A qualitative study to explore the healthcare-seeking experiences of men who have sex with men and transgender women in Rwanda

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Abstract

Background

Globally men who have sex with men (MSM) and transgender women (TGW) encounter many negative experiences when accessing health services compared to the general population. Stigma, discrimination, and punitive laws against same-sex relationships in some sub-Saharan African countries have made MSM and TGW more prone to depression, suicidal ideation, anxiety disorders, substance abuse, non-communicable diseases, and HIV. None of the prior studies in Rwanda on MSM and TGW had explored their lived experience in accessing the health services. Accordingly, this study aimed at exploring the healthcare-seeking experiences of MSM and TGW in Rwanda.

Methods

Semi-structured interviews were conducted on 16 MSM and 12 TGW, using purposive and snowball sampling approach in 5 districts in Rwanda. Results were summarized using thematic analysis approach.

Results

Four main themes emerged from the study: 1) The healthcare experiences of MSM & TGW were generally dissatisfactory, 2) MSM & TGW generally hesitate to seek care unless they were severely ill, 3) More services specialized in addressing MSM & TGW's needs are necessary, and 4) Advocacy and awareness for and among MSM & TGW communities are needed.

Conclusion

Rwandan MSM and TGW continue to face negative experiences within the healthcare delivery settings. These experiences include mistreatment, refusal of care, stigma, and discrimination. Provision of services for MSM and TGW, and on-the-job training cultural competence in the care of MSM and TGW patients is needed. Including the same training in the medical and health sciences curriculum was recommended. Furthermore, awareness and sensitization campaigns to improve the understanding of the existence of MSM and TGW and to foster acceptance of gender and sexual diversity in society are necessary.

Background

In many countries, men who have sex with men (MSM) - men who engage in voluntary sexual activity with other men, regardless their sexual identity; and transgender women (TGW) - persons who were born male but identify and express themselves as women (1, 2); often face hostility, social exclusion, discrimination, stigma, irrational fear and even denial of healthcare (3). In addition, the punitive laws against same-sex relationships in many countries escalated the situation. High rates of depression, suicidal ideation, anxiety disorders, substance abuse, HIV, AIDS, and non-communicable diseases were often found among MSM and TGW around the world (4, 5, 6, 7)

While these communities generally have more health issues, their utilization of healthcare, including HIV services, has been generally low (8, 9). Police harassment, previous negative health care experiences, societal discrimination, medical professionals' abusive behavior and refusal of treatment were some identified barriers (10). Such barriers were even more intense in many Sub-Saharan Africa (SSA) countries with more conservative culture, traditions, and religions, causing MSM and TGW to resort self-medication, or seeking health advice from their peers or the internet instead of health care professionals (4, 11, 12).

Even in countries where same sex practices are not criminalized, like Rwanda, many MSM and TGW still have similar experiences (13). Despite healthcare providers' professional obligation to care for and treat people in an equitable manner, research has shown that prejudice against MSM and TWG remained prevalent (14). The fear of being exposed and public humiliation caused delay in seeking healthcare services, making MSM and TGW more vulnerable to poor health outcomes (13). Similar situations did not only apply to HIV services, but also to cardiovascular, diabetes and cancer screening services (16, 17). Prior studies in Rwanda on MSM and TGW mostly focused on their vulnerability to HIV and other STIs (18, 14). None had explored their lived experience in accessing the health system. Accordingly, this study aimed to generate in-depth information to fill this knowledge gap and to inform the design of appropriate interventions to address the barriers.

Methods

Study Design

A qualitative study using a phenomenological approach was utilized to understand the lived experiences of MSM and TGW when seeking healthcare in Rwanda. Participants who were 18 years or older, identified themselves as MSM or TGW and had sought healthcare services within the last year were recruited from 5 districts in Rwanda via purposive and snowball sampling until theoretical saturation.

