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Being forced to become your own Doctor – Men who have Sex with Men's Experiences of Stigma in the Tanzanian Healthcare System

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Abstract

Objective—To acquire a deepened understanding of how stigma in healthcare affects health-seeking behaviours of same-sex practising men in Tanzania.

Methods—In-depth interviews with twelve men were conducted in Dar es Salaam, 2012. Data were interpreted through qualitative content analysis.

Results—Narratives revealed that men's healthcare perceptions were shaped by previous encounters, rumours in gay community, norms and legislation around homosexuality. Fears of exposure aggravated men's possibilities of giving full anamnesis and detached them from formal healthcare services.

Conclusions—Stigma in healthcare might lead to severe public health problems due to perceived exclusion from the health system by sexual minorities.

Keywords

Homophobia; Qualitative studies; Gay men; Sexual minorities; STIs

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Disclosure Statement

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Introduction

Men who have sex with men in sub-Saharan Africa face persistent risk of stigma because of their sexual identification and behaviours (Geibel et al., 2010; Smith et al., 2009). Goffman defined stigma as “an attribute that is deeply discrediting” and that reduces the value of the bearer (Goffman, 1963, p. 12). Those perceived as breaking prevailing values and norms are considered “deviants” (Goffman, 1963). Stigma is a social process that builds on dominant societal and cultural values and norms of what is considered acceptable in a society (Herek, 2002; Link & Phelan, 2001). By systematically excluding certain individuals and groups from full societal and political acceptance, powerful groups maintain their dominance (Herek, 2009; Link & Phelan, 2001; Parker & Aggleton, 2003). This indicates that stigma relies on, and is contingent upon, access to power since it enables identification and determination of what attributes that should be linked to certain stereotypes (Link & Phelan, 2001). Stigma towards homosexuality may thus be defined as the disapproval or condemnation by the heterosexual society, enabled by its hegemony over those who practice same-sex relations (Herek, 2004). Discrimination (the act) and prejudices (the attitudes) are both manifestations of stigma (Herek, 2002). However, these are only acts of stigmatisation if they are embedded in the broader societal relations and structures governed by access to power.

Discriminating practices within the healthcare system against men who have sex with men that could be linked to prevailing homosexual stigma have been reported across the sub-Saharan African continent, including in Malawi, Senegal and South Africa (Niang et al., 2003; Wells & Polders, 2009; Wirtz et al., 2014). The results of a cross-sectional study conducted in Botswana, Malawi, and Namibia concerning 537 same-sex practicing men showed that 5% of the respondents had ever experienced being denied health services, and 19% were afraid to seek healthcare (Fay et al., 2011). Risher et al. (2013) reported from a study conducted in Swaziland that 44.1% of 323 men who have sex with men experienced stigma in healthcare and that 61.7% were afraid of seeking healthcare due to stigma. Qualitative studies from the region have explored the coping strategies that same-sex practising men have resorted to in order to avoid being stigmatised. These include, but are not limited to, approaching known gay providers, delaying or avoiding healthcare services, asking a friend to visit the doctor to obtain a prescription or resorting to self-treatment (King et al., 2013; Okanlawon et al., 2013; Niang et al., 2003).

On Tanzania's mainland, according to the Penal Code of 1945 (as amended by the Sexual Offences Special Provisions Act, 1998) section 154 “Unnatural of offences” states that “Any person who- (a) has carnal knowledge of any person against the order of nature; /.../ or (c) permits a male person to have carnal knowledge of him or her against the order of nature, commits an offence, and is liable to imprisonment for life and in any case to imprisonment for a term of not less than thirty years.” (Government of Tanzania, 1998, p. 13). Section 157 “Indecent practices between males” further states that “Any male person who, whether in public or private, commits any act of gross indecency with another male person or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person, with himself or with another male person, whether in public or private, commits an offence and is liable to imprisonment for five years.” (Government of Tanzania, 1981, p. 61). Although it appears that the law has not

been implemented in recent years, a report by Human Rights Watch revealed that sexual minority populations face sexual abuse, assaults and arbitrary arrests by the police (2013). In 2014, a member of parliament submitted a proposal to toughen the current laws to also include “promotion” of homosexuality, similar to what was proposed, enacted and later nullified in Uganda (Muga, 2014, March 29). The proposal needs support from the majority of parliamentarians to be passed, and it currently remains unclear if this will succeed. However, the government reacted strongly to threats from the United Kingdom to withdraw aid from countries that violate homosexuals’ rights. The Minister of Foreign Affairs was quoted as saying: “Homosexuality is not part of our culture and we will never legalise it” (Ng’wanakilala, 2011, November 4).

