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Original Research Article

Reported Health Needs among Women Who Have Sex with Women in Dar-es-salaam, Tanzania: What Public Health Personnel and Primary Health Clinicians Should Know

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Abstract: Exiting empirical data on female homosexuality demonstrate women who have sex with women engage in risky sexual behaviors and practices that put them at risk of woman-to-woman transmitted infections and other same-sex sex health-related problems. However, the level of risk varies among women in same-sex relationship pending on sexual risk behaviors they engage in, posing differentiated perceived and real health needs. I present perceived health needs among women who have sex with women in Tanzania. Four qualitative methods were used to collect data: in-depth interviews, focus group discussions, collecting participants' life stories and observations. Data analysis deployed thematic approach where open systematic coding of data in the participants' language and combining emerging emic concepts with preconceived theoretical constructs was used. With the exception of the women who identify transgender men or tomboys, women interviewed reported having similar primary and specialized health needs like their counterparts. Transgender men reported in need of affordable sex toys, lubricants and trusted healthcare providers skilled to manage their specific health needs. Deep-rooted belief that homosexual females are at low risk of HIV and other STIs coupled with a lack of awareness of the link between female same-sex sexual practices and diseases informed the poor risk perception demonstrated by women studied. I recommend for larger ethnographic and multidisciplinary (longitudinal/cohort) studies, with different designs and nationally representative samples to assess women who have sex with women's health needs and wellbeing in the Tanzania context.

Keywords: Women who have sex with women, women's health needs, women who have sex with women's health risk behaviors and practices, female sexuality, qualitative field research, Tanzania.

INTRODUCTION

A review of literature on women who have sex with women's (WSW) health needs indicates they present specific health needs. WSW engage in a number of risk behaviors and are sexually active (Zaidi, *et al*., 2016). Most of them had their first sexual experience with a man (some at lower age of 9 years), have had multiple experiences with men or still have sex with men (Fethers, *et al*., 2000; Bailey, *et al*., 2003; Eowyn, 2011, ASHA, 2015; Zaidi, *et al*., 2016; Mbishi, *et al*., 2021). Some WSW report previous sexual contact with a homo/bisexual man (Fethers, *et al*., 2000, ASHA 2015). WSW report using and abusing drugs (Cloete, *et al*., 2010; Healthy People, 2020). HIV transmission is a risk between women through fingerling/fisting, oral sex and sharing sex toys (Zaidi, *et al*., 2016; ASHA, 205). However, the risk is lower than sex involving a man because less bodily fluids are exchanged between women (Avert, n.d).

Some WSW inject drugs or engage in sex work either regularly or occasionally (ASHA, 2015; Fethers, *et al*., 2000; Human Rights Watch/PEMA Kenya, 2015, Kamazima, *et al*., 2021a). Lesbians and bisexuals are more likely to be overweight or obese (Aaron, *et al*., 2001; Cochran, *et al*., 2001; Johnson, 2008; Johnson, 2008; Struble, *et al*., 2010; Knight &

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Jarret, 2017); lesbians and the transgender individuals in particular, have a high prevalence of HIV and STIs (Fethers, *et al*., 2000; ASHA, 2015; Knight and Jarret, 2017); discrimination, stigma, and internalized homo- and transphobia experienced by lesbians, gay, bisexual and transgender (LGBT) individuals in their daily lives are linked to mental health problems (Diaz, *et al*., 2001; Mravcak, 2006; Knight & Jarret, 2017; Morr, 2019); suicide (Kenagy, 2005); victimization (Whitbeck, *et al.*, 2004); bullying (Knight & Jarret, 2017) and other adverse health outcomes are common among WSW (Meyer, 2003; Herbst, *et al.*, 2010; Knight & Jarret, 2017).

