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“They treat us like we’re not there”: Queer bodies and the social production of healthcare spaces

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ABSTRACT

There is significant literature demonstrating the interpenetrability of identity and space, yet there is almost no work that explores the co-production of queer identities and healthcare spaces. We use Lefebvre’s triad of (social) space to explore how the social spaces of South African healthcare facilities shape and are shaped by queer service-users, drawing on data from interviews and focus group discussions with 29 queer service-users and 14 representatives of organisations. Findings reveal that healthcare spaces are produced by the spatial ordering of health policy inattentive to queer health needs; the enduring symbolic representations of queerness as pathological or ‘un-African’; and various identity assertions and practices of individuals, including queer service-users and healthcare providers. As a result, healthcare spaces are overwhelmingly heteronormative, although queer service-users’ subversive practices suggest alternative spatial configurations. However, such resistance relies on individual empowered action and risks disciplining responses. Wider efforts are needed to transform the material and ideological space of healthcare facilities through law and policy reform and continuing professional training for healthcare providers.

1. Introduction

In this paper we use the idea of the social production of space (Lefebvre, 1991) to frame empirical evidence from South Africa, in order to articulate a layered account of how healthcare facilities[1] are constructed as heteronormative and homophobic through historical, social and material processes, and how these processes shape and are shaped by queer[2] service-users. We argue that such an analysis of space and identity construction is important because the social production of healthcare space affects queer service users materially (ie. their health) as well as affectively (ie. their wellbeing and identity formation).

There is significant literature demonstrating the interpenetrability of identity and space, how “sexual politics permeate all space – private and public, urban and rural, at the macro and micro level” (Johnston, 2015: 808). Much of this work focuses on how queer bodies navigate a pervasively sexuality- and gender-normative socio-spatial order, and how they may carve out queer spaces in response (Bell et al., 1994; Bell and Valentine, 1995; Podmore, 2001; Brown, 2000; Moore, 2015; Visser, 2003, 2008). As Maliepaard (2015) points out, other authors have critiqued this literature as often portraying queer spaces as static and homogenous – resistive spaces inhabited by queers without the influences of heteronormativity or straight people (Oswin, 2008; Browne and Bakshi, 2011). However, in South Africa, as elsewhere, this work has also tended to focus largely on the experiences of gay and bisexual men (Visser, 2003, 2008; Rink, 2013; Tucker, 2009).

A considerable health studies literature, including on South Africa, documents the experiences of queer people in healthcare (Müller, 2016; Lane et al., 2008; Rispel et al., 2011; Smith, 2015). Whilst this literature is critical in highlighting pervasive homophobia and heteronormativity, it is largely aspatial in its analysis, and also focuses overwhelmingly on men, particularly those seeking sexual health and HIV services (see, for example, Meer et al., 2016, for a review of literature from Southern Africa). A notable exception is a recent article by Heyes, Dean and Goldberg (2016) who use phenomenological analysis to reveal the healthcare space as pervasively heteronormative. However, this work focuses on individual interactions and largely does not address the “larger relations of power that dictate experiences of heteronormativity in healthcare” (Heyes et al., 2016:1).

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[1] Healthcare facilities, in our study, include clinics and hospitals at primary, secondary and tertiary level, as well as individual doctor's rooms.

[2] As with any identity category, the term ‘queer’ does not precisely or adequately capture every expression or experience, and some may wholly question its appropriateness. However, following queer theorists (Warner, 1991), the term ‘queer’ denotes an identity outside and challenging of the heteronorm. For this reason, as in this paper, ‘queer’ is widely understood and used to convey the political and resistive aspects of non-normative sexual and gender identities. In addition, in describing participants we use the terms that they used to self-identify. Where other terms, such as LGBTI (lesbian, gay, transgender and intersex) are used they are the direct words of participants within quotations.

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The literature that specifically situates issues of space and queer identity within healthcare is much smaller, and can in part be traced back to health geography research on AIDS in the early 1990s (Philo, 1996). This includes Chris Philo's exploration of the import of Foucault's "The Birth of the Clinic" for medical geography (2000), followed by Michael Brown and Larry Knopp's "The Birth of the (Gay) Clinic" (2014), which articulate how queers are governed through the medical gaze. However, this and other empirical work has largely focused on gay men and queer-specific (sexual health) services in North America (Lewis, 2015a, 2015b; Catungal, 2014), but even in the global north such services are not always accessible to queer people, and in the global south these are even scarcer.

In this paper we aim to expand the study of queer bodies in health spaces beyond the mainstay of gay men and gay (sexual) healthcare in the global north. This is because we believe that other queer-identified people are further marginalised both in scholarship and healthcare; that local (mis)understandings of queerness in a global south context are under-explored; and that by focusing on the category queer, rather than gay or homosexual, we can tease out the diverse and shifting ways that identity may be produced and contested through the environment, discourses and interactions of healthcare. Following recent work on queer health and space (Lewis, 2016; Heyes et al., 2016; Brown and Knopp, 2014; Catungal, 2014) we situate the experiential accounts of individuals within an analysis of broader socio-political factors that influence queer people's experience of healthcare. In doing so, we purposefully focus on queer people's access to general health services, rather than on specific service needs, in order to locate the production of healthcare spaces within the broader ideological and policy regimes that inform healthcare (Lewis, 2016).

