The Impact of Hate Crimes and Hate Speech on Mental Health and Healthcare Access Among Men Who Have Sex with Men (MSM) in South Africa: A Qualitative Study

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Abstract

Background: Hate crimes and hate speech remain pervasive threats to the safety, dignity, and health of sexual and gender minorities. Although South Africa has a progressive constitutional framework and legal protections, men who have sex with men (MSM) continue to report victimisation, social exclusion, and stigma that can shape mental health trajectories and healthcare seeking.

Methods: This qualitative study explored how experiences of hate crimes and hate speech influence MSM's mental health and their access to and utilisation of healthcare services. Twenty-five MSM from Umlazi Township (KwaZulu-Natal) were purposively recruited through community networks and local LGBTQ+ organisations. Data were collected via semi-structured interviews (average 40–60 minutes), audio-recorded with consent, transcribed verbatim, and analysed using reflexive thematic analysis. Trustworthiness was enhanced through prolonged engagement, memoing, peer debriefing, an audit trail, and member reflections.

Results: Four interlinked themes were identified: (1) persistent exposure to hate speech and episodic hate-motivated violence; (2) cumulative psychological sequelae, including

hypervigilance, anxiety, depressive symptoms, and suicidality; (3) healthcare avoidance and constrained disclosure driven by fear of judgment, confidentiality breaches, and prior discriminatory encounters; and (4) multi-level intervention needs, including culturally competent care, confidentiality safeguards, accessible psychosocial support, community-based safe spaces, and implementation of hate crime/hate speech protections.

Conclusion: Hate crimes and hate speech operate as structural and interpersonal stressors that intensify minority stress and inhibit timely, affirmative healthcare engagement for MSM. Interventions must extend beyond individual-level counselling to include facility-level quality improvement, workforce development, and community–state accountability mechanisms that reduce violence, improve service acceptability, and protect confidentiality.

Keywords: MSM; hate crime; hate speech; minority stress; mental health; healthcare access; stigma; South Africa; qualitative research

1. Introduction

South Africa is frequently cited as a continental leader in the formal recognition of sexual and gender minority rights. Nonetheless, legal protections have not fully translated into lived safety and equitable access to health and social services for men who have sex with men (MSM). Daily experiences of stigma, discrimination, hate speech, and hate-motivated violence continue to shape MSM's health risks, coping strategies, and engagement with healthcare systems. Within high-burden HIV settings, these social stressors intersect with biomedical vulnerabilities, creating compounded risks for poor mental health and delayed care (Nel & Judge, 2008; The Other Foundation, 2016; UNAIDS, 2021; Beyrer et al., 2016; World Health Organization, 2016).

Globally, bias-motivated victimisation has been linked to depression, anxiety, post-traumatic stress symptoms, substance use, and suicidality among sexual minority populations. Hate speech functions as both a direct psychosocial assault and a socio-cultural signal that normalises exclusion, legitimises violence, and constrains self-expression. In clinical contexts, stigma and anticipated discrimination can suppress disclosure, undermine therapeutic alliances, and reduce utilisation of preventative services, including HIV testing and STI care (Herek, 2009; Mays & Cochran, 2001; Hatzenbuehler, 2009; Zochniak et al., 2023; Gyamerah et al., 2020).

Despite the salience of these pathways, empirical research on hate crimes and hate speech as determinants of mental health and healthcare access among MSM in township settings remains limited. Umlazi Township—one of the largest townships in KwaZulu-Natal—has diverse social networks but also entrenched socio-economic inequalities that can heighten exposure to community violence, reduce access to affirming services, and intensify the consequences of stigma (Imrie et al., 2013; Scheibe et al., 2017).

This study therefore examined: (i) how MSM describe and interpret hate crimes and hate speech within their everyday lives; (ii) the perceived mental health impacts of these experiences; (iii) how hate-related victimisation shapes healthcare seeking, disclosure, and service utilisation; and (iv) participant-identified strategies and intervention priorities to reduce harm and improve access.