WSW have the highest rates of tobacco, alcohol and drug use (Aaron, *et al.*, 2001; Cochran, *et al*., 2001; Johnson, 2008; Knight & Jarret, 2017; Healthy People, 2020) that increase the risk of type 2 diabetes, lung cancer, and cardiovascular diseases (White, *et al.*, 1997; Mravcak, 2006; Public Health England, 2018); suicide and self-harm (McDermott, 2015; Knight & Jarret, 2017); have lower rates of parity and thus less breastfeeding (Valanis, 2000; Cochran, *et al*., 2001; Johnson, 2008); have lower rates of contraceptives use (Valanis, 2000; Johnson, 2008); are less likely to have health insurance than heterosexual women, that affects their health seeking behaviors, healthcare access and healthcare services utilization (Cochran, *et al*., 2001, Johnson, 2008; National Gay and Lesbian Taskforce, 2009; Knight & Jarret, 2017) and WSW are at high risk of partner violence (Knight & Jarret, 2017; Bakar, *et al*., 2021). Tadele and Amde (2019) observed that lesbians in Addis Abba, "live under acute anxiety and fear of being exposed, or bringing shame and humiliation to themselves or their families".

WSW report having many-life sexual partners that increases their chance of contracting STIs, including HIV (Zaidi, *et al*., 2016; ASHA, 2015) and other sexual and reproductive complications. Just over two per cent of WSW who participated in one study reported needed alcohol or drugs in order to have sex, which was twice as high for non-binary and trans women (Rosario, 2008; Carvell, 2019). WSW engagement in risky sexual behavior, unsafe sex, could lead to unintended pregnancies (Fethers, *et al*., 2000; ASHA, 2015; Knight and Jarret, 2017); that could result into (unsafe) abortions (Bailey, *et al.*, 2003; Zaidi, *et al*., 2016). Rape is common among WSW and female same-sex couples (Cloete, *et al*., 2010; Bakar, *et al*., 2021). WSW have been reported raping other women or men (McKeever, 2018). 'Corrective rapes' where males rape LBT women to cure them from sexual orientations, lesbianism in particular, are on the rise in urban and rural South Africa (The Other Foundation, 2016) and similar cases are reported in the East coast Kenya (Human Rights Watch/PEMA Kenya, 2015) and in Dar es Salaam region, Tanzania (Bakar, *et al*., 2021). Studies conducted in the developed world demonstrate that WSW never disclose their sexual behaviors and practices to the healthcare providers (Zaidi, *et al*., 2016). Consequently, they miss diagnosis and treatment they dearly need (Gillepsie & Capriotti, 2016; Kamazima, *et al*., 2021b).

Perceived from the surface, WSW have the same sexual and reproductive health needs as any other women (Swish, nd.; Mayo Clinic Staff, 2017). However, they demonstrate some specific health concerns compared to straight/heterosexual women (Steele, *et al*., 2006; Rapid Response, 2014; Healthy People, 2020). For example, they are at risk of STIs due to the risky behaviors they engage in and poor services received at healthcare facilities they visit (Johnson, 2008). They need access to regular sexual health checkups and HIV testing. In Tanzania, a little is known about WSW's existence and lived experiences (Kamazima, *et al.*, 2021a; Kamazima, *et al.*, 2021c), and more so, on their health needs in their areas. In this paper, therefore, I present Tanzanian WSW's perceived and reported health needs.

MATERIALS AND METHODS

Study design and setting

Researchers conducted a cross-sectional descriptive formative study in Ilala, Kinondoni and Ubungo districts of the Dar-es-Salaam region, Tanzania between January and February 2021. The researchers purposely selected Dar-es-Salaam region because it is the largest commercial city in Tanzania, known to host people from diverse backgrounds, lifestyles and presenting wide range of sexual behaviors and practices (MoHSW/NACP, 2012). Dar-es-Salaam region, therefore, allowed easier access to study participants.

