Original Research Article

Journal of the International Association of Providers of AIDS Care
Volume 21: 1-8

DOI: 10.1177/23259582221121448
journals.sagepub.com/home/jia
SAGE

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

Alexander Mwijage Ishungisa, PhD[1], Dan Wolf Meyrowitsch, PhD[3], Elia John Mmbaga, PhD[1,2], Melkizedeck Thomas Leshabari, PhD[1], and Kåre Moen, PhD[2]

Abstract

Background: An increasing body of literature focuses on access to healthcare services for men who engage in sex with other men in Africa, but how healthcare workers conceive of this topic of healthcare workers' views on men's care has not been much studied. Drawing on qualitative research, this article explores healthcare providers' perspectives on access to HIV-related healthcare services among gender and sexuality diverse men in Tanzania. **Methods:** A qualitative study was conducted among healthcare workers in Dar es Salaam and Tanga, Tanzania in 2018/2019. Data collection 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. A total of 88 participants took part in the study. **Results:** This paper describes four different discourses that were identified among healthcare workers with respect to their perception of access to healthcare services for men who have sex with men. One held that access to healthcare was not a major problem, another that some same-sex attracted men did not utilize healthcare services although they were available to them, a third that some healthcare workers prevented these men 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 same-sex attracted men (SSAM), we suggest that they may all be "true" in the sense that they grasp and highlight different aspects of the same realities. More education is needed to healthcare providers to enable them accept SSAM who seek healthcare services and hence improve access to healthcare.

Keywords

men who have sex with men, healthcare workers, healthcare services, access to care, Tanzania

Date received: 29 November 2021; revised: 27 July 2022; accepted: 5 August 2022.

Introduction

Drawing on qualitative research with and among healthcare workers in Tanzania, this article explores "the provider perspective" on access to HIV-related healthcare for men who are attracted to and/or engage in sex with other men (MASM). How do healthcare professionals assess the "degree of fit" as Pechansky and Thomas[1] suggested we should take the concept of access to mean between this group of men and the health system. As far as we are aware, this topic has not been dealt with in previous scholarship, neither in Tanzania nor

[1] Department of Behavioural Sciences, Department of Epidemiology and Biostatistics of the Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania
[2] Department of Community Medicine and Global Health, Institute of Health and Society, University of Oslo, Oslo, Norway
[3] Global Health Section, Department of Public Health, University of Copenhagen, Kobenhavn, Denmark

Corresponding Author:
Alexander Mwijage Ishungisa, Department of Behavioural Sciences, Department of Epidemiology and Biostatistics of the Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania.
Email: mwijagealexander2014@yahoo.com

elsewhere in Africa. While there is a growing literature on various aspects of access to healthcare for sexual and gender minorities on the continent, how healthcare workers experience and perceive of this topic thus appears to remain largely unexplored.

But healthcare workers perspectives on access to healthcare for MASM would seem to be of quite some significance for at least three reasons. Firstly, doctors, nurses and other healthcare professionals occupy privileged positions from where to observe certain issues of relevance to healthcare access.[2] Secondly, as has been widely reported, healthcare providers appear to represent an important part of the problem of access to healthcare for minority populations such as that of men who have sex with men.[3–9] Thirdly, in programing aiming to improve healthcare access for this minority group, healthcare professionals may undoubtedly also represent part of the solution.[10,11]

In this paper, our focus is limited to healthcare workers' perspectives on access to HIV-related healthcare (as opposed to healthcare in general). We chose to focus specifically on this because HIV remains such a prominent health challenge among men who have sex with other men in Tanzania (as it does across Sub-Saharan Africa). In Tanzania, the overall prevalence of HIV among adults dropped from 8% to 4.7% between 2003 and 2017,[12] but it remains almost twice that among men who engage in sex with other men (it was 8.3% in this population in Dar es Salaam in 2017[13]).

Before we present the perspectives of Tanzanian healthcare workers on access to healthcare for men who engage in romantic and/or sexual relations with other men, let us briefly summarize some of what has been reported on the topic from other sources.

