Not a Problem at All or Excluded by Oneself, Doctors and the Law? Healthcare Workers' Perspectives on Access to HIV-Related Healthcare Among Same-Sex Attracted Men in Tanzania

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Abstract

Background: Same-sex attracted men in Tanzania are disproportionately affected by HIV. Drawing on qualitative research, the present study explores healthcare providers' perspectives on access to HIV-related healthcare services among same-sex attracted men.

Methods: A qualitative study was carried out among healthcare workers in in the cities of Dar es Salaam and Tanga in Tanzania between August 2018 and October 2019. Fieldwork entailed qualitative interviewing, focus group discussions and participant observation. A purposive sampling strategy was used to select study participants who varied with respect to age, education level, work experience, and the type and location of the facilities they worked in. Twenty-four interviews and six focus group discussions were conducted.

Results: This paper describes four different discourses that were identified among healthcare workers with respect to their perception of access to healthcare services for SSAM. One held that access to healthcare was not a major problem at all, another that some SSAM did not utilize healthcare services although they were available, a third that some healthcare workers prevented SSAM from gaining access to healthcare and a fourth that healthcare for gender and sexual minority persons was made difficult by structural barriers.

Conclusion: Although these are four rather different takes on the prevailing circumstances with respect to healthcare access for SSAM, we suggest that they may all be 'true' in the sense that they grasp and highlight different aspects of the same realities.

Introduction

Drawing on qualitative research in Tanzania, this article explores healthcare workers' perspectives on access to HIV-related healthcare for same-sex attracted men (SSAM). Like other Sub-Saharan countries, Tanzania has seen a decrease in overall prevalence of HIV in recent years, from 8–4.7% between 2003 and 2017(1). Until recently, HIV prevalence among same-sex attracted men has however remained much higher than this, and it was 22.3% in 2014 (2). A recent study indicates that HIV prevalence among SSAM in Dar es Salaam is now 8.3%; still almost twice that in the general population (3).

Previous studies from Tanzania have revealed that men who are sexually attracted to other men may experience prejudice, stigma, discrimination, mistreatment, harassment, abuse and rejection in healthcare settings (4, 5) and some fear being reported to authorities by healthcare workers (6). Because of experiences and concerns like these, some men act as their own doctors (6, 7); i.e., rather than seeking professional healthcare when sick, they attempt to diagnose their own health problems and buy drugs without prescription in medical stores and pharmacies (7, 8). In a recent study among SSAM in Dar es Salaam, when asked what counts as "good" healthcare services for gender and sexuality diverse men, a common view was that they are provided by healthcare workers who have positive attitudes towards SSAM and are well trained on their needs and circumstances (9).

A national guideline describing a 'comprehensive package of HIV interventions' (CHIP) for key populations was launched in in Tanzania 2014 and later revised in 2017 (10, 11). This guideline outlines a number of HIV-related health services that are to be provided to SSAM within a friendly environment, including STI and HIV preventative and care services (10, 11). As part of the implementation of this guideline, healthcare workers in selected healthcare facilities were trained to offer more friendly services to SSAM (10).

Previous studies have indicated that SSAM have limited access to HIV-related and other sexual health services across most of Africa (12, 13) and that there is often a lack of care that particularly takes into consideration the specific needs of SSAM (14). Many also experience stigma and discrimination when accessing healthcare (4, 15), or a lack of supportive attitudes from healthcare workers (16, 17). Studies from several countries across sub-Saharan Africa have found that negative attitudes from healthcare providers play a role in preventing men from accessing and utilizing healthcare services (16, 18–21). A study from Kampala, Uganda, for instance, revealed that some healthcare providers had negative reactions, relationships and attitudes towards SSAM seeking care (22). The same study also described how SSAM perceived that healthcare workers had a limited understanding of them (ibid). A study carried out in Nairobi, Kenya among healthcare providers and SSAM concluded that a lack of appropriate training and unsupportive attitudes among healthcare workers discouraged SSAM from seeking HIV prevention and treatment (23). Studies in other sub-Saharan African countries have indicated that legal policies, social inequalities and inadequate training of healthcare workers are key barriers to access to healthcare among SSAM (23–27). Recent studies among healthcare providers in Malawi and Kenya have found that there is low acceptability and will among health providers to deliver appropriate sexual health services in relation to HIV prevention, care and treatment targeting SSAM (17, 23).