Homosexual stigma in the Tanzanian health sector has previously been documented by Magesa et al. (2014) and Nyoni and Ross (2012). In a qualitative study, Magesa and colleagues found that men who have sex with men experienced negative attitudes and lack of confidentiality and privacy in healthcare. This caused delays in treatment and avoidance of certain facilities (Magesa et al., 2014). In a survey of 300 same-sex practising men, Nyoni and Ross reported that 14.8% perceived discrimination in care as an impediment to access to testing services for HIV and sexually transmitted infections (Nyoni & Ross, 2012). However, positive experiences of healthcare workers, in particular at private healthcare facilities, have also been documented (Magesa et al., 2014), as well as sympathetic attitudes among healthcare workers themselves (Sällberg & Nilsson, 2006). This suggests that while stigma in healthcare might be a problem for this population, it is not predominant and exclusive.

A growing body of evidence thus suggests that stigma affects the health outcomes of men who have sex with men. However, stigma is a multifaceted process, and there is currently a lack of in-depth studies that have attempted to describe and understand the personal experience of stigma among same-sex practising men in Tanzania and how this interferes with their health-seeking. The purpose of this study is to gain a deeper understanding of how stigma affects perceptions of, and access to, healthcare among men who have sex with men in Tanzania.

Methods

Study Setting

The study was performed in the city of Dar es Salaam, Tanzania. Dar es Salaam is the largest city in Tanzania with a population of more than 4 million, 10% of the Tanzanian mainland population (National Bureau of Statistics, 2012). Although Dar es Salaam is not the capital city, it remains the location of the central government administration and is also the main centre for trade and finance activities. The Tanzanian healthcare system is divided into public and private services, with the former being responsible for around 70% and the latter for 30% of services provided by both private profit-making and charitable organisations (Mtei et al., 2012). The utilisation of profit-making health services remains high, mainly due to the shortage of human resources, lack of functioning infrastructure, and insufficient medication supplies that characterise the public health system (Cowi Goss Gilroy Inc. & Epos, 2007).

Study Design

A qualitative approach was adopted to fully explore the healthcare experiences of men who have sex with men. Individual in-depth interviews were used to secure the required privacy and confidentiality that would enable exploration of men's recall and perceptions (Kvale, 1996). Open-ended questions were used to allow participants to reflect, develop, and give reasons for their views, with minimal influence from the interviewer.

Sampling of Participants

This study was nested within a cross-sectional study of 200 men who have sex with men in Dar es Salaam in 2012, which investigated the prevalence of sexually transmitted infections, including HIV, sexual networks and sexual risk taking behaviours. A full description of the selection methods, sampling frames, and findings has previously been presented (Anonymous, 2014a). Participants were selected through respondent-driven sampling (Salganik & Heckathorn, 2004). Five initial respondents, i.e. "seeds", were each asked to recruit three additional study participants, who they knew engaged in same-sex sexual activities and refer them back to the study site, using coupons with unique identification numbers. Eligible for the survey were those men who were 18 years old and above and who reported occasional or regular sex with other men in the past six months. Those men who agreed to participate in the study were each given three additional coupons to recruit a new round or wave of respondents. In total, seven waves of recruitment were done until a sample of 200 men was reached. During the recruitment process, eight declined participation in the survey after being informed that HIV testing was included.

In conjunction with the quantitative study, we conducted a qualitative study in order to explore participants' perceptions and experiences of stigma in healthcare. Every 10th respondent in the quantitative study was asked if he wanted to participate in an interview. The purpose of the interview was explained (always in Kiswahili, which is the official language of Tanzania), and the participant had the option to refuse. The total number of men who agreed to participate was 20 but eight did not appear at the time of interview, resulting in a final sample of 12 participants.

After the authors had reviewed the transcripts and the preliminary analysis, it was agreed that the data collected were sufficient to describe a variety of perceptions and experiences of the healthcare system with regards to stigma (Graneheim & Lundman, 2004).