A basic requirement when considering the issue of healthcare access is whether relevant services are available in the first place.[2] In its "Consolidated guideline on HIV prevention, diagnosis, treatment and care for key populations", the World Health Organization (WHO) is recommending a range of HIV-related healthcare services that ought to be available for men who have sex with men.[14] To what extent the recommended services are available in Africa is not well researched, but some countries have implemented comprehensive HIV intervention packages, including Tanzania,[8,9,15,16] where the Comprehensive HIV intervention package for key populations (CHIP) outlined some services. Whether services outline in the CHIP are available for MASM or not, is also not well researched.

In addition to service availability, Pechansky and Thomas'[2,17,18] proposed that evaluations of access to care should consider barriers that might act to hinder service utilization. They divided such barriers into those that might be considered (1) organizational, (2) personal and (3) financial.

In the literature on healthcare access for same-sex practicing men in Africa, several organizational barriers[2,17] have been identified.[6,19] Many of these have to do with the existence of stigma and discrimination in healthcare facilities. Studies have documented that men who have sex with men (MSM) may be denied healthcare altogether or be purposely delayed in healthcare facilities.[6,20,21] In Malawi, there was limited acceptability and willingness among healthcare providers to offer sexual health services to men who have sex with men,[22] and in Uganda and Ghana, disclosure of information about same-sex attractions could lead to denial of healthcare.[21,23] In Tanzania, it has been documented how men who are sexually attracted to other men may experience prejudice, stigma, discrimination, mistreatment, harassment, abuse and rejection in healthcare settings[3,4] and that some men fear being reported to the authorities by healthcare workers.[6] Other reports have highlighted that MSM may be insulted and called bad names by healthcare providers[6,24] or receive negative reactions from other patients.[20,21] Finally, some MSM have been reported to receive the wrong treatment because they do not dare to disclose information about their sexual practices to healthcare workers in fear of negative reactions.[5,19,23] The mentioned organizational barriers against healthcare access could be influenced by the training offered to healthcare workers. In Botswana and Namibia, some healthcare workers were reported to have limited knowledge on same-sex attracted men and their healthcare needs.[25] In South Africa, healthcare workers did not want to ask their patients questions related to homosexuality due to a lack of training.[26] Several studies have indicated that there is a positive association between supportive healthcare workers and access to healthcare services.[10,11,27,28]

Many of the organizational barriers just mentioned may easily translate into personal barriers against healthcare utilization as well. As long as negative experiences in healthcare units remain a possibility, potential care seekers may not *wish* to utilize the services they provide.[2,17,29] In Tanzania, some men who have sex with men have been reported to avoid seeking healthcare if at all possible, and instead try to act as their own and each other's doctors.[6,24,30,31] In our own recent study among same-sex attracted men in Dar es Salaam, some men said they would prefer to be served by healthcare workers who are themselves MSM since they would not be expected to stigmatize or discriminate, and because they would be expected to understand the healthcare needs and lived circumstances of men who have sex with men.[31]

The last of Pechansky and Thomas' categories was financial barriers to healthcare. While there has been a dearth of studies focusing on how cost may act to block same-sex attracted men from care in Sub-Sahara Africa, a study from Malawi[32] pointed out that cost was a main barrier there, and that most MSM lacked health insurance. There has been limited research into the role costs play for access to care among same-sex attracted men in Tanzania, but in our own recent study among members of this population,[31] costs were portrayed as a major obstacle for reaching and utilizing healthcare services among poor same-sex attracted men.

The research question for this study was "what perspectives do healthcare workers in Tanzania have on access to HIV care for same-sex attracted men (SSAM)?".

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 men who have sex with men there carry a substantial burden of HIV[33,34] and in part because there are considerable populations of such men in these two locations.[35] Fieldwork (data collection) entailed qualitative interviewing, focus group discussions and participant observation and was carried out between August 2018 and October 2019. (As part of this research project, we also carried out research among same-sex attracted men themselves. Findings from this part of our work have been reported elsewhere[31] and will not be further discussed in this paper.)

During fieldwork, the first author interacted with different cadres of healthcare workers employed in clinics and in non-governmental organizations involved in the implementation of HIV related projects. A purposive sampling strategy was used, with the purpose being to maximize difference in experiences and perspectives among study participants. The selection of study participants took into consideration differences in age, education level, work experience, the type and location of the facilities they worked in. In Total, 88 participants took part in this qualitative study as summarized in Table 1.

Qualitative interviews (IV) 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 min. Interviews were audio-recorded, transcribed verbatim and translated into English.