Study participants' recruitment

Due to the illegal context within which female same-sex behaviors are practiced in Tanzania, researchers used snowball method to recruit WSW aged 18 and above, had stayed in Dar-es-Salaam for six (6) months or more; have had sexual/physical attraction to other women, had engaged in same-sex sex in the past year or was in same-sex relationships; and knowledgeable of WSW's lived experiences. WSW's willingness to participate in the large behavioral and biological surveillance survey was an added advantage for inclusion in this study. Researchers used purposeful sampling method to recruit community leaders, community members and underground-operating NGOs/institutions' managers supporting LGBT in the study area as they are knowledgeable of issues around female same-sex relationships in their areas. Eligible women who, after several visits, were not available for arranged interviews or unable to participate in the study due to health conditions or unwillingness to consent were excluded from the study.

Methods and study tools

The main objective of this (unique and the first one in the country) formative study was to generate data to inform a planned larger national study: *"Behavioral and biological surveillance survey among women who have sex with women in Tanzania."* To generate such comprehensive data needed, researchers used four qualitative methods: focus group discussion (FGDs) with WSW; in-depth interviews (IDIs) with WSW and community leaders/members; observation (of openly presented female same-sex relationship-related behaviors and practices) throughout their stay in the study area; and documentation of WSW's life stories for qualitative information on motives, historical perspectives and same-sex experiences. The use of four methods of inquiry enabled the researchers to understand, recognize and appreciate female same-sex behaviors and practices from the WSW's perspective.

Focus group discussion (FGD): A focus group is a small-group (of between 6 and twelve relatively homogeneous individuals) discussion guided by a trained leader. It is used to learn about opinions on a designated topic, and to guide future action. Twelve WSW participated in each of the two FGD conducted and guided by the three research assistants (RAs) (a moderator, a time keeper and a recorder) and in Kiswahili, the Tanzania national language known and spoken by the participants. The RAs conducted the FGDs in Kinondoni District because it was reported harboring several recreational places frequented by and residence of majority of WSW (MoHSW/NACP, 2012). The RAs conducted FGDs in all-WSW supporting the NGOs/institutions or in places perceived convenient to the WSW invited to participate in the group discussions. With permission from the FGD participants, all FGDs were audio recorded. However, the recorder took short notes on emerging key issues to supplement recorded information. The average duration of the FGDs was one and half hours. However, as our participants had interest in this study, the two FGDs conducted took longer time, up to two hours.

Interviewing (IDI): is an optimal qualitative method for collecting data on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics are being explored (FHI360, 2005:2). Same-sex and female same-sex in particular is illegal in Tanzania making discussion around female same-sex sensitive that individuals would hesitate talking about openly. It is with this understanding that researchers applied different interviewing strategies to gather information needed for this study. Researchers conducted interviews in Kiswahili, the national language. Data generated from IDIs enabled capturing lived personal and general experiences created within and outside the WSW's-defined world.

The researchers conducted initial interviews with three leaders of WSW's organizations running services supporting all-WSW groups in the study area identified by a previous study on men who have sex with men (MSM) (Moen, *et al*, 2012). Through these initial interviews, we were able to identify participants in the FGDs we conducted in Kinondoni. Researchers conducted IDIs with eight WSW, three with community leaders, one with a male (businessman) community member and three with LGBT-NGOs managers. Three managers of NGOs/groups supporting WSW were interviewed three times each to clarify on issues that emerged from IDIs, FGDs and observations. The average duration of the IDIs was one and half hours. However, as our participants had interest in this study, some IDIs took longer time, up to two hours. With permission form the participants, all IDIs were audio recorded.