Data Collection

Audio-recorded interviews were conducted throughout three months in 2012 by two research assistants. Men who were willing to return for an interview were asked to agree on a suitable time and place that was of convenience for *them*. The interview took approximately one hour. Prior to interview start, the potential benefits (e.g., gaining an opportunity to talk and reflect about experiences related to stigma) and risks (e.g., painful memories causing emotional reactions) of participation were explained in Kiswahili and informed consent was taken orally. The research assistants were native Kiswahili speakers and had previously undergone survey-specific training regarding interviewing members of marginalised populations. The interview guide was developed in English and translated into

Kiswahili. It was pilot-tested with key informants from the gay community for comprehension and clarity prior to the in-depth interviews. Participants were given a minor incentive of 3000 Tanzanian Shillings (approximately 1.5 USD) to cover transportation costs.

Data Analysis

All in-depth interviews were transcribed verbatim by the research assistants who conducted the interviews. Back-translation into English was done by a professional translation bureau. A manifest and latent qualitative content analysis was performed, using the methods described by Graneheim and Lundman (2004). The manifest content analysis provides a systematic description of the surface or visible meaning of the text, whereas the latent content analysis is used to reveal the underlying meaning of the text; e.g., the tone or the feeling behind the words (Graneheim & Lundman, 2004; Downe-Wamboldt, 1992). The use of in-depth interviews enabled us to gain access to particularly rich information concerning participants' perceptions and personal experiences of stigma in healthcare. The confidential setting and the one-on-one dialogue enabled us to probe further their feelings and reflections that were being articulated regarding stigma, thus facilitating a sense of what these experiences meant to the individual participant, i.e. the "essence" or the implications of these experiences for the participant. Thus, we were able to move from the purely descriptive level of the text (i.e. the manifest content) to a more interpretive level (i.e. the latent content), whereby emergent themes could be identified (Graneheim & Lundman, 2004).

The analysis proceeded in several steps, and each step in the analysis was accompanied by thorough discussion among the authors to ensure consensus and to enhance the credibility of the findings. The first step involved repeated reading of the interviews to obtain a sense of the entire material. Next, we created four content areas corresponding to Steward et al.'s (2008) theoretical framework of stigma. Steward identifies four forms of stigma: enacted (direct experience), felt normative (individual expectations of the effects of stigma), vicarious (experiences transmitted from others) and internalised (individual acceptance of stigmatising attitudes) stigma. This model was found helpful since it distinguishes between various facets of stigma and enables a study of its manifestations. Each text section that could be related to a specific form of stigma was placed under the respective content area, thus affording us an overview of men's perceptions and experiences. The next step was to summarise the text by shortening it into condensed meaning units that could be assigned codes or labels. Codes that were similar were then clustered together into categories based on a commonality of code content. Categories were thus developed based on *what was said*, i.e. the manifest content, and were either direct quotes or expressions reflecting the commonality, typical for a group of codes. Categories were further examined for potentially emerging themes cutting across categories that could provide a sense of the underlying essence or thread of meaning running throughout the material, i.e. the latent content. Constant comparison of similarities and differences between categories was performed to facilitate the identification of themes. As an aid in the interpretative process, member checks with representatives from gay organisations provided valuable feedback. Four themes were

identified and agreed upon by the authors. See Figure 1 for a schematic overview of the final analytical model.

Ethical Approval

The study was reviewed and approved by (details omitted for double-blind reviewing) and (details omitted for double-blind reviewing).

Results

Four themes emerged from the analysis of the interviews, each representing an aspect of participants' perceptions and experiences of stigma within the healthcare system: Becoming third class citizens in healthcare, Appraising perceived threats related to one's sexuality, Balancing the seesaw of visibility, and Seeing public healthcare as the last resort. Each theme consists of categories, highlighted in bold and supported by selected quotations to show how the data have been interpreted.

Becoming Third Class Citizens in Healthcare

Experience of stigmatisation in healthcare was a recurring topic in the interviews. The first theme describes the perception among participants that gay men were less valued as patients in healthcare. The category being treated "like animals" is based on a quote from one of the participants, who summarised his experiences of stigma in healthcare with the following words: "If they find out that we are gay they treat us like animals" (Participant 10). This category is an aggregation of the various experiences of discrimination, threats and denial of treatment, as men in this study complained that healthcare workers were unwelcoming, rude, and harsh. The most common experience was that healthcare workers used derogatory words, calling them "evil" and "unnatural". Participants reported instances when doctors and nurses denied men services and treatment because of their sexual identification and behaviours, as illustrated in the following statement:

I: You told me earlier that you went to a hospital and met a doctor who knows that you are gay?