Participant observation (PO): During fieldwork, the first author occasionally 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 eight different healthcare workers at their workplaces, where he engaged in discussions with them about topics related to healthcare for SSAM. On six occasions he also took part in outreach services targeting SSAM. While participating in these events, he took "scratch notes",[36,37] and these were later expanded into fieldnotes.

Table 1. Distribution of Study Participants Versus Study Methods.

Cadre	# Of participants	Interviews	FGDs	Participant observation
Medical doctors (MD	17	4	10	3
Assistant MD	23	6	15	2
Clinical Officers (COs)	29	9	19	1
Enrolled Nurses (EN)	19	5	12	2
Total	88	24	56	8

Focus group discussions (GD): 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 six to eight and in total, 56 healthcare providers who took part in group discussions. 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, during the data analysis, we carried out content analysis of interview transcripts and fieldnotes. Open coding, an analytical process where concepts (codes) are identified from qualitative data, described and named,[38] was applied in the initial stage to identify emerging themes. Example of some of codes which emerged during the analysis include training providers, punishing MSM, changing laws and policies, reaching and educating men only to mention few. 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".

Positionality: As Jacobson and Mustafa argue that "the way we as researchers view and interpret our social worlds is impacted by where, when and how we are socially located and what society".[39] With that in mind, none of the author was a healthcare worker but all of the authors had experiences of both healthcare workers and men who have sex with men in different occasions and also had researched on different public health topics prior to this study. Being trained in anthropology, he first author believes that both the researcher and study participants together participate in knowledge construction and that there are no single but multiple realties.[40] The first author believes that his prior background may have impacted his interaction with study participants as well as the interpretation of the findings.

Ethical clearance number DA.251/267/01.C110 was provided by the Institutional Ethics Review Board of Muhimbili University of Health and Allied Sciences (MUHAS), 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. Data were stored in a secure offline computer. All names used in this manuscript to refer to study participants are pseudo names.

Findings

The healthcare workers who took part in this study had different perspectives on, impressions of, and opinions regarding the topic of access to healthcare for men who are attracted to and/or engage in sex with other men. In the following, we present these as four different "discourses" that circulated among healthcare workers. We take "discourse" to mean "how knowledge, subjects, behaviour, and events are depicted and defined in statements, assumptions, concepts, themes, and shared ideas".[41]

The first of the discourses we identify turned on the view that there was no major problem with access to HIV-related healthcare for men who sex with other men (although exceptions to the rule could sometimes occur). The three other discourses portrayed access to healthcare as suboptimal for such men, for three different main reasons. One held that same-sex attracted men distanced themselves from care, another that healthcare workers directly or indirectly blocked such men from care, and a third that structural barriers worked to prevent this group of men from gaining access to healthcare.

First Discourse: "Access to Care Is not a Major Problem"

Some of the study participants held the view that there was no fundamental or ubiquitous obstacle to healthcare for gender and sexuality diverse men in Tanzania. They had a clear belief in the ability of the healthcare system to provide this group of men with the health services it needed. Ezekia and Amani were examples of those who subscribed to this view,

> *"Care is always available for MSM, as it is for other populations. I don't think there has been a problem" (Ezekia, Participant #13, IV)*

> *"As far as I know, like other populations, MSM do not have any problem accessing healthcare services in health facilities." (Amani, Participant #31, PO)*

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 negative attitudes towards this category of men, 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, Participant #13, PO)*

Amani agreed and emphasized the importance of patients filing complaints if they experienced bad treatment. Such incidents 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, but access to services was still a problem for some men who have sex with men because they blocked *themselves* from appropriate care.

At times, it was as if this discourse existed in opposition to reports and discourses that blame healthcare workers for hindering gender and sexuality diverse men from accessing care,

> *"It is hard for us [healthcare workers] 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, Participant #28, GD)*

Among the envisioned reasons why some same-sex practicing men did not want to seek healthcare was a 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, Participant #1, GD)*

Other study participants pointed out that various kinds of fear could make same-sex attracted men stay away from care,

> *"I know that some MSM do not want to come to health facilities even when they are sick. They remain with their problems because of negligence, fear of disclosing their sexual information, and fear of stigma and law enforcers." (Edgar, Participant # 28, GD)*

A related challenge was that even among men who did turn up at clinics, some held back information about their sexual practices and identities,

> *"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, Participant #7, IV)*

Third Discourse: "Healthcare Workers Block MSM from Care"

A third discourse emphasized that there were healthcare professionals who actively contributed to limit access to healthcare for gender and sexuality diverse men. Some doctors and nurses referred to such men with insulting labels, or intimidated them in front of colleagues and other patients,

"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 workers] 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 an MSM looks 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, Participant #45, GD)

Another way in which healthcare workers intimidated same-sex attracted men was to deliberately delay them in the clinic. One study participant explained how he used this approach himself,

"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, Participant #9, GD)

Finally, some healthcare providers completely rejected care provision to same-sex attracted men.