2. Background and literature review

2.1 Defining hate crimes and hate speech

Hate crimes are criminal acts motivated wholly or partly by prejudice toward a person's real or perceived membership of a social group, including sexual orientation and gender identity. Hate speech encompasses expressions that demean, threaten, or incite hostility or violence toward a

group. In practice, participants' narratives suggested that hate speech and hate-motivated violence form a continuum: verbal harassment and social exclusion create permissive conditions for violence and, even in the absence of physical assault, communicate devaluation and danger (Herek, 2009; Republic of South Africa, 2024).

2.2 Hate-related victimisation and mental health among sexual minorities

Evidence from diverse contexts links bias-motivated victimisation to psychological distress, including anxiety, depressive symptoms, trauma-related symptoms, and suicidality. Minority stress processes such as hypervigilance and identity concealment can mediate these associations. Importantly, chronic exposure to a hostile climate (including hate speech) can function as a persistent stressor that erodes wellbeing even when overt violence is episodic (Meyer, 2003; Hatzenbuehler, 2009; Frost & Meyer, 2023).

2.3 Healthcare access and the role of stigma

Healthcare access is influenced by availability, affordability, acceptability, and quality. For MSM, acceptability and perceived safety are often decisive. Stigma can manifest through heteronormative assumptions, moralising language, denial of services, ridicule, and breaches of confidentiality. These harms can prompt delayed or avoided care, constrained disclosure, and reduced uptake of preventive and diagnostic services (Link & Phelan, 2001; Parker & Aggleton, 2003; Pescosolido et al., 2008; Phelan et al., 2008; Scheibe et al., 2017; Müller et al., 2021).

2.4 South African context and township realities

South Africa's formal legal framework recognises equality and includes statutory and policy initiatives aimed at addressing discrimination and hate-related harms. Nevertheless, attitudinal ambivalence remains widespread, and lived experiences of stigma and violence persist. In

township settings, dense social networks and limited privacy can intensify social surveillance, increase the perceived risk of being 'outed' in public services, and heighten the psychological costs of visibility (Republic of South Africa, 2024; The Other Foundation, 2016; Nel & Judge, 2008).

2.5 Study contribution

While prior studies have described stigma in healthcare settings for MSM in South Africa, less is known about how hate crimes and hate speech are experienced as linked, cumulative harms that shape both mental health and healthcare engagement in township contexts. This study provides qualitative evidence that foregrounds MSM narratives from Umlazi Township and supports multi-level intervention planning (Duby et al., 2018; Scheibe et al., 2017; Müller et al., 2021).

3. Conceptual framework

This study is informed by two complementary lenses. First, Minority Stress Theory conceptualises stigma-related stressors (e.g., discrimination, violence, concealment pressures, and internalised stigma) as chronic, socially produced exposures that increase vulnerability to adverse mental health outcomes. Second, the Social-Ecological Model highlights that hate crimes and hate speech are not only interpersonal events but also shaped by community norms, institutional practices, and policy environments. Integrating these frameworks supports a multi-level interpretation: hate speech and violence elevate distal stressors, amplify proximal stress processes (e.g., hypervigilance, anticipatory fear, concealment), and constrain healthcare access through both structural barriers (e.g., clinic culture, confidentiality failures) and interpersonal dynamics (e.g., provider judgement) (Meyer, 2003; Frost & Meyer, 2023; Hatzenbuehler, 2009; Bronfenbrenner, 1979).

4. Methods

Study design

This study adopted a qualitative descriptive design to explore lived experiences of hate crimes and hate speech and their perceived impacts on mental health and healthcare access among MSM. A qualitative approach was selected because it supports in-depth exploration of meaning-making, context, and the pathways through which social harms shape health behaviours (O'Brien et al., 2014; Tong et al., 2007).

