

**Health services we can trust: How same-sex attracted men in Dar es Salaam, Tanzania would like their HIV healthcare to be organised**

Alexander Mwijage Ishungisa\*<sup>a</sup>, Mucho Mizinduko<sup>a</sup>, Samuel Likindikoki<sup>a</sup>, Elia John Mmbaga<sup>a</sup>  
<sup>b</sup>, Melkizedeck Thomas Leshabari<sup>a</sup>, Kåre Moen<sup>b</sup>

Department of Behavioural Sciences, Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania<sup>a</sup>; Department of Community Medicine and Global Health, Institute of Health and Society, University of Oslo, Oslo, Norway<sup>b</sup>

\*Corresponding Author: Alexander Mwijage Ishungisa  
Email: mwijagealexander2014@yahoo.com

## **Abstract**

Drawing on qualitative research in Dar es Salaam, Tanzania, this article explores how men who engage in sex with other men perceive their interactions with healthcare providers, and how they would prefer healthcare services to be organised and delivered. The paper describes the strengths and weaknesses men associate with private and public healthcare; the advantages and disadvantages they associate with dedicated clinics for sexual minority persons; what they conceive of as good healthcare services; and how they would characterise a good healthcare worker. The paper also presents recommendations made by study participants. These include the view that health services for same-sex attracted men should be developed and delivered in collaboration with such men themselves; that health workers should receive training on the medical needs as well as the overall circumstances of same-sex attracted men; and that there should be mechanisms that make healthcare available to poorer community members. We analyse men's views and recommendations in the light of theoretical work on trust and discuss the ways in which same sex attracted men look for signs that healthcare workers and healthcare services are trustworthy.

**Keywords:** same sex attracted men, healthcare services, Tanzania

## **Introduction**

Same-sex-attracted men have limited access to healthcare services and carry a disproportionate burden of HIV both in Africa and globally (UNAIDS 2017). Experiences of stigma and discrimination (Shangani et al. 2018), abuse from healthcare workers and difficulties in accessing care (Matovu et al. 2019), and rejection from care (Peters 2016) have been reported among same-sex attracted men seeking healthcare services in African countries. Drawing on qualitative research in Dar es Salaam, this paper explores how men who engage in sex with other men perceive their interactions with healthcare providers in Tanzania's largest city, and how they would prefer their healthcare services to be organised.

Previous studies have indicated that same-sex attracted men in Tanzania experience prejudice, stigma, discrimination, mistreatment, harassment, abuse and rejection in healthcare settings (Anderson et al. 2015; Crutzen et al. 2016). Such experiences, together with a lack of confidentiality and privacy in clinics, negative attitudes among healthcare workers, and financial challenges (Scheibe et al. 2014), have been described as barriers that may prevent healthcare access (Magesa et al. 2014). It has also been reported that some same-sex attracted men avoid seeking healthcare due to fear of being arrested or reported to the authorities by healthcare providers (Magesa et al. 2014; Larsson et al. 2016). Due to experiences and perceptions such as these, same-sex attracted men have been reported to act as their own doctors (Magesa et al. 2014; Larsson et al. 2016); that is, rather than seeking professional healthcare they try to diagnose themselves and buy drugs from medical stores and pharmacies (Ross et al. 2016; Agardh et al. 2017).

Against the backdrop of reports like these, we set out to explore what same-sex attracted men in Dar es Salaam conceive of as good healthcare services, how they would characterise a good healthcare worker, and how they would prefer their healthcare services to be organised and delivered. Questions like these are of general interest in the context of healthcare delivery to sexual and gender minority populations and are of particular importance in the context of the pronounced HIV epidemic among same-sex practising men in Tanzania. Recent studies have estimated that the prevalence of HIV in this population ranges from 11.1% in Tanga region (Ross et al. 2014) via 12.5% in Zanzibar (Dahoma et al. 2011) to 22.3% in Dar es Salaam (Mmbaga et al. 2018).

In 2014, Tanzania launched national guidelines for a comprehensive package of HIV interventions for key populations, coupled with training of healthcare workers (Ministry of Health, 2015). The plan was revised in 2017. Since it was first launched, there has been no study that has evaluated how services are provided to and experienced by same-sex attracted men. There is also a dearth of data on the relationship between same-sex attracted men's perspectives on and preferences of healthcare services.