Recruitment and consent

The recruitment took place between September and October 2021. Representatives from three LGBTQ + Rwandan-led non-governmental organizations (NGOs) contacted their members and explained the purposes of the study. Members who agreed to take part in the study were referred to the research team for the

interviews. Appointments were made based on the participants' preferred date, time and location.

Prior to the interview, consent to conduct and record the interviews was sought after a detailed explanation of the study. All interviews were conducted in Kinyarwanda; the local language spoken by the participants. Each interview lasted for approximately 60 minutes.

Data collection

A semi-structured interview guide was developed based on previous literature. It had 10 main questions, with probes to assist data collectors to acquire further in-depth information. The guide included questions related to the respondents' healthcare seeking experiences, barriers and challenges, and resources available and suggestions from them to facilitate their care. The interview guide was developed in English and translated to Kinyarwanda; and was pre-tested and piloted before the actual data collection.

Data Analysis

The audio recordings were transcribed and translated to English before analysis. De-identified transcripts were read by all authors independently then together to create the codebook. The investigators coded independently and together to resolve any discrepancies by discussion and revision of the definition of the codes. Dedoose software was used to facilitate the coding process. The coded transcripts were grouped into categories, then themes. Representative excerpts were included in the findings.

Results

Twenty-eight in-depth interviews were conducted, with 12 (42.9%) TGW and 16 (57.1%) MSM from all five districts in Rwanda. Their age ranged from 20 to 44 years, with 17 (60.7%) less than 30 years of age. Many of the participants (n = 20, 71.4%) have completed high school education, and 18 (64.3%) were unemployed at the time of the study (Table 1).

Table 1
Demographic information of participants

	Variable	N (%)
Sample		28
Age (Years)	< 30	17 (60.7%)
	30–50	11 (39.3%)
Gender identity/sexual orientation	Trans woman	12 (42.9%)
	MSM	16 (57.1%)
Place of residence	Kigali	9 (32.1%)
	Musanze	3 (10.7%)
	Muhanga	6 (21.4%)
	Kayonza	6 (21.4%)
	Rubavu	4 (14.3%)
Education	Less than high school	1 (3.6%)
	High school graduate	20 (71.4%)
	University level	7 (25%)
Employed	Yes	10 (35.7%)
	No	18 (64.3%)

Four major themes emerged from the interviews: 1) The healthcare experiences of MSM & TGW were generally dissatisfactory, 2) MSM & TGW hesitated to seek care unless they were severely ill, 3) More services specialized in addressing MSM & TGW's needs are necessary, and 4) advocacy and awareness for and among MSM & TGW communities are needed.

Theme 1. The healthcare experiences of MSM &TGW were generally dissatisfactory

All respondents reported some negative experiences when seeking care at health facilities and generally were dissatisfied with the care they received. The sources of dissatisfaction were many, including the required services or supplies were not available, being ignored or refused for treatment, or different forms of mistreatment and abuse from healthcare providers (HCP). HCP not only disrespected the patients, but also to a larger extent violated their professional code of conduct.

1.1 Required services were not available in the health facilities

Respondents stated that not all health facilities offered the services they needed. Patients often went to health facilities and were not able to receive treatment. It could be the entire service was not available at all, or the supplies required for the services were in shortage, or the healthcare provider was not knowledgeable enough to give them the needed treatment. It was reported that some HCP seemed not to know the diseases that are common in MSM & TGW, and not knowing how to treat them. One respondent described his experience when he accompanied his friend to a health facility:

"Recently, I accompanied my friend to the health facility. He was suffering from anal STI. He had pus coming from the anus. The nurse did not know how to treat that case and told my friend to go to the pharmacy, she said that the pharmacy might have a cream to help with that condition. I was really shocked" (MSM, 36 years old).

Another participant stated the following:

"There are no condoms, and lubricants. Even if you go to the youth friendly centers you will not find them there" (MSM, 22 years old).