Setting

The study was conducted in Umlazi Township, KwaZulu-Natal Province, South Africa. Umlazi is characterised by diverse residential areas, high levels of unemployment and socio-economic inequality, and limited access to specialised sexual health and mental health services. Participants described navigating highly visible community spaces where privacy is constrained, and stigma can be readily enacted.

Participants and recruitment

Twenty-five MSM aged 18 to 55 years participated. Eligibility criteria included: (i) self-identification as a man who has sex with men (regardless of sexual identity label), (ii) residence in Umlazi Township, (iii) age 18 years or older, and (iv) willingness to provide informed consent. Purposive sampling was used to capture a range of ages and life circumstances. Recruitment occurred through community networks and local LGBTQ+ organisations, complemented by peer referrals. To reduce risk of involuntary disclosure, initial contact emphasised participant autonomy, and interview scheduling prioritised privacy and participant-selected safe locations.

Data collection

Semi-structured interviews were conducted using a topic guide covering: experiences of hate speech and hate-motivated incidents; perceived psychological impacts; coping and support; healthcare seeking, disclosure, and clinic experiences; and intervention priorities. Interviews lasted approximately 40–60 minutes and were audio-recorded with consent. Field notes captured contextual observations and reflexive insights.

Data analysis

Data were analysed using reflexive thematic analysis. Transcripts were read repeatedly to achieve immersion. Initial codes were generated inductively, emphasising both explicit content and latent meanings (e.g., anticipatory fear, concealment pressures). Codes were iteratively grouped into candidate themes, refined through constant comparison across transcripts, and reviewed against the full dataset to ensure coherence and distinctiveness. Analytic memos documented interpretive decisions, and a thematic map was produced to represent relationships between themes (Braun & Clarke, 2006, 2022; Nowell et al., 2017).

Reflexivity and researcher positioning

Given the sensitive nature of sexuality and stigma in township settings, reflexivity was prioritised throughout design, data collection, and analysis. The researcher maintained a reflexive journal to monitor assumptions, potential power dynamics, and interpretive influences. During interviews, participants were encouraged to challenge interpretations and clarify meanings (O'Brien et al., 2014).

Trustworthiness

Credibility was supported through prolonged engagement with community networks, iterative questioning, and member reflections on preliminary interpretations. Dependability and confirmability were enhanced through an audit trail documenting coding iterations, analytic memos, and theme development. Transferability was supported by thick description of context and participant narratives (Lincoln & Guba, 1985; Shenton, 2004; Nowell et al., 2017).

Ethical considerations

Ethical approval was obtained from the University of South Africa's Ethics Review Board. Participants provided written informed consent and were informed of their right to withdraw at any time. Transcripts were de-identified, and pseudonyms/participant IDs were used in reporting. A distress protocol was in place, including referral pathways to psychosocial support services. Data were stored securely on encrypted devices with access limited to the research team.

5. Results

The analysis produced four interlinked themes that describe how hate crimes and hate speech shape MSM experiences in Umlazi Township and how these experiences influence mental health and healthcare access. Theme 1 describes the continuum of hate speech and hate-motivated violence. Theme 2 explains the mental health sequelae and coping patterns. Theme 3 focuses on healthcare avoidance, disclosure constraints, and confidentiality concerns. Theme 4 synthesises participant-identified intervention needs and priorities.

5.1 Participant characteristics

Twenty-five MSM participated (age range: 18–55 years). Participants reported diverse sexual identity labels and varying degrees of openness about sexuality across family, community, and

healthcare contexts. Most participants described living within dense social networks where privacy is constrained, with implications for anticipated stigma and disclosure decisions.

Table 1. Participant characteristics (summary)

Characteristic	Summary
Sample size (n)	25
Age range	18–55 years
Setting	Umlazi Township, KwaZulu-Natal, South Africa
Recruitment	Purposive sampling via community networks and local LGBTQ+ organisations; supplemented by peer referral
Data collection method	Semi-structured interviews (approximately 40–60 minutes), audio-recorded with consent
Analytic approach	Reflexive thematic analysis

5.2 Thematic findings

Three overarching themes were identified: experiences of hate crimes and hate speech; impacts on mental health; and effects on healthcare access. Table 2 provides a summary.