***Observation*:** observation method helps qualitative researchers to learn the perspectives held by study populations. In this study, researchers presumed that participants had multiple perspectives of female same-sex, which we were interested to understand the interplay between and among them. To accomplish this task, therefore, the research team conducted observations alone or both observing and participating, to varying degrees, in the study community's daily activities. The goal was, in regard to female same-sex, to learn what life is like for an "insider" while remaining, inevitably, an "outsider." While in these community settings, the research team recorded what they saw and informal conversations and interactions with members of the study population in as much detailed as possible. Researchers used data from observations in different ways: facilitate developing positive relationships (rapport) among researchers and key informants, stakeholders, and gatekeepers, whose assistance and approval were needed for this study to become a reality; identifying and gaining access to potential study participants; improving the IDI and FGD guides and facilitating the interpretation of data collected through interviews.

***Life stories*:** We collected life-stories [or personal account of informant's life and in her/his own words] of some WSW. Life stories allow the researcher to explore a person's micro-historical (individual) experiences within a macro-historical (history of the time) framework and challenge him/her to understand an individual's current attitudes and behaviors and how they may have been influenced by initial decisions made at another time and in another place (Ssali, *et al.*, 2015). Data from life stories enabled capturing personal experiences in the WSW's-defined and external worlds. Therefore, WSW's life stories collected facilitated the understanding of individual and general motives for a female's sexual or physical attraction to other women that would trigger long term relationships or same-sex marriages and the contexts within which female same-sex behaviors and practices are conducted in Tanzania. With permission form the participants, eight life stories collected were audio recorded.

Research assistants' qualifications, selection, training and roles

Researchers selected and trained three female RAs to assist in some aspects of this study: data collection and transcribing recorded interviews. The RAs held first degrees in social sciences, had good experience in conducting field research and with good probing skills. Researchers had worked with these RAs on other studies, specifically during the baseline human trafficking studies (Kamazima, 2009; Kamazima, *et al.*, 2016), the HIV Behavioral and Biological Surveillance Survey among Female Sex Workers in Dar-es-Salaam, 2010 (MoHSW/NACP, 2012) and cross-border cooperation along the Tanzania-Uganda border (2002 and 2017/2018). Researchers trained the RAs for five days to orient them on the objectives and procedures for this study. In addition, the RAs were made aware of the vulnerability of WSW and exposed to proper interaction and interviewing procedures/ethics with the study participants and all study tools were pre-tested among WSWs not included in the study. However, tools' pretesting results were used to modify the tool, mainly adding terms and concepts as known and used among the WSW's community.

Data Analysis

The RAs transcribed recorded IDIs and FGDs verbatim. Data was analyzed by using thematic analysis approach by applying five stages according to Braun and Clarke was performed to establish meaningful patterns: familiarization with the data, generating initial codes, searching for themes among codes, reviewing themes and presenting the results (Braun & Clarke, 2013; 2019); where open systematic coding of data in the participants' language and combining emerging emic concepts with preconceived theoretical constructs. Nvivo 12 version computer software was used to aid data analysis process data (Mangalakse, *et al*., 2004; Hannakaisa, *et al*., 2018).

Ethical considerations

Researchers applied and obtained research clearance for the study protocol from The Muhimbili University of Health and Allied Sciences (MUHAS) Institutional Review Board (IRB). The District Administrative Secretaries (DAS) granted permission to collect data needed in their respective areas. The Street authorities, managers of NGOs/institutions caring for WSW granted permission to conduct the study in their respective areas and institutions. The process of interacting with the study participants (interviewing and observing) had no harm to them (NOT putting them at higher risk of danger) and we kept their story telling to only needed information (NOT re-traumatizing them).

With permission of the participants all FGDs and IDIs were audio recorded. Due to the illegal status of female sex behaviors and practices in Tanzania, all study participants provided oral consent. Researchers anticipated chances of encountering cases of traumatized (potential) WSW, their relatives or fellow WSW. Researchers, therefore, arranged with the LGBT activist organizations and healthcare providers to provide appropriate assistance. Researchers compensated study participants with TShs, 10,000 [Appr. $4] for transport fare (to and from interview places) and for time spent during the interviews.