1.2 Healthcare providers refuse to offer treatment to MSM and TGW

While services not being available was a source of dissatisfaction for the MSM & TGW, it was worse when the service was available, but HCP refused to provide the treatment. Some HCP would ask other HCP to offer the treatment, while some simply ignored them until they left after waiting for a long time. And some HCP sent them away without treatment because they perceive them as sinners or abominations.

"*Recently I went to the HF, in fact that was a few months ago but there was no nurse or doctor who was ready to receive gays or trans people. I couldn't receive care. They told me that I should go home and repent because I am a sinner." (MSM, 26 years old)*

"I went to a health facility, the doctor who received me was surprised of seeing transgender women, she went outside and after a few minutes, she came with other colleagues. They surrounded me and it seemed there was something she told them about me. After a few minutes they all left the consultation room. I waited a long time for her to come again, then I felt tired, demoralized and I decided to go without being treated" (TGW, 30 years old)

1.3. Healthcare providers could not separate sexuality from health conditions

Some HCP perceived homosexuality as a disease and focused on "treating" their sexual orientation, instead of the patients' health conditions. In some cases, the HCP even showed anger and hatred towards them.

"They all began telling me that the tumor I had was a result of my anal sex. I was shocked, and I was not convinced by their diagnosis. I mean they really did not treat me; they used that time to convince me to be straight. They even added that I am a curse to my family and society. I was unhappy." (TGW, 20 years old)

"*I told her the truth that I had sex with male partner. Her face immediately changed; she did not seem ready to digest that information. She yelled at me and added that homosexuality is not good at all, and I should stop it." (TGW, 22 years old)*

1.4. Healthcare providers violated provider-patient privacy and openly mocked them

Many respondents reported that the HCP did not respect their privacy and would share their personal information with colleagues or other patients, to humiliate them.

"He was very surprised to know I have sex with other men, he advised me to quit homosexuality. I told him that I am proud of who I am. Can you imagine, he even shared my result with everyone, luckily, I was HIV negative." (MSM, 27 years old)

"The last time I went to the health facility, it was for HIV testing, and I was with my partner. A nurse who received us told other people that we are gay men. Everyone started staring at us." (MSM, 27 years old)

Most of our participants had negative healthcare experiences and expressed their dissatisfaction with the services they received.

Theme 2. MSM and TGW generally hesitate to seek care unless they are severely ill

Respondents narrated hesitancy in seeking care unless they were critically ill, mostly due to their previous negative experiences at health facilities. But social exclusion and stigma all contributed to their reluctance. As a result, many utilized inappropriate and sometimes risky treatment methods. Due to fear or avoidance of physical, verbal or mental abuse, some either resorted to lying about the condition, sending another person to fake a sickness, or simply self-medicating.

2.1. MSM and TGW face social exclusion and stigma, affecting their health seeking behavior

All respondents stated that they experienced social exclusion from friends and families, which often caused them to hide their sexual orientation to avoid rejection. However, the exclusion and stigma did not stop at the community level. They felt stigma and social exclusion in health facilities, too. As they were whispered about, asked inappropriate questions about their sexual orientation and gender identity and sometimes harassed by other patients and healthcare providers. Out of such fear, many would not seek care until they were severely sick. And when they visited the HCP, they lied about their sexual orientation, gender identity or partially disclosed information related to their symptoms and conditions. One participant shared the following experience:

"When I was suffering from STIs, my colleagues accompanied me to the health facility because I was seriously sick and at that time, I refused to go to the health facility because it was the same place I had been bullied and insulted in the past. But finally, I accepted. When I arrived there, the person who attended to me was a nurse who really made me feel uncomfortable with her questions. Moreover, she asked them in front of everyone. I decided to lie to her that I had sex with a woman". (MSM, 24 years old)

Another participant narrated the following:

"I only go to the hospital when I am severely ill. You know, it is very worrying when you are walking on foot, heading to the health facility or another location; neighbors and other people on the street begin to harass you and sometimes they throw stones at you. We have some TGWs who killed themselves because of bad treatment from society and the family.". (TGW, 25 years old)

2.2. Previous negative experiences at health facility caused MSM & TGW not to want to return for care

Besides social exclusion and stigma, respondents' previous negative experience at health facilities including hostility, being denied services, verbal abuse, and being asked inappropriate questions by HCP discouraged them from returning for future care. Although two participants stated that they would still seek care when sick albeit previous negative experiences, many considered that health facilities as a last resort.