Table 2. Summary of themes and subthemes

Theme	Subthemes	Description
Experiences of Hate Crimes and Hate Speech	Verbal abuse and physical violence	MSM experiences verbal abuse, threats, and physical attacks.
	Daily microaggressions	Microaggressions, such as stares and exclusion in public spaces, contribute to a hostile environment.
Impact on mental health	Emotional distress	Participants reported significant emotional turmoil resulting from

		experiences of discrimination and fear of potential hate crimes.
	Anxiety and depression	Many participants described symptoms of anxiety and depression, often linked directly to their experiences as MSM in a hostile social environment.
	Internalized stigma	Participants frequently expressed internalized negative attitudes about their sexual orientation, reflecting the pervasive societal stigma they face.
Effects on healthcare access	Delayed or avoided care-seeking	Fear of discrimination led many participants to postpone or completely avoid seeking necessary healthcare services.
	Discrimination in healthcare settings	Participants recounted experiences of prejudice and discrimination from healthcare providers, creating barriers to adequate care.
	Reluctance to disclose sexual orientation	Many participants expressed hesitation in revealing their sexual orientation to healthcare providers, fearing judgment or subpar treatment.

5.2.1 Theme 1: Experiences of hate crimes and hate speech

Participants described hate speech as a routine feature of public life, occurring in streets, public transport, workplaces, and social spaces. Hate speech ranged from slurs and ridicule to explicit

threats. For several participants, hate speech functioned as 'everyday policing' of gender expression and perceived sexuality, signalling that visibility is unsafe.

In addition to chronic verbal harassment, participants reported episodic incidents that they interpreted as hate-motivated violence or intimidation. These incidents were described as unpredictable, often occurring when participants were alone or leaving spaces perceived as 'gay-friendly'. Such experiences reinforced the perception that perpetrators felt socially authorised to harm MSM.

Participants emphasised that the cumulative burden was not only driven by major incidents. Microaggressions stares, whispers, social avoidance, and humiliating commentary were described as exhausting and corrosive, producing an ever-present sense of threat.

Participant P01 (age 32), described a harrowing experience: "Last year, I was walking home from a gay club when a group of men started shouting slurs at me. They followed me for blocks, threatening to 'teach me a lesson'. I've never been so scared in my life."

This narrative illustrates how hate-motivated hostility can escalate from verbal harassment to threats of violence, producing acute fear and an enduring sense of insecurity. Importantly, the participant framed the incident as a lesson to be taught suggesting disciplinary intentions that extend beyond a single encounter and communicate group-based domination.

Participant P02 (age 28), shared: "It's not just the big incidents. It's the constant, everyday things - the whispers, the stares, people refusing to sit next to you on the bus. It wears you down over time." Such repeated microaggressions contributed to an ongoing sense of alienation, fear, and psychological distress among participants.

Accounts of everyday microaggressions underscore the chronicity of stigma-related stress. Participants described how repeated social rejection and surveillance accumulate, eroding social belonging and amplifying anticipatory fear. This cumulative pattern provides a plausible pathway from community stigma to sustained psychological distress and behavioural restriction (e.g., avoiding public spaces).

5.2.2 Theme 2: Impacts on mental health and wellbeing

Participants linked hate-related exposures to multiple dimensions of psychological distress. A central mechanism was hypervigilance: many described monitoring their surroundings, anticipating harassment, and planning routes or behaviours to avoid being targeted. Hypervigilance was experienced as physically and emotionally exhausting and was associated with disrupted sleep and reduced daily functioning.

Participants also described depressive symptoms, including persistent sadness, low motivation, social withdrawal, and hopelessness. For some, distress escalated to suicidal thoughts or attempts. These accounts highlight the intensity of affective burden that can follow chronic exposure to hostility.

