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Intimate partner, familial and community violence among men who have sex with men in Namibia

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Abstract

Men who have sex with men in sub-Saharan Africa are known to experience high levels of violence, yet little research has focused on their perceptions of intimate partner violence (IPV). This study examines the perceived typologies and sources of multiple forms of violence, including IPV, family/community violence and discrimination from healthcare workers, among men who have sex with men in Namibia. Focus-group discussions and in-depth interviews were conducted with a 52 men residing in five cities across Namibia. Results indicate that violence, in varying forms, is commonplace in the lives of men who have sex with men in this community, and may be associated with HIV testing patterns.

Keywords

men who have sex with men; intimate partner violence; Namibia

Introduction

While the issue of violence against women and children has been examined in the literature for quite some time, particularly in regards to domestic violence in heterosexual relationships, studies focusing on experiences of violence among lesbian, gay, bisexual and transgender individuals and in same-sex partnerships are comparatively rare in the literature (Renzetti 1992; Krug et al. 2002). While early studies on the intimate partner violence (IPV) among gays and lesbians preceded a recent increase in studies of IPV among men who have sex with men (Renzetti 1992; McClennen, Summers, and Vaughan 2002; Aulivola 2004; Finneran and Stephenson 2013), data on experiences of family and healthcare-related violence among men who have sex with men are sparse. To some extent, this deficit in scientific attention is influenced by the lack of legal protection of same-sex relationships, issues of shame on the part of the male victim that limit the reporting of violence, inadequate recognition of violence by healthcare personnel and difficulty in sampling hard-to-reach populations (McClennen, Summers, and Vaughan 2002; Aulivola 2004; McClennen 2005).

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Research on the epidemiology of HIV among men who have sex with men in sub-Saharan Africa is nascent (Bautista et al. 2004; Beyer et al. 2005; Wade et al. 2005; Baral et al. 2007; Beyer 2007; van Griensven 2007; Sullivan and Wolitski 2008; Smith et al. 2009). Men who have sex with other men are inadequately studied in many countries and, despite well-characterised risks for HIV acquisition and transmissions, they continue to be under-represented in national HIV surveillance systems and in targeted prevention programmes (Baral et al. 2007). In medium and high HIV-prevalence settings, men who have sex with men have odds of HIV-positivity that are approximately nine times higher than those of heterosexuals (Baral et al. 2007; Kajubi, Kamya, and Raymond 2008; Lane et al. 2008b; Baral et al. 2009). A growing body of literature shows that men who have sex with men exist in all parts of Africa (Murray and Roscoe 1998; van Griensven 2007; Kajubi, Kamya, and Raymond 2008; Smith et al. 2009; Baral et al. 2011; Poteat et al. 2011; Beyrer et al. 2012; Dramé et al. 2012), despite strong local convictions that sexual behaviour between men is not compatible with 'traditional' African cultures (van Griensven 2007). Same-sex behaviour is currently criminalised in more than half of African states, indicating a climate of pervasive, legalised homophobia. Against this backdrop, there is a dearth of studies that have examined the experiences of violence by men who have sex with men. This paper examines perceptions and experiences of interpersonal, familial and community violence among such men in Namibia, adding to the understanding of the experience of violence among men who have sex with men in a low-resource setting characterised by high levels of both HIV and homophobia.

Background

The existing literature on violence among men who have sex with men is focused largely on the USA and has largely concentrated on IPV to the exclusion of other forms of violence (Finneran and Stephenson 2013). It is only recently that IPV among men who have sex with men has begun to be researched rigorously, and researchers have used varying definitions and measurements of violence, resulting in vastly different reported rates of differing kinds of violence. When using lifetime recall, estimated prevalences for receipt of IPV among men who have sex with men range from 19.2% (Houston and McKirnan 2007) to 39% (Kalichman et al. 2001) for physical violence, 5% (Greenwood et al. 2002) to 28% (Braitstein et al. 2006) for sexual violence and 32% (Koblin et al. 2006) to 52% (Feldman et al. 2008) for any violence. Perpetration rates of IPV among men who have sex with men against their partners have been comparatively less studied, with 5.9% (Waterman, Dawson, and Bologna 1989) to 21.6% (Waldner-Haugrud, Gratch, and Magruder 1997) of men admitting to perpetrating partner violence against their partners (Finneran and Stephenson 2013).