"Many [healthcare workers] 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" (Bariki, Participant #45, PO)

"If I had a relative choosing to be a 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 be associated with practices or people who are not supported by the laws of the country (Florian, Participant #17, IV)

Fourth Discourse: "Structural Barriers Block MSM from Care"

The fourth discourse we identify highlighted access to care as difficult for SSAM because of structural barriers. Prominent among these was the colonial time law that still prohibits "carnal knowledge against the order of nature" in Tanzania,

"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, Participant # 10, IV)

Anti-homosexuality sentiments in the political debate were also perceived as a significant structural barrier to healthcare access for gender and sexuality diverse men,

"In addition, 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?" (Mwemezi, Participant #3, IV)

While fieldwork for this study was ongoing, the Tanzanian media had prominent coverage of political debate that severely criticized 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.[42] Several of the study participants reasoned that some same-sex attracted men avoided healthcare in this period for fear of being arrested.

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 same-sex attracted men in Tanzania, and in this article, we have categorized and presented these as four different "discourses". While these discourses differ to quite some extent and could at times seem 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 emphasized that healthcare services are accessible to same-sex attracted men. In support of their view, one might note that there exists a policy for a comprehensive package of HIV intervention for key and vulnerable populations (CHIP),[16,43] and that previous research has indicated that many healthcare workers in Tanzania are supportive of this group of men and may have been so for quite some time. As far back as in 2006, Nilsson and Ewalds-Kvist (quoted in Moen et al[44]) 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. In our own overall research project, which also entailed a survey among MSM in Dar es Salaam and Tanga (Ishungisa, forthcoming), a large majority (87%) of men who engage in sex with other men indicated that they were treated well by healthcare providers. We find it important to highlight these findings, because in some discourses, Tanzania is at times been portrayed as a country in which the circumstances are *only* difficult for same-sex attracted men. While we do not in any way want to detract attention from 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[45] who describe that healthcare services 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 men who have sex with men 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, stigmatizing 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, sensitive and friendly services to SSAM. We notice that a similar argument has been put forward by healthcare providers in Malawi.[22]

In some of the conversations and discussions we draw on in this paper, there was a tendency among healthcare workers to "turn the tables", ie, 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. There would seem to be a notable lack of understanding in these accounts of the difficulties that may be associated with disclosure of same-sex practices to healthcare workers in the context of stigma, discrimination and criminalization. It is of course highly understandable that SSAM may avoid care seeking whenever they are fearful of negative reactions. On the other hand, these comments at the same time seem to highlight that there are well-intended healthcare workers who feel they do not get to serve gender and sexuality diverse men to the degree they want because they are not given a chance to do so. An interesting question that follows from this would seem to be whether something could be done to better link MSM to healthcare providers who are MSM friendly. For example, would healthcare providers agree to see their names on lists of professionals who provide care to MSM without reservation or stigma?

Because, that there exists a very real risk that same-sex attracted men 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 this group of men, including some of the healthcare workers that were interviewed for this study. Among the ways in which they demonstrated their disapproval was through the use of insulting labels and through a sensationalizing of the presence of MSM in the clinic. Some providers also deliberately delayed or outrightly rejected care for this group of men. These findings are in line with those of previous work in Dar es Salaam which has found that due to homophobic attitudes among healthcare workers, some MSM did not seek healthcare and resorted to self-medication instead.[6,30] They are also in line with findings of previous studies in other key populations.[21] It is regarded a matter of great important that healthcare providers adhere to basic ethical guidelines. To do so is part of their 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.[46] Rhodes's[47] 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. The less this is the case in relations between healthcare providers and their MSM patients, the more one would expect that MSM avoid seeking medical care or open up to healthcare providers about their sexuality.