## **Methods**

### ***Data collection***

This paper draws on qualitative research with and among same-sex attracted men in Dar es Salaam, which is Tanzania's largest city and has a population of approximately five million (National Bureau of Statistics 2018). Data collection was done by the first author, who had experience with qualitative research but who had not been involved in research with and among same-sex attracted men in the past. Fieldwork entailed a mix of qualitative interviewing, focus group discussions and participant observation and aimed to provide access

to a multitude of feelings, views and experiences relating to same-sex attracted men and healthcare.

Fieldwork was carried out between August 2018 and March 2019. Study participants had to be at least 18 years old and have had engaged in sex with one or more men in the past six months. A purposive sampling strategy was used where the intended purpose was to maximise variation in experiences and perspectives. There was no refusal to participate in the study among those invited. Participants were of different ages, had dissimilar education levels and occupations, came from diverse socio-economic backgrounds, lived in several different neighbourhoods across the city, had different sexual preferences, and varied with respect to HIV serostatus (see table 1). Participants who took part in the study and needed psychological support were offered psychological debriefing.

Table 1 about here

Qualitative interviews were conducted with 15 persons, each of whom were interviewed twice. The language used was Swahili and most interviews lasted between 60 and 90 minutes. Interviews were audio-recorded, transcribed verbatim and translated into English. The first author also participated in daily activities together with study participants and engaged in informal discussion with them about various topics and experiences. He joined some men when they were seeking healthcare and took part in social events including birthday parties and *vigodoro* (a local dance that goes on until dawn). He also participated in two burial ceremonies for same-sex attracted men. While participating in these events, he took rough notes which were later expanded into field notes.

Three focus group discussions were conducted to further explore topics that came up during individual interviews and participant observation. Among them were how study participants defined good healthcare services and good healthcare workers, issues related to medical costs, and whether the study participants preferred care in private or public health facilities. The number of participants in these discussions ranged from six to ten. Each discussion lasted between one and two hours and took place on the campus of the Muhimbili University of Health and Allied Sciences (MUHAS). Discussions were semi-structured. Swahili was the language used and all sessions were audio-recorded and transcribed verbatim.

### ***Data analysis***

Open coding was applied to interview transcripts and fieldnotes in an initial stage to identify emerging themes. Related codes were later subsumed into three broader thematic categories: (1) views on whether there should be dedicated clinics for same-sex attracted men or not; (2) views on what defines good healthcare services and good healthcare providers; and (3) perspectives on how to deal with medical costs. Trust in healthcare services emerged as a crosscutting theme in the analysis, and in this paper, we further consider the findings in light of theoretical work on trust.

Ethical approval for the study was provided by the MUHAS Institutional Ethics Review Board, and community entry permits<sup>1</sup> were provided by the Ministry of Regional

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<sup>1</sup> Community entry permits meant that after getting ethical clearance from MUHAS Institutional Review Board, we had also to get permission from President's Office responsible for Regional Administration and Local

Administration and Local Government as well as by the Dar es Salaam regional authorities. Written informed consent was obtained from all study participants. No directly personally identifiable information was recorded, and data were stored in a secure offline computer with protected password.

## Findings

### *Dedicated clinics for same-sex attracted men?*

Among the topics discussed with study participants was whether they thought it was preferable to have dedicated clinics that would cater only for sexual and gender minority persons, or whether healthcare should rather be provided in mainstream healthcare facilities. There were several different views on this.

#### *Advantages of integrated services*

Among study participants who preferred that health services be integrated into mainstream health facilities, two main rationales emerged. The first derived from the notion that all citizens should be treated equally, irrespective of their sexual orientation and gender identity. The aim for same-sex-attracted men was equality, not segregation. Among those who promoted this view was Babu,

[...] there should not be segregation in care delivery between *mashoga*<sup>2</sup> and other patients [...]. Services must be provided equally to all. In cases where there is separation of patients in care delivery, there is always stigma. (Babu)

Another argument in favour of integration was that specialised health facilities for same-sex attracted men might come to be known as 'gay clinics' and could then reveal the sexual identity of their clients. Moreover, if a clinic became widely known as 'gay', it risked attracting attention from persons who might seek to criticise or harm this segment of the population.