In addition to IPV, previous studies have shown that men who have sex with men experience other forms of violence at rates equal to or higher than heterosexual populations, including familial and peer violence. Welles et al. (2010) reported a higher prevalence of lifetime abuse among men who reported having sex with men compared to men who did not report having sex with men (49% versus 22%), including early physical abuse (36% versus 15%) and sexual abuse both by age 11 and by age 21 (Welles et al. 2010). Specific to familial violence, Balsam (2005) reported higher rates of physical, psychological and sexual

abuse by parents or caretakers among men who have sex with men than among heterosexual male participants (Balsam, Rothblum, and Beauchaine 2005). Herek, Berrill and Berrill (1992) reported high rates of gay-related violence relative to the general population and found that the majority of this violence originated in the family. It is also well-documented in the literature that lesbian, gay, bisexual and transgender youth experience higher levels of bullying and peer violence over the course of their lifetimes than other youth (Savin-Williams 1994; Garofalo et al. 1998; D'augelli, Grossman, and Starks 2006). All cited studies concur that these high rates of violence were associated with negative outcomes among the participants, including suicidal ideation, IPV victimisation and perpetration in adulthood, and increased risk behaviour in both adolescence and adulthood (Savin-Williams 1994; Garofalo et al. 1998; Balsam, Rothblum, and Beauchaine 2005; D'augelli, Grossman, and Starks 2006; Welles et al. 2010).

This final point is especially salient for men who have sex with men, who continue to be at elevated risk of HIV worldwide, and in sub-Saharan Africa in particular (Wade et al. 2005; Sanders et al. 2007; Baral et al. 2009; Ayala et al. 2010). A wide variety of studies in the USA have found that psychosocial stress, depression and, specifically, experiences of childhood violence and partner violence may elevate risk for HIV infection among men who have sex with men (Relf et al. 2004; Heintz and Melendez 2006; Wright et al. 2006; Burchell et al. 2010). Clear associations have been found between traumatic life events and HIV infection risk, often through increases in sexual-risk behaviour, and this relationship has been found to be stronger among men who have sex with men than within the population at large (Garofalo et al. 1998; Burchell et al. 2010).

Studies conducted in sub-Saharan Africa have also found links between internalised homophobia, the criminalisation of same-sex behaviours and HIV risk (Niang et al. 2003; Johnson and Cameron 2007; Ross et al. 2010a, 2010b; Altman et al. 2012). In light of reports of violence against men who have sex with men and high suspected levels of partner and familial violence, this association is expected to be an especially significant driver of HIV risk among men who have sex with men in Africa (Anyamele et al. 2005; Lane et al. 2008b). Furthermore, same-sex behaviour is either criminalised or legally unprotected in every African country except South Africa, which can further amplify the interaction between violence and HIV risk (Anyamele et al. 2005; Lane 2009; Ayala et al. 2010). Criminalisation generally precludes targeted health or prevention programmes directed towards lesbian, gay, bisexual and transgender populations and excludes men who have sex with men from access to legal protection from acts of violence and discrimination (Johnson 2007; Ayala et al. 2010). The risks of arrest or incarceration also force men-who-have-sex-with-men communities to operate underground, which increases both the chances of violence among partners and the incidence of potentially having multiple partners rather than steady relationships (Lane et al. 2008a).

In the light of the high prevalence of HIV among men who have sex with men in Africa, the significant vulnerability of men who have sex with men to violence, and the demonstrated link between violence and HIV, it is important to investigate experiences of violence among men who have sex with men in Africa. In this paper, we describe perceptions of violence, including IPV, family violence, community violence and discrimination by healthcare

workers as described by self-identified men who have sex with men in Namibia, and examine how the experience of violence can shape the willingness and ability to test for HIV.

