

HEALTHCARE PROVIDERS' ATTITUDES AS DETERMINANTS IN HIV CARE-SEEKING BEHAVIOURS IN MEN HAVING SEX WITH MEN IN UASIN GISHU COUNTY, KENYA

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Abstract

Background: HIV/AIDS remains a significant health burden in Kenya, with an estimated prevalence of 5.5% in Uasin Gishu. Men having Sex with men (MSM) have a Human-Immunodeficiency Virus prevalence rate of 18.9% in Kenya and 3.7% in Uasin Gishu. **Objective:** To investigate healthcare providers' attitudes as determinants in HIV care-seeking behaviours in MSM in Uasin Gishu county, Kenya. **Methodology:** A cross-sectional study was conducted among the adult MSM population in Uasin Gishu in 2020. Participants were identified through Queer-Initiative and a total of 286 participants enrolled through purposive and snowballing sampling. Quantitative and qualitative data were collected using questionnaires and in-depth interviews respectively and the healthcare providers' attitudes were assessed using Likert Scales. Fisher's exact test was used to determine associations, with a statistical significance of $p < 0.05$ and qualitative data was analyzed using thematic coding. **Results:** The median age for MSM was 23 years old. 51.6% of the participants believed that care providers treated MSM differently ($p = 0.018$). MSM who felt comfortable revealing their sexual orientation were more likely to seek HIV care ($p = 0.044$). MSM who revealed their sexual orientation were more satisfied with the care provided ($p = 0.004$). Younger participants (18-25 years) were more likely to engage in unprotected anal sex ($p = 0.048$). MSM that accessed quality care services were more likely to refer their peers to the specific care centres ($p = 0.012$). Major themes from the qualitative analysis included stigma associated with sexual orientation, abuse while seeking HIV care, difficulties in accessing HIV care, and risky sexual behaviors. 20.5% of the participants reported having visited Moi Teaching and Referral Hospital (MTRH) for HIV care, while 29.5% visited Pioneer Hospital and 22.5% visited QI. **Conclusion:** Healthcare providers' attitudes were significant in determining the HIV care-seeking behaviors of MSM. MSM-friendly care facilities included Pioneer Health Centre, QI, and MTRH. MSM used referrals or avoided revealing their orientation to access safe care.

Keywords: MSM, HIV, AIDS, healthcare provider, sexual orientation

1. Introduction

Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome (HIV/AIDS) remains a significant health burden for many African countries. In the last three decades, HIV/AIDS has been a public health burden in the world. It is estimated that only 75% of the 36.9 million people living with HIV/AIDS (PLWHIV) were aware of their HIV-positive status, and only 21.7% of these 75% percent were accessing antiretroviral therapy drugs (Feyissaet al., 2019). Unprotected anal sex among the Men who sleep with Men (MSM) is a major risk factor in the transmission of HIV/AIDS among the MSM.

Section 162 of the Kenyan Penal Code states that sodomy is a felony punishable by up to 14 years imprisonment and under section 165, 'gross indecency' described as any sexual practice between males, is punishable by five years imprisonment (Kenya Law., 2010). Despite its declaration against discrimination of any kind in Article 27, the Kenyan Constitution is not explicit on protection against discrimination based on sexual orientation. It, therefore, becomes challenging for the MSM to access health services in Kenya given the illegality of their way of life.

According to the Kenya Medical Research Institute- Wellcome Trust Research Program in Kilifi, HIV-1 incidence is much higher in MSM who have exclusive sex with men than bisexual men (Sanders et al., 2015). Recent studies show that MSM are 24 times more likely to get infected with HIV than the general population and 28 times more likely to be infected with HIV compared to men having sex with women alone (Musyoki H et al, 2013; Bhattacharjee, et al., 2020). According to NASCOP, HIV prevalence among the MSM is 18.9%, 6% overall HIV prevalence, and 33% of new HIV infections are attributed to key populations (Bhattacharjee, et al., 2020; NASCOP, 2020).

MSM play a crucial role in the prevention and reduction of HIV prevalence and incidences in Kenya. Discrimination and homophobia have been major drawback in the MSM community in Kenya, and this is extended to the delivery of health services (USAID, PEPFAR, and AIDS-Free). Research indicates that negative attitudes directly influence the ARVs uptake, limiting HIV control in Kenya (Ronoh et al., 2020).

Queer-Initiative is among the organizations targeting the MSM and the fight against HIV/AIDS in the MSM population in Uasin Gishu. Uasin Gishu has an HIV/AIDS prevalence rate of 5.5% in the general population, and 3.7% in MSM (National Aids Control Council, 2018). MSM in Uasin Gishu face discrimination, which could potentially strain intervention measures aimed at HIV prevention and reduction. Despite previous research showing that MSM share significantly in the HIV burden, they are continually excluded systematically from the public initiatives targeted towards the prevention and management of HIV/AIDS services.

Previous studies have not focused on the healthcare providers' role in influencing MSM's attitudes towards access to HIV care. This research reports findings on the association of healthcare providers' attitudes and HIV care-seeking behaviours in MSM in Uasin Gishu County, Kenya.

