

The New Cultural Politics of the Waiting Room: Straight Men, Gay-Friendly Clinics and ‘Inclusive’ HIV Care

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Abstract Community-based health services which provide HIV care in Australia are typically known as ‘gay-friendly’, but little is known about what this might mean for engaging the broader diversity of people with HIV, particularly heterosexual men. We conducted a secondary analysis of qualitative interviews with key informants and clinicians to capture the meanings attributed to gay-friendly HIV clinics and to explore what these also reveal about the dynamics between sexual identity and HIV care today. Described as safe and welcoming for gay men, and promoting a politics of inclusion, the ‘branding’ of HIV health services as gay-friendly was also believed to have unintended effects, including the misconception that others are not welcome and that heterosexual men will stay away for fear of being misidentified as gay. Countering this were stories about heterosexual men who had challenged their own assumptions about HIV health services and clinicians who viewed the changing demographics of their patient population as both a challenge and an opportunity. Taking account of the shifting meanings ascribed to HIV health services is essential in responding to the changing needs of the positive community and in understanding the new cultural politics of the waiting room.

Keywords HIV/AIDS · Targeted health services · Sexual identity · Inclusion · Australia

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Introduction

Pioneered by the women’s health movement (Kuhlmann 2009), the targeting of health services according to gender, cultural background or age group is an accepted means of addressing population health inequities today, particularly among groups who may feel unsafe attending mainstream health care settings (Armstrong 2006; Scott et al. 2012; Thomas and Zimmerman 2007). The gay and lesbian health movements were critical in highlighting how sexual and gender differences can shape health service access (Landers et al. 2011), with evidence continuing to emerge about the complex ways in which health services can contribute to the production and reproduction of heterosexist assumptions and practices (Khan et al. 2008; Knight et al. 2013; McNair et al. 2011). Australia has a unique history in this regard, with a number of general practice (community-based, privately operated) and sexual health (publically funded) clinics forming in inner city areas in the 1970s and 1980s to deliver targeted health care to gay-identified and other men who have sex with men as well as other marginalised groups. Providing a safe and welcoming primary health care environment for people identifying as gay, lesbian, bisexual or transgendered (GLBT) can be viewed as both a medical and social triumph in a country which has historically featured high levels of homophobia (Plummer 2001), although in recent years this have begun to improve (Flood and Hamilton 2008).

Gay men continue to be disproportionately affected by HIV in Australia, so it is entirely appropriate that many of these deliberately ‘gay-friendly clinics’ developed a broad and widely recognised expertise in HIV medicine from the beginning of the epidemic (Pell et al. 2008). This synchronicity between HIV and gay men’s health was facilitated by the political ‘partnership’ forged between these two social movements and was similarly evident in other Western

nations with high rates of HIV among gay men (Dowsett et al. 2005; Landers et al. 2011). Other primary health care clinics operating in inner city areas also developed expertise in HIV medicine in response to local community needs. Together, these community-based HIV health services have provided a range of medical and other health care services to people living with HIV and to gay men, more generally in the 30 years since HIV was first diagnosed in Australia (Newman et al. 2011). A central, guiding purpose of these clinics has been to provide a space to challenge, or at least counter, the social stigma attached to HIV since its earliest detection (Sontag 1990[1989]), one which continues to shape the health care experiences of people living with HIV today (Sayles et al. 2007). Clinics that aim to counter the negative effects associated with the stigmatisation of HIV are clearly crucial. However, in this paper, we are interested in exploring some of the more complex or unintended effects of the particular histories of these ‘inclusive’ HIV health services, particularly in light of the increasing number of new HIV diagnoses attributed to heterosexual transmission in Australia (The Kirby Institute 2012).