Methods

The research took place in five cities of varying sizes across Namibia: the Katutura Township in Windhoek, Luderitz, Keetmanshoop, Mariental and Khorixas. A qualitative design was employed to allow for exploration of the depth and breadth of perceptions and experiences of violence among the research population. A combination of participatory focus-group discussions (FGDs) of 5–10 participants and individual in-depth interviews (IDIs) was used to enhance the rigor of the data by comparing and contrasting findings across the two methods (Bernard 2000). Participatory focus groups provide a mechanism to reach marginalised or vulnerable populations such as men who have sex with men, and an emphasis on interaction among group members allows participants to explore beliefs, attitudes and personal feelings among the group (Freire 1968; Powell and Single 1996). Likewise, IDIs afford respondents heightened privacy and focused attention, which allows for a deeper exploration of discrete topics and experiences of the individual (Charmaz 2006). Interviewees were primarily chosen from focus-group participants based on availability and demonstrated interest on the part of the respondent.

Participants

A total of 7 FGDs and 28 IDIs were conducted. Four FGDs were conducted in Windhoek, two in Luderitz and one in Khorixas. The majority of the IDIs were conducted in Windhoek (12), followed by Khorixas (8), Luderitz (4), Keetmanshoop (3) and Mariental (1). The participant group in total was comprised of 52 men who reported sex with another man within the past year and reported residing in one of the five cities. Of 43 focus-group participants, 19 (44%) completed IDIs and 9 additional interviews were conducted. The age of participants ranged from 18 to 33 years in FGDs and 18 to 28 years in IDIs, with a mean age of 22.3 years overall.

When asked about ethnicity, 32 of 52 participants identified as Damara, with 8 respondents self-identifying as Nama, 5 as Coloured, 2 each as Black and Xhosa and 1 each as Angolan, Baster and Twana. Of all participants, 30 of 52 reported they were single, 2 that they were married (to a woman) and 18 that they were in a relationship, 6 of whom indicated that the relationship was monogamous. The majority of respondents reported having both male and female partners, particularly in Katutura and Luderitz.

Data collection and analysis

Participants were chosen through a targeted variation on a purposive sampling strategy (Watters and Biernacki 1989; Patton 2002), utilising local non-governmental organisations (NGOs) working with men who have sex with men, key community figures and study participants to identify men who were willing to participate. Recruitment was conducted with emphasis on variety in geography and socioeconomic status. Attempts were made to recruit across a range of ages and ethnicities, but this proved difficult due to differential

acceptability of discussing same-sex behaviour based on age and tribal heritage and the lack of accessibility of men who have sex with men of different ethnicities. Participants were compensated approximately USD\$7 for their time (approximately 60–90 minutes).

Informed consent was obtained from all participants prior to FGDs and IDIs, and all participants completed an anonymous screening questionnaire to determine eligibility and collect demographic data. All sessions were recorded in a private and safe location identified by local partners. Sessions were moderated in English by the two researchers and two employed trained translators, as requested by participants. For both the IDIs and the FGDs, the researchers worked with key informants in the community to develop question guides. Recorded sessions were later transcribed verbatim, with the aid of a translator when needed. During the FGDs, notes on the order of speaking among participants were not taken, therefore findings taken from the FGDs are not attributable to any individual respondents.

The research adapted techniques from grounded theory to complete rigorous analysis of the qualitative data (Strauss and Corbin 1990). Analysis of the data involved verbatim transcription, line-by-line coding of the transcripts and classification of all recordings using the guideline questions and conceptual frameworks as initial categories in order to detect emerging themes and divergent attitudes among the respondents (Patton 2002). Coding of the qualitative data employed the use of inductive codes based on expected influences, followed by deductive codes representing unexpected themes and patterns as they emerged organically from the data. This dual mechanism allowed for identification of main themes, attitudes and perceptions and their variations among participants.

Ethical considerations

This study was conducted according to the rules and regulations of the Internal Review Boards of both Emory University and the Namibian Ministry of Health and Social Services. All participants agreed voluntarily to take part and were taken through the informed consent procedure individually, with a translator if needed. Special attention was given to prevent accidental targeting of research participants based on their participation in the project. All FGDs and IDIs were held in a mutually agreed-upon safe space, where entering and exiting would not identify them as men who have sex with men to the surrounding community.