To our knowledge, there has been no study that has examined how healthcare providers in Tanzania perceive access to healthcare services among SSAM. This article focuses on healthcare providers' perspectives on accessibility to health care among SSAM in Tanzania.

Methods

This paper is based on qualitative research with healthcare providers in the cities of Dar es Salaam and Tanga in Tanzania. We selected these cities in part because previous work had demonstrated that SSAM there carry a substantial burden of HIV (28, 29) and in part because there are considerable populations of SSAM in these two locations (30). Fieldwork entailed qualitative interviewing, focus group discussions and participant observation, and was carried out between August 2018 and October 2019.

During data collection, the first author interacted with different cadres of health care workers in healthcare facilities and in non-governmental organizations involved in the implementation of HIV related projects. A purposive sampling strategy was used with the aim to maximize differences in experiences and perspectives among study participants. Their selection took into consideration differences in age, education level, work experience, type and location of the facilities they worked in, and the type of services offered, and people served.

Qualitative interviews were conducted with 24 healthcare providers in Dar es Salaam (14) and Tanga (10), and all were interviewed twice. The language used was Swahili, and most interviews lasted between 60 and 90 minutes. Interviews were audio-recorded and transcribed verbatim and then translated into English.

Participant observation: The first author took part in daily activities and events together with healthcare providers (and also with SSAM seeking healthcare services) and engaged in informal discussions with them about various topics and experiences. He joined some healthcare workers at their workplaces, where he engaged in discussions about topics related to healthcare for SSAM. On six occasions he took part in outreach services targeting SSAM during day or night (outreach services provided at night were commonly referred to as 'moonlight services'). While participating in these events, he took scratch notes, and these were later expanded into fieldnotes.

Focus group discussions (FGD): Six focus group discussions (three in each city) were conducted with healthcare providers to further explore some of the themes and topics that had come up during individual interviews and participant observation. Some of those who participated in the FGDs had previously also participated in interviews and/or participant observation. One of the discussions comprised of healthcare providers working in a public healthcare facility, another of healthcare workers working in a private facility, two of personnel who had received trained on serving SSAM, and two of providers who had not received this type of training. The number of participants in the discussions ranged from eight to ten. Each discussion lasted between one and two hours. Discussions were semi-structured and guided by a set of questions prepared prior to the event. Swahili was the language used and all sessions were audio-recorded and subsequently transcribed verbatim.

For this paper we carried out content analysis of interview transcripts and fieldnotes. Open coding was applied in the initial stage to identify emerging themes. Codes which were related were later subsumed into broader thematic categories. For this paper, we draw on portions of the material that fell into a category we referred to as 'healthcare workers' views on accessibility to services for SSAM'.

Ethical clearance was provided by the Muhimbili University of Health and Allied Sciences' (MUHAS) Institutional Ethics Review Board, and community entry permits were provided by the Ministry of Regional Administration and Local Government as well as by Dar es Salaam and Tanga regional authorities. Written informed consent was obtained from all study participants. No direct personal identifiable information was recorded, and data were stored in a secure offline computer.

Findings

In the following, we present four different discourses that were identified among healthcare workers with respect to their perception of access to healthcare services for SSAM. One discourse turned on the view that there was no major problem with access (although exceptions to the rule could sometimes occur). The three other discourses portrayed access to healthcare as suboptimal, but for different main reasons. One held that SSAM distanced themselves from care, another that healthcare workers directly or indirectly blocked SSAM from care, and a third that structural barriers worked to prevent this group of men to gain access to healthcare.