RESULTS

Profile of study participants

A total of 39 participants were selected and interviewed to generate data needed for this study; of whom two were men. Their ages ranged between 26 and 60 years. Participants' education level ranged from primary school education completed to tertiary level (college and university). All the WSW were currently single or in unstable same-sex relationships. Four WSW reported never married, and two were divorced. WSW who reported ever-given birth, had one to three children. Five of the eight WSW interviewed reported having sex with men and three of them reported regularly engaging in sex work (with men, women or both) for survival.

Reported WSW's health needs

During FGDs and IDIs researchers asked our participants to discuss on health problems they face and whether they perceived these problems similar to or different from those faced by their counterparts – the heterosexual women. With the exception of transgender men, the WSW studied perceived themselves having similar health needs like heterosexual women in the country. A participant aged 35, divorced, a female sex worker (FSW) and started engaging in same-sex sex at the age of 19 reported, "*We [WSW] are not different from those who do not engage in female same-sex sex [heterosexuals]… Hence, we suffer from common disease like other women in this country"* (IDI_B, 35 years, 2021). A participants aged 27, has O-level education, and has sex with men stated, *"My sister [the RA], we [WSW] are similar to other women in this country … Hence, our health needs are the same as those of heterosexual women … Malaria, fevers, stomachaches, headaches and sometimes magonjwa ya zinaa [STIs] …. I attend clinic at a public facility [name] to access family planning services [male condoms and pills (Pre-exposure prophylaxis, PrEP)]"* (IDI, A, 27 years, 2021).

A participant aged 28, never married, a bottom, with O-level education and has five years practicing same-sex sex, narrated, *"We [lesbians] have similar health needs like any other women … We are not different from heterosexual women … I am not sure if the transgender men who are undergoing transitioning treatment have different health problems … You better check with them … You should ask the one who introduced me to you [name]"* (IDI_E, 28 years, 2021). A community leader interviewed in Kinondoni observed, *"WSW are biologically similar to other women … They, therefore, have similar health*

needs like us [straight/heterosexual women]" (IDI_K, 60 years, 2021). A religious leader interviewed noted, *"WSW are like other women; hence, they have the same [health] needs like their counterparts … However, I might be wrong, you should get it from the horse's mouth [interview them]"* (IDI_I, 43 years, 2021).

Discussing on health needs for transgender men a participant aged 30, O-level education graduate, a diploma in information technology (IT) holder, never married, a transgender man and runs an NGO that supports WSW, had this to tell,

> "*As I have told you, I have never been attracted to men since I was young at the age of 10 [years] … I exclusively have sex with women … Three of us [names and places of residence] are currently undergoing hormonal treatment to become masculine … I am at the advanced stage of this process … The problem we face is the lack of specialized doctors to treat us … You know this treatment is very expensive and illegal in this country … The injections we take every three months are quite expensive … I get treated in Nairobi [Kenya] and South Africa [names of doctors and facilities] … Luckily, we have identified one doctor at [name of doctor and facility] who supports us in this process … We trust him … He keeps our treatment records a secret and advises us on the dos and don'ts during this period … He also orders injectable hormones for my colleagues who cannot afford travelling out of the country for treatment*" (IDI_C, 30 years, 2021).

Researches asked the study participants to comment on the impact of the 2017 and 2018 government orders banning community organizations from importing and distributing lubricants; conducting HIV outreach to LGBT people; and shutting down about 40 drop-in centers that provided health services to LGBT community including lubricants used during same-sex sex. A participant aged 35, started engaging in same-sex at the age of 19, divorced and engages in sex work, had this to say;

> *"As you may be aware, our [Tanzania] government banned importing lubricants … As a result, we use what is available for us … We use Vaseline jelly to avoid bruises from fingering or genital-genital contact … However, our doctor told us that the jelly is harmful to delicate membranes in the vagina … We plead the [Tanzania] government to lift the ban on lubricants importation for our safety"* (IDI_B, 35 years, 2021).