Findings

Experiences of IPV

Experiences of IPV were widespread among participants and particularly common among the IDIs conducted in Katutura and Luderitz. There were almost universal reports of violence from male partners. Frequently, power differentials and jealousy were cited as direct causes of violent interactions and emotional abuse. While verbal and physical violence were described as occurring among persons with both male and female partners, there were varying perspectives on whether disagreements with male or female partners were more likely to lead to physical violence:

When it comes to a lady, a lady is usually weak and you can easily kill her, you understand and you can also hurt her a lot and you can get arrested for that, but in a relationship with a man, things are solved between the two of you.

Yeah it's worse with men, because you can't, in most cases men don't beat women, but if you beat a woman, it's a case for the law.

Because when you are arguing or fighting with a woman maybe you are ... sparing your anger or your arguments for the person, but if you are arguing with a man, then you are maybe just getting furious ... you are just start to want to fight.

The lady can be violent, but not the guy, because he is the one who needs me.

The most common forms of IPV experienced were verbal and emotional IPV, with almost all participants reporting personal experiences of abuse. Reports of verbal abuse were commonly described as coming from both male and female partners, however respondents often described their male partners as more abusive. By far the most commonly cited cause of this behaviour was jealousy regarding both women and other men: 'man-to-man relationships are all about jealousy'. While physical IPV was reported less commonly among the participants, it was another result of jealousy and perceived cheating. Respondents also talked about controlling behaviour from their partners, such as being unable to hug or talk to women in front of their male partners, while simultaneously describing their own jealousy around their male partners' female partners. Participants indicated that these women were occasionally a source of verbal violence as well, including public name-calling and bragging about sexual exploits with the male partner in question:

Pure jealousy. I'm not even allowed to talk to another man while I'm with my boyfriend, then he gets the intention that they are guys interested in me and all that, and at the end of the day we end up arguing and all that.

It happens that the other guy can have a girlfriend and that can cause jealousy, which can cause violence between the two guys and the two might later attack each other physically because of the girlfriend's story.

The relatively small size of the 'community' of men who have sex with men in Namibia was also commonly discussed as a cause of jealousy and its resultant emotional violence, as men who have sex with men in the same area were likely to know one another, frequent the same social events and bars and share sexual partners:

We guys who are having a relationship with the other man are few, you know. So that immediately causes the problem because one and two guys have to share one. [Jealousy] is the main problem.

We are very small community here, and everyone knows each other. So today he might be my boyfriend, tomorrow he's now another's boyfriend, and that's what stirs most of the violence that has been taking place.

Another main cause of tension between respondents and their male partners was the perception that they were 'open and out' while their male partners were still 'in the closet'. Respondents frequently referred to their male partners with overtly masculine language while referring to themselves in feminine language, commonly calling their male partners

‘the straight man’ or even ‘the man’. These perceived differences in sexual and social roles were described as contributing to verbal and emotional altercations. Participants referred to their male partners as ‘the head of the house’. This clear power differential, combined with their partners’ lack of openness about their same-sex behaviours, was seen as contributing to emotional abuse. For instance, ‘straight’ men would berate their male partners in public and deny any prior involvement with them, leading to significant emotional distress:

He came to me and he touched my private parts, but ... if I touch him he is like, I will go and report you, you are touching me ... but he is the one that is coming to me.

Because of embarrassment, guys are always saying if they have sex with you ... in the morning they are saying you have raped me, you have raped me. I wasn’t the one that was doing anything ... you are the one that put my thing into you and you raped me. Then you are carrying that, eh?

Reports of power differentials based on masculinity and sexual roles were most common in Luderitz and Khorixas, where respondents more commonly self-identified as homosexual and less commonly reported having female partners. These power differentials led to numerous instances of reported sexual coercion and abuse. Participants reported that when their male partners assumed the more traditionally masculine social and sexual roles in their relationships, sexual compliance was expected and could result in physical violence if withheld. According to the participants, this attitude was consistent with the common perception of male sexual behaviour with female partners:

That’s what one man was telling me. Men are the head of the house. Whenever the man is feeling horny or wants sex, that’s the time that you must just lay, open your legs and tell the man, come in.

And I’m the man, you just keep your mouth shut, I will do my work according to what I think I’m qualified for. He will just push you around, pull you over, do whatever to you ... if you want to open your mouth he will just start beating you.