First discourse: 'Access to care is not a major problem'

The first discourse we describe held that there was no fundamental or ubiquitous obstacle to healthcare for SSAM in Tanzania. This discourse radiated a clear belief in the ability of the healthcare system to provide gender and sexuality diverse men with the healthcare services they needed. Ezekia and Amani were among those who subscribed to this view,

"Care is always available for MSM, as it is to other populations. I don't think there has been a problem" Ezekia, IV6

"As I know, like other populations, MSM do not have any problem with accessing healthcare services in health facilities." Amani, IV9

While these study participants were of the view that access to healthcare was mostly unproblematic for men who have sex with other men, they did not rule out that there could -be challenges at times. Ezekia, for example, was in no doubt that individual healthcare workers had a negative attitude towards SSAM and that this would cause problems in some instances,

"There might be problems with some providers since we cannot all have the same attitude, that comes naturally. But care is available." Ezekia, IV6

Amani agreed and emphasized the importance of patient complaint in cases where individuals experienced bad treatment in healthcare facilities. Such treatment would need to "be reported to the relevant authorities" so that appropriate corrective action could be taken.

Second discourse: 'SSAM block themselves from care'

The second discourse we identify partly agreed with the 'no major problem' discourse just described. That is, it held that there were no major obstacles to healthcare access caused by the healthcare system itself. However, in this discourse, SSAM were still considered to have healthcare access problems, albeit primarily because they were blocking themselves from appropriate care.

At times, it was as if this discourse existed in opposition to discourses that blame healthcare workers for hindering SSAM from accessing care,

It is hard for us [providers] to give care to people who do not come to the facility, but more importantly, how would facilities put in place services needed by such people when they do not come?" Edgar, GD6

Among the promoted reasons why SSAM did not seek care was a perceived tendency among them to internalize stereotypical negative views of their own kind and to project these onto healthcare workers,

"MSM have something like self-stigma and they put their problems on others [and claim] that we don't give them care." Patrick, GD1

Other study participants pointed out that various kinds of fear could make SSAM stay away from care,

"I know that some MSM do not want to come to health facilities to get care even when they are sick. They remain with their problems because of negligence, fear to disclose their sexual information, and fear of stigma and law enforcers." Edgar, GD6

Even among SSAM who did turn up at clinics, some were said to hold back information about themselves and their sexual practices and identities, and this also contributed to make access to appropriate care difficult,

"I have been working in different facilities, and I am sure it is not easy for any provider to identify mashoga [a Swahili term used to refer to men who engage in receptive anal sex] unless they decide to open up for you. They know how to hide their information about specific health problems and their sexual behaviour, and some describe other problems than those they actually suffer from. Kanjanja, IV17

Third discourse: 'Health workers block MSM from care'

A third discourse among healthcare workers held that many healthcare professionals actively contribute to limit access to healthcare for SSAM.

Some doctors and nurses were said to disapprove of SSAM and disparage them. Among examples mentioned was that they might refer to such men with insulting descriptors and labels, or verbally abuse them in front of colleagues and other patients. Sometimes they might call attention to SSAM clients by calling on fellow staff members to come and see or surround such them in the clinic.

"For MSM it is really difficult to get care in some facilities, and when it is known to providers that they are MSM, getting care becomes hard. Many of us [healthcare providers] do not accept MSM. I have witnessed some being referred to in bad and harsh language, insulted and given bad names by providers. I remember that one provider called us [other staff members] to come and see what a MSM look like. Such treatment is meant to help them stop their sexual relations and be good people, but they never came back to facilities for care" Bariki, GD5

Another way healthcare workers were said to intimidate SSAM was to deliberately delay them when they sought care. One study participant described that he used this approach himself. He explained how he would first treat all non-SSAM patients and only thereafter the SSAM,

"When I know that an MSM is in the facility for care, I provide services to other patients first and serve him last. He must know that other people are more important than him so that he struggles to change. But also, I need to get enough time to know him and his problems" Hangwa, GD3

Finally, some healthcare providers completely rejected care provision to SSAM.

"Many of us [providers] do not accept MSM. I have been serving MSM for three years now, but many other providers are not willing to give care to MSM and to HIV patients" Bariki, GD5

"If I had a relative choosing to be shoga[1], I would stop him because I know he is choosing problems. I have seen that in clinics, it is a problem to get care. No provider would like to associate with practices or people not supported by the laws of the country "Florian, IV1

Fourth discourse: 'Structural barriers block MSM from care'

The fourth discourse we identify also highlighted access to care as difficult for SSAM, but mainly because of structural barriers.