Beyond acute distress, several participants described internalised stigma—absorbing negative societal messages about same-sex sexuality which undermined self-worth and contributed to self-blame. Some participants reported that family or community responses framed sexuality as a moral or spiritual problem, leading to coercive attempts to 'change' sexuality and deepening psychological harm.

"Sometimes I feel like I am constantly on edge. Every time I leave the house, I wonder if today will be the day something bad happens. It is exhausting."

The participant's description reflects anticipatory anxiety and persistent threat appraisal. Such hypervigilance is consistent with minority stress processes whereby stigma exposure produces chronic stress reactions that persist beyond discrete events.

Participant P04 (age 23) described the psychological burden of public scrutiny: "Walking on the street with the look of people steering at you brings fear and emotional distress that I always fail to overcome."

Public scrutiny was described as emotionally destabilising and difficult to 'overcome', indicating the embodied nature of stigma. Feelings of being watched and judged can reduce mobility and public participation, which in turn can increase isolation.

"There are days when I can't even get out of bed. The fear and sadness just overwhelm me. I've been diagnosed with depression, and I know it's because of all the hate I've experienced."

This account indicates clinically salient depressive symptomatology linked by the participant to cumulative hate exposure. While causality cannot be inferred, the narrative highlights the perceived etiological role of stigma and violence in mental health trajectories.

"I can't remember how many times I have tried committing suicide in the past due to anxiety and depression based on the reason trying to satisfy peoples expectation for me based on my sexuality."

Suicidality emerged as a critical concern. The participant connected suicide attempts to anxiety, depression, and pressure to meet societal expectations, suggesting that both external hostility and internalised demands for conformity may contribute to crisis states.

"Sometimes I catch myself thinking that maybe they're right. Maybe there is something wrong with me. I hate feeling this way about myself, but it's hard not to when everyone around you seems to think it."

Internalised stigma was framed as an unwanted yet recurring cognitive pattern. Such narratives illustrate how social messages can become internal psychological burdens, undermining self-esteem and increasing vulnerability to depression.

"I have tried to change my self-several times, been taken to church and traditional healers as they belief being gay is a demon that need to be casted out. All this encounter made me see myself as unworthy and dirty."

Coercive 'conversion' efforts via religious or traditional pathways were described as harmful and shame-inducing. The participant articulated enduring feelings of being 'unworthy and dirty', indicating moral injury and the psychological costs of pathologising sexuality.

5.2.3 Theme 3: Effects on healthcare access, disclosure, and service utilisation

Participants described hate-related experiences as shaping healthcare behaviour through two interrelated pathways: (i) fear of discrimination and mistreatment by healthcare workers; and (ii) fear of breaches of confidentiality that could lead to involuntary disclosure within tight-knit community networks.

Several participants reported delaying or avoiding care even for potentially serious symptoms. Where care was sought, participants described withholding sexual history and avoiding disclosure unless they judged it unavoidable, which they perceived as safer but clinically suboptimal.

Participants also described specific forms of clinic-based stigma, including heteronormative questioning, moral judgement, and dismissive treatment when they disclosed sex with men.

Concerns about confidentiality were prominent, with participants citing experiences where sensitive information was allegedly shared between staff.

"I have been having these chest pains for months, but I am terrified of going to the doctor. What if they treat me differently when they find out I am gay? So I just keep putting it off."

Delaying evaluation for chest pain indicates how anticipated discrimination can outweigh perceived clinical risk. This dynamic has major implications for timely diagnosis and management of both acute and chronic conditions.

Participant P10 (age 29), affirmed: "I remembered having an anal STI and I have this phobia of going to my local clinics because I know they will ask me stupid questions on how I got the infection."

The participant anticipated humiliating questioning and judgement in local clinics, leading to avoidance. Such expectations can be shaped by prior experiences, community narratives, and the perceived heteronormativity of clinical encounters.