Sexual coercion was also frequently described when there was a differential in money and/or age between the partners. Financial support and gifts of money and possessions were almost universally reported to be aspects of same-sex relationships. Participants discussed trading sexual favours for clothes, sneakers, cigarettes and alcohol, in addition to sustained financial support, paying for school and other large financial contributions. Interestingly, participants in Katutura and Khorixas discussed being paid for sex by male partners, while participants in Luderitz reported paying for sex instead. Violence could result if they were unwilling to provide these payments:

Give me 10 dollars then we can have sex, or buy me a shoe, a sneaker, then we can have sex. That’s what they go for.

You sleep with me out of desperation, you are desperate, and then you sleep together, but, then you say afterwards, okay I’ll give you the money afterwards and then you don’t have the money that time and then it can cause violence.

While these arrangements were often portrayed as a fact of life and mutually beneficial, frustrations and abuses were reported on both sides of the financial spectrum. Among those men who have sex with men who paid for sex, participants perceived that exchange sex was the only way for them to have sex with another man. They reported that their male partners were not emotionally involved with them, had all the power in the relationship and were only using them for financial gain. Participants in Luderitz agreed that this was a form of emotional abuse. Among men who were paid for sex, on the other hand, the overriding impression was also that their partners had all the power. As they had received gifts and support, they felt pressured to be sexually compliant or risk this support being withdrawn:

Some of the guys who date gays ... when we have the hard [time] financially and stuff like that, they demand ... that you must have sex with him every time he wants ... so when you are then with him, you have to give him sex every time he demands it because it's his money and he's paying you.

Age was particularly important in these situations, since the financially supportive partner was often described as being significantly older. In addition, respect for and obedience to elders were presented as important values in Namibian society. Thus, an older partner would have an increased amount of power over a younger partner in a sexual relationship:

So they're taking advantage and saying, 'I'll have sex tonight with you.' For example, he's older than me and I'm younger. He would just basically come and grab me and saying, 'Hey just come, come we're having sex tonight,' and for example if he finds me alone, he would just rape me and all that stuff.

Experiences of violence and discrimination from family members

Although less common than IPV, another commonly reported experience among the participants was violence and discrimination from family and friends based on being a man who has sex with men. Among the respondents who did speak about this experience, the physical violence came exclusively from male relatives, while discrimination and verbal violence could come from any family member. Issues of ruining the 'family name' and accusations of having no 'family pride' were common:

Okay, there was an incident whereby my uncle, I was out on my friend's birthday and I came home and he was now drunk, and he heard rumours ... that I'm sleeping with men and whatever, so he wanted to stab me.

But my mother would like say nasty things about it ... she would use the words, 'you faggot, don't you even feel ashamed about having sex with men, how could you do that, Jesus Christ didn't make you this way. You're supposed to be attracted to women'.

These kinds of reports led to several descriptions of families 'turning against' their sons due to same-sex behaviour. These included being asked to leave their family home entirely or experiencing emotional abuse and rejection from the people in their households:

Yes, yes, yes, I have seen that, there were people that were discriminated against, even they were not accepted by their families, and they were, that family turned against them, I have personally watched, seen that in my own family also.

Fathers' reactions to discovery of their sons' same-sex behaviour, in particular, were described as universally poor. Participants perceived that their same-sex behaviour destroyed their fathers' view of them and led to intense feelings of rejection from a major male role model:

I was also beaten by my father the time that he found out that I went out from the cold closet, and I was now being gay, and he was physically abusive. He came to me and he beat me up. He really beat me up and I was having pain in the chest and blood would come out from my knees and he beat me up, just ... for my sexual orientation.

Experiences of violence and discrimination in the healthcare setting

Although less commonly reported, several participants reported discrimination by healthcare workers, including instances of neglect and discrimination. There were several stories of healthcare workers telling men who have sex with men patients that they were sick because of their behaviour and that they deserved having contracted HIV. These reports included accounts of abusive language and anti-gay slurs. There were also several stories of neglect on the part of doctors and nurses because the patient was a man who has sex with men. For instance, one experience of a man-who-has- sex- with men- patient in hospital for several weeks was described as follows:

That's where equal rights come in because he would lay there in his bed with a lot of pain. The doctor would just pass by him because he's gay. Or then the doctor would ask him, 'What happened, were you fucked with a big penis?' or something like that.