For one, the existing colonial time law that still prohibits "carnal knowledge against the order of nature" in Tanzania was said to interfere with healthcare delivery to SSAM.

"All problems causing difficulties in accessing care for MSM emanate from the laws. When you have laws that do not support some groups of people, like MSM, such groups will not get services. And even those who do manage to give them care, will not do so in public. The problem and solutions are in the laws and policies" Mangi, IV10

In addition to the law, anti-homosexuality sentiments in the political debate while fieldwork was ongoing was also said to represent a significant structural barrier to healthcare access for SSAM.

Moreover, the anti-gay politics in this country make accessing care very hard. How can MSM seek care while they are being hunted and may be caught in the hospital? You remember what has happened in the last two years… Many of them died and many remained at home with their health problems" Mwemezi, IV3

While fieldwork was ongoing, the Tanzanian media had prominent coverage of political debate that severely critiqued same-sex relations. Among proposals put forward was that the general public should report persons suspected to be gay to the authorities so that they could be punished (31). Some healthcare workers said that some SSAM understandably avoided seeking healthcare in in this period for fear of being arrested.

[1] *Shoga* is a Swahili term used to refer to same-sex attracted men who take a receptive position in same-sex sex.

Discussion

The participants in this study were all healthcare workers. They provided a diversity of views on the topic of access to healthcare services among SSAM in Tanzania, and in this article, we have categorized and presented them as four different discourses. While these discourses differ to quite some extent and could at times perhaps be said to be entirely contradictory, we would like to suggest that they could all be 'true' at the same time – in the sense that they grasp and highlight different aspects of the same realities.

The first discourse emphasizes that healthcare services are accessible, at least to some SSAM. Although previous research is limited, there may be indications that many healthcare workers in Tanzania are indeed supportive of SSAM and may have been so for quite some time. As far back as in 2006, Nilsson and Ewalds-Kvist reported that a majority (fully 82%) of nursing staff at two hospitals in Dar es Salaam were of the opinion that "homosexual HIV/AIDS patients were entitled to the same care" as their heterosexual counterparts (quoted in Moen et al. 2014). Even in our own overall research project, which also entailed a survey among MSM in Dar es Salaam and Tanga (Ishungisa, forthcoming), a majority (87%) of SSAM answered that they had been treated well by healthcare providers. We find it important to highlight this finding, because in some discourses, including in much international media reporting, Tanzania is at times been portrayed as a country in which the circumstances are only difficult for SSAM. While we do not in any way want to detract attention from any of the challenges and injustices that exist, we find it important to bring to the fore as nuanced as possible a description of the prevailing circumstances. In the context of access to healthcare for SSAM, it is of considerable significance that there are both healthcare workers and SSAM themselves (33) who describe that this may, at least in some contexts, be well functioning.

The point just made would seem to provide some of the background for the second discourse we identify in this paper, which highlights that some SSAM may not access care because they keep themselves away from services. Some of the healthcare workers who took part in this study clearly seemed tired of being blamed for delivering unfriendly and/or deficient healthcare services to SSAM. In light of the first discourse, and the points raised just above, we find this understandable. Few have explicitly acknowledged that there are many healthcare workers in Tanzania that provide excellent and friendly services to SSAM. It is of interest that a similar argument was put forward by some healthcare providers in Malawi (18).

In some of the conversations and discussions we draw on in this paper, there was a tendency among some healthcare workers to "turn the tables", i.e., to direct blame towards SSAM themselves for their suboptimal access to care. The argument went that some men simply do not seek the care they need, or do not open up to healthcare workers about their sexuality when they do seek healthcare. Apart from the unfortunate "blame game" between healthcare providers and their clients, and the apparent lack of sympathy with the difficulties that may be associated with disclosure of same-sex practices in the context of stigma, discrimination and criminalization, this situation seems to highlight that there may be well-intended healthcare workers who feel they do not get to serve SSAM to the degree they want because they are not given a chance to do so. It is of course highly understandable that SSAM may avoid care seeking whenever they are fearful of negative reactions, and an interesting question would seem to be whether something could be done to better link SSAM to SSAM-friendly healthcare providers. For example, would healthcare providers agree to see their names on lists of professionals who provide care to SSAM without reservation or stigma?

