REPRODUCTIVE HEALTH matters

FEATURE

Sexual identity stigma and social support among men who have sex with men in Lesotho: a qualitative analysis

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Abstract: *Men who have sex with men (MSM) face sexual identity stigma in many settings, which can increase risk for HIV by limiting access to care. This paper examines the roles of social support, sexual identity stigma, and sexual identity disclosure among MSM in Lesotho, a lower-middle income country within South Africa. Qualitative data were collected from 23 in-depth interview and six focus group participants and content analysis was performed to extract themes. Four primary themes emerged: 1) Verbal abuse from the broader community is a major challenge faced by MSM in Lesotho, 2) participants who were open about their sexual identity experienced greater stigma but were more self-sufficient and had higher self-confidence, 3) relationships between MSM tend to be conducted in secrecy, which can be associated with unhealthy relationships between male couples and higher risk sexual practices, and 4) MSM community organisations provide significant social and emotional support. Friends and family members from outside the MSM community also offer social support, but this support cannot be utilised by MSM until the risk of disclosing their sexual identity is reduced. Greater acceptance of same-sex practices would likely result in more open, healthy relationships and greater access to social support for MSM.*

Keywords: Lesotho, male homosexuality, stigma, sexual behavior, social support

Introduction

Men who have sex with men (MSM) are among those at highest risk for HIV infection worldwide.[1] Even in the context of the broadly generalised HIV epidemics of Southern Sub-Saharan Africa, MSM have been found to carry a higher burden of HIV compared to other age-matched reproductive age men.[2,3] In a recent study of more than 500 MSM in Lesotho recruited via respondent-driven sampling across two urban centers, prevalence was 31.1% in the capital of Maseru and 35.4% in Maputsoe.[4] Prevalence data such as these have been previously described across Sub-Saharan Africa, with MSM estimated to have nearly four times the odds of living with HIV compared to other reproductive aged adults.[5] In addition, MSM in these regions face high levels of stigma secondary to sexual practices and sexual identities including verbal, physical, and sexual harassment from friends, family members, or broader community members; and discrimination within healthcare settings.[6-10] While zero HIV-related stigma has been described as an international goal, a recent report shows that very few of the studies that characterise the burden of HIV or associated determinants of prevalent HIV infections had measured any form of stigma.[11] Studies have consistently demonstrated that punitive laws criminalising same-sex practices combined with high levels of stigma and discrimination affecting MSM exacerbate the epidemic by limiting the provision and uptake of HIV prevention, treatment, and care services.[2,12,13]

Lesotho is a lower-middle income country in southern Africa with one of the highest burdens of HIV in the world, estimated to be 23.4% among adults aged 15-49.[14] In Lesotho, same-sex acts were

decriminalised in 2012 but remain highly stigmatised.[13] To our knowledge, there are only two studies assessing HIV risks in relation to stigma among MSM in Lesotho, both conducted by the authors.[10,15] Baral et al noted a high prevalence of stigma among these men, with 76% reporting at least one event including rape (10%), blackmail (21%), fear of seeking healthcare (22%), or verbal or physical harassment (60%).[15] Further, Stahlman et al found a strong positive association between stigma experienced from broader community members and depression, as well as an inverse association between social capital and depression.[10] These studies indicated a need for in-depth qualitative studies to characterize a nuanced understanding of the relationships between stigma and social support among MSM in Lesotho.

In such stigmatising social environments, MSM and lesbian, gay, bisexual, and transgender (LGBT) community groups are often the only groups willing to and competent in providing HIV-related services to MSM.[16] These programs also provide social support to communities of MSM in the form of social capital,[17] in that they can strengthen bonds between group members, increase the availability of resources through social networks, improve perceptions of the trustworthiness of others and the ability to work together to solve problems. Improved social capital can result in increased uptake of HIV services and also in greater feelings of connection and self-esteem among MSM.[16,18] In various settings, perceived social support has been associated with increased levels of mental well-being as well as increased preventive health behaviours and lower risk for HIV infection.[10,19-21]

Seeking support and resources from peers can be a successful strategy among MSM for coping with sexual identity stigma in highly stigmatised settings.[18,22] In particular, recent research suggests that openness about one's stigmatised identity can improve the impact of social support on positive health outcomes.[23] However, MSM who have disclosed and are open about their sexual identity often experience greater stigma from members of the broader community, potentially because they are more easily identified as targets for discrimination or harassment.[22,24] Among MSM in sub-Saharan Africa, factors associated with disclosing one's sexual identity include self-confidence, financial security, and educational attainment.[22,25] MSM also tend to disclose their sexual identity to different individuals based on their anticipated reactions, such as being less inclined to tell a family member who would likely have a negative reaction.[26]

Overall, a better understanding of sexual identity stigma, social support, and openness about sexual identity could facilitate improved HIV prevention and treatment services, as well as improved mental well-being and self-efficacy of MSM community members. Subsequently, these analyses seek to describe the adverse health and social consequences of sexual identity stigma, the positive influences of social capital (i.e., social support), and the role of sexual identity disclosure in the lives of MSM in Lesotho, ranging from the broader community to the smaller MSM community.

Methods

In-depth interviews were conducted with 23 MSM in Maseru and Maputsoe, Lesotho, in April and May of 2014. A single focus group was conducted with six MSM in Maseru who were not part of the in-depth interviews. MSM at both sites were eligible to participate if they were aged 18 years or older, assigned male sex at birth, and reported having receptive or insertive anal intercourse with another man in the past 12 months. In addition, participants were required to have lived in Lesotho for the past three months, to be capable of providing informed consent, and to understand either English or Sesotho. All eligible participants provided informed oral consent prior to completing the face-to-face interview or focus group with a trained interviewer who was either an MSM or an LGBT ally. This study was approved by the Johns Hopkins Bloomberg School of Public Health Institutional Review Board and the Lesotho National Health Research Ethics Committee.

Interviews and focus group included a discussion of family and livelihood including relationships with the community, sexual identity, sexual behaviours, the general situation of MSM in Lesotho including main social concerns and challenges, social experiences, HIV prevention, testing, and treatment, and concluding with ideas for programs/services/support services for MSM and any advice that the participant would offer to other MSM. For the purpose of these analyses, we focused on social relationships between MSM and the larger community and also within MSM groups. All interviews took 60-90 minutes to complete and were audio- and digitally-recorded. The focus group lasted approximately 90 minutes. Each participant was reimbursed approximately 2 USD for participation and 2.60 USD for transportation.