There is very little research available which describes the perspectives of HIV-positive heterosexual people regarding the health services they attend for HIV-related care. In the late 1990s, a small amount of social research began to report that some HIV-positive women felt unwelcome at clinics which had been established in the context of a largely gay men’s epidemic (Metcalf et al. 1998). Then, in 2006, the Straightpoz Study, a qualitative study of heterosexual men and women living with HIV in Australia, reported that many participants described feeling like ‘cultural outsiders’ in HIV health services due to the perceived focus of some of those services on gay men:

HIV services in [New South Wales] are open to all people with HIV, regardless of gender and sexual identity. Yet, the particular language and imagery commonly used in the sector, along with the explicit focus of some services on gay, lesbian and transgender communities, contributed to a sense of exclusion among participants or to a perception that many HIV services were not for them....The majority of participants recognised that the gay community had been disproportionately affected by the virus and that it had been intimately entangled with the HIV epidemic from the very beginning....[But] because of the historical connection between HIV and gay men in Australia, a community and a sector has developed that has a culture, language and particular ways of relating that are safe and meaningful for that community, but not always perceived as safe, welcoming or supportive by those living heterosexually with HIV. (Persson et al. 2006, p. 41)

In a more recent paper based on the same study, Persson reproduced the following extract from an interview with a heterosexual man who was described by the authors as ‘trying to articulate a place in the epidemic’:

It is difficult for me to have my condition defined in a foreign sexuality to me, and have the services almost shaped around that. And that’s completely separate to—like because I think there should be gay everything, really, I’ve got no problem with that. But the shortage of, not services but, an overview and perspective on straight HIV people is profound, I think...they don’t fit. I think what I’m trying to say is; they don’t seem to fit. There’s no place that they actually plug in to, whereas gay positive people seem to at least have a place to plug in to. (Persson 2012, p. 321)

Similar accounts were provided in a recent Canadian paper which describes the ‘help-seeking experiences’ of heterosexual men living with HIV, concluding that “heterosexual men perceive themselves to be an afterthought when funding for health services...is at stake...[And] resign themselves to accepting whatever they can get after the priorities of gay men and heterosexual women are addressed” (Antonioni et al. 2012, p. 7). These insights build our understanding of the challenges that heterosexual men living with HIV can face in finding a place to ‘fit’ in, particularly in countries where HIV has been predominantly represented as a gay men’s health issue.

This paper builds upon these observations by examining the meanings that circulate in relation to community-based HIV health services in Australia. We consider some of the potential tensions and dissonances which may be associated with the aim of providing socially inclusive HIV care. We draw upon interviews conducted with two groups of people who have an explicit stake in the ‘inclusive’ nature of these services: senior key informants in the HIV field and clinicians who provide HIV care. Given the continuing debates about adapting HIV care models to demographic and geographic changes in the epidemic (Savage et al. 2009), it is more important than ever to think carefully about the meanings attributed to HIV services by different service users and to critique and challenge assumptions that may circulate in policy and clinical contexts about how service users feel about the clinics made available to them.

Methods

This paper describes a secondary analysis of qualitative data collected for the HIV General Practice Workforce Project, comprising in-depth interviews with (1) ‘key informants’ ($n=24$), i.e. senior representatives of government, non-government and professional organisations which shape

HIV care policy around Australia (Newman et al. 2012, 2011) and (2) ‘clinicians’ ($n=47$) who provide general practice care to people living with HIV around Australia (Newman et al. 2013). Ethics approval for this study was received from the National Research and Evaluation Ethics Committee of the Royal Australian College of General Practitioners and the Human Research Ethics Committees of participating universities. All interviews were conducted in-person or by phone between 2010 and 2011. A semi-structured interview guide examined workforce issues shaping the provision of HIV care in general practice in Australia as well as a range of related issues. Audio recordings were transcribed and checked for accuracy and then all participants were allocated numbered codes during the process of deidentification to protect confidentiality.

The ‘key informants’ were recruited on the basis of their professional roles in government, non-government and professional organisations involved in the HIV response in Australia (across all states and territories), including policy making, advocacy, and education and training of medical practitioners. A significant number were trained in medicine and allied health, with the remainder describing their professional backgrounds as ‘community’ and ‘public’ sector or ‘other’. The setting in which they were currently engaged was fairly evenly split across the non-government, government and medical education/training sectors. Their scope of interest in relation to HIV was mostly state or national, but three participants were explicitly concerned about the needs of particular affected populations. The ‘clinicians’ were recruited on the basis of their experience in providing HIV care in general practice settings, across both urban and regional Australia. The majority were family doctors, known in Australia as ‘general practitioners’ (GPs), and accredited to prescribe HIV medications ($n=31$). The remainder had been HIV prescriber GPs in the past, or provided other forms of (non-treatment) HIV care, or were HIV practice nurses. This group of clinicians had been working in the HIV field between 1 and 30 years and represented different HIV caseload settings, with 20 participants reporting a high caseload of HIV-positive patients, 19 low/medium and 8 none (the ex-prescribers).