"In fact, most of the time I do not go to the hospital when I am sick, and it has consequences for my health. You see the issue here is when you have a bad experience of judgement, verbal abuse, stigma, being asked inappropriate questions or discrimination at the hospital - it really affects you, and the next time you fall sick, you feel like you do not want to go there."(MSM, 28 years old)

"It is really hard particularly after a bad experience at the hospital. Personally, when I go and find that a nurse hates trans people, I immediately conceal any information related to my gender identity and sexual orientation" (TGW, 22 years old)

2.3. MSM & TGW utilized inappropriate and risky treatment methods

Instead of going to the health facility for treatment themselves, many respondents sent someone else who's not MSM or TGW on their behalf, due to fear of mistreatment and anticipated negative experiences within the health facility. Respondents preferred seeking medical advice from other MSM & TGW and they often bought medicines from pharmacies without proper diagnoses.

"One day when I was severely sick, I think I had an STI. I went to the same health facility which had stigmatized me in the past. While at their gate, I remembered what had happened before, and I decided to stop and went back home. I was afraid of what could happen to me again; I was afraid to meet the same healthcare providers. So, I decided to go in pharmacy and bought medications." (TGW, 28 years old)

"Many healthcare providers mistreat us, and exhibit stigma. I decided to stop going to the health facilities, instead I send a friend to the health center on my behalf when sick or I consult my friends in our MSM community for information about medications I can buy in private pharmacy." (MSM, 22 years old)

2.4. Many negative health impacts on them as a result

Only one out of all participants stated that his STIs symptoms got better after self-medicating. All the others reported they got sicker. Combining the social exclusion from the community and mistreatment from HCP, many reported to have depression, substance and alcohol abuse and suicidal thoughts.

"Recently, when I went to the health facility, a nurse I found there looked at me astonished. She started telling me discouraging words, asking me how a handsome man like me could be engaged in homosexuality. She didn't treat me, and I had to walk to the pharmacy to buy some medicine. I was unhappy and dissatisfied with the services received. On my way back, I lost control to the point where I almost had an accident with the bike I was riding. I was absent minded, wondering why there was so much hate and mistreatment from the healthcare providers. Also, I took the medicine for many days without feeling any relief. I nearly died" (MSM, 22 years old)

"I always wonder why so much hate? If I am a transgender or gay, how does that affect the society? Why so much hate? Hate in the health facility, hate in the society, hate everywhere! In 2018, I attempted suicide because of what I was going through. I was chased from different jobs because of my gender identity, and I had no one to support me. One night, I went out and bought some acid and mixed it with other stuff just thinking people would find me dead in the morning. But luckily, I didn't die." (TGW, 22 years old)

Theme 3. More services specialized in addressing MSM & TGW's needs are necessary

The approach to provide health services for MSM and TGW patients is different from that for the general population to address their needs. Providing training to HCP to enhance their understanding of the issues MSM and TGW are facing can help improve health care management. The services can also be improved by either assigning designated HCP or creating more LGBTQ+ friendly health facilities.

3.1 Limited LGBTQ+ friendly facilities and having a "focal person" to provide treatment to MSM & Transgender patients.

LGBTQ+ friendly facilities are few across the country, especially in rural districts, making seeking health services difficult. Many participants mentioned that they often had to travel long distances to seek care from trusted facilities or providers. Naturally, such spatial constraint imposed additional financial burden on them, further heightened the barrier to accessing health services. Many participants proposed health facilities that are dedicated to only serving MSM and TGW communities could make them feel more comfortable to use the services. Alternatively, having one focal person designated to provide health services to MSM and TGW at each health facility would also enhance their trust.