2. Methods

2.1 Study area

The study was carried out in Uasin Gishu County, located in Kenya's Rift Valley Midwest with six wards; Turbo, Kesses, Moiben, Kapseret, Ainabkoi, and Soy, and an estimated population 1,163,186. It has a general HIV prevalence of 5.5% in the general population with a 3.7% prevalence in the MSM population (National AIDS Control Council , 2018). This makes MSM among the populations with a high risk of HIV infection in Uasin Gishu County.

2.2 Data collection and analysis

Quantitative data was collected through semi-structured questionnaires, and qualitative data was collected using in-depth interviews. According to Gerrish and Lacey (2010), a good sample size for in-depth interviews (IDIs) was based on the grounded theory of saturation (Gerrish & Lacey, 2010). The IDIs were 12, and the questionnaires were 256. The study participants (1) were men reported to have had anal or oral sex with other men within the past six months (2) residing within Uasin Gishu County for more than one month before the study (3) adults of 18 years of age and above (4) can consent. Additionally, the participants had to be above 18 years. The study used the University of California Brief Assessment of Capacity to Consent (UBACC) tool to assess capacity to consent.

The study focused on the MSM's past interaction with the healthcare providers, their HIV testing history (No disclosure of status), barriers to access to HIV/AIDS services, ways to overcome the discrimination, and their motivation on HIV/AIDS care-seeking behaviors.

The in-depth interviews were carried out in a private and safe place approved by Q-Initiative. Data collection was facilitated by the principal investigator and two research assistants, who are peer counselors at QI. The research assistants were trained on survey administration, obtaining informed consent and confidentiality. Research assistants were expected to hold at least an undergraduate degree from a recognized University, have spoken and written English and Kiswahili fluency and respect MSM. Before selection, the principal researcher interviewed research assistants to ensure they hold no conflict of interest in the study.

The IDIs lasted for approximately 20 minutes per session, and the surveys lasted for 10 minutes per participant. Data from IDIs was captured using audio recorders and note-taking.

The data was entered into Ms-Excel and later exported to SPSS version 25 for further analysis. The descriptive analysis used median and interquartile ranges to summarize continuous variables and frequency with proportions to summarize categorical variables. The associations of various factors with different outcomes of interest were determined using Fisher's Exact Test because of cells values, with-value set at < 0.05 as a significant association. This data was presented in tables and bar graphs. The 12 audiotaped interviews were transcribed and entered into NVivo for analysis using thematic coding. The number of interviews was determined using the Grounded theory saturation. 12 was used because it was evident that gathering more information beyond the 12 interviews would not add new information or reveal new properties beyond the core thematic categories. The attitudes of healthcare workers towards the MSM and the attitudes if MSM towards seeking care were assessed using Likert Scales. Interviews were carried out in English and Kiswahili. Interviews conducted in Kiswahili were translated into English. "Framework approach" was adopted to map the concepts, systematically code, and define themes emerging from the data as defined by Ritchie and Spenser (Ritchie & Spencer, 1994). The main themes from the data included: risky sexual behavior, abuse while seeking care, the stigma associated with sexual orientation, and access to HIV care.

2.3 Ethical approval

The study and informed consent documents were approved by the Institutional Research and Ethical Committee (IREC) and NACOSTI. The participants used pseudonyms to protect their identities. Before data collection, the study's objectives were explained to the eligible participants. They were guided through the consent letters for clarity. Participants gave their consent by signing the consent letters before commencing the study. The research investigator had no conflict of interest in the study.

3. Results

3.1 Quantitative Results

3.1.1 Background characteristics

Two hundred and fifty six (256) MSM were recruited in this study with an estimated median age of 23 (IQR: 21-23) years, 251 (98.05%) of them ever attended school. Among those who attended school, 87 (33.98%) had a secondary level of education, 65 (25.39%) were undergraduates, 41 (16.02%), and 42 (16.41%) had certificate or diploma qualifications. In the last four weeks before the study, 119 (46.5%) used alcohol less than once a week or never, 106 (41.4%) used alcohol at least once a week, 13 (5.1%) used alcohol daily in the last four weeks while the rest did not know. In the last one year before the study, 115 (44.9%) used drugs (Table 1).

Table 1: Socio-demographic characteristics of the study participants (N=256)

Variables	Number	%
Median age, year	23 (21-23)	
Median numbers of years lived in UG	6 (4-12)	
Ever attended school		
Yes	251	98.05
No	5	1.95
Level of education		
Primary	4	1.56
Secondary	87	33.98
Certificate	41	16.02
Diploma	42	16.41
Undergraduate	65	25.39
Post-graduate	12	4.69
None	5	1.95

Table 2: Marriage

Variable	Number	%
Ever Married		
Yes	26	10.2
No	230	89.8
Median age at married, years	25.5 (23.8-27.3)	
Currently married/living with a woman		
Yes	11	4.3

No	239	93.36
Living with male sexual partner	6	2.34
Have children		
Yes	15	5.86
No	241	94.14

Table 3: Sexual behavior

Variable	Number	%
Oral sex with condom		
Yes	99	38.7
No	117	45.7
Don't Know	40	15.6
Median number of partners for oral sex	3 (2-6)	
Median number of partners for anal sex	3 (2-4)	
Forced sex in the past six months		
Yes	66	25.78
No	190	71.48
Last Anal sex with a condom		
Yes	179	69.9
No	60	23.4
Don't Know	17	6.6
Discussed HIV/AIDS with Partner		
Yes	219	85.55
No	37	14.45