2. Contextualising healthcare in South Africa

In order to contextualise the experience of queer service-users an adequate account of the complexities and specificities of healthcare provision to queer people in South Africa is essential. In this regard the social and legal backdrop, as well as the context of pervasive transphobic and homophobic violence, is significant.

Under the South African Bill of Rights (Republic of South Africa, 1996) every citizen is guaranteed: the protection and promotion of their collective and individual rights; the enjoyment of rights, regardless of "race, gender, sex, […] sexual orientation […]"; the respect and protection of their inherent dignity; the right to life; freedom and security of their person including protection from inhumane and degrading treatment and the preservation of "bodily and psychological integrity," including sovereignty in decisions regarding reproduction and the body; and access to healthcare services. To reinforce this, the state has also passed the Promotion of Equality and Prevention of Unfair Discrimination Act 52 of 2002 (Republic of South Africa, 2003), which protects individuals on the basis of gender while explicitly differentiating between gender and sex. In the past 20 years, legal discrimination based on sexual orientation has been reduced through the revision of a number of legislative Acts, including the establishment of the Civil Union Act which extends equal marriage rights to same-sex couples (Judge et al., 2008).

Despite this progressive legislation, staunchly conservative social attitudes persist. In a recent representative survey, 72% of South Africans felt that same-sex sexual activity is 'morally wrong' (The Other Foundation, 2016). South African government officials have repeatedly voiced opinions at odds with liberal constitutional values, both in their personal and official capacities. For example in 2008, Jon Qwelane wrote an opinion piece 'Call me names but gay is NOT ok' in a widely circulated national newspaper, and although the Equality Court found him guilty of homophobic hate speech, in the same period he was deployed as the South African ambassador to Uganda, which at the time was deliberating the introduction of severe anti-homosexuality laws (Mail and Guardian, 2011). In 2010, Lulu Xingwana, then Minister of Arts and Culture, burst into tears at the opening of an exhibition by prominent photographer Zanele Muholi, portraying the lives of black lesbians, including depictions of intimacy, nudity and violence, on the grounds that it was "immoral, offensive and going against nation-building" (Timeslive, 2010). Her behaviour not only demonstrated her deep discomfort with queer bodies, identities and representations, reflecting and perpetuating the views of the wider public, but also revealed her imagining of 'nation-building' as a heteronormative exercise, and of the nation as heterosexual and cisgender.

Recently, the South African delegation to the United Nations abstained from voting on the establishment of a special rapporteur on transphobic and homophobic violence because it would create divisions between African countries (Judge, 2016). Such *spaces of representation*, or collective imaginings of community, whether national or continental, are grounded in ideas of homogeneity and the (violent) exclusion of difference (Bridge and Watson, 2003). Although the South African delegation later voted against the African leaders' efforts to block the establishment of the special rapporteur, and expressed support for the protection of queer people from discrimination, the ambivalence demonstrated in this process reflects the deeply conflicting attitudes prevalent within South African society.

In daily life, homophobia and transphobia manifest in exclusion, discrimination, and violence against queer people, including in healthcare (Rispel et al., 2011; Smith, 2015). Accounts of homophobic sexual assault of queer women (often problematically labelled 'corrective rape') have increasingly been reported (Nath and Mthathi, 2011). While prevalence of sexual violence in South Africa is relatively high (Jewkes and Abrahams, 2002), assaults against queer women are often marked by the homophobic motivation of the perpetrator(s), who claim that rape will 'cure' lesbian and gender non-conforming women (or women perceived as such) from their homosexuality; and particularly affect women of colour who live in resource-poor urban or rural areas (Nath and Mthathi, 2011). Such violence is associated with the perception that queer people's, particularly queer women's, sexuality, appearance, and behaviour violate accepted religious, gender, and cultural norms (Nath and Mthathi, 2011), including the perception that homosexuality is 'un-African' (Swarr, 2012).

At the same time, queer people are generally wary of the healthcare system due to reluctance to disclose their minority status, a lack of providers' knowledge of queer health issues, structural limits on health insurance and decision-making, and previous negative healthcare experiences (Müller and Hughes, 2016). This can have severe consequences for treatment, especially where assault has resulted in injury, sexually transmitted infections, HIV or pregnancy. Addressing such shortcomings is not prioritised within the South African health system, a dual system with both public and private healthcare and considerable inequalities between the two. The vast majority rely on the public system, which is severely resource-constrained, with a shortage of physicians and nurses and high patient loads (Mayosi and Benatar, 2014). Under these conditions, efforts to provide competent and appropriate care for queer people's health concerns have not been prioritised in health policy (Morison and Lynch, 2016; Tucker, 2009).

It is within this specific ideological, symbolic and material context that we analyse the experiences of queer people seeking public healthcare in urban and peri-urban locations in South Africa using the theoretical framework of Lefebvre's social production of space (Lefebvre, 1991), and to elucidate the broader socio-political factors that influence such experiences.

3. Methods

Our study used a qualitative methodology with a strategic snowball sample of 29 queer health service-users: 15 people participated in one-on-one in-depth interviews and 14 in focus group discussions. An additional 15 one-on-one semi-structured interviews were done with

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