The first stage of analysis identified all of the sections of interview transcript that captured meanings attributed to community-based HIV health services in Australia. We then discussed what was emerging in this material and noted that much of it was concerned with the social dynamics between sexual identity and HIV care. This same set of concerns was evident in both sets of interviews, even though participants were not prompted to discuss these matters by any of the questions on the interview schedule. The second stage of analysis comprised a thematic analysis to identify patterns and variations in the ways these concepts were articulated and managed in the interviews (Braun and Clarke 2006).

Rigour was established through an iterative process of discussion and revision within the writing team and in consultation with members of the original study teams.

Although we do make some broader statements in this paper about ‘community-based HIV health services’, it is important to note that as our data were focused on the general practice setting, it cannot be presumed to encompass meanings attributed to the publically funded sexual health or other primary health care services also accessed by people living with HIV. In addition, although many of the clinics that provide HIV care in Australia also care for GLBT people, this does not mean they do not have considerable expertise and experience in also providing care to heterosexual people. On the contrary, these clinics may have featured more sexual, cultural, class and generational diversity in their patient populations than many other health services in Australia. What we are interested in, however, is the particular historical moment we find ourselves in today, in which clinics which explicitly welcomed GLBT people because they were not served well by mainstream health care, and were then faced with a singularly devastating and stigmatising epidemic, may now be viewed as having less capacity or interest in supporting the needs of heterosexual people. Our interest is not in testing the value of the health services which care for people living with HIV, but in thinking through some of complex meanings attributed to ‘inclusive’ HIV clinics in the context of a changing epidemic.

Findings

An Extraordinary Artifact: The History and Value of Inclusive HIV Health Care Services

The first theme identified in our data describes a series of beliefs and understandings regarding the history and value of the HIV health services which have also provided targeted health care to the gay community. The following quote describes this history as something that has played a unique and valuable role in the Australian response to HIV:

[T]hese practices, many of which were catering to gay men before HIV and then expanded as it came along, they’ve played an extraordinarily important role in care and treatment and research. But you’ve got to say that it’s an artifact, in many ways. This is not a typical GP model. This is a model that evolved in response to an epidemic. It evolved because it was a particular community: gay men who were getting this disease. It would not have evolved that way, probably, if the circumstances had been different. (Key informant: KI_20)

This quote provides a sense of both the value and the precariousness of these clinics. There is a sense of history in the making, with this particular approach to HIV care delivery viewed by this informant as an ‘artifact’, embedded in a particular time and set of circumstances, even whilst it is recognised as continuing to play a valuable role within the community that was originally so central to its development.

The interviews with GPs working in some of these clinics show how meaningful this ‘mission’ can be.

[I]n the beginning it was very much servicing marginalised groups. I mean we’ve always seen gay men and trannies and prostitutes...[Now] We’ve got quite a few students who are gay but can’t talk about it in their home countries and stuff like that. So, you know, lots of south-east Asian guys or Arabic guys. And we get people from [outer suburb] who, you know, say, ‘My family would kill me if they saw me going into the STD clinic or if, if they found out I was gay and had HIV’...I still see that as important charter for the place, that we serve not only the local community but we be accessible to people who feel marginalised from wherever they are. (Clinician: AP_11)

[T]here’s so many doctors out there who really aren’t comfortable talking, discussing sexuality, discussing sexual health, who find it really uncomfortable to do, to talk about these things. So you really need a specialist service where people are comfortable and knowledgeable about sexual health issues. So, and it’s the same in HIV but it’s more about discrimination or feelings of homophobia. (Clinician: AP_25)

Gay-friendly HIV clinics are described here as providing a space for gay men and ‘other’ marginalised groups to feel comfortable, in contrast to mainstream settings where they can feel silenced or unsafe. Experiences of social discrimination and stigmatization continue to provide a mandate for providing services where non-normative sexual identities and practices can be expressed and articulated in an open, honest and productive way.

A discourse of ‘inclusion’ can be seen to shape these accounts, underlining why these clinics are keen to welcome those who do not feel safe in mainstream health care settings. General practice clinics were described by both GPs and nurses as particularly well placed to enact this inclusive model of HIV care.