A participant aged 35, divorced, started engaging in same sex behaviors and practices at the age of 19 and engages in sex work, stated, "*As I told you, the [Tanzania] government banned importing lubricants some years ago … As a result, we use petroleum jelly, especially Vaseline jelly or cooking oil … We plead the government to lift this ban"* (IDI_B, 35 years, 2021). A participant in the FGD with WSW narrated,

> *"We know there are condoms for the fingers and the tongue that we would like to use whenever we have sex … However, they [protective gears] are so expensive and are not available in this country … You may remember, a few years back the [Tanzania] government banned importation of lubricants claiming their availability could fuel homosexual behaviors and practices among the citizenry … As a result, we have unprotected sex"* (FGD_1, 2021).

Reporting on the lubricants used by fellow WSW, a participant aged 26, identify a tomboy, never married and a university graduate narrated, *"I never use any lubricant … However, my colleagues claim using petroleum jelly … Vaseline or Baby Care … Others use coconut or cooking oil"* (IDI, F, 26 years, 2021). Reporting on the price of lubricants used, a participant aged 46, never married and engages in sex work, stated "*Vaseline jelly, cooking oil and coconut oil are sold at retail shops at a price of TShs. 5000 [appr. $2]*" (IDI_G, 46 years, 2021). Our study, unfortunately, had no power to establish the relationship between female same-sex sex practices and health-related problems. This is an area for further research in this direction.

DISCUSSION

WSW as defined in our study

In this study, researchers used the term "women who have sex with women" (WSW) referring to women who engage in same-sex sexual behavior, regardless of their identity (National LGBT Health Education Center, 2016; Kamazima, *et al*., 2021a; Kamazima, *et al*., 2021c). This definition is preferred because the focus was on WSW's behaviors and practices rather than labels (Knight & Jarrett, 2017) and the public health implications of same-sex relationships that develop from intimacy or sexual/physical attraction. Furthermore, "Not all women who have sex with women are lesbians … They might identify as span, bi, queer, straight, bi curious or gay … They might be cis gendered, trans or non-binary (National LGBT Health Education Center, 2016; Power, 2018: Brabaw, 2018). Moreover, it is known that "Women who don't identify as lesbians, bisexual, queer or even questioning often have had sexual relationships with other women" (Carvell, 2019).

Same-sex relationships in the Tanzania context

Like in many African countries, homosexuality or same-sex relationships are illegal in Tanzania (Kamazima, *et al.*, 2021a; Kamazima, *et al.*, 2021b; Kamazima, *et al*., 2021c). Thus, same-sex relationships/couples have no recognition on Tanzania Mainland (The Tanzania Penal Code of 1945 as revised by the *Sexual Offences Special Provisions Act, 1998*)

and Zanzibar (The Zanzibar Penal Code of 1934, as amended in 2004). Same-sex behaviors and practices, therefore, are crimes punishable on conviction by life imprisonment (URT, 1998; Petro, 2019; Kamazima, *et al*., 2021a; Kamazima, *et al*., 2021b; Kamazima, *et al*., 2021c). Consequently, receiving death threats and persecutions is normal for LGBT individuals making it a matter of survival to keep their homosexuality hidden and rarely reported on (Izugbara, 2020; Kamazima, *et al*., 2021a; Kamazima, *et al*., 2021b). Violence, rape, social exclusion (denial, rejection, stigma, and isolation), and discrimination characterize the daily life of individuals engaged in same-sex relationships in this country (Kamazima, *et al*., 2021b; Bakar, *et al*., 2021). This context has adverse effects to the WSW's health, healthcare and livelihoods (Ghoshal, 2020; Izugbara, 2020; Kamazima, *et al*., 2021b) triggering horror of facing difficulties accessing and utilizing healthcare services available in their areas (Kamazima, *et al.*, 2021a; Mbishi, *et al.*, 2021; Saronga, *et al*., 2021b).

