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Perceived barriers to access available health services among men who have sex with men in Dar es Salaam, Tanzania

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Abstract
Background: Men who have sex with men (MSM) continue to be highly affected with the HIV infection worldwide. Studies have shown that the organization of healthcare systems and how the MSM perceive it play a major role in granting or denying them access to healthcare services. Little is known in Tanzania regarding the barriers that MSM face while accessing health services within the country. The study was geared towards determining the proportion of MSM who accessed health care and disclose their sexual orientations to health care workers (HCW). It also intended to find out the anticipated barriers from HCW's if they were to disclose their sexual orientations to them and consider the types of social networks used when facing various challenges.
Methods: The study employed both quantitative and qualitative methods. Participants were enrolled in the study Respondent Driven Sampling. Quantitative data was entered and analysed using the Statistical Package for the Social Sciences v.20. Qualitative data was collected using in-depth interviews read and interpreted to identify themes and create categories. These were manually analysed and interpreted according to the study objectives.
Results: The majority (87.7%) of MSM accessed healthcare services when sick, only a few (3.4%) did nothing due to lack of financial resources. Only a third of them had ever disclosed their sexual orientations to healthcare workers. This was due to lack of confidentiality, fear of stigma and discrimination, shame and mistreatment at the health facilities, and fear of the healthcare worker's reaction after they disclosed their sexual orientation to them.
Conclusion: MSM need to be empowered to overcome their perceived fears towards healthcare workers and health facilities. Efforts should be put into breaking the cycle of negative information and perceptions MSM have about healthcare workers and how they deal with same sex practices' health related problems.

Keywords: men having sex, health services, barriers, health workers, Tanzania

Introduction

The term "men who have sex with men" (MSM) is an inclusive public health term used to define the sexual behaviour of males who engage in sexual activity with other males, regardless of their motivation for doing so or identification of a specific sexual orientation (WHO 2011; UNAIDS 2006). The term encompasses both gay men and bisexual men. The reasons behind this engagement are complex and can lead to various interpretations. There is emerging scientific evidence showing that these behaviours may be due to some chromosomal, genetic, or psychosexual disorder (Burton, 2006). Furthermore, evidence suggests that underexposure of male sex hormones in pre-natal life may lead to female differentiation of the hypothalamic region of the brain (Ahrens *et al*., 1983). Other potential triggers could be sexual abuse and financial gains. Sexual abuse has the potential to influence orientation (Feldman *et al*., 2005). Some men see the benefit of practicing commercial sex; this can push or pull them towards same sex practices in order to sustain themselves (Bengtsson *et al.* 2013). Sex between men can include insertive or receptive anal sex, as well as oral sex, inter-crural sex (thigh sex), and mutual masturbation (Companions on a Journey, 2000).

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The UNAIDS report on AIDS and men who have sex with men showed that the risk of HIV transmission among them is high, especially when condoms are not being used due to the fact that the rectal lining is so thin and is prone to tearing during intercourse, giving the virus access to transfer. Furthermore, it is also thought that cells lining the rectum have a lower immunity level compared to those of the vagina (UNAIDS, 1998).

In most of Sub-Saharan Africa there is an increased prevalence of HIV in the MSM population when compared to the general population (Van Griensven *et al.*, 2009). A study done in Zanzibar, Tanzania revealed a prevalence of 12.3% among MSM, which was 60 times that of the general population (Dahoma *et al.*, 2011). This is in part due to the culture and laws that prevent them from seeking HIV services because of fear surrounding the treatment (Ottoson, 2007). Furthermore, MSM face various challenges when seeking healthcare services including stigma, discrimination, lack of confidentiality among healthcare workers, criminalization of homosexuality, and the lack of awareness and sensitivity healthcare workers possess towards the needs of MSM (Lane *et al.*, 2008)..

The healthcare environment in most of Sub-Saharan countries is very unfriendly towards the MSM population (Fay *et al.,* 2010). A When healthcare workers deny MSM access to treatment it creates a negative perception towards the services. This can be a major factor in discouraging these men from seeking healthcare treatment at their leisure. When MSM expose themselves to healthcare workers, they often report that healthcare workers try to convince them that being homosexual is wrong and/or refuse to treat the individual (Rispel *et al.,* 2011). Previous negative experiences are leading to delay or avoidance of treatment for HIV and other sexually transmitted infections (STI) within the MSM population (Lane *et al*., 2008). In Dar es Salaam there is low testing rates for HIV among MSM due to fear of discrimination and shame brought on by other members of this vulnerable group (Nyoni & Ross, 2012).