P: Yes, and when he told the others that I am gay the doctor, who was going to assist me, left without saying a word.

I: Did he leave?

P: Yes, he left and refused to treat me." (Participant 4)

Phrases such as "we don't treat people like you here" were commonly reported. Men said that they were chased away like "a dog", with nurses screaming at them to leave the hospital. One participant said that he had been threatened if he did not leave immediately.

"The doctor told me to leave as soon as I could because he could inject me with poison otherwise." (Participant 10)

Participants took these threats seriously but could not report them without revealing the reason for being threatened in the first place. Revealing oneself as gay was seen as potentially dangerous as homosexual behaviour is illegal in Tanzania.

The analysis further revealed that participants felt that healthcare workers tried to minimise the interaction between themselves and the patient. Men described that doctors and nurses at times hurried through the examination. One man described his experience of this and contrasted it to how non-homosexual patients were treated:

“The doctor or nurse will use his or her two fingers to touch you ... We’re not treated like ordinary people, you may be given drugs without even being tested.”
(Participant 10)

Participants felt embarrassed and confused by this treatment and wondered whether healthcare workers were afraid that associating with a homosexual person would contaminate them.

“Maybe they think that by treating a gay they will devalue their personalities as medical providers?” (Participant 9)

Situations of particular distress involved those when nurses and doctors violated the confidentiality code. Participants described how healthcare workers encouraged other staff members to enter the examination room in order to “look at the homosexual” instead of providing assistance.

“You can get there and find a nurse and instead of giving you services she calls a doctor and they start staring and talking about you.” (Participant 4)

According to participants, they felt obliged to terminate the interaction following such treatment by healthcare workers and were not able to return to that provider due to feelings of distrust and shame.

Appraising Perceived Threats Related to One’s Sexuality

The second theme illustrates how elements beyond participants’ own experience and control influenced their perceptions of healthcare services.

“I usually hear from other friends that they have experienced stigma in hospitals. They tell me it’s so bad.” (Participant 3)

The statement above refers to rumours of ill treatment, harassment, abuse and even murder of other men at healthcare centres, when accused of being gay. Such rumours reappeared during the interviews. The category believing frightening anecdotes to be true captures these stories and delineates how rumours of stigmatisation turned into real threats for participants. The following excerpt describes this sense of fear:

“I remember that a best friend of mine, [name], who used to dress like a woman, had dreadlocks and used to wear high heels. One night when he looked for sex clients he had a car accident. I heard from someone that he was taken to a hospital but when they found out that he was gay they injected him with poison, so he died. That really hurt me and made me so scared.” (Participant 7)

The participant had not received confirmation of the murder of his friend from any sources apart from second-hand rumours. However, the rumour had affected him strongly, and he was afraid of becoming victimised if a healthcare worker discovered his sexual history.

Participants' stories also revealed that rumours circulated regarding those health facilities that were known to treat men who engaged in same-sex relations badly.

“Stigma is very bad in public hospitals. There is one gay man I know who went to [name] hospital for treatment. But once the health providers discovered that he is MSM [men who have sex with men] he was denied services and he was forced to leave.” (Participant 12)

This account demonstrates that there was a high degree of trust between these men. They exchanged stories, which influenced their expectations of stigma and consequently their health-seeking behaviours.

Participants perceived that their right to healthcare was threatened, should it become known that they had been engaging in sexual relations with other men. The law was seen as contributing to stigmatisation.

“If the law changed we could not be stigmatised and all gays could be treated like other people whenever they go to the hospital”. (Participant 3)

This became apparent when participants discussed consequences of being publicly identified as gay or a same-sex practising man. Participants felt unable to defend themselves.

“When people find out that you're having sex with other men they can take you to the police station. When you get there you don't have the right to defend yourself just because you're gay.” (Participant 2)

Participants shared concerns about their sexual practices being illegal.

“Everything I do, I feel like I am going against the laws of the country”.
(Participant 5)

As a consequence, participants felt discouraged from seeking healthcare in the first place, as they felt that they lacked the ability to protect themselves from discrimination.