The illegal context of same-sex relationships (female same-sex in particular), explains, in part, why there is no (public) research among this group in this country compared to countries where same-sex relationships are legal or tolerated. In addition, this fact explains why WSW in this country would be reluctant utilizing health care services available (Saronga, *et al*., 2021b). Consequently, this formative qualitative cross-sectional descriptive and retrospective study with WSW was unique, an eye-opener and of its kind on women's sexuality in Tanzania.

WSW-perceived and reported Health needs

Scholars are divided on lesbian's (including WSW) health needs. On the one hand, some scholars present that WSW are a unique group that has different health needs and coping strategies compared to their counterparts (National LGBT Health Education Center, 2016; Fritz, 2016; Knight & Jarret, 2017; Public Health England, 2018; Tadle & Made, 2019); face differentiated barriers accessing healthcare services (Jonnson, 2008; Rapid Response, 2014; Knight & Jarret, 2017) and require lesbian-friendly environment as they seek healthcare (Johnson, 2008; Rapid Response, 2014). In these scholars' view, lesbians require a LGBT-friendly environment (social, cultural, political and health systems) to cater for their health needs.

On the other hand, some scholars like Swish, (nd.); Cochran, (2007) and Mayo Clinic Staff, (2017) observed that as a basic principle, most health concerns of WSW (lesbians) are comparable to those of heterosexual women. That is, WSW have the same sexual and reproductive health needs as any other women. Pebody, (2019) claimed, the risk of female-to-female sexual transmission is extremely rare, with only a handful reported cases; HIV-positive women who identify as lesbian may have acquired HIV through injecting drug use or sex with men and transmission is possible through sharing of sex toys and exposure to blood during sex. In Pebody's view, WSW face similar risk as the rest of the population and do not require unique care in this respect.

The American College of Obstetricians and Gynecologists (2012) observed "There are no known physiologic differences between lesbians and heterosexual. There may, however, be health risk behaviors or health risk factors that are more common among lesbians and bisexual women that have health consequences." However, Cochran, (2007) recognized four issues that differentiate lesbians from heterosexual women. First, lesbians, different from heterosexual women, do not practice penile–vaginal intercourse, and may not be aware that same-sex behaviors and practices put them at risk for diseases. Second, lesbians who wish to become mothers may face difficulties accessing normal mode of getting pregnant. Third, there is limited research on chronic illness and mental health issues among lesbians compared to their counterparts. Finally, lesbians live in an inimitable psycho-social-economic environment.

In our study, the transgender men undergoing transitioning treatment considered themselves having specific health needs not experienced by other categories of WSW and straight women. They reported in need of transitioning treatment (hormone and gender-affirming surgeries) performed by a specialized doctors they trust. Their concern was that there are few doctors with this specialization, which forces them to seek treatment out of the county, mainly in Kenya and South Africa. One of them reported receiving treatment in the United States of America (U.S.A.). The tomboys and transgender men reported difficulty accessing substances they need for same-sex sex such as lubricants and dental dams in particular. Whenever they are available in undercover shops and pharmacies, they are too expensive over and above the WSW's purchasing powers; which forces them to practice unsafe same-sex sex (Kamazima, *et al*., 2021b; Saronga, *et al.*, 2021a).

In 2019, for example, the then Deputy Home Affairs Minister and other government officials threatened to conduct mass arrests of LGBT people (Human Rights Watch, 2020; KTV TZ Online. 2019]. Through the then Ministry of Health, Community Development, Gender, Elderly and the Children (MoHCDGEC), in October 2017 and February 2018, the Tanzania government banned community organizations from distributing lubricants and conducting HIV outreach to LGBT people. In addition, the government shut down about 40 drop-in centers that provided health services to LGBT society and other key populations (female sex workers, FSWs; and people who use drugs, IDUs) in the fight against HIV (Goshal, 2020). The Human Rights Watch (2020) reported that

Tanzanian police engage in widespread abuse of LGBT citizens and pro-LGBT media outlets have been shut down by the government. This crackdown denied the WSW access to free lubricants and other services meant for them.

