment of hidden identities, creating the vicious cycle of stigmas leading to concealment, social isolation, and further stigmas (see also Chaps. 1, 2, and 3 in this volume).

Layered stigma will be greatest in contexts with strong masculine-defined male roles and perceived taboos of AIDS, such as peri-urban townships. Same-sex relationships among men in South African black townships are therefore often clandestine for fear of being stigmatized and ostracized by family members and friends. In addition, MSM and gay couples in black South African townships are physically attacked for their sexual orientation (Lillah-Chiki 1999).

To illustrate the experiences of layered stigma, we draw briefly from a qualitative study conducted with HIV-positive MSM in Cape Town. Survey data were also collected in 2005 and reported in previous research (Cloete et al. 2008). A qualitative study was conducted as part of formative research for the adaptation of two risk-reduction interventions to the South African context for people living with HIV/AIDS. Fourteen key informants were interviewed, seven of whom were affiliated with support groups for people living with HIV/AIDS and the other seven represented nongovernmental organizations, activist groups, government departments, or training services. We also conducted eight focus group discussions with existing support group structures that were situated at either antiretroviral (ARV) treatment sites or organizations that provide services to people living with HIV/AIDS. Access to these support groups was obtained through the same key informant participants described above.

Two focus groups were conducted with MSM; participants were accrued using convenience sampling techniques, mostly by word of mouth (Liamputtong 2007, 2013). Issues explored in both the individual and group interviews included the challenges facing people living with HIV/AIDS. The interviews and focus groups were audio-recorded, transcribed, and translated as needed. A thematic analysis was undertaken to distill and interpret the data (Liamputtong 2013). We used a grounded theory approach to extract data from the narratives. All interviews were conducted either by the first author or under the direct supervision of the first author. The study was approved by the Research Ethics Committee of the Human Sciences Research Council.

In this formative research, among self-identified HIV-positive gay men, it was found that AIDS-related stigma were pervasive in their lived experiences. Examples of self-blame and internalized AIDS stigma were common. Examining the views of men that we interviewed illustrates the common stigmas and discrimination that MSM experience and how AIDS stigma becomes layered on stigmas of homosexuality. For example, one participant said:

> For gay men the experience is slightly different to straight people because it confronts us on another level with our own sexuality, and the sense of shame and guilt that resonates from that internal phobia is quite profound for gay men, it makes the crisis of acceptance much more difficult than for straight people.

Experiences of stigma were closely tied to sexual identities as illustrated when a man stated his sense of self: "us as gay men, our sense of self is often very, very heavily invested in our sexuality, our bodiliness…"

Others reiterated this sentiment expressing that

> It's not the crisis of going out and telling the people, the sense of shame is internal. And it often confronts us with our sexuality, yes, and that sense of shame and guilt.

HIV-positive MSM mentioned that they talked more to their straight friends about HIV than their gay ones stating, "there [is] almost more discrimination within the gay community." They also suggested a sense of not confronting the possibility of becoming infected, "what the gay community in Cape Town is doing is that there is a collective denial."

The discrimination and rejection from the gay community then seemed to stem from this denial, as one participant said "and they go into denial and then you come along and you … and you like, they don't want to know about you because you are the thing they afraid of."

According to the participants in our focus groups, being gay and HIV-positive was like a "double whammy," and feelings of internalized AIDS stigma are greater among MSM compared to heterosexual experiences. This sentiment reflects layering of stigmas as stated by one man:

> It's made more difficult for those people who are homosexual because in many cases they in the closet about their sexuality and if all of a sudden the situation concerning the HIV status come out it's double the trouble as it were.

In addition to dealing with the issues of discrimination and stigma, many HIV-positive MSM find it challenging to access services that meet their HIV treatment and care needs. Considering the layered stigmatization experienced by many HIV-positive MSM seeking health services remains a formidable problem. One of the primary reasons for this is that MSM are still discriminated against by healthcare practitioners working within mainstream public health facilities. Rectal exams are not routinely performed and requesting this procedure will surely disclose ones sexual orientation. In addition, experiences of internalized stigma can impede HIV-positive MSM from seeking health and treatment services:

> … [for those men]…who want to be straight but are having gay sex and so they are HIV positive and they "gay" but they trying to live a straight lifestyle…I mean I know a lot of people like that, that never face any of the issues and they die because of they can't get medical help because they don't want to acknowledge they've got HIV.

A theme that recurred throughout our discussions with these South African MSM was that there remains a general lack of understanding in mainstream healthcare about the issues facing MSM and ignorance of their HIV prevention and treatment needs. Another recurring theme focused on the challenges of adhering to antiretroviral drug regimens and finding a suitable health practitioner or service provider working within the gay community. In our focus groups, there was much concern about the challenges of taking ARVs. Participants talked of taking "cocktail breaks,"

> … if for instance you are going on holiday and you are going to use recreational drugs … they (doctors) advice you to stop the ARVs.

Such interruptions in ARV treatment regimens run the greatest risk for developing treatment-resistant strains of the virus. It was also common for men in the group discussion to talk of engaging in alternative medications and therapies for maintaining their health status other than adhering to the ARV treatments. A general reluctance by HIV-positive MSM in seeking mainstream medical services was evident in our discussions around health, care, and treatment issues and poses a significant threat to public health as well as infringements on human rights.