“We are not accepted publicly at the hospitals. One stays home until he dies.”
(Participant 4)

Thus, participants' fears concerning interaction with healthcare workers and their perceptions that the current law failed to protect their right to healthcare created a barrier to healthcare-seeking.

Balancing the Seesaw of Visibility

The possibility of being exposed as a gay man during interactions with healthcare providers was given a great deal of reflection during the interviews. Participants balanced the possible consequences of being exposed with the need to receive proper and timely treatment. Concerns about visibility with regard to certain characteristics that were recognised as typically associated with being gay seemed to be mediated by the societal homophobia prevalent in their lives. A typical description of concerns about stigma was the following:

“In Dar es Salaam once people know that you are gay they see you as nothing in the society.... To be honest stigma causes us a fear to go to the hospital once we get any health problems.” (Participant 12)

Participants seemed to have accepted the need to avoid identification and had adopted strategies that they tried to use during interactions with healthcare workers to disguise their sexual background and preferences. These could be successful and enabled men to access healthcare services. The most commonly reported strategy was to conform to socially accepted dress codes and hence circumvent any possible associations with existing stereotypes of homosexuality. The following account describes how one of the participants avoided stigmatisation by adopting this strategy:

“They did not recognise me because of my clothes. I wore the same as other men. I don’t put myself in a position that anyone could detect my status as a gay so it’s difficult for a nurse or doctor to realise that I am a gay.” (Participant 1)

Participants explained that they wore the type of clothing they preferred (“khangas”, fashionable shirts, dresses etc.) at home or at private functions, but refrained from doing this in public in order to minimise risk of stigmatisation. This also included the use of make-up and accessories that could draw unnecessary attention to them while at the hospital.

Another strategy to disguise sexual background and preferences from healthcare workers was to control the information provided. Before a healthcare visit, participants prepared themselves for potentially dangerous questions that could reveal them as someone who engaged in same-sex practices.

“When I must go to the hospital I have to find a way to explain the problem I have to the doctor.” (Participant 4)

Avoiding discussing their sexual history and being careful about the personal information that they shared with healthcare workers were, according to participants, useful strategies to gain control of the situation. However, when seeking treatment for discomfort due to suspected sexually transmitted infections, they resorted to other strategies. Below is a description of how a participant acted in such a situation:

“...//...For example if I have gonorrhoea I will tell the doctor I have it in my penis even though I know myself that I have it in my anus. He will prescribe proper medication to use.” (Participant 5)

If the doctor insisted on examining the penis, the participant said he would come up with an excuse to divert the doctor’s attention in order to leave the hospital.

Paying in exchange for preserved self-image refers to the utilisation of private healthcare services and the desire to be able to be honest and open with the provider. Men reported that private healthcare workers treated them in a respectful way.

“Doctors in these private hospitals are so friendly and listen to us. Maybe because we pay a lot of money to them so it’s more of a business than providing services.” (Participant 12)

Thus, private healthcare workers were described as “friendly” and “pampering”. However, the fee seemed to play a significant part in how men perceived that they were treated.

“Even if they have something against you, they can’t show it because all they want is money.” (Participant 11)

Participants expressed the view that the money they paid to private healthcare workers would reduce the chances of becoming stigmatised. This instilled a sense of safety, and participants could break through existing or perceived barriers against revealing same-sex sexual practices or identity to the healthcare worker.

Seeing Public Healthcare as a Last Resort

Feelings of not being accepted and accommodated by public healthcare services appeared to have devaluated its beneficial aspects. Accounts from participants indicated a sense of exclusion from these services and they described their alternative strategies. Delaying healthcare visits captures experiences of postponing healthcare visits until a critical stage of illness. A typical example of the consequences of fear of stigma was the following:

“Stigma really is a problem because sometimes you may find a person is really sick but end up using pain killers like HEDEX since he has a fear that if he goes to the hospital, people will stare at him. This causes him to go to the hospital when he is in a critical condition and [to] end up dying.” (Participant 12)

Another participant reported that he completely avoided the healthcare system.

“It has been more than 3 years since my last visit to the hospital.” (Participant 10)

Men in this study expressed a strong preference for private healthcare services. However, this was heavily dependent on their financial situation, and participants described that a lack of resources constituted a problem for them.