"When I went for an HIV test, the nurse asked me how many women I'd slept with. When I told her I only have sex with men, her whole demeanor changed. She became cold and judgmental. I left without getting tested."

This narrative highlights how heteronormative assumptions in sexual history taking can alienate MSM clients. The reported change in demeanour after disclosure suggests stigma enacted through tone and interpersonal withdrawal, which can directly interrupt care.

"The Nurses in my local clinics needed training as they don't keep patients confidentiality as I have been a victim where a Nurse told another Nurse about what I told her in confidence during consultation"

Confidentiality concerns were described as both experienced and anticipated. In township settings where health workers may be neighbours or connected to family networks, perceived confidentiality failures can have disproportionate consequences for safety and social standing.

"I never tell doctors about my sexuality unless it's absolutely necessary. I'm always afraid they'll treat me differently or breach my confidentiality. It's safer to keep quiet, even if it means not getting the best care."

Concealment was described as a protective strategy. While concealment may reduce immediate risk of stigma, it can compromise clinical decision-making (e.g., screening recommendations, differential diagnosis for rectal symptoms) and increase psychological burden through inauthenticity and anxiety.

"I am too old to be answerable to anyone about my sexuality, I have lived with this throughout my life so I don't owe anyone any explanation or disclosure as they will always use it negatively against me."

Participants also articulated autonomy over disclosure, emphasising the right not to explain sexuality. This stance can be understood as resistance to stigma and a means of self-protection; however, it also underscores the need for clinical environments where disclosure is not coerced yet can occur safely when relevant to care.

6. Discussion

6.1 Principal findings

This study provides qualitative evidence that hate crimes and hate speech remain salient stressors in the lives of MSM in Umlazi Township. Participants described a continuum of hostility ranging from routine verbal harassment and social exclusion to threats and incidents perceived as hate-

motivated violence. These experiences were interpreted as socially sanctioned, unpredictable, and therefore difficult to prevent. The psychological consequences described by participants—hypervigilance, anxiety, depressive symptoms, and suicidality are consistent with the broader literature linking bias-motivated victimisation to mental health distress among sexual minorities (Meyer, 2003; Frost & Meyer, 2023; Hatzenbuehler, 2009) (Herek, 2009; Nel & Judge, 2008; Zochniak et al., 2023).

Participants further described how hate-related experiences shaped healthcare seeking. Anticipated stigma, fear of judgement, and concerns about confidentiality breaches were central barriers to accessing care, including for HIV testing and STI-related symptoms. These accounts align with South African evidence that stigma and negative health worker attitudes can reduce service acceptability and interrupt HIV prevention and care among MSM (Rispel et al., 2011; Sandfort et al., 2015; Duby et al., 2018) (Scheibe et al., 2017; Müller et al., 2021; Duby et al., 2018).

6.2 Interpretation through minority stress and socio-ecological lenses

Minority Stress Theory posits that stigma-related stressors are chronic and socially produced, adding to general life stress and increasing vulnerability to adverse mental health outcomes (Meyer, 2003). Participants' narratives suggested high levels of distal stressors (hate speech, discrimination, threats of violence) that triggered proximal processes such as hypervigilance, concealment, and internalised stigma. These proximal processes may protect against immediate danger but carry psychological and behavioural costs. For example, concealment can limit access to social support and disrupt clinical communication (Meyer, 2003; Frost & Meyer, 2023; Hatzenbuehler, 2009).

From a social-ecological perspective, the harms described are shaped by interacting levels of influence. At the community level, gender norms and moral discourses can legitimise hostility and

intensify social surveillance. At the institutional level, clinics may reproduce heteronormativity through routine questioning, staff attitudes, and weak confidentiality practices. At the policy level, formal rights may not translate into felt protection if reporting mechanisms are inaccessible, trust in policing is low, or survivors anticipate secondary victimisation (Bronfenbrenner, 1979).