I cannot accept going to care facilities separated for *mashoga* or with special services for *mashoga*. There will be so many consequences, because everyone has his own understanding about *mashoga*. They can decide to poison or inject you with cancer virus because they don't like us, and they know how to get us. [...]. So, if you have separated care and related facilities, it will be easy to access us for those who don't want us, and because the government does not want us, it will be easy to arrest and make efforts to eradicate us. (Abuu)

Here, Abuu warns that there are people capable of seriously harming service users, and even wanting to 'eradicate' them. Against this background, he was adamant there was a need to avoid dedicated clinics for sexual minority persons.

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Government as well as the Dar-es-Salaam Regional Authorities before conducting the study among Same-sex attracted men.

<sup>2</sup> Mashoga [singular: shoga] refers to a Swahili term used to refer to same-sex attracted men.

### *Advantages of dedicated healthcare services for sexual minority persons*

Among study participants who preferred separate health services for same-sex attracted men, the main rationale was that such services would be better attuned to their needs. Dedicated health services would also provide spaces where men would feel free and be able to engage in open discussion about the issues and challenges they faced.

But when there are special places, *wasenge*<sup>3</sup> will be free. You can talk about your own challenges with colleagues while seeking care. When we have our own spaces, we can *kujichetua* [speak one's mind and reveal one's mood freely without fear], but you cannot do that in presence of people who are not *wasenge*. (Gideon)

Some study participants envisioned dedicated healthcare services not only as places where they could access biomedical care, but also as places where same-sex attracted men could network.

When you come for care at the facility, you need not only to get care, but you can network with other gays from different places and classes. How can it be done when we are mixed with other patients in the facilities? (Yohana)

### *Intermediate solutions: dedicated sections for same-sex attracted men in mainstream health facilities*

Among study participants who preferred health services to be delivered to same-sex attracted men along with everyone else, a few recommended that there should be a special section in healthcare facilities that dealt with same-sex attracted men. Even to have a dedicated room might simplify the process of explaining oneself when seeking and receiving care.

It is good to allocate a room or facility for *mashoga*. When you enter there, you finish everything there. The problem starts when you start moving from one room to the other for different care packages. (Daudi)

Other study participants wished there would not only be a dedicated room, but one or more doctors in each facility that were experienced in providing services to same-sex attracted men. Adili, for example, thought such an arrangement would lead to increased trust and openness among patients.

If MSM have their own doctors in the facility, then we are sure to have trust in them and open up our problems to them since we know they are only there for us and that they don't react negatively to us. (Adili)

One envisioned advantage of having dedicated and supportive doctors was that it could reduce the fear associated with seeking care.

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<sup>3</sup> Wasenge [singular: *msenge*] is another Swahili term used to refer to same-sex attracted men in Dar es Salaam

When you have gay-related diseases, you are always in fear: how to go to the facility, how to tell the doctors. [...] Having our own doctors, *mashoga* will no longer have fear about what to tell doctors. (Athuman)

Several study participants were worried that healthcare workers did not always keep information about queer patients confidential and thought that this might change if there were doctors who were dedicated to caring for same-sex attracted men.

The best way to deliver care to *wasenge* is to let us have our own doctors. This is because we can trust them and our information can remain confidential, but now you go to a health facility and tell them your information, and tomorrow you find everything in the street, someone is a gay. Who does that? It is doctors. (Moris)

To sum up, study participants variously provided rationales for dedicated healthcare for sexual and gender minority persons, for the integration of their care into mainstream healthcare delivery, and for intermediate solutions through which care would be provided in ordinary clinics but by specialist staff. A few interviewees also mentioned that whether dedicated clinics were needed or not was dependent on the type of services involved: there was perhaps no need for separate healthcare services for diseases perceived as having no relationship to sexuality, such as diarrhoea, malaria, headache, diabetes or cancer.

### ***Preference for public or private healthcare services***

Study participants were also asked what kind of services they preferred. Participants variously highlighted the strengths and weaknesses of government-run facilities, private facilities and low-threshold drop-in centres.

#### ***Public healthcare facilities***

Those who preferred to receive healthcare in government-owned health facilities provided several reasons for this preference. A perceived advantage was that public clinics provided affordable care.

You know, public facilities are run by the government, hence their cost for services are also lower than in private facilities, which depend on patients' payments to run. (Babu)

Many also perceived government-owned facilities to have better trained staff than private facilities, as well as doctors who tended to be professionally motivated rather than driven by money.