Because, that there exists a very real risk that SSAM in Tanzania may encounter healthcare workers who discriminate against and stigmatize them becomes crystal clear in the third discourse. Some healthcare workers openly and vehemently disapprove of SSAM, including some of the healthcare workers that were interviewed for this study. Among the ways in which they demonstrate their disapproval was through the use of insulting labels and through a sensationalising of the presence of SSAM in the clinic, as when they call fellow staff members to come and see or surround patients from this population. Some providers also deliberately delayed or outrightly rejected care to SSAM. These findings are in line with those of two previous studies in Dar es Salaam which found that due to homophobic utterances in healthcare settings, some SSAM do not seek healthcare and resort to self-medication instead (6, 34). They are also in line with findings of previous studies in other key populations (35).

It is imperative that healthcare providers adhere to basic ethical guidelines when offering healthcare services to SSAM. To do so is among their basic professional obligations, as set out for example in the ethical code of the World Medical Association (WMA) (of which the Medical Association of Tanzania is a member). Healthcare providers are required to take the health and wellbeing of their patients as their first consideration (36). Rhodes's (1995) (38) argues that healthcare workers should not only ensure that justice is done to their patients, but that the care they provide should also be inspired by some degree of love for those they serve. Whenever SSAM do not seek medical care or do not open up to healthcare providers about their sexuality, this would most likely occur within patient-provider relations that are *not* experienced as characterized by love, care and justice. It is difficult to envision that trust can emerge in such relations, and more so the more adverse the attitudes among healthcare workers are, such delaying SSAM when they seek care, verbally abuse SSAM in the clinic or deny SSAM medical attention altogether. Such experiences will not be likely to have adverse impacts only on individual patients but more likely on the entire community they belong to.

As previously mentioned, while fieldwork for this study was under way, there was ongoing media coverage of political debate in Tanzania about the acceptability of same-sex attractions and practices. Among the proposals put forward was that the general public should be encouraged to report SSAM to the authorities so that they could be corrected and/or punished (31). Even when the central government distanced itself from this proposal (9), it remained a topic that emerged in discussions between many of the healthcare workers who took part in this study. Some wondered what might happen to themselves if they were suspected to relate to SSAM in the context of healthcare. The situation was clearly perceived to play a significant role as a structural barrier to healthcare provision to SSAM.[2]

[2]At the time of writing, this political debate appears to no longer be active. One of the prominent participants in it, the previous regional commissioner of Dar es Salaam, no longer holds office, and the central government distanced itself from his proposals. As a result, the media landscape is different now than when fieldwork for this study was ongoing. How and to what extent this has played a role for access to healthcare may still be unknown.

Conclusion

This paper is the first to explore healthcare providers' views on and assessment of access to healthcare among SSAM in Tanzania. The healthcare workers described a situation where access to care is not always a problem for SSAM. However, some healthcare providers ill-treat and/or reject SSAM, and some SSAM avoid healthcare if at all possible due to fear of negative reactions in the clinic. Finally, the colonial time criminal code which prohibits "carnal knowledge against the order of nature", as well as contemporary anti-homosexual sentiments in political debate, act as barriers to make universal access to healthcare more difficult for men who are attracted to other men.

Declarations

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We thank participants for contributing to this study.

Authors' contributions

AMI contributed to the design of the study, analyzed data, interpreted results and drafted the manuscript. KM contributed to design the study, analyze data and interpret results. EJM, MTL and DM contributed to design the study and interpret the results. SLL and MMM contributed to collect data and interpret the results. All authors revised and approved the final version of the manuscript.

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Conflict of interest

Authors declare that they have no competing interests.

Availability of data and materials

The dataset generated during and/or analysed during the current study are not publicly available due to the sensitivity of the topic as well as personally identifying nature of the interviews which are not able to be completely de-identified.

Ethical approval and consent to participants

Ethical clearance was obtained from the Muhimbili University of Health and Allied Sciences' (MUHAS) Institutional Ethics Review Board, then the Ministry of Regional Administration and Local Government and Dar es Salaam and Tanga regional authorities provided community entry permit. Each study participant provided a written informed consent.

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