6.3 Implications for clinical practice and health systems

1) Confidentiality as a quality-of-care priority: Participants' narratives indicate that confidentiality is not merely an ethical principle but a determinant of service utilisation. Facilities should strengthen confidentiality protocols, reduce opportunities for informal disclosure between staff, and implement patient flow and consultation practices that protect privacy (Müller et al., 2021; Scheibe et al., 2017).

2) Competency-based training and supportive supervision: Routine training on MSM sexual health, non-judgmental communication, and inclusive history-taking is essential. However, training alone is insufficient without supportive supervision, accountability mechanisms, and explicit leadership commitment to non-discrimination (World Health Organization, 2016; Scheibe et al., 2017).

3) Integration of mental health support: Given the prominence of anxiety, depression, and suicidality, programmes serving MSM should include accessible psychosocial services. This can include brief evidence-based psychological interventions delivered within primary care, referral pathways to specialised services, and peer-led support groups (Mays & Cochran, 2001; Hatzenbuehler, 2009; UNAIDS, 2021).

4) Affirming sexual health services: MSM-friendly HIV/STI services (including appropriate risk assessment, STI screening, and PrEP information where available) can reduce avoidance and

improve continuity of care. Community-based or mobile services may be particularly valuable in township settings where clinic attendance can heighten exposure to stigma (World Health Organization, 2016; Beyrer et al., 2016; Rispel et al., 2011; Sandfort et al., 2015; Stone et al., 2021).

6.4 Implications for policy and community safety

South Africa has taken statutory steps to address hate-motivated harms, including the Prevention and Combating of Hate Crimes and Hate Speech Act, 2023. While legislative developments are important, participants' accounts illustrate that the everyday enforcement environment and community norms remain critical determinants of safety. Violence prevention, therefore, requires multi-sector collaboration spanning justice, policing, social development, education, and community leadership. Public communication campaigns should move beyond tolerance messaging to address the social drivers of violence, including gender norms and moral stigma (Republic of South Africa, 2024).

6.5 Recommendations

Table 3 synthesises multi-level recommendations derived from the findings and the conceptual framework (UNAIDS, 2021; World Health Organization, 2016).

6.6 Strengths and limitations

This study provides context-rich evidence from a township setting and illustrates how hate exposure can shape mental health and healthcare engagement through multiple pathways. Nonetheless, findings should be interpreted in light of limitations. The sample was purposively recruited and may not represent MSM who are more socially isolated or who avoid LGBTQ+ networks. The cross-sectional design limits causal inference. Additionally, participants self-

reported mental health experiences without clinical assessment. Future research should examine longitudinal relationships between hate exposure, mental health outcomes, and service utilisation, and evaluate multi-level interventions (Nowell et al., 2017).

6.7 Conclusion

Hate crimes and hate speech are not only social injustices but also public health issues. In Umlazi Township, participants described these exposures as pervasive, psychologically damaging, and consequential for healthcare access. Improving MSM health and rights requires a package of interventions: confidentiality and competence in health services, accessible mental health support, community-based safe spaces, and effective implementation of protections against hate-motivated harms.

Table 3. Multi-level recommendations to address hate-related harms and improve healthcare access for MSM

Level	**Problem statement (from findings)**	**Actionable recommendations**
Individual / interpersonal	Hypervigilance, anxiety, depression, suicidality; limited support; internalised stigma	Scale up confidential psychosocial support (brief therapies, crisis pathways); peer support groups; culturally relevant psychoeducation; strengthen social support and safety planning.
Health facility	Fear of judgement, heteronormative questioning, and confidentiality breaches; avoidance/delayed care	Competency-based training with supervision; explicit confidentiality protocols and enforcement; inclusive sexual history taking; signage and patient rights information; referral pathways to MSM-affirming services.