Additionally, prejudice among healthcare workers was common. Participants described encountering such prejudice in a variety of ways, including 'they are always laughing', describing judgment 'with their eyes'. Several participants reported nurses openly trying to convert them to heterosexuality or citing religious reasons why their behaviour was wrong:

Some of the nurses at the hospital are persuading you to become a Christian, so that you must stop with those things that you are doing. They are saying that ... if you come to our church you will stop with dating guys. You will stop doing those bad things that you are doing, just become a Christian.

By far the most common concern about healthcare workers was the perceived lack of confidentiality, particularly with regards to HIV testing. There was the near-universal opinion that if the participant went for HIV testing, their results 'would be spread around the town', leading to significant discrimination if they received positive results.

Experiences of community violence and discrimination

While instances of physical violence were reported, reports of verbal and emotional violence by community acquaintances and strangers were almost universal in the study population. Specifically in Luderitz and Khorixas, participants suggested that they, as men who have sex with men who were 'out of the closet' received more discrimination than their partners who were less likely to be identified as men who have sex with men:

For me, if maybe they find out that I'm dating a guy, I don't think that they are going to discriminate against that guy. All they are going to discriminate against is me for being open and out.

Participants also reported that community members universally associated male-to-male sex with HIV, men who have sex with men were discriminated against based on their inferred HIV-positive status in addition to their sexual preference:

People are having stereotypes about gays in Namibia, like in general life they just assume that if you gay, if you die one day, it's HIV/AIDS.

There will be violence in the community, because you start going out with a gay, they will ask whether you are insane or going crazy and they will start teasing you. The worst would be if you go for a test to [NGO] or any other place with your male partner. This guy went for a test with a gay, you will be chased out of the community in a very bad way and end up committing suicide.

In addition to reports of verbal abuse and discrimination, experiences of physical violence or the threat of physical violence were reported in all focus groups and many interviews, particularly in Luderitz and Khorixas. Many respondents discussed times they had avoided specific locations or people for fear of being attacked, and cab rides were identified as particularly dangerous due to the immediate vulnerability of being mobile with a stranger:

For example they come to a gay person knowing that they can take advantage, because they think because that person is gay, he can't actually fight back.

There is also physical [violence] because what the guys are hearing is, if I beat this guy that is acting like a gay, he will change into a man.

Participants also discussed the role of institutionalised prejudice from ingrained cultural and religious beliefs, formal education and the legal ban on same-sex behaviour. Several participants reported people on the street telling them that 'the Bible says it's wrong' and asking if they were 'ashamed of themselves'. Participants also described open discrimination and neglect from police and prison staff resulting in lack of follow-up for their attackers and occasionally assault within the prison itself:

It is still a problem because I mean, the Namibian community, most of the elders still don't understand these type of issues, and it's still condemned, and men cannot have sex with men.

My ancestors said man and woman should be together, so man and woman should be together, if you are man and a man, woman and a woman, it's unacceptable.

And to look at like here the police the law in the south, if you [are] gay you go to the police station, you don't have any rights there.

Discussion

Interpersonal violence among lesbian, gay, bisexual and transgender men who have sex with men is a significantly understudied issue. The results presented here add to the very small body of literature on violence among men who have sex with men in Africa (Lorway 2006;

Currier 2012). The results show persistent and prevalent violence aimed at men who have sex with men at different levels, including IPV, family violence, violence from within the local community and violence from healthcare providers. Overall, the experience of the participants suggests that discrimination, violence and the threat of violence are dominant features in daily life for men who have sex with men in Namibia, imposing restrictions on their normal movements and behaviours and affecting men's conception of themselves and their communities.

These findings add to the substantial body of literature describing prevalent homophobia and homonegativity directed against men who have sex with men in sub-Saharan Africa (Aarmo 1999; Reid and Dirsuweit 2002). Homosexuality has been characterised as 'un-African', with several political leaders in sub-Saharan Africa directly calling for the criminalisation or even expulsion of homosexuals from their countries (Reddy 2001; Reddy 2002; Epprecht 2005) and describing homosexuality as an imported relic of a European colonial history, thus depicting men who have sex with men as a direct link to colonialism and therefore antithetical to any concept of national pride (Aarmo 1999; Epprecht 2005; Lorway 2006). This characterisation of men who have sex with men as separate from and subversive to African identity has clear links to the acceptability of committing violent acts against these individuals. The results point to explicit provocation and tacit agreement with acts of violence against men who have sex with men, with respondents reporting violence from family members, healthcare workers and even strangers to be commonplace. As reported by participants, violence often grew from perpetrator's anger or, in the case of family members, shame, surrounding their same-sex behaviour. The frequent exposure to violence and feelings of alienation among men who have sex with men in this context place them in a vulnerable position not only due to their lack of legal protection, but also through creating an internalised sense of shame which may then manifest itself as violence in their intimate relationships.