Figure 1: Condom use

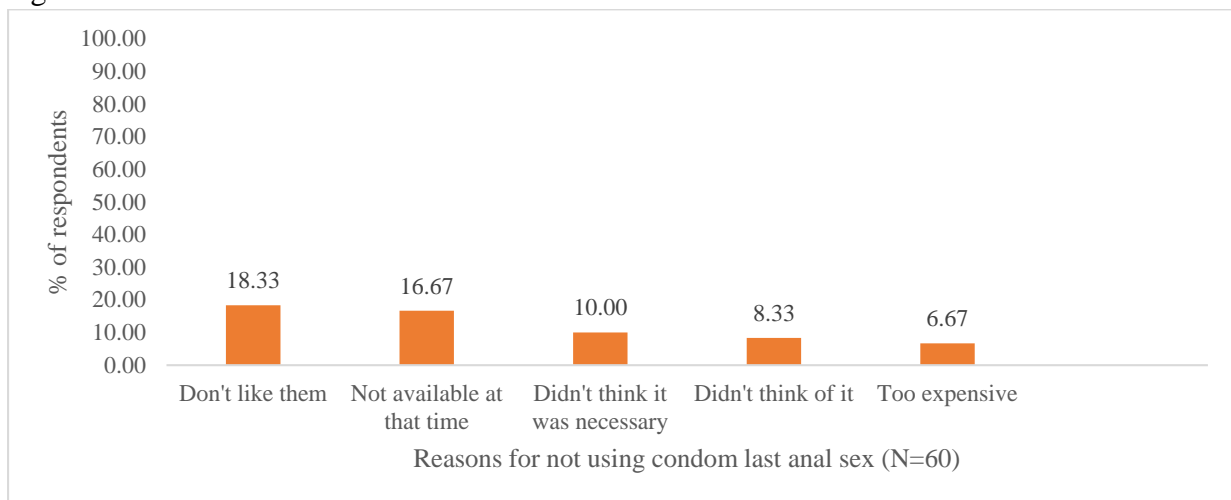


Table 4: Experience with health care providers

	Number	%
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Safety with healthcare facility visit for HIV care		
Not safe at all	33	12.9
Safe	135	52.7
Somewhat safe	59	23.0
Very safe	29	11.3
Healthcare provider refused to attend to you		
Yes	60	23.4
No	196	76.6
Satisfied with the last hospital visit		
Reasonably poorly satisfied	28	10.94
Very poorly satisfied	21	8.20
very satisfied	3	1.17
Very well satisfied	25	9.77
well satisfied	179	69.92
Would you refer another MSM to the last clinic visited		
No	79	30.9
Yes	177	69.1
Healthcare provider treat MSM differently		
Don't know	37	14.5
True	132	51.6
Very true	58	22.7
Very untrue	15	5.9
Reasonably untrue	14	5.5
Ever abused while having care		
No	204	79.7
Yes	52	20.3
Type of abuse(n=52)		
Physical	7	13.5
Verbal	42	80.8
Physical and verbal	3	5.8
Asked about orientation		
No	201	78.5
Yes	55	21.5
Feels comfortable when ask about sex orientation		
Comfortable	93	36.3
Don't know	9	3.5
Not comfortable at all	73	28.5
Somewhat comfortable	65	25.4
Very comfortable	16	6.3
Revealed sexual orientation last visit		
Don't know	12	4.7
No	196	76.6
Yes	48	18.8
Healthcare provider react negatively about sexual orientation		
Don't know	19	7.4

No	140	54.7
Yes	97	37.9
What made you feel he reacted negatively		
Asked me to leave	25	9.8
Don't know	142	55.5
Other	5	2.0
Stopped talking to me	7	2.7
Verbally abused or scolded me	22	8.6
was very uncomfortable discussing	55	21.5