"I got an anal infection when I was visiting my family in the South of Rwanda. I feared to go to the health facility there, I waited until I returned to Kigali City because it is urban, there were at least some healthcare providers who could receive LGBTQ+ community." (MSM, 26 years old)

"My wish is to have our own health centers which solely serve the community of MSM, gay and TGW in Rwanda. That's the only place where I would feel safe." (TWG, 30 years old)

3.2 Training all healthcare providers in receiving and providing treatment to MSM & TGW patients

Apart from having a focal person to address MSM & TGW health issues, participants also mentioned that all HCP across the country need to be trained in handling the health needs of MSM and TGW. The majority of respondents expressed that the HCPs they had encountered lack the knowledge and skills required to treat MSM and TGW patients and have limited awareness and understanding of the diversity among this population. As such, they recommended that HCP in all facilities across the country should be trained on how to better serve and understand the health issues of MSM and TGW patients.

"Healthcare providers need to be told that we exist. The training [for HCPs] should focus on reminding them that it is their responsibility to treat people equally, we are all Rwandans! So that we can have access to healthcare services just like any Rwandan, not only relying on only a few health facilities that are specialized to treat LGBTQI community." (MSM, 25 years old)

"I recommend more training targeting these healthcare providers so that they can learn how to receive us with dignity and to respect us as they do for other people. I also believe that if there was one focal person to receive LGBTQ+ community at each health center, this would be great". (TGW, 24 years old).

Overall, participants expressed the desire of having dedicated HCP and health facilities to serve MSM and TGW patients, as well as having training programs to increase health providers' knowledge and awareness of the LGBTQ community.

Theme 4. Advocacy and awareness for and among MSM & TGW communities are needed

Additionally, one of the most frequently mentioned recommendations was the importance of advocacy and improved awareness about MSM and TGW in the bigger communities since discrimination and stigma do not only happen within health facilities. It is equally important to raise awareness of Sexual and Reproductive Health (SRH) services among MSM and TGW communities.

4.1. Training on awareness/diversity for general public to reduce stigma and discrimination

The government has an important role in sensitizing the general public, community, government and service providers to help fight for social justice for MSM and TGW, by addressing their special needs and challenges in accessing health services. The need for engaging organizations working on the issue was also emphasized.

"I know that our President knows that we exist - perhaps he doesn't know that we face this kind of stigma and discrimination. I believe that if he learns about these issues, there will be a change. I believe there is one voice that can advocate and save us!" (TGW, 25 years old)

"I wish there could be advocacy so that even policymakers can learn about the issues we are facing. I mean the Rwanda Biomedical Center and even other high level government officials so that they can know that we exist and that our human rights are being violated. We would like them to advocate for us. (TGW, 25 years old)"

"My recommendation and wish are to urge the government to support our members [LGBTQ+ persons] who are HIV positive. They live a miserable life. They need support with food so that they can take ARVs, and they need to get involved in some income generating activities." (MSM, 28 years old)

Beyond service providers, measures should also include the wider society, according to some study participants.

"I want to see changes in the way healthcare providers treat us. I also want to tell parents and society that we are born like this, this is not something acquired. We need to be respected as human beings." (MSM, 34 years old)

"Please advocate for us. We don't have peace. They consider us cursed people. There is a time when someone told me that we are the reason pandemics such as Covid-19 exist, that we are from the Devil." (TGW, 26 years old)

Participants also expressed their wish to see a society with social justice and equal treatment between persons. As a participant put it,

"If I had the capacity, I would educate society to accept us and to offer equal treatment to everyone. Because this is the only way for us to live peacefully and in harmony." *(TGW, 35 years old)*

Overall, as reflected by participants' responses, stigma and discrimination, which affect access to quality health services, can only be reduced, through the concerted efforts of community and service providers including government, at various levels. Underlining this, a participant stated,