The fourth main point raised by healthcare workers in this study, was the structural barriers against healthcare for same-sex attracted men in Tanzania. As 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 men who have sex with other men to the authorities so that they could be corrected and/or punished.[42] Even when the central government distanced itself from this proposal,[31] it remained a topic that emerged in discussions between many of the healthcare workers who took part in this study. Some even wondered what might happen to themselves if they were provided services to same-sex attracted men, as also reported is a recent study by Sadgrove.[48] This situation demonstrates with great clarity how profoundly healthcare access may be limited as a result of political action.

Conclusion

This paper is the first to explore healthcare providers' assessment of access to healthcare among men who have sex with men in Tanzania. The healthcare workers described a situation where access to care was sometimes unproblematic for MSM. However, some healthcare providers ill-treated and/or rejected members of this population, and some MSM were assumed to 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 the political debate, were seen to act as barriers against universal access to healthcare for men who are attracted to other men. More education is needed to healthcare providers to enable them accept SSAM who seek healthcare services and hence improve access to healthcare.

Authors' Contributions

AMI contributed to the design of the study, analyzed data, interpreted results and drafted the manuscript. KM contributed to design the study, data analysis, interpretation of results and drafting of the manuscript. EJM, MTL and DM contributed to design the study and interpret the results.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The research described in this paper received funding from the Danish Fellowship Centre-DANIDA through project number 16-P03-TAN as part of the Access to Healthcare Services among Key Populations in Tanzania project. A portion of this work was supported by the National Institute of Health's Fogarty International Center, award 5D43TW009573–07. No funding bodies had any role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Ethical Approval and Consent to Participate

Ethical clearance (DA.251/267/01.C110) was obtained from the Institutional Ethics Review Board of Muhimbili University of Health and Allied Sciences (MUHAS). The Ministry of Regional Administration and Local Government and Dar es Salaam and Tanga regional authorities provided community entry permits. Each study participant provided written informed consent to take part in the study.

Availability of Supporting Data and Materials

The dataset generated during and/or analyzed during the current study are not publicly available due to the sensitivity of the research topic and as part of our strategy to fully protect the identity of the study participants.

Consent for Publication

Authors have read and consented for publication of this final draft of the manuscript.