Figure 2: Motivation for HIV testing

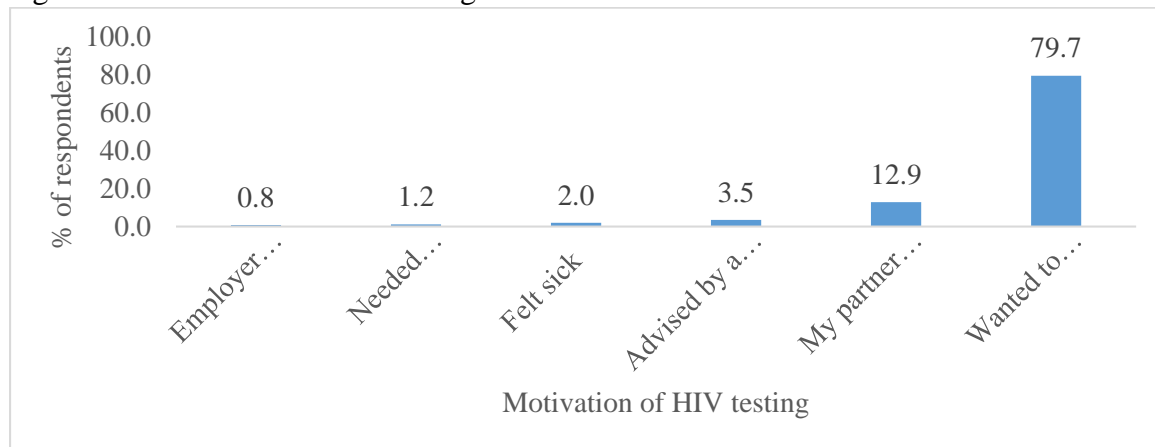


Table 5: Health utilization

	Number	%
Sought medical care last 12 moths		
No	40	15.6
Yes	216	84.4
Visited care for MSM services in UG last 12 moths		
No	73	28.5
Yes	183	71.5
Difficulty getting care in the last 12 months		
No	128	50.0
Yes	128	50.0
Kind of difficulty		
Covid-19	11	4.3
Long waiting time	44	17.2
No response	128	50.0
Too expensive	47	18.4
Too far away	26	10.2
Ever attended HIV/AIDS Program last 6 months		
No	17	6.6

Yes	239	93.4
Meeting sponsor		
Ampath	1	0.4
FHOK	5	2.0
GUMZO	1	0.4
ICL	1	0.4
NIAK	2	0.8
No response	24	9.4
Pioneer	1	0.4
QI	210	82.0
QI/Safaricom/Blaze,KIMS	1	0.4
QI/Pioneer	1	0.4
Rafiki center	5	2.0
Red cross	3	1.2
Red cross/QI/Rafiki center	1	0.4

93(36.3%) participants that reported they were comfortable when asked about their sexual orientation, and 67 (72.0%) of them sought care in health centers in or around Uasin Gishu in the past year before the study. Seven three participants (28.5%) were not comfortable when asked about their sexual orientation. However, 47 (64.4%) of them visited health centers in or around the region, 65 (25.4%) of the respondents were somewhat comfortable. Of these, 54 (83.1%) visited a health facility in the region in the last 12 months. There was a significant association between being comfortable when asked about sexual orientation and visiting a health facility in or around Uasin Gishu in the last 12 months (p-value=0.044).

Referring fellow MSM to the last facility was significantly associated with visiting a health facility in or around Uasin Gishu in the last 12 months (p-value=0.012). Proportions of participants who were comfortable, somewhat comfortable, and very comfortable to refer another MSM to the last care facility and reported visiting a health facility within the region were 78.5% (n=73), 72.3% (n=47), and 68.8% (n=11) respectively. Of those who were not comfortable referring other MSM to the last facility, 39 (53.4%) visited a health facility in the last 12 months versus 61% who avoided seeking HIV care from the hospitals.

Table 6: Utilization of health services in the last 12 months by socio-demographic and lifestyle characteristics

Characteristics	Sought medical care last 12 months			Fisher's exact P-value
	Yes	No	Total	
Attended school				0.576
Yes	212 (84.5)	39 (15.5)	251	
No	4 (80.0)	1 (20.0)	5	
Level of education				0.703
Certificate	37 (90.2)	4 (9.8)	41	
Diploma	37 (88.1)	5 (11.9)	42	
None	4 (80.0)	1 (20.0)	5	
Post-graduate	9 (75.0)	3 (25.0)	12	
Primary	4 (100.0)	0 (0.0)	4	
Secondary	71 (81.6)	16 (18.4)	87	
Undergraduate	54 (83.1)	11 (16.9)	65	
Religion				0.004
Adventist	25 (83.3)	5 (16.7)	30	
Anglican	37 (94.9)	2 (5.1)	39	
Atheist	19 (59.4)	13 (40.6)	32	
Catholic	76 (86.4)	12 (13.6)	88	
Muslim	22 (84.6)	4 (15.4)	26	
Pentecostal	37 (90.2)	4 (9.8)	41	
Frequency of alcohol consumption				0.937
At least once a week	91 (85.8)	15 (14.2)	106	
Everyday	11 (84.6)	2 (15.4)	13	
Less than once a week	99 (83.2)	20 (16.8)	119	
Never	15 (83.3)	3 (16.7)	18	

Table 7: comfort while visiting health center in Uasin Gishu

Characteristics	visited a health center in or around Uasin Gishu last 12 months			p-value
	Yes (n=183)	No (n=73)	Total (N=256)	
Comfortable when asked about your sexual orientation				0.044
No response	4 (44.4)	5 (55.6)	9	
Not comfortable at all	47 (64.4)	26 (35.6)	73	
Comfortable	67 (72.0)	26 (28.0)	93	
somewhat comfortable	54 (83.1)	11 (16.9)	65	
very comfortable	11 (68.8)	5 (31.2)	16	

Would you refer another MSM to the last care facility				0.012
No response	7 (77.8)	2 (22.2)	9	
Not comfortable at all	39 (53.4)	34 (46.6)	73	
Comfortable	73 (78.5)	20 (21.5)	93	
somewhat comfortable	47 (72.3)	18 (27.7)	65	
very comfortable	11 (68.8)	5 (31.2)	16	

Of the total participants, only 48 (18.8%) revealed their sexual orientation to HCP, 179 (69.9%) of them reported they were well satisfied with services they received during the last time they attended the health facility. Of these, 36 (20.1%) revealed their sexual orientation to HCP. One in four of the participants were very well satisfied with the service of the last health facility attended, and they revealed their sexual orientation to HCP. The level of satisfaction in the last attends health facility was significantly associated with revealing the sexual orientation to HCP (p-value=0.004).