“Stigma makes me feel bad because I can’t go to any hospital. I must go to private hospitals and this means I must pay a lot of money, which I don’t have.” (Participant 12)

Because of the fear related to visiting public hospitals men described how they were forced to become their own doctor for lack of money to utilise private healthcare. Further, they felt that it was easier to go to a pharmacy than to a hospital when falling ill. At a pharmacy they could buy a specific drug over the counter without being requested to explain their symptoms or source of infection.

“When you get sick you feel it’s better to go to the nearest pharmacy and buy medicine rather than going to the health centre because you think that going to hospital will lead to stigmatisation from doctors or nurses.” (Participant 1)

Those who engaged in receptive anal sex were particularly vulnerable to being exposed as gay men when seeking care for sexually transmitted infections. Hence, they were more likely to go directly to the pharmacy when suffering from symptoms as illustrated in the following statement:

“Bottom partners usually don’t like going to the hospital because of stigma. That’s why they usually stay at home and treat themselves unprofessionally, which isn’t safe.” (Participant 9)

Participants also discussed previous experiences of disease among themselves, and when someone had symptoms they helped each other to identify adequate drugs without having to go to a hospital.

P: Whenever I get sick I normally ask my friends if they know any medicine that can they can help me

I: Why?

P: Sometimes going to the hospital embarrasses me because I fear people finding out that I am gay.” (Participant 6)

Discussion

The current study explored stigma in Tanzanian healthcare from the viewpoint of same-sex practising men. We gained insight into how stigma was perceived and how it affected men’s health-seeking behaviours. Our interpretation of the findings at group level is that participants either had personal experience of stigma or knew men who had been stigmatised. Their accounts suggest that while these men faced direct stigma in healthcare their expectations of being targeted as ‘deviants’ added to their mistrust of the healthcare system. To manage stigma, these men developed various coping strategies to regain some sense of control of the situation or distance themselves from the healthcare system. They navigated between various healthcare options based on their assessment of becoming stigmatised by a healthcare worker. This aided them in their decisions as to whether and how to approach a healthcare provider. Thus, an important finding in the current study is that these men are more than mere passive recipients of stigma.

Becoming Third Class Citizen in Healthcare

The enacted stigma faced by men in this study appeared to have created a perception among them of being devalued as patients in care. This limited participants’ possibilities to seek healthcare when they experienced illness and health-related problems. These findings are corroborated by other qualitative studies from the region, which indicate that homophobia in care negatively affects access to healthcare for men who have sex with men (King et al., 2013; Lane et al., 2008; Magesa et al., 2014; Niang et al., 2003; Okanlawon et al., 2013). The majority of these studies have explored how men experience stigmatisation caused by illnesses that may expose their same-sex sexual behaviours, such as sexually transmitted infections. While our findings confirm that symptoms of sexually transmitted infections were related to the particular vulnerability of being exposed as a same-sex practising individual, we also observed that men were stigmatised in other care situations when healthcare workers assumed that they were homosexual men. This exposure, in turn, seemed to be closely related to pervasive stereotypes and prejudices associated with the social construction of gender roles and sexuality in the Tanzanian society. Appearances, rumours or being accompanied by other men who were perceived as “feminine” were mentioned as

reasons for being mistreated by the healthcare workers. Thus, a range of different factors seemed to affect whether the healthcare worker would stigmatise participants, and most of these factors were beyond their control.

The current findings offer a deepened insight into how stigma contributes to negative healthcare seeking among men in our study and reflect the receiver's point of view. In a study of the extent to which nurses felt comfortable with providing care to HIV positive patients in Dar es Salaam, a larger majority revealed that they had positive attitudes towards homosexual patients (Sällberg & Nilsson, 2006). Evidence also suggests that healthcare providers in Tanzania already in the late 1980s were aware of same-sex sexual practices (Moen et al., 2014). In neighbouring Kenya, an evaluation of the sensitivity training for healthcare workers concerning sexual health issues of men who have sex with men revealed substantial improvements in knowledge and reduction of homophobic attitudes (van der Elst et al., 2013). This suggests that there currently are healthcare workers, who are cognisant to the health needs of men who have sex with men in Tanzania- and in the region. However, participants in our study felt that they were not entitled to the same care as other patients, which suggests that there may well be other attitudes and practices operating, despite capacity-developing initiatives in the region. Looking at the larger quantitative study sample, to which the current participants belonged (Anonymous, 2014a), eight out of ten respondents stated "no" to the question "During the service was the staff polite?" for almost every genital or sexual condition that they sought services for, and 83% said there was "a lot of stigma" toward gay/homosexual men from doctors and nurses (Anonymous, 2015). This indicates that our qualitative findings represent a wider experience but also that there may be a potential discrepancy between the perspectives of the caregiver and that of the patient regarding how services are provided. This may be a noteworthy observation in light of existing capacity-developing initiatives in the region. Thus, the care receiver's perspectives are especially important in order to design, implement and evaluate interventions.