Understanding the perceptions that MSM have towards healthcare services will help providers understand the barriers that exist among MSM and provide a basis for developing user-friendly health services. In most of Sub-Saharan Africa they generally feel that the guidelines are directed towards heterosexual individuals and ignore their needs. For this reason this study was carried out to determine the local situation with regards to MSM accessing health services in Dar es Salaam. Specifically, it aimed to determine: (i) barriers to access health services among MSM in Dar es Salaam; (ii) the perceptions that the MSM population had surrounding the reactions healthcare workers had to their sexual orientation, and (iii) the social networks used by the MSM community when accessing health services.

Materials and Methods

Study area

This study was conducted in the three districts of Dar es Salaam City, namely Kinondoni, Ilala and Temeke in Tanzania. Dar es Salaam city is a cosmopolitan region composed of many differing origins, backgrounds, and behaviour patterns that increase the likelihood of varying interactions including sexual interactions such as homosexuality. The HIV prevalence within the MSM population in the city is approximately 9% (THMIS, 2008).

The study was based at Pastoral Activities and Services for People with AIDS Dar es Salaam Archdiocese (PASADA). PASADA is a faith-based organization providing various health services for people infected and affected by HIV. PASADA has been providing services that are friendly and non-discriminatory to key populations including MSM since 2007.

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Study design and population

A descriptive study design was used, in which both quantitative and qualitative methods were utilized. Information was gathered from MSM who have been living in Dar es Salaam for at least one year prior to the conduction of the study. Inclusion criteria included; the individual was involved in MSM practice; was having anal intercourse with another man; was were living in Dar es Salaam; and provided verbal consent to be used as subjects in the study. The exclusion criteria included: a refusal to participate in the study; if he was disturbed or intoxicated at the time; and if he was very sick or very old.

During this study five initial seeds were identified. Each were given three coupons to recruit the first wave of participants. Each wave then got three coupons to recruit the next wave and so on. Recruitment for this study occurred in three waves. The first wave was expected to recruit a first wave of 15 participants, the second wave was expected to consist of 45 participants, while the third wave was expected to comprise of 135 participants for a grand total of 195 recruits. After three waves in this study 204 participants were recruited.

Data collection

Using a respondent driven sampling (RDS) technique data was collected from March to May 2012. This technique is often used to study hidden populations such as MSM; members of the subgroup are used to recruit their peers (Heckanthorn, 1997). Seeds are used to identify other eligible recruits from the subgroup. Each new recruit is then asked to recruit the same number as the initial seeds. Each subgroup is now independent which mitigates the biases that can result from a snowball technique.

Interviews were conducted using a questionnaire; focused on gathering information on identity, barriers to access available healthcare, disclosure, community life, utilization of healthcare services, perceptions among MSM with regards to healthcare workers, and social networks used for solving social problems. Furthermore, there were semi-structured interviews conducted using open-ended questions exploring perceptions of reactions of healthcare workers once MSM had disclosed their sexual orientation to them. The interviews were conducted in a private and safe environment for the participants. The interviews were developed in English but carried out in Kiswahili and lasted approximately 60 minutes each. The participant responses were identified using study identification numbers, avoiding personal information for the protection of the participants.

Data analysis

Quantitative data was entered onto a computer and analysed using the Statistical Package for the Social Sciences (SPSS for Windows version 2.0). Frequencies of the various variables were determined, as well proportions and cross tabulations were statistically calculated. The Kiswahili transcripts were translated to English, creating categories from the quotations, and developing themes recorded qualitative data. Verbatim quotations and word tables were used to display quotations of responses.

Ethical considerations

Ethical approval was requested from the Muhimbili University of Health and Allied Sciences Ethical Committee. Permissions to conduct the study were granted by Temeke District Executive Director and Temeke District Medical Officer. Verbal consent was given by participants as opposed to written in order to protect them from punitive country laws against homosexuality.

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Results

Social demographic characteristics

Most of the study participants (64.3%) were between 17 and 24 years old, while only a few (5.4%) were 35 years of age or older. The mean age (+standard deviation) of the study population was 24.3± 6.2 years. The majority of the participants (40.7%) were from Kinondoni district, while a significant portion (36.8%) of them came from Temeke, and the least amount of participants (22.5%) came from Ilala. Of the participants 90.7% were single and less than 10% were married, while 22.5% of them reported having children. With regards to the level of education, 38% completed primary school education while 9.8% had not and 26.1% had completed secondary and post-secondary school while 26% had not completed secondary school. One third (37.3%) of the participants were unemployed, the remaining were employed in either the public or the private sector.