[I]f you’re dealing with a disease that still is marginalised, you don’t want to be feeling that when you go to the doctor, from anybody in the clinic. It needs to feel like a place where all comers are welcome...And so I think general practices that do a lot of HIV provide an alternative venue for people

who just wouldn’t go to hospital...[O]ur waiting room is an interesting microcosm of, you know, [the] inner city I guess...[T]here’s gay men with HIV. There’s the tattoos. Lesbians with multiple piercings. There’s a few trannies. There’s a couple of kids brought in by their mum because they’ve got a fever. There’s a football player with a sore leg...So yeah, but they’re all mixed in there together. (Clinician: AP_24)

[S]ometimes the cross-section of humanity in that waiting room is just awesome but there’s no antagonism in there, you know? This is a medical centre where anyone can come to, irrespective of status, ethnicity, gender, age. (Clinician: OC_03)

Clearly, there is a lot invested here in the idea that everyone feels welcome. An inclusive health service is seen to accommodate the needs of people living with HIV as just one aspect of the rich diversity of inner-city life. These clinics are conceptualised as spaces that can transcend ‘real-world’ politics by embracing ‘all comers’ and the ‘awesome...cross-section of humanity’. The waiting room is envisioned as a ‘microcosm’ which provides evidence of the success of this project: ‘ordinary’ people can find themselves ‘mixed in together’ with ‘alternative’ identities, but with no resulting ‘antagonism’.

Whilst we can see that this model of health service is being rendered as a kind of clinical utopia, the significance of celebrating social diversity in a health service setting should not be underestimated. Some of the other clinicians we interviewed provided disturbing examples of prejudiced attitudes expressed by their medical peers, describing instances of “real redneck physicians and surgeons...who just would wash their hands of these people” (Clinician: AP_02). This reveals some of the political motivations behind this model of health care service and may provide some explanation for why these clinicians present such a rosy ideal of what it is like to work in an inclusive health service. However, the following section will explore in more detail some of the more unintended, and culturally significant, effects of uncritically deploying a discourse of inclusion in the provision of HIV care.

Is This The Clinic For Me? The (Unintended) Effects of Inclusive HIV Health Services

As noted above, a discourse of inclusion can play out in multiple ways in the context of HIV care. For some, an inclusive clinic is envisioned as one that values and supports the provision of care to all people living with HIV, in contrast to those more mainstream services which may be unfamiliar with and unprepared to provide HIV care. For others, an inclusive clinic is one that appreciates and celebrates a diversity of sexual identity and practices. Often, the

two are seen to be merged, presuming that a clinic that is ‘inclusive’ welcomes both HIV-positive and GLBT-identified people. The following quote provides some insight into the discursive complexities of this conceptual merger, relying as it does on a type of cultural ‘branding’ regarding who the clinic serves:

I make sure that my patients know that I’m doing HIV medicine. And it’s, well I don’t make sure they know but there’s plenty of obvious signs around. And if they’re not happy with that well, yeah, I’d rather they don’t come here really. So, yeah. I’m very much into inclusive, you know, being as inclusive as possible. (Clinician: AP_14)

This clinician believes that the purpose and politics of an inclusive health service are made ‘obvious’ to clients through a subtle but deliberate arrangement of particular signs and symbols in the waiting room. There is an assumption being made here that anyone who finds themselves in that room will have the cultural literacy to be able to decode those signs as ‘gay-friendly’ (e.g. rainbow stickers) or as explicitly supportive of people living with HIV (e.g. HIV community media).

The following extract suggests, however, that for the most part, this branding does tend to work, and when it does not, the outcomes are more humorous than problematic:

I can only think of one incident—there may have been others—where a woman came into the clinic...and sat down, and looked around at the other patients, and then looked at some of the magazines in the rack, which ranged from National Geographic to whatever the latest gay newspaper is, and flounced up to the desk and said, ‘I don’t think this is the sort of clinic for me.’ To which one of our acerbic type receptionists said, ‘Probably not.’ But that happens so infrequently...Straight, gay, whoever. It’s a real mishmash. (Clinician: AP_24)

This quote, which describes an event which occurred in the past few years, suggests that there continues to be a place for ‘inclusive’ clinics in Australia since prejudiced attitudes such as this clearly persist. However, it also suggests that a clinic which promotes a politics of inclusion is not necessarily welcoming of just anyone. From this perspective, an inclusive clinic seems to be one that welcomes only those with an accepting or tolerant attitude to social diversity—which includes being understanding and supportive of sexual difference—but one which also actively discourages the participation of those who disagree with this politics.