Appraising Perceived Threats Related to One's Sexuality

Factors that had an impact on participants' decisions concerning whether to seek healthcare were closely related to their expectations of becoming stigmatised in particular situations. This was sometimes linked to stories and rumours from other men who have sex with men, i.e. vicarious stigma (Herek & Capitano, 1997; Sengupta et al., 2010; Steward et al., 2008). Rumours that portrayed particularly negative incidents, such as murders in hospitals of men who were believed to be homosexuals, had begun to grow into urban legends. These rumours circulated in our participants' communities and contributed to give the public healthcare system a reputation of not being welcoming and accommodating towards men who have sex with men. The impact of such a reputation on the health-seeking behaviours of an already marginalised population should not be underestimated. Participants revealed that they lacked trust in and were afraid of public healthcare services. In addition, this study found that the fear of exposure with possible negative consequences, such as police involvement, was perceived as a potential barrier for claiming one's right to healthcare when exposed to maltreatment. Similar findings have been reported from both Kenya and Uganda, where study participants reported that the current legal environment created fears of disclosing identity and approaching healthcare providers (Onyango-Ouma et al., 2005;

Wanyenze et al. 2016). While we did not find any evidence of enforcement of the law, our findings suggest that its existence has contributed to participants being less inclined to seek healthcare, in the event that something would go wrong. This calls for attention to the impact that punitive laws may have on the health of marginalised populations. Viewing stigma as a social process arising from differential access to power (Herek, 2002) suggests that it would be difficult, if not impossible, to empower marginalised populations without adopting policies or legislation that assert and protect the rights of these individuals and groups.

Balancing the Seesaw of Visibility

The findings from this study suggest that societal attitudes to homosexuality played a crucial role for men's health-seeking behaviours. This is also referred to as felt normative stigma (Scambler, 1989). Expectations of stigma contributed to men in our study developing strategies to counter discrimination and maltreatment in healthcare settings. One strategy used by participants was to engage in selective disclosure of their behaviours and identity. This involved enacting perceived masculinity norms during the interaction with a healthcare worker in order to appear to be heterosexual. Cain (1991) defines selective disclosure of homosexuality as a strategy deployed by gay individuals to "reduce the inner costs of possessing a discrediting identity and protect their social identity in situations where disclosure may have negative consequences" (Cain, 1991, p. 72). However, strategies to "pass" as a heterosexual came with a cost, in particular when suffering from a sexually transmitted infection. Participants had to conceal or modify symptoms and sexual history in order to receive care. Similar coping strategies have been shown in other studies from the sub-Saharan region (Lane et al., 2008; Niang et al., 2003). The extent to which this affects the quality of care and treatment has yet to be explored- in particular for medical issues that necessitate disclosure for correct diagnosis and treatment.

In the context of an unresponsive public healthcare system, men in this study were forced to use private healthcare facilities in spite of increased cost. Those who could afford private services described a *quid pro quo* relation: by paying an extra fee to healthcare workers participants received services that they otherwise might have been denied on grounds of their sexual identification or behaviours. This preference for private health facilities has also been documented by Magesa et al. in their study of men who have sex with men in Tanzania (Magesa et al., 2014). Because of the friendlier attitudes among healthcare workers in private hospitals, the men opted, when possible, for these services. This corresponds with the findings in our study, as there appeared to be a higher standard of patient interaction and care in private facilities. In a report from TACAIDS (unpublished paper) targeting men who have sex with men in Tanzania, the response to the question regarding what kind of health facility was associated with the most stigma showed that 73.2% reported government health facilities, 9.7% private health facilities and 17.1% both government and private health facilities (Mmbaga et al., 2014). These results are consistent with our own findings on differences between public and private facilities. However, our qualitative data further revealed that participants did not necessarily perceive private healthcare providers as less discriminatory, but rather that it was the payment that reduced the risk of being stigmatised. Hence, it is critical to also include private healthcare providers in anti-discriminatory training to combat stigma and to restore trust in the entire healthcare system.