"I want to see our government putting more efforts to sensitize society from local authority to the government level about our rights. To end stigma and discrimination, all Rwandans should be aware about our rights and protection as other Rwandans. We too are human beings." *(MSM, 30 years old)*

4.2. There is a need to make sexual reproductive health and right (SRHR) information and material supplies available

Apart from educating the general population to become more aware and accepting of the MSM and TGW communities, it is equally important to make sure the MSM and TGW communities are aware of their own health needs and better understand their sexuality. MSM and TGW, because of their special health needs and challenges, require specific information on SRHR, mental health care and LGBTIQ+ health in general. Ensuring accurate SRHR information is disseminated and relevant medical supplies such as lubricants, condoms, and pre-exposure prophylaxis (PrEP) are available are important.

"My final wish is to recommend the distribution of condoms and lubricants through different channels to reach our members in every corner, not only at the central level [Kigali]." (TGW, 44 years old)

"My recommendation is for our community [MSM & TGW] members to have training to help them understand their sexual orientation and gender identity so that they can be proud of who they are and [can] come out. This will help those who are still hiding themselves or struggling with self-acceptance to seek health services freely." (TGW, 28 years old)

Discussion

To our knowledge, this study is the first study to present the healthcare seeking experiences of MSM and TGW in Rwanda. The results provided unique insights into the challenges faced by MSM and TGW in the Rwandan healthcare delivery systems and demonstrated how these challenges are intensified by multifaceted stigma and discrimination.

Two previous studies in Rwanda were found and they focused on understanding healthcare service provision for key populations; including MSM and TGW. These studies were centered primarily on HIV services. Isano and colleagues in a 2019 study assessed the barriers to HIV post-exposure prophylaxis access among MSM in sub-Saharan Africa, reported that Rwandan MSM face rampant stigma and discrimination at various levels: family, community, and the healthcare settings which negatively impacted their healthcare seeking behavior (19). The other study explored the perspectives of healthcare providers on providing HIV prevention and treatment services for key populations in Rwanda, found MSM and commercial sex workers experienced stigma within the communities and health facilities resulting in their delay to seek care (20). Similar stigma hampered access to healthcare services for key populations were found in sub-Saharan African region as well as neighboring countries including Uganda and Kenya (3, 19, 20, 21, 22).

Our study went beyond understanding the challenges in accessing HIV services. Our results showed MSM and TGW were facing challenges in being recognized and accepted by society - including healthcare providers, community members, and even their own families. They were not seen as people who deserve quality healthcare services like the rest of the population. There is a need for different stakeholders to foster stigma and discrimination reduction educational interventions. Further study to identify the champions for such education, and the best practice to the most effective mechanism to deliver the knowledge is needed. However, Rwandan MSM and TGW should be engaged in the creation and the dissemination of educational materials to ensure that accurate information is crafted and disseminated in a competent way.

Although same-sex relationships are not criminalized in Rwanda, the healthcare-seeking experiences of MSM and TGW in Rwanda were similar to that in neighboring countries where same-sex acts are illegal; causing many of them to resort to self-medication rather than seeking proper care (21, 23, 24, 25). Same-sex relationships not being criminalized does not translate to acceptance; homophobia and transphobia remain rampant in Rwanda, resulting in many negative consequences on the health and well-being of MSM and TGW. Even in countries with longer history of legalization of same sex acts, many MSM and TGW continue to face inequality. For examples, the USA and South Africa have legalized same sex act since 2003 and 2006 respectively, and both countries have made tremendous progress in improving MSM and TGW equalities. Yet they continue to still face hostility, stigma and discrimination (26, 27, 28, 29). In many African countries, Rwanda included, the strong culture and religion beliefs do not necessarily promote tolerance to people of different sexual identities or orientation, having a law will not likely translate into immediate changes on how MSM and TGW are perceived by the society. Nevertheless, as proven by countries that currently have progressive LGBTQ + laws and policies, having MSM and TGW protective legal mechanisms and social policies in Rwanda could go a long way in addressing the health inequities and social injustices faced by MSM and TGW. (30, 31, 32)