This begins to reveal some of the complex effects of branding an HIV health service as ‘inclusive’ through the

use of gay-friendly signifiers. But in addition to its cultural complexity, this branding can also have unintended effects on those who may not feel that those markers of inclusivity are intended to also welcome them. Indeed, the way that heterosexual people might view the inclusiveness of community-based HIV health services was of great concern to some of the clinicians who took part in this study.

I think for the females that I have that come here, they definitely feel very uncomfortable at the [clinic name] because they’re going to a doctor for their HIV: they’re not going to a gay clinic. And I just think they, they just feel a bit uneasy about that. (Clinician: AP_14)

I think that it would be great if there was more available in the community for HIV positive women. They’re a growing number and certainly we don’t have as many in this clinic because this is sort of [a] ‘gay-focus’ clinic, but it’s also an ‘HIV-focus’ clinic so we’re getting more. (Clinician: AP_28)

[A] lot of the men who have sex with men who don’t identify as being gay tend to go to the hospital because maybe this clinic might identify as being gay or gay associated or gay friendly. (Clinician: AP_15)

These extracts operate on the assumption that there is an explicit and recognised ‘gay focus’ to many community-based HIV health services and that heterosexually identified people living with HIV will feel excluded as a result. In the first two examples, women are believed to feel particularly left out: they want to attend the clinic with the best expertise in HIV care, but do not want to sit in a waiting room where they might feel they stand out. In the last quote, men who have sex with men but do not identify as gay are also described as being reluctant to engage with these services: they may have sex with other men, but only those who identify as gay are seen to be comfortable in those waiting rooms.

Among the key informants, the most explicit concerns related to the needs of heterosexually-identified men, and we observed persistent beliefs regarding how that group feels.

Heterosexual men, I think, have a really difficult time because they, people just think, ‘Oh well they’ve, you know, they must be gay men or bisexual men.’...[E]ven depending how they get it, they’re still asserting that, you know, ‘I’m not, I’m not gay’...[U]sually sexual identity has nothing to do with your healthcare. But suddenly here’s, you know, straight guys going, ‘Well, I want someone who just understands that I’m not [gay]. And [who] isn’t going to insinuate that my lifestyle is similar to that.’ (Key informant: KI_09)

[T]he challenge of, I suppose, having GP practices in places where people are comfortable to go to talk openly about sex and things like that with their partners is, at the same time, them being able to do that and be seen to be doing that for heterosexual people with HIV [as well]. Because, you know, if your practice looks like a gay practice, that's a real barrier for... a heterosexual guy in particular...I've met a few, talked with a few heterosexual guys with HIV recently, I'm very aware of how huge that is. And that, yeah, and how it plays out...like it's this almost irrational fear of being seen to be gay. (Key informant: KI_02)

As can be seen here, several of our key informants were particularly concerned that heterosexual men living with HIV might choose to not attend a gay-friendly HIV clinic in order to avoid having their own sexual identity brought into question. There are several inferences that underpin these extracts. The first is that any man who attends these clinics will be assumed by others to be gay. The second is that heterosexual men are always offended by that assumption. The third is that they will go to great lengths—even to the extent of choosing a health care service which does not specialise in HIV—to prevent such a misunderstanding from occurring. Whilst this points to a possible range of 'unintended' effects that targeted clinics may have, this is likely to be a superficial reading of what all heterosexually identified men will feel. As Persson argued in her reading of the emphatic 'declarations' of sexual identity observed of heterosexual men living with HIV: "We should be careful not to dismiss [this] as simply an expression of homophobia, but rather try to understand the dynamics behind it and the purposes it might serve" (2012, p. 325). This suggests that a more considered approach is required to unpack the assumptions that underpin these narratives.