Seeing Public Healthcare as a Last Resort

Men in this study seemed to have accepted that their sexuality was “deviant” from societal norms and that their sexual behaviour or identification could be provocative for a healthcare worker. Participants therefore minimised their interaction with the healthcare system when accessing treatment, which illustrates how self-stigma, or internalised stigma, impacts health-seeking behaviours (Steward et al., 2008). One strategy commonly described when falling ill was self-treatment, especially when suffering from symptoms of a sexually transmitted infection, as this potentially would require physical examination by a healthcare worker. Self-treatment as an alternative to formal health services for men who have sex with men has been described in various settings such as Kenya, Indonesia and Eastern Europe (Longfield et al., 2007; Morineau et al., 2011; Sharma et al., 2008). In this study, participants saw self-treatment as a simple transaction of payment for drugs over the counter without any requirements for details of themselves or their sexual history.

However, using pharmacies to manage sexually transmitted infections has implications for public health. Viberg and colleagues (2009) in a study from Tanzania found that private pharmacies often gave incorrect drug regimens and failed to provide complete drug combinations for syndromic management of sexually transmitted infections. The data from the quantitative part of this study indicated that 33.8% of the men “never”, and 29.3% “sometimes”, used a condom during anal sex with their partner (Anonymous, 2014b). Given the high prevalence of HIV infection and STIs in this population (30.2%, and 21.4%, respectively) in Tanzania (Anonymous, 2014a), incorrect drug regimens may contribute to increased drug-resistance. Proper medical training of pharmacists in the management of sexually transmitted infections is therefore of high importance.

Limitations

This study provides new insights into how Tanzanian men who have sex with men perceive and experience healthcare. It has, however, some limitations. Stigma could be a sensitive issue to discuss, in particular in a country where homosexuality is criminalised. This may have affected whether participants felt safe enough to fully share accounts of their perceptions and experiences of stigma. An attempt to address this was made by arranging one-on-one interviews at venues that the participants themselves chose in order to establish a secure and comfortable interview setting. The utilization of native Tanzanian interviewers may have influenced how men described their experiences. However, the choice of having local researchers with previous experience of working with this population was made to encourage men to describe their experiences.

Another limitation is that the participants’ responses were not analysed in their own language. Hence, there is a possibility that some of their original meanings were lost in the translation to English, alternatively that the translator attributed unintended meaning to responses by English words and phrases chosen. We tried to mitigate this risk by allowing the research assistants to take part in the English transcriptions. Furthermore, during the analytical process, agreement was continually sought among the co-researchers, with additional member checks with representatives of the gay community who also provided information about the cultural context in which the study was performed and the meaning of

certain local expressions. The use of quotations to illustrate the themes lends transparency to the interpretation of the findings and provides the reader with an understanding of how the themes were derived.

It may also be noted that most of the men in our sample identified themselves as gay, and men who identify themselves as bisexual or heterosexual might have other experiences of contact with healthcare providers in Tanzania. Moreover, the current study is based on participants who had been part of a survey study that used a Respondent Driven Sampling strategy, which may have limited the variety and range of experiences gathered. A more purposive sampling strategy could have given us access to other experiences of the healthcare system, including more positive ones. The findings are, however, informative, as they reveal the experiences of some same-sex practicing men in Dar es Salaam, and therefore capture part of the complex realities experienced by this population.

Conclusions

Stigma is a complex process and has multiple facets. This study found that men who have sex with men resort to different strategies to encounter stigma in healthcare, of which some affected their health-seeking behaviours negatively. Given that the Tanzanian government has prioritised men who have sex with men as a key population for HIV transmission, urgent efforts are needed to improve their access to healthcare. Due to the preference for pharmacies as first line providers of treatment shown in this study, these could play a potential role in reaching out to marginalised populations. However, proper training and monitoring of adherence are required to prevent mismanagement of drug regimens and doses. Exclusion of certain groups from the healthcare system might also have serious implications for the population health in general, also concerning conditions other than HIV and sexually transmitted infections. Thus, the recent Ebola outbreaks in West Africa demonstrate the importance of being able to disseminate proper and timely treatment. Because of the bridging role of key populations, barriers to healthcare could have profound implications on the health of the general population.

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Figure 1.
Four themes of men’s perceptions and experiences of healthcare.