Well-trained doctors, after school, get employment in public, not private, facilities. They will normally use knowledge acquired from their training to treat, and not because of your money. They will do what they were trained to do. (Salum)

A common argument against public healthcare was that they had an owner who several interviewees perceived to be against same-sex attracted men.

I like government facilities, but it's hard to tell because I don't know if *wasenge* are allowed to get services from government hospitals like other people if it is known [that they are gay]. Because the government is against what they are doing. I think if they go to government hospitals, they will be treated harshly since the government has been totally against it. (Bahati)

### *Private healthcare facilities*

Study participants who preferred private healthcare facilities also gave different reasons for their preference. One was that private clinics were more likely to accept and respect gender and sexuality diverse men.

If you are a *msenge* and want good treatment, go to private health facilities, because they will always respect you and talk to you in a good language. (Godfrey)

Among the perceived reasons why there was greater acceptance in private health facilities was the disciplining effect of money. It was not in the best interest of private providers to send away patients while they were dependent on their payments.

They cannot chase or neglect you with care even if you are *msenge*, because what will they eat? We are their source of income; without patients they will not run their facilities. They will accept you in order to get money. (Majebejebe)

Even if an employee wanted to stigmatise same-sex attracted men, it was thought more unlikely to happen in a private clinic because such conduct could have serious implications for his or her employment.

In private clinics, providers cannot stigmatise you even if they don't like you; they will keep it to their heart. Because they know I can report to their bosses and they will lose their job. But in a government facility, once one has got a job there, he is sure you can't remove him, so they can do what they want to you and you cannot do anything. They can chase you from facility or call the police for you. (Mauma)

Several interviewees portrayed private healthcare providers as more client-oriented and flexible. Patients could easily make appointments, and doctors would do their best to please and support their patients. Also, private care was associated with clean facilities that were run without prolonged waiting time or delays.

The main disadvantage of private facilities was a perceived tendency to over-treat patients.

You will be surprised when you go to a private facility; you have one problem, but they will tell you to take several medical tests, each with different cost. Even when they give medicine, they give a variety of them at the same time. What they need is to accumulate money. (Athuman)

### *Low-threshold drop-in centres*

A third type of health facility mentioned during discussion were low-threshold drop-in centres. Such centres were available for same-sex attracted men in Dar es Salaam in the



recent past (Kabendera 2017; Human Rights Watch 2016). They were located in different places across the city, and men could access them without having an appointment. These centres were originally part of the government's HIV strategy, funded by PEPFAR and run by JHPIEGO, a US non-governmental organisation. However, they were closed by the government in 2016 (Human Rights Watch 2016). Many study participants remembered them and thought they had provided excellent services.

Do you remember the period that we had drop-in centres? [...] many *mashoga* were going for services [...]. There was no stigma, no bureaucracy and no payment. Everyone could get care there. (Erick)

That the services had been free was perceived as a major advantage in a community where many were poor.

But those with low income will end up dying. But if they will restart working with drop-in centres by providing services, many gays will go there because there were serving us for free. Not every *shoga* can go to health facility or pay. There was no need of money; I think that is why many were going there for services. (Hamduni)

It was stressed that the drop-in centres had provided spaces in which same-sex attracted men and transgender women felt they could interact freely in an environment without condemnation or stigmatisation.

At the drop-in centre, you knew you find only fellow *mashoga* and you could discuss anything you wanted, get there and leave any time you wanted without insults or stigma from doctors. (Mabumba)

### ***Characteristics of a good healthcare worker***

A third theme discussed with study participants was what they felt characterised a good healthcare worker.

#### ***Being trained on the overall circumstances and medical needs of Same-sex-attracted men***

Many men emphasised that a good healthcare worker was one who had gone through training about the lives, circumstances and medical needs of sexual and gender minority persons.

My idea is that using providers who are well trained about the situations MSM live in, and their health needs, is most important in getting care. Because they know you better and you cannot fail to get services. You can explain and they understand. (Kitundu)

Such training was felt to yield providers who could be trusted.

We need healthcare services to be provided by well-trained providers about needs and how to treat *mashoga*. We can trust them and be sure that telling them our problems they will help. (Yusuph)

In addition to positive implications for individual patients, some study participants reasoned that the training of healthcare workers could also contribute to improved acceptance of sexual and gender minority persons more generally in society.