Am I Still Allowed to Come Here? Challenging Assumptions About Inclusive HIV Health Services

As reported in the Straightpoz Study, many heterosexual men living with HIV in Australia recognise that HIV health services were traditionally targeted to the gay community because of the particular history of the local HIV epidemic (Persson et al. 2006, p. 41, 2009, p. 19). With this in mind, we can see that the reluctance of some heterosexual men to attend a gay-friendly HIV clinic may therefore be less about homophobia and more about wanting to feel connected and supported. As the Straightpoz participant quoted at the beginning of this paper put it, heterosexual men and women living with HIV often feel that they do not have a place to 'plug in' or 'to fit into'. This desire to find a clinic that feels safe mirrors what many of the clinicians and key informants we interviewed described as motivating gay men to seek out

gay-friendly HIV health services. In recognition of this shared desire for HIV health services to be genuinely welcoming to all potential clients, our final theme describes some of the ways that assumptions about inclusive HIV health services can be challenged and changed, including stereotypes of what heterosexually identified men will feel about those clinics and why.

Although, as noted in the previous section, it was quite common for participants to believe that heterosexual men living with HIV were reluctant to attend gay-friendly HIV health services, they also offered several examples of men who were happy to do so and those who had successfully challenged their own assumptions: "Once those [heterosexual] patients end up going to one of those so called 'gay clinics' they just love them, you know, because it's a perceived barrier, it's not a real barrier" (Key informant: KI_12). But for those potential clients who remain reluctant, how does a clinic go about making themselves more welcoming to all? In the following extract, a series of historic shifts are described as marking out the changing attitudes of both staff and patients towards those who attend an HIV health service:

We've got a lot more women coming now...[And] it's been really good...because, you know, sometimes straight guys would come and they'd go, 'I'm not gay. Am I still allowed to come here?' Because the room [is] so obviously gay downstairs. And that was bad in the nineties when we were being assertive. You know, you'd have two leather queens on the couch tongue kissing one another while they're waiting to see the doctor, you know. 'Come on guys!' And, you know, there'd be some middle aged Greek woman that a [doctor in outer suburb] would have referred to see me because she had pelvic inflammatory disease or something. And she'd be thinking, 'I've done something wrong and ended up in hell with these perverts around!' And,...so we were a bit too gay friendly for a while. Anyway, the poofs now are going, 'Oh, what's happened? There's so many women here.' It's good. And that certainly makes the straight guys feel more comfortable if there are a couple of other women in the room and not, they're not just surrounded by gay men. But I think that's really important for us [too]...you get a variety [of clients]...I see that with some of the doctors...they get burnt out, you know. I just think it's too, you're seeing one kind of gay man all the time. (Clinician: AP_11)

This doctor believes that inclusive clinics such as these played an important historical role in supporting the expression of 'assertive' queer sexualities, but that clinicians also have a responsibility to respond to the changing demographics of their patient population and to assure all of their

potential service users that they are in fact ‘allowed to come here’. This clinician sees adapting to an evolving client base as both a challenge and an opportunity, with everyone benefiting from the new cultural politics of the waiting room.

There may, however, be additional complexities associated with the changing dynamics between sexual identity and HIV care, as revealed in the following clinician accounts:

[W]e’re no longer the gay practice that we were actually about fifteen years ago. And in a way I’m a little bit disappointed because I think, ‘Oh, I’m not seeing all these gay guys anymore.’...I think what’s actually happened is that gay men have, I think, have actually felt more accepted in normal society. And I think a lot of them now don’t feel that there’s a problem about seeing a normal GP and letting their GP know that he’s gay. And hence there hasn’t been that need to actually go to a specific gay-friendly practice. (Clinician: AP_18)

I think that history has provided that impetus for men and women who are of different sexualities to come to this practice and the various expertise set that is here. I think it’s different though for young gay and lesbian men and women....I mean often people who are now coming out, now are more comfortable with their sexuality and will access mainstream healthcare services. I think things are changing. (Clinician: AP15)

These quotes remind us that the social and political context in which health services developed expertise in the diagnosis and management of HIV operation has changed. Not only has HIV itself become a very different health condition, with treatments now offering someone who is newly diagnosed the chance for a long and healthy life, albeit one requiring ongoing and close medical management (Lima et al. 2007). Simultaneously, a patient who identifies as GLBT today will be likely to have more health service options available to them than in the past. Whilst they may continue to experience an unacceptable level of homophobic prejudice, they may also be more willing to access health care in ‘mainstream’ settings and no longer need to be quite so careful about discussing matters of sexual identity and sexual practice. Whilst this provides a range of optimistic possibilities for the accessibility and, indeed, ‘inclusiveness’, of health care more broadly, it may be a bittersweet development for those clinicians who sought out an area of medicine which involved working with gay men: for those clinicians who sought out or created clinics which have become famous for their success in engaging ‘marginalised’ populations—populations which are, perhaps, no longer quite so marginalised.