5 Human Rights and HIV/AIDS

As declared by former President of South Africa Nelson Mandela, HIV/AIDS is a human rights issue, perhaps even more so among MSM. South Africa was the first country to include the right to express sexual orientation in its national constitution. The Equality Clause of the Constitution specifically states:

> Everyone is equal before the law and has the right to equal protection and benefit of the law… The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth (Constitution of the Republic of South Africa, No.108 of 1996, Issue 23: 1247)

This constitutional right protects the freedom of sexual expression but its implementation and transformation of social and cultural daily practise have not been realized by many South Africans. Fear of disclosing sexual orientation remains commonplace, with MSM experiencing a sense of vulnerability that they could fall victim to stigmatization and discrimination. The pressing concealment of sexual orientation also creates barriers to seeking healthcare. In fact, only in 2007 did the HIV/AIDS and STI Strategic Plan for South Africa 2007 – 2011 acknowledge that MSM have been neglected in the country's efforts to prevent and treat HIV/AIDS.

South Africa's constitutional protections against discrimination for sexual orientation afford countless opportunities to bring MSM out of the shadows and into the reach of public health interventions. AIDS stigmas add a layer of concealment that ultimately propagates the spread of HIV. Leadership at the highest levels is necessary to change the course of public attitudes and beliefs about HIV/AIDS. The credibility of President Mandela and his stand on AIDS have helped to counter denialist and anti-medical forces in South Africa. Nevertheless, policies are set by sitting presidents and health ministries, and here, South Africa has suffered great setbacks. Increasing access to antiretroviral treatment has been slower in South Africa than in most other countries in the region, with mother-to-child transmission rates remaining high in South Africa, whereas the rates of infected infants among their much poorer neighbors have plummeted. For example, the rate of HIV transmission from

pregnant women to their newborns in Botswana, a poorer country than South Africa, is approaching nearly zero because of the country's universal testing and treatment program for pregnant women. In South Africa, nearly one in five babies born to HIV-positive women are born HIV infected. These statistics represent the more general resistance in the health ministry to increase treatment access. The slow roll out of HIV treatments by the South African government is the result of a confused HIV/AIDS policy that has historically embraced HIV/AIDS dissident views. The lack of a science-based HIV/AIDS health policy obviously impacts everyone affected by AIDS but perhaps even more so among those who are marginalized by the healthcare system, particularly gay and bisexual men.

There are also apparent inequalities in access to HIV prevention for MSM in South Africa. Gay men's health clinics and gay-friendly clinical services are scant and located in the major socio-economic hubs of South Africa. The lack of gay-sensitive health services is particularly problematic for the detection and treatment of sexually transmitted infections in rural areas. Health workers who exhibit homophobia may mistreat men who require rectal examinations for diagnosis and treatment. Men are likely to withhold symptom complaints that can be indicative of rectal infections which can become life threatening when untreated. Discriminatory practises in healthcare are violations of basic human rights that require structural interventions at all levels of government and civil society. One alternative could be to establish specialized gay-sensitive clinics in targeted areas that approximate gay communities. However, this approach will isolate services in only a few large cities and will not provide any true increase in services. Specialty clinics for men are also unrealistic given the lack of resources in South Africa, especially outside of large cities. The more realistic alternative is to train health workers in gay-related health issues and provide sensitivity training. At the very least, intensive sensitivity training is needed for health workers in prisons, migratory work camps, and mines. It is also essential that existing laws and constitutional protections be enforced to assure the rights of all people to receive health services without discrimination including those who are incarcerated (see also Chap. 8 in this volume).

6 Conclusion

Society-level interventions need to be put in place to protect the rights of South African MSM, just as they are needed for women and other marginalized and disempowered populations. For example, HIV voluntary counseling and testing (VCT) services can be tailored for MSM to address issues of sexual orientation and gender power. Outreach and community-based VCT can help engage MSM to access HIV prevention services. Promoting HIV testing for everyone reduces the stigma of anyone getting tested. Assurances of privacy in the counseling context afford opportunities for honest discussions of risk and risk reduction. Still, community-based HIV-VCT will not be trusted by some people in terms of privacy, especially those who are suspicious of public health systems. Centralized and clinic-based VCT can

offer a greater sense of confidentiality and anonymity for some people seeking VCT. In South Africa, it is common for people to travel considerable distances to nearby cities to receive sexually transmitted infection services and HIV-VCT rather than utilize neighborhood clinics where others know them and see individuals who are receiving services. From both a human rights and a public health perspective, assuring multiple options for receiving VCT in a variety of settings will help promote testing access and uptake.

In addition, HIV prevention campaigns aimed to reach MSM can be venue-motivated. Prevention campaigns for MSM can be delivered at places where MSM congregate, such as gay-friendly businesses, social clubs, Internet cafes, bars, massage parlors, and so on. Besides targeting gay-identified venues, national prevention campaigns should explicitly include sexual behaviors frequently practised among MSM, especially anal intercourse, in their prevention campaigns. Researchers should also be encouraged to collaborate with gay communities and sexual rights organizations when conducting HIV/AIDS research. Collaborations with local gay organizations and sexual rights organizations should be developed with consultation to representatives of such organizations. Collaborative research that is conducted in a culturally sensitive manner improves our chances for attaining meaningful and implementable research findings.

In conclusion, MSM should be considered a high-priority population for HIV prevention in South Africa. The layered stigmas ascribed to homosexuality and HIV/AIDS pose unique challenges to HIV/AIDS prevention, detection, and treatment. Fears associated with stigma keep people from seeking testing and treatment. Health services in prisons, work camps, and mines should provide nondiscriminatory and non-stigmatized services to all men. In South Africa, layered stigma is further complicated by historically salient perspectives on masculinity and homophobia which invariably lead to gender-based discrimination. Gender- and sexual orientation-sensitive sexual health services, particularly for detecting and treating sexually transmitted infections and accessing HIV counseling and testing, will be necessary for South Africa to stem the HIV epidemic among MSM.

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