When you go to a healthcare facility where you find trained providers, they do not ask many questions, they use good language and you know that you are recognised as a person. You also know that because providers accept you, and your services are there, then one day the government will accept you. (Babu)

#### *Being friendly to same-sex attracted men*

When asked what characterised a friendly provider, several traits were mentioned. Among them was that they would not be stigmatising or discriminating, but able to interact positively with sexual and gender minority persons.

To be friendly, a provider needs to know our medical needs, have no stigma or a discriminatory mind, but be able to interact with *mashoga* in all environments, not only at the care facilities. (James)

Among those who emphasised how friendly healthcare workers could contribute to the well-being and sense of self-worth among sexual minority persons was Erick:

You feel valued when you are treated by a friendly doctor, because most of us have been chased from homes, we are not accepted in the communities where we live, and when you come to health facilities and find the same situation you become disappointed. (Erick)

#### *Having same-sex attracted men as doctors*

In discussion about what constituted a good healthcare worker, some men said that they would feel especially comfortable if their doctors were same-sex attracted men themselves.

It's important that I'm going to get tested, but who's going to test me? Let's say I have a wound in my anus; who will look at it and test me. It's all important that we be given doctors who are MSM, who see *mashoga* as normal people. (George)

It was anticipated that healthcare workers who were same-sex attracted themselves know better the experiences, situations and challenges that same-sex attracted men face.

But we most prefer providers who are MSM because they know our problems better. We can trust and speak to them confidently and openly about our problems. They also know all corners and situations we live in. (Kitundu)

### ***Characteristics of good healthcare services***

A fourth theme concerned what study participants associated with good healthcare services. Six different characteristics that came up during discussion.

#### *Services developed and run in collaboration with same-sex attracted men*

Some informants said that good health services for same-sex attracted men would be those that were run in collaboration with this population's own organisations.

If you want to reach *wasenge* with good healthcare, you should use their respective organisations. You can also use those doing gay programmes. MSM will feel recognised and have ownership of services. That is the most efficient method and the best way to reach *mashoga*. (Mauma)

#### *Services involving same-sex attracted peer educators*

A related view was that good healthcare services would entail the involvement of peer health educators recruited among same-sex attracted men. To illustrate the perceived impact of this, some study participants highlighted how peer educators had successfully contributed to introduce pre-exposure prophylaxis (PrEP) and HIV self-testing (NACP 2019).

You see, like now they have introduced new medicine called PrEP, it's MSM who are distributing it. I am sure everyone will be reached in this way. (Erick)

#### *Using special cards to introduce same-sex attracted men to providers*

Some participants were of the view that good healthcare services would use a kind of identification card to introduce same-sex attracted men to healthcare workers. They argued that such cards would reduce the number of questions asked by providers. Upon seeing the card, they would immediately know to what population the holder belongs.

To avoid many questions from providers, we can be given special cards that identify us as gays, and the card providers will know the special care we need. (Abuu)

In one focus group discussion, however, there were also study participants who argued against such cards, pointing out that they could potentially pose challenges if they got lost or were forgotten at home.

The idea of using MSM and providers who are friendly and well trained about MSM is more important than having cards. Because the card can get lost and you fail to get services. That is a big challenge of using a card. (Yusuph)

#### *Providing Internet connection and access to information and interaction*

Some study participants said that good healthcare services would provide access to information related to their health and health-related problems. They viewed health

facilities not just as places to receive care, but also as places where they could enrich themselves with health information.

MSM need not only doctors and treatment at health facilities. They want to have free Internet. They do not have to come to facilities only for testing, maybe a person wants to get some information so he can come and Google, read, chat and do other things about their health problems. But now it is still not possible. (Juhudi)

#### *Assured presence of 'the comprehensive package of HIV interventions'*

Study participants were also asked to comment on the comprehensive package of HIV interventions (CHIP) for key populations, including MSM, that had been launched in Tanzania in 2014 (Ministry of Health, 2015) and later revised in 2017. Among the persons participating in this study, only a few had heard of this package.