ORCID iD

Alexander Mwijage Ishungisa https://orcid.org/0000-0002-6810-8312

Note

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

References

1. Mutambo C, Hlongwana K. Healthcare workers' perspectives on the barriers to providing HIV services to children in sub-Saharan Africa. *AIDS Res Treat*. 2019;2019:1–10. doi:10.1155/2019/8056382
2. Gulliford M, Figueroa-Munoz J, Morgan M, et al. What does "access to health care" mean? *J Health Serv Res Policy*. 2002;7(3):186–188.
3. Anderson AM, Ross MW, Nyoni JE, McCurdy SA. High prevalence of stigma-related abuse among a sample of men who have sex with men in Tanzania: implications for HIV prevention. *AIDS Care*. 2015;27(1):63–70.
4. Crutzen R, Ross MW, Nyoni JE, et al. Depression and HIV risk among men who have sex with men in Tanzania. *AIDS Care*. 2016;28(suppl 1):140–147.
5. Agardh C, Weije F, Agardh A, et al. Using pharmacists and drugstore workers as sexual healthcare givers: a qualitative study of men who have sex with men in Dar es Salaam, Tanzania. *Glob Health Action*. 2017;10(1):1389181.
6. Magesa DJ, Mtui LJ, Abdul M, et al. Barriers to men who have sex with men attending HIV related health services in Dar es Salaam, Tanzania. *Tanzan J Health Res*. 2014;16(2). doi:10.4314/thrb.v16i2.8
7. Stephens JH, Surjan A. BARRIERS preventing access by men who have sex with men to HIV-related health services in Southeast Asia: a scoping review. *Glob Public Health*. 2022;17(2):235–253.
8. Beyrer C, Sullivan PS, Sanchez J, et al. A call to action for comprehensive HIV services for men who have sex with men. *Lancet*. 2012;380(9839):424–438.
9. King R, Sebyala Z, Ogwal M, et al. How men who have sex with men experience HIV health services in Kampala, Uganda. *BMJ Glob Health*. 2020;5(4):e001901.
10. Scheibe AP, Duby Z, Brown B, Sanders EJ, Bekker L-G. Attitude shifts and knowledge gains: evaluating men who have sex with men sensitisation training for healthcare workers in the Western Cape, South Africa. *South Afr J HIV Med*. 2017;18(1):1–8.
11. Larsson M, Ross MW, Tumwine G, Agardh A. Determinants of unmet needs for healthcare and sexual health counselling among Ugandan university students with same-sex sexuality experience. *Glob Health Action*. 2016;9(1):30790.
12. Final results from Tanzania HIV impact survey shed light on priorities for strengthening the country's efforts to control HIV - PHIA project. Accessed May 4, 2021. https://phia.icap.columbia.edu/final-results-from-tanzania-hiv-impact-survey-shed-light-on-priorities-for-strengthening-the-countrys-efforts-to-control-hiv/
13. Alexander Ishungisa M, Moen K, Leyna G, et al. HIV Prevalence among men who have sex with men following the implementation of the HIV preventive guideline in Tanzania: respondent-driven sampling survey. *BMJ Open*. 2020;10(10):e036460.
14. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Accessed October 22, 2021. https://www.who.int/publications/i/item/9789241511124
15. Welfare S. Comprehensive package of HIV interventions for key populations in Tanzania; 2014.
16. NACP. A revised guideline for a comprehensive package of services for key population in Tanzania, April-2017-April (3).pdf.
17. Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care*. 1981;19(2):127–140.
18. Saurman E. Improving access: modifying Penchansky and Thomas's theory of access. *J Health Serv Res Policy*. 2016;21(1):36–39.
19. Ross MW, Nyoni J, Larsson M, et al. Health care in a homophobic climate: the SPEND model for providing sexual health services to men who have sex with men where their health and human rights are compromised. *Glob Health Action*. 2015;8(1):26096.
20. Duby Z, Nkosi B, Scheibe A, Brown B, Bekker LG. 'Scared of going to the clinic': contextualising healthcare access for men who have sex with men, female sex workers and people who use drugs in two South African cities. *South Afr J HIV Med*. 2018;19(1). doi:10.4102/sajhivmed.v19i1.701
21. Wanyenze RK, Musinguzi G, Matovu JKB, et al. If you tell people that you had sex with a fellow man, it is hard to be helped and treated": barriers and opportunities for increasing access to HIV services among men who have sex with men in Uganda. *PLoS One*. 2016;11(1):e0147714–e0147714.
22. Kapanda L, Jumbe V, Izugbara C, Muula AS. Healthcare providers' attitudes towards care for men who have sex with men (MSM) in Malawi. *BMC Health Serv Res*. 2019;19(1):1–9.
23. Kushwaha S, Lalani Y, Maina G, et al. "But the moment they find out that you are MSM …": a qualitative investigation of HIV prevention experiences among men who have sex with men (MSM) in Ghana's health care system. *BMC Public Health*. 2017;17(1):770.
24. Magesa DJ, Leshabari M. Perceived barriers to access available health services among men who have sex with men in Dar es