The findings of our study note incidences where participants left the health facilities untreated, incidences of which participants attributed to HCPs' lack of knowledge and skills on how to treat diseases common to them. This finding is consistent with the Matovu et al study in Uganda where participants stated that health workers had limited skills and knowledge in treating MSM.(21) Another study in Kwazulu-Natal, South Africa, demonstrated a paucity of healthcare providers' knowledge on treating transgender patients resulting in poor relationships between patients and healthcare e providers. (s.(33) Our findings suggest that healthcare providers did not know how to handle MSM and TGW, not that they are medically untrained to treat diseases common to them. A possible explanation for this is that diversity and cultural competence training in the care of MSM and TGW patients (34) is probably not included in the basic training curriculum taught to healthcare providers, and on-the-job training could help deliver high-quality stigma-free services. Developing and delivering such training in partnership with LGBTQ + organizations in Rwanda could be helpful. An online training program could be effective in reducing homophobic attitudes, as suggested by evidence from Kenya (35). Piloting a similar training in Rwanda should be considered.

While our participants as well as from other studies had indicated their preference to have designated facilities for MSM & TGW to increase their comfort while in the healthcare delivery settings 12), this recommendation should be considered with caution. As isolating MSM and TGW in their own clinics could potentially increase their unwanted exposure, leading to even more opportunities to become targets of stigmatism and discrimination for themselves as well as to the healthcare providers serving in those clinics. More intentional analysis of such suggestions is needed. Psychological distress and suicide ideation were common in MSM and TGW. They often experience isolation from family and friends, hostility, stigma, discrimination, bullying (36, 37, 38, 39). Mental health services catered for MSM and TGW should be incorporated into the existing mental health services in Rwanda (40). With the advance in information technology and internet, mobile phone penetration, the use of mobile phone-based mental health interventions should be considered (41) Future studies to assess the mental health needs of MSM and TGW and m-health feasibility could be beneficial.

This study explored the lived experience of MSM and TGW in seeking health care. However, the results should be viewed in light of some potential limitations. The respondents of this study were contacted through LGBTQ + organizations. These organizations usually provide support to the MSM and TGW communities, including health information, making their members to be more likely to have better access to healthcare services. Our study did not capture the experience of younger MSM and TGW, future studies should consider that.

Conclusion

Our findings seek to inform various stakeholders including the ministry of health, healthcare providers, LGBTQ + organizations, and advocacy organizations in Rwanda to collaboratively design and deliver innovative training to build competency in diversity and inclusiveness to provide healthcare services to MSM, TGW and the larger LGBTQ + community.

Abbreviations

HIV: Human Immunodeficiency Virus

IDI: In-depth interview

LGBTQ+: Lesbian, gay, bisexual, transgender, queer and other gender identities

MSM: Men who have sex with men

MOH: Ministry of Health

NGO: Non-governmental organization

NCDs: Noncommunicable diseases

RBC: Rwanda Biomedical Centre

STI: Sexually transmitted infection

TGW: Transgender Women

Declarations

Ethics approval and consent to participate

This study was conducted in accordance with the Declaration of Helsinki. The Ethical approval was given by the University of Global Health Equity Institutional review board [Ref:UGHE-IRB/2021/001]. The PI and the research assistants kept all the research records in a locked file.

To participate in the study, written informed consent was required and obtained from MSM and TGW aged 18 years or older. The purpose of the study and the consent process were explained to participants before collecting signed written informed consents.

Consent for publication

Not applicable

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to privacy and confidentiality considerations but are available from the corresponding author on reasonable request

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

SI and RW designed the study. SI, RW, TY, and GI reviewed all data and SI led the analysis and writing of the manuscript. SI, RW, TY, GI, and GN contributed to data analysis and manuscript writing. All authors reviewed and approved the final version of this paper.

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