Access to healthcare

The majority of the study participants (87.7%) consulted a healthcare worker when sick. Among the MSM who did no, 6.9% were self-medicating and 3.4% did nothing due to lack of financial resources. The proportion of MSM consulting healthcare workers when sick decreased with age. About two thirds (63.7%) of MSM aged 17-24 years consulted healthcare workers while only 5% of MSM aged 35 years or older did so. There was no significant difference between those with primary education and secondary education. Less than half (45.8%) of those with a primary education consulted healthcare workers when sick compared to 50.8% of MSM with secondary education. In terms of employment, 11.7% of MSM employed consulted healthcare workers when sick, 38.5% of unemployed MSM did so, and 49.7% of self-employed MSM sought healthcare. Of those you were seeking treatment 7.3% reported poor treatment by healthcare workers due to their sexual orientation. Furthermore, 54.9% of the participants expressed that there are no facilities providing MSM friendly health services in Dar es Salaam.

Disclosure of sexual orientations to healthcare workers

Among the MSM who consulted healthcare workers when they fell sick only 54 (30.2%) disclosed their sexual orientation. Disclosures were more prevalent in government health facilities (59.3%) than in private health facilities (40.7%). Among them, more than half (59.3%) disclosed to a male healthcare worker. The proportion of MSM disclosing their sexual orientation increased with an increased level of education. Among MSM with primary education, 45.6% disclosed, while 54.4% of MSM that had reached a secondary education had done so. There was also a slight difference in disclosure between receptive and insertive MSM. One third (33.3%) of receptive MSM had disclosed and 28% of insertive MSM has disclosed. As the level of perceived confidentiality increased among the healthcare workers as did the proportion of MSM disclosing their sexual orientation. One-tenth (11.1%) of participants disclosed in facilities perceived as having very poor confidentiality, while 51.8% of the participants disclosed in a facility that was perceived as having good confidentiality. Factors leading to not disclosing included shame, stigma by healthcare workers, and mistreatment at health facilities. After disclosure 36.4% of participants stated healthcare workers in private facilities were surprised and 22.7% stated that they were laughed at. In government facilities only 25% of participants reported that healthcare workers were surprised and just 15.6% expressed that these employees laughed at them.

MSM perception of healthcare worker's reaction after discloser of sexual orientation

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More than half of the participants (57.8%) expressed being fearful of disclosing their sexual orientation to healthcare workers. Fear of the their reaction decreased with an increase in age, with 65.6% of participants 24 and younger being afraid and 36% of participants above 35 were afraid. An increased level of education showed an increased level of fear. Two thirds (64.5%) of the participants with secondary education and above were fearful, while 50.5% with only a primary education were afraid. Of the participants with a past history of sexually transmitted infections, 55.8% were fearful of disclosing their sexual orientation. Slightly over half (54.9%) of the participants felt as though they would not be treated as equals to heterosexual patients once they disclosed their sexual orientation. Furthermore, 54.9% felt the healthcare system, as a whole could not support the needs of their population appropriately.

Social networks used by MSM

The participants expressed leaning on their parents for support when they were sick (34.4%) and when they needed food (44.1%). They also expressed consulting their friends when they felt down or sad (30.9%). But, in terms of financial troubles, 33.8% sought support from their boyfriends.

Perceptions of MSM on fair treatment by healthcare workers

There was divided responses when it came to this treatment by healthcare workers. Receptive MSM often found it to be a negative experience, while insertive MSM did not see anything wrong with the current processes. Most receptive MSM thought they would not be treated equally once they disclosed their sexual orientation, mainly because of stigma. As one participant put it: *"When you go to a health facility you are stigmatized. I once went to one hospital and told them I am involved in same sex practices. The doctor told all his colleagues at the clinic and they started laughing at me and said their hospital does not provide services to people of my kind. Afterwards one of the doctors started to seduce me."* The MSM population also believe the healthcare workers are lacking the knowledge to provide appropriate services to them. As another participant put it: *"It is difficult for healthcare workers to treat us as well as other patients because most of them do not have adequate knowledge on same sex practices. They think we have adapted this from Western countries."* Another factor pointed out by the participants was that the laws and the culture in Tanzania are creating barriers for them in the healthcare system because they are against same sex practice. One in particular expressed that: *"This cannot happen because men having sex with men are not accepted in our society and same sex practices are against the laws, culture, and traditions of our country"*

Most insertive MSM had the opposite opinion. They felt that even after disclosure of their sexual orientation they would be treated equally. They were positive that healthcare workers were ready to provide services to whomever regardless of their sexual orientations. One participant pointed out: *"For someone to become a doctor, he must be aware of same sex practices and I do not think he can have problems with treating men who have sex with men."* Another added by saying: *"Healthcare workers are good people. They will treat you as well as any other patient and they do not discriminate us as we are all human beings."*

Perceptions of MSM on fair treatment by the available healthcare systems

The majority of the participants agreed on the opinion that healthcare system could not treat them equally because of the stigma brought on by the healthcare workers. One participant stated: *"Most of the healthcare workers do not want to provide services to us. Unless they are ready to do so the healthcare system will not be able to treat us as other patients"* Some had the view that the system itself is a barrier to them accessing equal treatment. One expressed that:

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"The whole infrastructure and systems in our hospitals are not friendly to cater for the needs of men who have sex with men." The participants pointed out that the healthcare system couldn't handle their needs unless special clinics are available to them. As one participant put it: *"The healthcare system will not treat them the same as others until the gay people rights are recognized in the country and special centres for our treatment are established."* Other respondents thought that the healthcare system couldn't handle the needs of MSM because the government and culture of the country are against same sex practices. One participant boldly stated: *"The government knows same sex practices are there, but our culture, traditions, and religions are all against same sex practices. Therefore, the government is afraid of coming up with a healthcare system which will be friendly to us."*

Discussion

A fairly large proportion of MSM who were recruited in this study accessed healthcare services when sick. However, a few of them did nothing because they did not have the financial freedom to pay for the health services. More than half of the study participants pointed out that there were no facilities with MSM friendly health services in Dar es Salaam. Only less than a third had ever disclosed their sexual orientations to a healthcare worker. A key factor in the result of disclosing was confidentiality. The number of participants who disclosed their sexual orientations increased with the level of confidentiality. The level of fear decreased with increasing age and decreasing level of education.

Receptive MSM felt the healthcare workers could not treat them equally to that of heterosexual patients due to stigma, low level of knowledge on same sex practices, laws, culture, and religious issues. They showed concerns towards the entire healthcare system, in that it is not responsive to their needs. They also pointed out that unless they have special health facilities to cater to them, they would continue to be denied access to adequate health services. These findings are similar to those reported by the study conducted in South Africa and Senegal where MSM were reported being threatened, verbally abused, and not being given private or confidential services (Niang *et al.*, 2003; Lane *et al*., 2008).

The findings of this study suggest that treatment provided by healthcare workers plays a role in facilitating or denying access to health services for the MSM population. This is demonstrated in the study findings where by facilities that treated study participants nicely, also were the ones perceived to have good or very good confidentiality by them. The majority of the participants who did not consult a healthcare worker when they had STIs said they were afraid of stigmatization and had fear of being mistreated at health facilities. This was similar to the explanation given by those who delayed seeking medical care in studies in USA and Tanzania (Beckerman & Fontana, 2009; Nyoni & Ross, 2012). These studies showed expressions of being angry, scared of doctors, not ready, and feeling ashamed for being MSM as reasons for the delay.

The participants in this study who did not choose to disclose their sexual orientations to healthcare workers pointed out reasons such as shame of being a homosexual, stigma by healthcare workers, and mistreatment at health facilities. Similar observations have been reported in China (Wong *et al*., 2006). In this study it was observed that confidentiality among healthcare workers played a major role in determining whether MSM would disclose their sexual orientations or not. Similar to the study in China, our findings indicate that confidentially is one of the factors for choosing to never discussing MSM sexual orientations with healthcare workers (Wong *et al*., 2006).

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Similar to a study in Boston, USA, the MSM involved in this study felt that they could not be treated the same as other patients once they disclosed their sexual orientation to healthcare workers. They pointed out that stigma and discrimination by healthcare workers as being the main obstacle for them to utilize these services (Mimiaga *et al*., 2007). The participants also had a perception that doctors could not help them because same sex practices are a new thing in the society and they lacked the knowledge to treat them. Similarly, it has been reported from a study in Florida, USA that MSM were concerned with the availability of physicians with knowledge about health issues facing MSM (Beckerman & Fontana, 2009). Strategies for reaching more MSM and empowering them to overcome perceived fears with regards to healthcare workers and health facilities needs to be put in place.

In this study it was observed that most participants shared information with their guardians before reaching out to friends or sexual partners when they were sick. This differed from the study in China which found that MSM were mainly using their social networks for sharing most of their health-related information (Liu *et al*., 2009). This could be due to the fact that MSM in Dar es Salaam do not possess enough information to share in their network or the network is not strong enough to allow mutual sharing of such information.

In conclusion, the majority of MSM in this study accessed healthcare services when they were sick. However, of those seeking services only a third of them had ever disclosed their sexual orientation to healthcare workers. The main reasons for not doing so were lack of confidentiality, fear of stigma and discrimination, shame and mistreatment at the health facilities, and fear of the healthcare worker's reaction after they disclosed their sexual orientation. It is noted that a significant proportion sought help from their families for medical treatment, while a third of them consulted their significant others when they were in need of financial assistance. In light of these findings it is evident that MSM need to be empowered in order to overcome their perceived fears of healthcare workers and healthcare facilities. This goes hand in hand with breaking the cycle of wrong information and perceptions about MSM that healthcare workers possess. There should be an overall increase of knowledge on dealing with same sex practices' health related problems. Furthermore, to mitigate the financial burdens within the population it is important to introduce income-generating activities among this vulnerable group to enhance access to available health services and create financial freedom.

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