Salaam, Tanzania. *Tanzan J Health Res*. 2017;19(4). doi:10.4314/thrb.v19i4.5
25. Fay H, Baral SD, Trapence G, et al. Stigma, health care access, and HIV knowledge among men who have sex with men in Malawi, Namibia, and Botswana. *AIDS Behav*. 2011;15(6):1088–1097.
26. Rees K. Providing healthcare to men who have sex with men is complex but possible. University of Pretoria. Accessed September 6, 2021. https://theconversation.com/providing-healthcare-to-men-who-have-sex-with-men-is-complex-but-possible-95163
27. Graham SM, Micheni M, Secor A, et al. HIV care engagement and ART adherence among Kenyan gay, bisexual, and other men who have sex with men: a multi-level model informed by qualitative research. *AIDS Care*. 2018;30(suppl 5):S97–S105.
28. van der Elst EM, Gichuru E, Omar A, et al. Experiences of Kenyan healthcare workers providing services to men who have sex with men: qualitative findings from a sensitivity training programme. *J Int AIDS Soc*. 2013;16:18741. doi:10.7448/IAS.16.4.18741
29. Mooney GH. Equity in health care: confronting the confusion. *Eff Health Care*. 1983;1(4):179–185. http://europepmc.org/article/med/10310519
30. Larsson M, Ross MW, Månsson SA, Nyoni J, Shio J, Agardh A. Being forced to become your own doctor: men who have sex with men's experiences of stigma in the Tanzanian healthcare system. *Int J Sex Health*. 2016;28(2):163–175.
31. Ishungisa AM, Mizinduko M, Likindikoki S, Mmbaga EJ, Leshabari MT, Moen K. Health services we can trust: how same-sex attracted men in Dar es Salaam, Tanzania would like their HIV healthcare to be organised. *Cult Health Sex*. 2021;23(10):1329–1343.
32. Why men who have sex with men have problems with health care in Africa. Accessed October 18, 2021. https://theconversation.com/why-men-who-have-sex-with-men-have-problems-with-health-care-in-africa-49985
33. Mmbaga E, Moen K, Leyna GH, Mpembeni R, Leshabari MT. HIV prevalence and associated risk factors among men who have sex with men in Dar Es Salaam, Tanzania; 2017. Accessed October 23, 2019. https://www.jaids.com
34. Mpondo BCT, Gunda DW, Kilonzo SB. HIV Epidemic in Tanzania: the possible role of the key populations. *AIDS Res Treat*. 2017;2017:1–7. doi:10.1155/2017/7089150
35. Leshabari M. Prevalence of the Human Immunodeficiency Virus, other sexually transmitted infections, and health-related perceptions, reflections, experiences and practices among men having sex with men in Dar es Salaam. For ansatte - Universitetet i Oslo. University of Oslo. https://www.uio.no/for-ansatte/arbeidsstotte/fa/regelverk-og-forskningsetikk/kvalitetssystem-helse/prosjekter/med/helsam/samfunssmedisin%20og%20global%20helse/integrated-bio-behavioural-survey-among-men-who-have-sex-with-men-people-who-inject-drugs-and-female-sex-workers-in-dar-es-salaam-tanzania/index.html
36. Morse JM. Critical analysis of strategies for determining rigor in qualitative inquiry. *Qual Health Res*. 2015;25(9):1212–1222.
37. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res*. 2005;15(9):1277–1288.
38. Republic of South Africa. Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007. *Gov Gaz*. Published online 2007. doi:10.1350/jcla.68.3.220.34454
39. Jacobson D, Mustafa N. Social identity map: a reflexivity tool for practicing explicit positionality in critical qualitative research. *Int J Qual Methods*. 2019;18:160940691987007. doi:10.1177/1609406919870075
40. Berger PL. Berger social-construction-of-reality.pdf.crdownload.
41. Braham P. Key concepts in sociology. Published online 2013. Accessed October 19, 2021. https://books.google.com/books/about/Key_Concepts_in_Sociology.html?id=nZwQAgAAQBAJ
42. Ratcliffe R. Thousands 'living in fear' after Tanzania calls on public to report gay people | Global development | The Guardian. The Guardian. https://www.theguardian.com/global-development/2018/nov/01/thousands-living-in-fear-after-tanzania-calls-on-public-to-report-gay-people
43. NACP. National guideline for comprehensive package of HIV interventions for key populations the United Republic of Tanzania Ministry of Health and Social Welfare Tanzania Mainland. NATIONAL GUIDELINE FOR COMPREHENSIVE PACKAGE OF HIV INTERVENTIONS FOR KEY POPULATIONS; 2014.
44. Moen K, Aggleton P, Leshabari MT, Middelthon AL. Same-sex practicing men in Tanzania from 1860 to 2010. *Arch Sex Behav*. 2014;43(6):1065–1082.
45. Renggli S, Mayumana I, Mboya D, et al. Towards improved health service quality in Tanzania: an approach to increase efficiency and effectiveness of routine supportive supervision. *PLoS One*. 2018;13(9):e0202735.
46. WMA Declaration of Geneva – WMA – The World Medical Association. Accessed February 4, 2021. https://www.wma.net/policies-post/wma-declaration-of-geneva/
47. ResearchGate. Accessed May 4, 2021. https://www.researchgate.net/publication/229727904_Rhodes'_contribution_to_governance_theory_Praise_criticism_and_the_future_governance_debate/link/5b927098299bf14739202f2a/download
48. Sadgrove J, Vanderbeck RM, Andersson J, Valentine G, Ward K. Morality plays and money matters: politics of homosexuality in Uganda. *J Mod Afr Stud*. 2012;50(1):103–129.