Community	Normalisation of hate speech and social surveillance; limited safe spaces	Community dialogues addressing gender norms and stigma; establish safe spaces/drop-in centres; bystander interventions; partnerships with faith/traditional leaders who support non-violence.
Policy / justice	Low perceived protection; barriers to reporting and accountability for hate-motivated harms	Awareness and operationalisation of hate crime/hate speech protections; survivor-centred reporting mechanisms; training for police/prosecutors; monitoring and public reporting of implementation; collaboration with civil society.

7. Declarations

Author contributions: IAI conceived the study, led the study design, data collection, analysis, and drafted the manuscript. The author reviewed and approved the final version for submission.

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Ethics approval and consent to participate: Ethical approval was obtained from the University of South Africa's Ethics Review Board. All participants provided informed consent.

Consent for publication: Not applicable.

Patient and public involvement: Participants contributed to interpretation through member reflections on preliminary themes.

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Appendices

Appendix A. COREQ (32-item) reporting checklist mapping (summary)

This appendix provides a brief mapping of how key COREQ items are addressed in the manuscript. A full checklist can be provided on request (Tong et al., 2007).

COREQ domain/item (abridged)	**Where addressed in manuscript**
Research team and reflexivity (credentials, relationship with participants, reflexivity practices)	Methods: Reflexivity and researcher positioning
Study design (sampling strategy, approach to participants, setting, presence of non-participants)	Methods: Participants and recruitment; Setting; Data collection
Data collection (topic guide, repeat interviews, audio/field notes, duration)	Methods: Data collection

Data analysis (coding approach, derivation of themes, software, analyst triangulation)	Methods: Data analysis; Trustworthiness
Reporting (quotations, consistency between data and findings)	Results: Themes 1–3 with illustrative quotations

Appendix B. SRQR reporting checklist mapping (summary)

This appendix maps the manuscript to selected SRQR items to support Q1 journal reporting expectations (O'Brien et al., 2014).

SRQR item (abridged)	**Where addressed in manuscript**
Problem formulation and purpose	Introduction; Study aims
Qualitative approach and rationale	Methods: Study design
Researcher characteristics and reflexivity	Methods: Reflexivity and researcher positioning
Context and sampling strategy	Methods: Setting; Participants and recruitment
Ethical issues	Methods: Ethical considerations; Declarations
Data collection methods	Methods: Data collection
Data analysis methods	Methods: Data analysis
Techniques to enhance trustworthiness	Methods: Trustworthiness
Synthesis and interpretation	Results; Discussion
Limitations	Discussion: Strengths and limitations

Appendix C. Indicative semi-structured interview topic guide

The following topic guide summarises the domains used to structure interviews. Wording was adapted to participant language, and probes were used flexibly to elicit detail and meaning.

Domain 1: Background and context

• Can you tell me a bit about yourself and your community context in Umlazi?

• How comfortable do you feel being yourself in different spaces (home, friends, public places)?

Domain 2: Experiences of hate speech

• What kinds of things do people say about MSM in your community?

• Have you experienced verbal harassment or threats? What happened and how did you respond?

• How often do these experiences occur, and in which settings?

Domain 3: Experiences of hate crimes or violence

• Have you experienced violence or intimidation you believe was related to your sexuality or gender expression?

• What were the short-term and longer-term effects of that incident?

• Did you report it? Why or why not?

Domain 4: Mental health and coping

• How have these experiences affected your mood, sleep, anxiety, or sense of safety?

• What coping strategies do you use (e.g., friends, family, faith, avoidance, substances, professional support)?

• Have you ever felt hopeless or thought about harming yourself? (If yes: distress protocol and referral.)

Domain 5: Healthcare access and disclosure

• When you need healthcare, where do you go? What influences your choice?

• Have you ever felt judged or treated differently in a clinic because of your sexuality?

• How do you decide whether to disclose sex with men to a health worker?

• What would make clinics safer and more welcoming for MSM?

Domain 6: Recommendations

• What changes are most needed to reduce hate speech/violence in your community?

- What support services should exist for MSM in Umlazi?