Table 8: Satisfaction and revealing sexual orientation

Characteristics	Reveal sexual orientation to HCP			P-value
	Yes (n=48)	No (n=208)	Total (N=256)	
satisfied were you when you last attended a health care facility				0.004
No response	1 (20.0)	4 (80.0)	5	
Poorly satisfied	0 (0.0)	1 (100.0)	1	
Reasonably Poorly satisfied	4 (18.2)	18 (81.8)	22	
Satisfied	0 (0.0)	1 (100.0)	1	
very poorly satisfied	2 (9.5)	19 (90.5)	21	
very satisfied	0 (0.0)	2 (100.0)	2	
very well satisfied	5 (20.0)	20 (80.0)	25	
well satisfied	36 (20.1)	143 (79.9)	179	

A total of 179 (69.9%) of the participants reported using condoms during the last anal sex. Of these, 122 (68.2%) were in the 20-25 age group. Teenagers (18-19 years) and older MSM were

8.4% (n=8.4) and 3.9% (n=3.9%) respectively. There was a significant association between the age group of the participants and condom use in the last anal sex (p-value=0.048).

Only 3 (1.2%) of the respondents reported that the health care providers do not treat MSM differently. The majority (51.6%, n=132) reported that healthcare providers treated MSM differently. Of these groups, 100 (75.8%) were in the 20-25 age group, while teenagers were 12 (9.1%), and 58(22.7%) of them reported that they were being treated differently in hospitals.

Table 9: Treatment of MSM by healthcare providers across age groups

Characteristics	Age-groups				Total	P-value
	18-19	20-25	26-30	31-40		
The last time you had anal sex was a condom used						0.048
Yes	15 (8.4)	122 (68.2)	35 (19.6)	7 (3.9)	179	
No	6 (7.8)	57 (74.0)	11 (14.3)	3 (3.9)	77	
Healthcare providers treat MSM differently						0.018
No	0 (0.0)	2 (66.7)	1 (33.3)	0 (0.0)	3	
Don't Know	3 (8.8)	21 (61.8)	8 (23.5)	2 (5.9)	34	
Reasonably untrue	1 (7.1)	10 (71.4)	3 (21.4)	0 (0.0)	14	
TRUE	12 (9.1)	100 (75.8)	16 (12.1)	4 (3.0)	132	
very true	4 (6.9)	38 (65.5)	13 (22.4)	3 (5.2)	58	
very untrue	1 (6.7)	5 (53.3)	5 (33.3)	1 (6.7)	15	

Figure 3: Why not reveal sexual orientation to healthcare providers

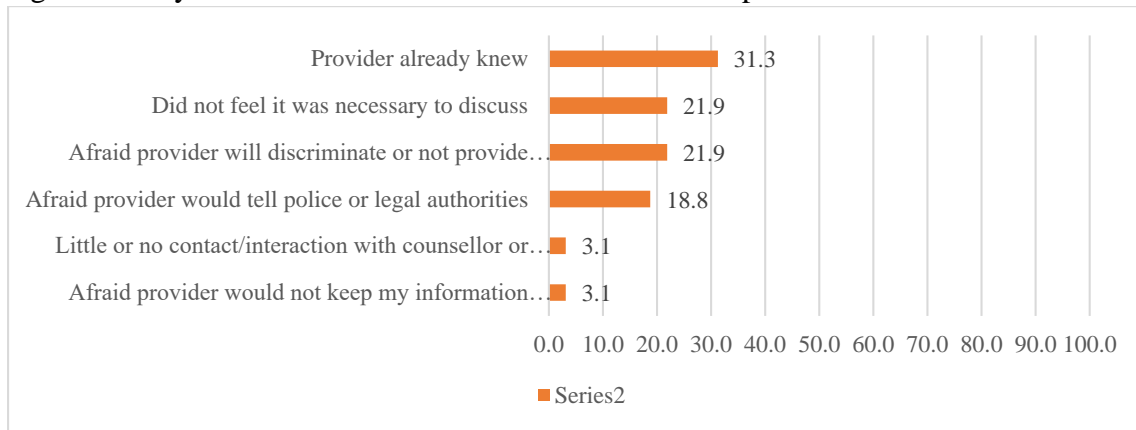
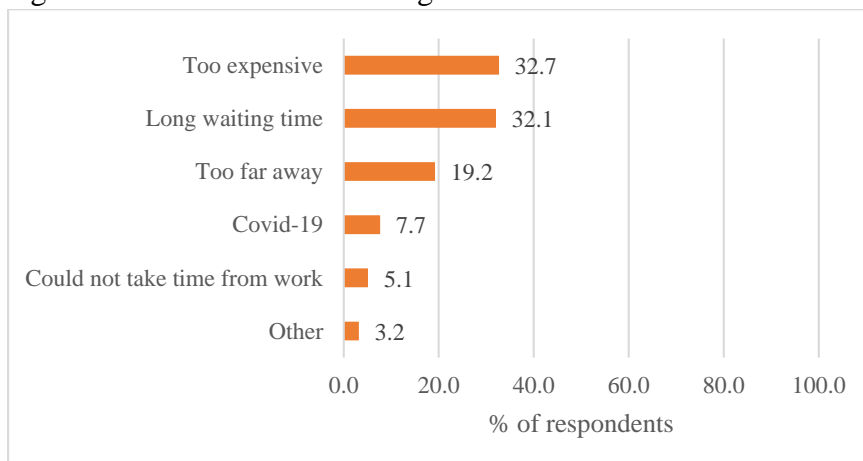