Conclusions

This secondary analysis of interview data from the HIV General Practice Workforce Project, reviewed in dialogue with findings from the Straightpoz Study, provides a valuable opportunity to explore the contemporary meanings attributed to inclusive HIV health services, as well the assumptions and beliefs that may shape these meanings regarding the complex social dynamics between sexual identity and HIV care.

We believe that there are a number of key insights that have been gained from this analysis. The first relates to the achievements of gay-friendly HIV clinics as successfully targeted health services. As noted, community-based HIV clinics in Australia were originally mobilised through the energies of the gay men’s health movement, and even if the relationship between gay men and their ‘communities’ is itself contested and dynamic (Altman 2004; Dowsett et al. 2005; Holt 2011), they continue to provide a valuable service for those gay-identified and other men who have sex with men who do not feel as safe accessing health care in mainstream settings. The provision of inclusive health care to populations who have been traditionally marginalised is aligned with both the tenets of primary health care—accessibility, equity and putting people first, amongst others (WHO 2008)—as well as with the growing interest in and commitment to addressing heterosexism in health care settings (McNair and Hegarty 2010). In relation to HIV, the World Health Organization and the United Nations Development Programme recognise and advocate for improved HIV prevention efforts targeting men who have sex with men around the world (UNDP 2013; WHO 2013). However, the marginalisation of these groups continues to be persistent and widespread, with significant implications for their engagement with HIV care and treatment (Cáceres et al. 2008; Persson et al. 2011). What has been missing from this global push for more socially inclusive HIV and sexual health services, however, is social research that explores the complex dynamics of ‘doing’ inclusivity. How exactly do service users, providers and other stakeholders contribute to the making of an inclusive health service, and how successful are they?

There is a literature on HIV and sexual health services in developed countries which has described how some services have gone about the targeting of specific population groups such as young people and women, in recognition of the barriers that can exist in accessing sexual health care in mainstream settings (Jones et al. 2006; Morgan and Haar 2008; Ralph et al. 2011). A subset of this literature has described client perceptions of sexual health services, typically supporting the tailoring of services to make them as convenient and accessible as possible to their target groups (Eisenberg et al. 2012; Ingram and Salmon 2010; Lewis et

al. 2004), including making increasing use of online platforms to provide sexual health information and support, particularly for young people. In relation to clinic spaces, clients have reported feeling most comfortable around staff of the same gender or a similar age to them (Tilson et al. 2004). Many appreciate the respectful and nonjudgmental attitudes of staff and prefer waiting rooms that contain pamphlets and posters targeted to them (Hayter 2005; Shoveller et al. 2009). Our analysis shows that community-based HIV health services in Australia have adopted similar strategies, engaging in a process of ‘branding’ their services as inclusive in an attempt to make both people living with HIV and GLBT people feel welcomed. This fits with a publication recently endorsed by the Royal Australian College of General Practitioners, which provides ‘A Guide to Sensitive Care for Lesbian, Gay and Bisexual People Attending General Practice’. These guidelines recommend, as one example, “Having discrete signs in the waiting room that indicate an inclusive approach. Examples include a rainbow symbol (a universal symbol for the LGB community), a visible anti-discrimination policy that includes sexual orientation, and LGB specific posters or pamphlets” (McNair 2012). However, what our analysis also suggests is that this very process can potentially have the unintended effect of making some other groups of people living with HIV, including heterosexually-identified men, feel excluded.