You talked about special package of services for men who have sex with men. It is my first time to hear about it, and I think in this group maybe one or none has heard about it. It would be a good service for us and the problems we get. (Babu)

Observation in six public and private primary healthcare facilities during the fieldwork gave an impression that was in line with the one Babu conveyed. While HIV testing and antiretroviral therapy was available in all visited care and treatment clinics and sexual and reproductive health departments, some of the other services listed as part of the CHIP (including condoms, counselling, STI treatment, and sexual and reproductive health education) were not available in any of the facilities. However, a few of the services that were not available in primary healthcare facilities were provided in referral facilities, but at higher cost than many same-sex attracted men could afford.

#### *Affordable care*

Cost was perceived as a major obstacle for reaching and using healthcare services among poor same-sex attracted men, and many suggested that this group needed to be offered support that would help them access care. Such support could reduce the risk of HIV infections and could help retain people living with HIV on medication.

Healthcare services will always need money. Unless gays are supported, those with low income will end up dying. Without assistance, a poor gay living with HIV cannot adhere to treatment. (Athuman)

To deal with the costs, some participants recommended that same-sex attracted men be supported through establishment of income-generating activities.

We are neglected, we have nothing, and nobody will trust you. [...] If we are given support to have our income-generating initiatives, like business, MSM can access health services, because we want them, but we cannot manage [to pay for them]. (Mabumba)

An alternative approach was to establish a security fund for poor same-sex attracted

men in order to enable them to access medical care and cover basic needs. Study participants gave the example of the Tanzania Social Action Fund (TASAF), which provides poor households with financial assistance for healthcare, education and nutritional needs.

We see other people assisted by TASAF are well now, but no one has ever thought of including *wasenge* in such system. Are we not people? We are also vulnerable, just like TASAF's people. (Kitundu)

We used to have our own organisations and associations, but now they are all closed. We need other ways of being assisted. Maybe we have sponsors like those of TASAF or different. (Majebejebe)

## Discussion

Participants in this study provided a variety of views on what would constitute good healthcare services for sexual and gender minorities in Tanzania. Collectively, they generated what can only be characterised as a rich analysis of the issues that mediate between themselves, their healthcare providers and their health.

While study participants' reflections were diverse and their preferences varied, we find that there are some themes that cut across and unite several of the views and recommendations. One of them was an unmistakable quest for healthcare services that could be trusted by sexual and gender minority persons.

Grimen's (2009) metaphor for trust is willingness to leave something of value in the custody of an Other. In other words, when someone trusts someone else, they are ready to transfer their power over something valuable to that other. When same-sex attracted men in Dar es Salaam seek healthcare, they often leave precious "stuff" in the hands of the human and non-human actors (including the state) that make up their healthcare system. Among other things, they provide sensitive information to them, including about their sexual identities and practices, their whereabouts, the partners with whom they have romantic and sexual relations, as well as details from their medical histories. Also, they may leave their own bodies, or parts of them, in the hands of their doctors, including blood and urine that need to be tested, anal canals that need to be examined, and bodies that need to be managed with drugs, syringes or knives.

When a person's information, body and wellbeing is in the hand of the professional other, then that other has power to decide what should happen to it. To trust this person is to assume that that power is not going to be used against one's interests. But hardly ever is there a way of knowing for sure whether these expectations will be met. Trust therefore comes along with risk. The healthcare worker could potentially inflict harm by misusing information or mistreating someone's mind or body. In short, to trust renders the trustier vulnerable.

Men in this study were clearly engaging in reflections about what their risks and vulnerabilities might be when seeking healthcare. One of the risks they identified had to do with medical safety, especially in private clinics. Study participants were concerned that there might be an enduring pressure on healthcare workers in such clinics to provide examination and treatment in order to generate income, even when the condition might not require such diagnostic procedures or medication, and that health providers could come to prioritise generation of money over the safety of their patients.

Another risk was associated with the sharing of knowledge about one's sexual or gender identity. Some healthcare workers might respond negatively to such information. Several study participants thought that this was more of a risk of this in public than in private healthcare facilities, where the wish to generate income from patients might prohibit healthcare providers from showing antipathy or disrespect.

A third risk was associated with the possibility that information about one's sexual conduct might leak out of the healthcare unit and lead to trouble, either with people opposed to homosexuality, with the law and/or with the authorities. While fieldwork for this study was ongoing, there was media coverage of political debate in Tanzania that turned on the acceptability of same-sex relations. Among proposals put forward was that the general public should report same-sex attracted men to the authorities so that they could be corrected and/or punished (Ratcliffe 2018). Even when the central government distanced itself from this proposal (Agency France-Presse 2018), it remained a topic that was much discussed among study participants, with men considering to what degree information sharing about their sexuality could make them vulnerable in the context of healthcare.