Table 10: Healthcare facilities visited by MSM for HIV/AIDS care

Facility name	Frequency	%
District Hospital	20	8.9
Eldoret Hospital	1	0.4
Elgon View	1	0.4
FHOK	5	2.2
Huruma Hospital	1	0.4
Kesses Dispensary	6	2.7
Mediheal	5	2.2
Moi University Dispensary	4	1.8
MTRH	46	20.5
Pioneer	66	29.5
QI	51	22.8
Qi/Pioneer	1	0.4
Rafiki Center	9	4.0
St. Lukes	8	3.6
Total	224	100

Figure 4: Reasons for not visiting care centers



3.2 Qualitative Results

3.2.1 Stigma associated with sexual orientation

Most of the MSM stated that they faced stigmatization while seeking care. Some of the care providers believe that being gay is sinful; therefore, homosexuality should not be tolerated. Consequently, MSM feel that they are being treated differently, discouraging them from seeking the services from the healthcare facilities in the county. When asked if how they were treated differently, one responded that after he was asked about his sexual orientation,

"They asked 'how can a man go with another man?' They stopped talking to me. So, I walked out" (Respondent 5).

Other respondents stated that he was scared to reveal his sexual orientation because,

"The health provider was not good. I felt that it wasn't safe for me" (Respondent 4)

"MSM patients are treated differently because healthcare providers see MSM as a sin" (Respondent 8).

3.2.2 Abuse while seeking care

Some of the care providers insulted the MSM or physically abused them while seeking care. The fear of being abused scared away some of the MSM, making it hard to seek safe HIV care in the county. The verbal insults increased distrust between MSM and the care providers. One of the MSM stated,

"No, they didn't beat me, but they were talking about my gender and whether am male or female. They called me 'Shoga' cat walking and they taunt how we dress" (Respondent 5).

Another participant reported having been told,

"unatembea kama msichana. Wewe ni shoga hapa hatutaki mashoga (Why are you walking like a girl, you are gay, we don't want gays here" (Respondent 1)

Other verbal abuses included "Hatutibu mashoga hapa, enda uokoke (we don't treat gays here, go get saved). Mashoga mnafaa muchomwe (gays should be burned)" (Respondent 7).

You look like a girl. God made a mistake creating you. I can't treat you. You are cursed. Mashoga mnafaa kuombewa, mna mapepo (gays need prayers, demons possess you). Mnasambaza ukimwi mashoga mnatuharibia watoto (you are spreading HIV, spoiling our children). Wewe ni shoga ndio maana ukonaugonjwa kamahii (you have this disease because you are gay)" (Respondent 12).

3.2.3 Access to HIV care

Negative attitudes by healthcare providers hindered access to HIV care. Some of the participants reported feeling discouraged, shy and embarrassed to explain their health issues. When asked any difficulties they faced while seeking care services, some of the participants responded,

"It's embarrassing to explain some issues to a doctor. I feel shy" (Respondent 5)

"Specifically it's just self-esteem. I am afraid" (Respondent 3)

"I went to MTRH and met a very nice doctor. However, I was scared that given that it was a government hospital, I thought I would be required to be "normal" to get the services. I feel that I would not get the same treatment in other public hospitals like the District hospital" (Respondent 2).

3.2.4 Risky sexual behavior

The participants engaged in risky sexual behaviors such as multiple sexual partners, unprotected sex, and commercial sex. These behaviors increase the risk of HIV exposure.

"I have several men, around 25. Yes, most were one night stands" (Respondent 3)

"I have had 5 men in the past six months. No, I did not use condoms." (Respondent 6)

"Yes, around 10 men in the past six months and five commercial sex workers. I did not use a condom" (Respondent 8).

4. Discussion

4.1 Quantitative analysis

The study showed associations between the care providers' attitudes and MSM's behaviours in seeking and accessing quality HIV care within Uasin Gishu County. From the findings, care providers who showed negative attitudes towards MSM, discouraging most of them from seeking care. The results reported that some care providers abused some of the MSM or refused to attend to them after they revealed their sexual orientation. This is reflected in the study conducted by Mirza and Rooney (2018), which reported that hospital staff refused to provide HIV care for patients who disclosed that they were homosexuals (Mizra & Rooney, 2018). Further, Ayhan et al. (2019) found that healthcare providers portrayed discriminatory attitudes when the MSM revealed their sexual orientation, discouraging MSM from seeking HIV care in healthcare facilities (Ayhan et al., 2019). To avoid the negative attitudes from the care providers, MSM sought referrals to help them identify trusted HIV care providers. From the findings, MSM failed to reveal their orientation to avoid negative attitudes, preserve their identity because they did not trust the care providers, and avoid being reported to the police and for confidentiality purposes. This shows that the care providers have failed to build trust for MSM to seek HIV care services confidently. Consequently, MSM fail to reveal their orientation, influencing the services provided because the services might fail to address the specific challenges that the MSM are having, increasing their risk of HIV/AIDS exposure.