The results suggest that violence was also shaped by 'traditional' African views of masculinity and the potential of men who have sex with men to subvert gender roles. Participants described the power dynamics within same-sex male relationships as mirroring 'traditional' heterosexual relationships, including the use of violence as a way to maintain power. In this study population, respondents consistently referred to themselves in feminine terms, while referring to their partners as 'the man', reinforcing the notion that traditional power dynamics of masculinity are being maintained in Namibia through frequent abuse at the hands of their partners. These findings are furthermore supported by literature that suggests that men who assume signs of femininity are at increased risk of physical and sexual violence (Namaste 1996). Further complicating this issue are the 2003 domestic violence laws enacted by the Namibian Parliament which, after much public debate, defined acts of domestic violence as explicitly occurring between members of opposite sexes to the intentional exclusion of acts of partner violence between same-sex couples. The result is that IPV and gay-bashing serve to assert the power and prove the masculinity of the assailant (Reid and Dirsuweit 2002). This is particularly significant in southern Africa given the histories of colonisation and Apartheid in the region, resulting feelings of disempowerment, and thus the amplified need to demonstrate masculine dominance, even a generation later (Reid and Dirsuweit 2002).

One of the most disturbing implications of our findings is the link between violence and HIV-testing behaviour. The reluctance of respondents to utilise testing services for fear of discrimination and gossip may represent a significant barrier to HIV testing among men who have sex with men in this setting. As mirrored by findings in other southern African countries, doubts about confidentiality among our study population create a significant barrier to the ability to utilise testing services (Lane et al. 2008a; Knox et al. 2011; Rispel et al. 2011). Considering African men who have sex with men have elevated rates of HIV and other STIs, failure to provide targeted, confidential and unbiased services has the potential limit HIV-prevention efforts. Training for clinic personnel needs to include sensitisation to lesbian, gay, bisexual and transgender health and social issues and training on counselling and care provision for those individuals.

Despite the strength of these findings, there are several limitations to this study. First, as with all qualitative research, the results here are restricted to a small group of men and are not generalisable to all men who have sex with men in Namibia. Due to the difficulty of recruiting men who have sex with men in a country with criminal penalties for same-sex behaviour, our participants are likely men who have sex with men who are more open to talking about their experiences, either because they are particularly outspoken about their opinions or because they are already recognised within their community and are therefore less afraid of being exposed. There may thus be a bias towards the recruitment of subjects who are more open about their sexual preferences, including people who are more educated, leaders within their communities and individuals who embody more outwardly feminine characteristics. Additionally, defining violence within any community or any culture is a difficult task, and it is possible that there are additional or different domains of violence.

Conclusion

The results presented here indicate high levels of violence experienced by a qualitative sample of men who have sex with men in Namibia. Violence is potentially linked to HIV risk in a number of ways: the perceived threat of violence from healthcare workers is a serious barrier to HIV testing, and the stress caused by multiple forms of violence may place some men who have sex with men at an increased propensity for sexual risk-taking. Given the high levels of violence described here, this study provides preliminary evidence that all Namibians should receive legal domestic violence protection, regardless of the gender of the perpetrator of the violence, although such changes to policy likely currently lack popular or political support. Additionally, healthcare providers who serve men who have sex with men should be trained to screen for and identify violence in the lives of their clients, given the discussed links between violence, HIV risk and HIV testing. Further research is needed to build on the results of this qualitative study, to determine the prevalence of the differing forms of violence identified here and to assess the associations between violence and sexual risk-taking. A better understanding of these issues is essential to the development of social- and public-health interventions aimed at reducing homophobia, violence and negative health effects among men who have sex with men in Namibia.

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