Given this, men looked for ways in which their vulnerabilities could be lessened. At least three of the proposals they brought forward when asked about what they thought of as good healthcare services and healthcare workers can be understood as strategies to reduce the risk of negative consequences of identity exposure (Logie et al. 2017).

First, clinics should employ persons who shared the same sexual or gender identities as study participants themselves, e.g. doctors and/or peer health educators who were same-sex attracted men. If they could safely make their living working in a given healthcare unit, it might easily be understood as an indication that same-sex attracted patients could safely access its services, as well.

Second, healthcare units could engage in collaboration with community-based groups favoured by same-sex attracted men. Clinics that would do so would be understood to be investing some of their symbolic capital into the preservation of the safety and wellbeing of their clients.

The third proposal was that healthcare providers would take part in training intended to provide them with insight into the lived realities of same-sex attracted men. To attend training of this kind would serve as a demonstration of good will and intentions, and many study participants believed that participation in training had the power to lead to a change in attitudes.

Trust is of crucial importance to the function of healthcare. Indeed, as Hall and Berenson (1998) point out, trust allows the beneficial power of healthcare to exist. In the context of the Tanzanian HIV epidemic, the beneficial power of contemporary healthcare can enable long and healthy lives for HIV positive men who are attracted to other men. It is also widely understood to be key to attainment of the goal of zero new HIV infections, which Tanzania has adopted. To earn the trust of same-sex attracted men is therefore not only a question of providing them with timely healthcare, but also a way of contributing to the overall control of the HIV epidemic.

### ***Limitations***

As with all qualitative research, this study did not access information about frequencies of experiences, views and preferences. While this was not our aim, quantification of some of the

findings would have provided useful additional information (e.g. about the proportions of same-sex attracted men who preferred various type of healthcare services).

## **Conclusion**

To our knowledge, this is the first paper to explore what same-sex attracted men in Tanzania think should be done to make preventive and curative health services more welcoming and attuned to their needs and circumstances. To address the HIV epidemic among members of this population, there is a need to integrate user perspectives in the planning, organisation and delivery of HIV care. The less user perspectives and concerns are taken into consideration, the higher the risk that users are lost to follow up across the HIV care continuum. Central to the success of service provision is trust in the provider – both the individuals concerned and the organisation they work for.

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## **Conflict of interest**

The authors declare that they have no competing interests.

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**Table 1. Sociodemographic information on interviewees**

<b>Information</b>	<b>Participants in Interviews</b>	<b>Participants in Focus Group Discussion</b>	<b>Key Participants in Participant Observation</b>
<b>Age</b>			
<i>Below 25 years</i>	5	9	7
<i>25-40 years</i>	6	10	6
<i>Above 40 years</i>	3	4	2
<b>Place of birth</b>			
<i>Dar es Salaam</i>	4	6	3
<i>Kilimanjaro</i>	3	4	2
<i>Arusha</i>	1	2	1
<i>Zanzibar</i>	1		2
<i>Mwanza</i>	1	3	1
<i>Morogoro</i>	2	2	1
<i>Tanga</i>	1		
<i>Bunda Mara</i>	1		
<i>Mbeya</i>	1		
<i>Lindi</i>		2	
<i>Kagera</i>		1	1
<i>Kigoma</i>		1	2
<i>Mara</i>		2	1
<i>Singida</i>			1
<b>Highest education</b>			
<i>Primary school</i>	3	8	7
<i>Secondary school</i>	4	6	4
<i>Certificate</i>	2	5	2
<i>Diploma</i>	2		
<i>Bachelor's degree</i>	3	4	2
<b>Occupation</b>			
<i>Employed</i>	7	8	2
<i>Retired</i>	1		
<i>Sex workers</i>	5	8	7
<i>Unemployed</i>	2		
<b>Sexual preference</b>			
<i>Top</i>	9	8	5
<i>Bottom</i>	3	9	7
<i>Versatile</i>	3	6	3
<b>Socio-economic background</b>			
<i>High income</i>		3	

<i>Middle income</i>	6	8	6
<i>Low income</i>	9	12	9
<b>HIV status</b>			
<i>Positive</i>	4	7	5
<i>Negative</i>	11	16	9