The current study showed that failing to reveal their orientation increased dissatisfaction since the care providers failed to address their needs adequately. This is supported by Mirza & Rooney (2018), who revealed that LGBT individuals failed to disclose their sexual orientation, affecting the quality of care they received (Mizra & Rooney, 2018). Revealing one's orientation gave greater satisfaction when not discriminated upon since an individual would access comprehensive and appropriate care (Mizra & Rooney, 2018).

MSM who did not feel comfortable revealing their orientation failed to visit healthcare facilities for HIV care. Several studies note that homosexuality is illegal; hence, a threat to MSM seeking genuine care. According to Hagopian et al., 2017, Nigeria imposed a death penalty for persons found engaging in consensual anal sex (Hagopian et al., 2017). In Ethiopia, DR Congo, Ghana, Swaziland, Botswana, and Lesotho, the act was considered immoral and indecent, punishable by law (Hagopian et al., 2017). In DR Congo and Angola, engaging in homosexual acts led to the disqualification of the professional practices of the men (Hagopian et al., 2017). In East African countries, Uganda, Kenya, Tanzania, Zambia, and Malawi, carnal knowledge was illegal and punishable by law, including 14 years in prison in Zambia and 30 years in Tanzania (Hagopian et al., 2017). These laws discourage MSM from seeking HIV medical care and revealing their orientation, as indicated by the study. MSM feared revealing their orientation because of the fear of the healthcare providers failing to keep confidentiality or reporting them to the police. Shangani et al. (2018) showed that MSM in Western Kenya greatly distrusted healthcare providers who judged and stigmatized them, discouraging them from seeking care (Shangani et al., 2018).

The current study showed that some MSM were chased away from the care facilities, verbally abused, or physically assaulted after revealing their orientation. These findings are supported by Kimathi et al. (2020) and Muraguri et al. (2015), who reported physical and verbal abuse towards the young MSMS seeking HIV/AIDS care (Kimathi, et al., 2020; Muraguri, et al., 2015). Verbal and physical abuses were reported in qualitative and quantitative studies, revealing the high prevalence of negative attitudes from the care providers towards MSM in Uasin Gishu County.

The participants in this study were primarily youths of ages 20-25 years old. The young MSM were exposed to increased discrimination from care providers while seeking HIV care. Similar findings were reported by Kimathi et al. (2020), who showed that young people faced

discrimination and violence while seeking HIV care (Kimathi, et al., 2020). Most of the youths had limited negotiation for condom use compared to older MSM since they had limited knowledge of HIV, attributed to limited access to HIV care and information (Kimathi, et al., 2020). This is shown in the current study, where young participants reported failing to use condoms because they did not like them, they felt it was unnecessary or due to the unavailability of the condoms. The participants had 2-4 mean numbers of sexual partners. This pattern was also reported by Embleton et al. (2015), who noted that young MSM on the streets had 3 to 4 sexual partners (Embleton, et al., 2015). The lack of HIV care and useful information gained by accessing proper healthcare contributes to these risky behaviors in young men.

4.2 Qualitative Analysis

Major concerns found included stigma and discrimination associated with gay sexual orientation, abuse while seeking HIV care, and negative attitudes discouraging MSM from seeking care. The current study found that MSM who sought care, mainly from the public hospitals, faced stigmatization and discrimination because of their orientation. This discouraged most of them from seeking affordable HIV care from government-sponsored hospitals. This hinders effective HIV with this sensitive population because seeking care from private hospitals could be expensive for them.

Further, some are discouraged from visiting any care facility due to this fear of stigmatization. These findings were supported by Ayhan et al. (2019), who found that care providers who portrayed discriminatory attitudes towards MSM discouraged them from seeking HIV care in healthcare facilities (Ayhan et al., 2019). Kimathi et al. (2020) also reported that MSM faced the risk of being ridiculed by the healthcare providers, discouraging them from seeking care from hospital (Kimathi, et al., 2020). To get care, some MSM reported hiding their identity to avoid the negative attitudes, making them access dissatisfied services.

Despite their efforts to access care, MSM are abused verbally and physically by the care providers, who associate homosexuality with sin and crime. From the analyzed transcripts, MSM were called insulting names, chased from the care facilities, and denied services. Such experiences make it difficult for the MSM to access care due to humiliation and possible injuries confidently. This was also reported by Kimathi et al. (2020) and Muraguri et al. (2015), who stated that young MSM seeking HIV care reported frequent physical abuse from healthcare providers (Kimathi, et al., 2020; Muraguri, et al., 2015). Shangani et al. (2018) also reported verbal abuse, especially in public hospitals (Shangani et al., 2018).

MSM are unable to access quality services that help address their HIV risks and issues adequately to fear of being humiliated. The current study indicates that as long as care providers view MSM as sinners and criminals, they would hinder the effective control of HIV. In Uganda, Kenya, Tanzania, Zambia, and Malawi, homosexuality is punishable by 14 years to 30 years imprisonment (Hagopian et al., 2017).