Therefore, the second major contribution of this paper is to identify some of the broader complexities and tensions in the meanings attributed to inclusive HIV health services in Australia. It has been occasionally noted in the literature that some services can be perceived as catering to particular groups when in fact they are intended to provide services to a much broader range of people. For example, men can view the gender of staff and clients or the décor of the waiting room as suggesting that sexual health services are only targeted towards women (Lichtenstein 2004; Pearson 2003) and that this can act as a deterrent to their willingness to use them (Donnelly 2000; Shoveller et al. 2009). Our analysis goes further than this, demonstrating that assumptions can be made about not only what services do and who they are for but also about what particular groups of potential clients might feel about that. For example, some of our participants subscribed to a misconception that Australian HIV health services were aiming to target gay men to the exclusion of other groups. Others subscribed to the misconception that all heterosexual men living with HIV are fearful of being misidentified as gay by attending a gay-friendly HIV clinic. In alignment with the findings of the Straightpoz Study, we have suggested that whilst some heterosexual men may indeed feel uncomfortable in attending an overtly gay-friendly health service, a more complex range of meanings is likely to explain this. Some heterosexual men may simply want to also feel included, to feel that their particular health and emotional

needs are recognised and supported and their ways of being and relating are welcomed. And as our data suggest, if heterosexual men are supported in challenging their own assumptions about gay-friendly clinics, they may come to recognise that they too are ‘allowed to come here’. We also heard from clinicians who have invested considerable time and energy into adapting their services to their diversifying client base over time and considered the loss that this may pose to those for whom caring for gay men had held an important political and personal resonance.

Our qualitative approach means that these insights are not necessarily generalisable or transferable. However, if, as Pope and Mays have argued, qualitative research aims to give “due emphasis to the meanings, experiences and views of all the participants” (1995, p. 42), then our approach offers a unique opportunity to understand how multiple—relevant but distinctive—viewpoints contribute to the ways in which a particular set of health care services are viewed and accessed. This is particularly important for populations who may be more ‘hidden’ than others, and therefore less likely to be engaged by traditional service and policy mechanisms. In the Australian context, it is heterosexual people living with HIV who have been most ‘hidden’ from health, social and public policy because of a desire to keep their status confidential and the absence of a shared community of positive peers due to their low numbers, diversity and geographical dispersal relative to HIV-positive gay men (Persson et al. 2006). Qualitative research is therefore most appropriately placed to reveal and share their perspectives. It is also best placed to reveal what we view as the overarching policy implication of this analysis. We know that HIV epidemics look different in every part of the world and that inclusive HIV care will therefore require different forms of engagement in different locations. But in the Australian setting, it is heterosexual men and women who are typically the outsiders when it comes to HIV care. Policy at both the global and national levels must therefore always be sensitive to not only the marginalisation of GLBT people, or women, but whomever it is that is less well engaged in each particular health service setting. A celebration and understanding of sexual diversity in the HIV field should not be limited to targeting gay men: as we have shown in this paper, in some contexts, heterosexual men become the hidden, less engaged, minority group.

We recognise that the relevance of our findings will be limited to those country settings in which HIV treatments are made broadly available and in which there is a degree of choice available to consumers in attending clinics. Australia is relatively unusual in the sense that, in addition to publically funded sexual health and HIV specialist clinics (Pell et al. 2008), HIV treatments can be prescribed by accredited medical practitioners working in private community-based clinics (Newman et al. 2012). But the broader implication of this analysis, which is relevant to any health service setting, is that

there is a risk in assuming we can know or anticipate how any group of people feels about accessing a targeted health service.

Seeking and taking account of the (confidential) opinions of all current and potential service users must be prioritised in every dimension of health service planning and evaluation, and the ways in which those opinions are accessed need to also adapt over time in response to social change. Both the clients and providers of HIV health services should be supported in finding new ways to adapt to the changing demographics of the waiting room and to contribute to developing clinic spaces and processes which are genuinely accommodating of sexual diversity, in addition to gender and cultural differences. Opportunities for this kind of mutual learning exist within the clinic space already, but must be actively facilitated if the design and delivery of HIV health services is to maintain pace with changing epidemics.

Two related areas of social complexity in the delivery of HIV health services would also benefit from further research. The first relates to those general practice clinics that provide drug and alcohol services in addition to HIV care and which must negotiate the additional range of cultural stereotypes and stigmas associated with illicit and injecting drug use (Holliday et al. 2012). The second relates to those general practice clinics which provide HIV care to and within migrant communities and which may be staffed by members of those same communities (Johnson et al. 2008). The cultural politics of HIV care in the context of harm reduction and multicultural health warrant careful observation and reflection and may have much to teach us about the successful negotiation of complex social dynamics in health care service settings more broadly.

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