These findings express the effects of negative attitudes towards MSM, diluting the efforts by different organizations and the government to reduce HIV prevalence and associated complications in Kenya. Some MSM were married and living with women, showing the risks they put the rest of the population in, given their increased risk of contracting HIV. Care providers fail to recognize the effects of HIV in the MSM population and society at large. The study also revealed that MSM engaged in risky sexual behaviors that most preventive health initiatives target to control.

5. Limitations

Most of the participants were young, with a median age of 23 (21-23). Therefore, the results cannot be generalized to older age groups of the MSM population.

6.0 Conclusion

The study showed that HCP's attitudes were associated with HIV care-seeking behaviors of MSM. Most of the MSM reported visiting care facilities referred by other MSM. These were hospitals regarded as friendly due to the limited or absence of discriminatory attitudes displayed by the care providers. MSM-friendly care facilities included Pioneer health center, QI/FHOK, and MTRH. To address challenges faced when seeking care, MSM rely on referrals from other MSM regarding MSM-friendly hospitals. They also refrained from revealing their sexual orientation to the care providers to avoid being discriminated against or abused. MSM also preferred not revealing their sexual orientation to care providers due to fear of being reported to the legal authorities or exposed. Physical and verbal abuses were rampant in hospitals against MSM who revealed their orientation while seeking HIV care services.

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Conflicts of interest

The author declares no conflict of interest.

References

- Ayhan, C. B., Bilgin, H. H., Uluman, T. O., Sukut, O., Yilmaz, S., & Buzlu, S. (2019). A Systematic Review of the Discrimination Against Sexual and Gender Minority in Health Care Settings. *International Journal of Health Services* .
- Bhattacharjee, P., Isac, S., Musyoki, H., Emmanuel, F., Olango, K., Kuria, S., et al. (2020). HIV prevalence, testing and treatment among men who have sex with men through engagement in

virtual sexual networks in Kenya: a cross-sectional bio-behavioural study. *Journal of the International AIDS Society* , 32 (S2).

Embleton, L., Wachira, J., Kamanda, A., Naanyu, V., Winston, S., Ayuku, D., et al. (2015). “Once You Join the Streets You Will Have To Do It”: Sexual [Practices of Street Children and Youth in UasinGishu County, Kenya. *Reproductive Health* , 12 (106).

Feyissa, G, T; Lockwood, C; Woldie, M; Munn, Z. (2019). Reducing HIV-related stigma and discrimination in healthcare settings: A systematic review of quantitative evidence. *Plos One* , 14 (1).

Gerrish, K., & Lacey, A. (2010). *The Research Process in Nursing*. Blackwell Publishing.

Hagopian, A., Rao, D., Katz, A., Sanford, S., & Barnhart, S. (2017). Anti-homosexual legislation and HIV-related stigma in African nations: what has been the role of PEPFAR?. *Global health action*. 10 (1).

Kenya Law. (2010, August 27). *Kenya: The Constitution of Kenya*. Retrieved November 17, 2019, from Kenya Law Organization:

<http://www.kenyalaw.org/lex/actview.xql?actid=Const2010>

Kimathi, R., Mireku, M., J, K., L, D., H, M., A, I., et al. (2020). Factors influencing access of HIV and sexual and reproductive health services among adolescent key populations in Kenya. *International Journal of Public Health* , 65 (4), 425–432.

Mizra, A. S., & Rooney, C. (2018). *Discrimination Prevents LGBTQ People from Accessing Health Care*. Retrieved september 17, 2019, from Center for American Progress:

<https://www.americanprogress.org/issues/lgbtq-rights/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/>

Muraguri, N., Tun, W., Okal, J., Broz, D., Raymond, H. F., Kellogg, T., et al. (2015). HIV and STI prevalence and risk factors among male sex workers and other men who have sex with men in Nairobi, Kenya. *Journal of acquired immune deficiency syndrome (1999)* , 68 (1), 91–96.

Musyoki H et al. (2013). (2018) Changes in HIV prevention programme outcomes among key populations in Kenya: Data from periodic surveys. *PLoS ONE* , 13 (9).

NASCOP. (2020). *2020 KENPHIA 2018 Preliminary Report*. NAIROBI: NASCOP.

National AIDS Control Council . (2018). *County HIV Financial Profiles*. Nairobi: National AIDS Control Council .

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In B. A, & R. G. Burgess (Eds.), *Analyzing qualitative data* (pp. 173-194). London, UK: Routledge.

Ronoh, M; Chirove, F; Wairimu, J; Ogana, W. (2020). Evidence-based modeling of combination control on Kenyan youth HIV/AIDS dynamics. *15* (11).

Sanders, E, J; Jaffe, H; Musyoki, H; Nicolas, M; Graham, S, M. (2015). Kenyan MSMS: No Longer a Hidden Population. *AIDS* , 29, 195-199.

Shangani, S., Naanyu, V., Operario, D., & Genberg, B. (2018). Stigma and Healthcare-Seeking Practices of Men Who Have Sex with Men in Western Kenya: A Mixed-Methods Approach for Scale Validation. *AIDS patient care and STDs* , 32 (11), 477–486.

Spencer, L., & Ritchie, J. (1994). Qualitative data analysis for applied policy research. In B. R. Bryman A (Ed.), *Analyzing qualitative data*. (p. 173_94). London, UK: Routledge.

, 16 (3).