Ostensibly, "When police have conducted arrests, they have sometimes instructed medical professionals to conduct forced anal examinations to collect "evidence" of anal intercourse [which] have no scientific basis and are a form of cruel, inhuman, and degrading treatment that can amount to torture" (Goshal, 2020; Human Rights Watch ,2020; Human Rights Watch. 2021). As Saronga, *et al*., (2021a) have indicated, safe sex among WSW can be achieved through use of protective barrier methods such as condoms, use of latex gloves for digital penetration, use of dental dams (a latex sheath (square) that serves as a barrier or protection against STIs during oral sex), and cleaning sex toys before reuse or other partner's use.

With the exception of the tomboys and transgender men, our study participants perceived themselves similar to and have analogous health needs like other (heterosexual) women in the country. However, they recognized one issue that differentiates them from their counterparts, engaging in same-sex behaviors and practices that are socially, culturally and legally unaccepted (Kamazima, *et al*., 2021b). The fact that WSW studied were unaware of health risks they face by engaging same-sex sexual behaviors and practices (Kamazima, *et al*., 2021c; Mbishi, *et al.*, 2021), explains, in part, why they considered themselves having similar health needs like other women in the country. This perception roots in the myth held by the WSW, (public) health professionals and some members of the public that female same-sex practice has low rates of disease (STIs, including HIV) development and transmission or that it is completely risk-free (Fethers, *et al.,* 2000; Muzny, *et al*., 2013; Muranda, *et al*., 2014; ASHA, 2015).

Through interviews with recruited study participants, like other WSW in other parts of the globe (Muzny, *et al*., 2013; Kowalczyk & Nowosielski, 2019), demonstrated low understanding and awareness on health-related problems linked with female same-sex behaviors and practices. Majority of interviewed WSW cited never experienced any STI like gonorrhea in their lifetime of female same-sex sex, those who had had such infections associated them with sex with men. In their view, they only experienced other commonly occurring diseases which include Malaria and urinary-tract infections (UTIs) unrelated to their sexual activities (Muzny, *et al*., 2013; Kowalczyk & Nowosielski, 2019; Mbishi, *et al.,* 2021). The implication is that WSW in the study area may be facing health problems they do not associate with their sexual behaviors.

Not being aware of female same-sex sex heath implications does not mean WSW in Tanzania are free from risks associated with their sexual behaviors and practices they reported. These WSW are at risk of STIs (including HIV) transmission and the risk could vary by specific infection and type of sex: oral-genital sex; vaginal or anal sex using hands, fingers, or penetrative sex toys; and oral-anal sex (ASHA, 2015). Studies indicate that the prevalence of bacterial vaginosis estimates are significantly higher for WSW than exclusively heterosexual women; WSW demonstrate *Bacterial Vaginosis* (BV) prevalence of 20-50% (ASHA, 2015). In addition, lesbians are 3 to 4 times more likely than heterosexual women to have sex with men who were at high-risk for HIV (Eowyn, 2011).

WSW, and those studied in particular, engage in risky behaviors such as: oral sex (oral vagina or anus sucking), which increase risk if a woman has cuts or sores in her mouth, or if the partner receiving oral sex has sores on her genitals or is having her period; sharing sex toys that have vaginal fluids (juice), blood or feces on them; rough sex that could lead to bleeding or cuts/breaks in the lining of vagina or anus; and donor insemination, mainly when the donor has not tested for STI/HIV infected. Consequently, WSW need to use protective gears like dental dams or condoms cut open and spread to stop any vaginal fluid, menstrual blood, and feces from getting into the mouth; avoid sexual activities (sadomasochism or fisting, for example) that could lead to bleeding, cuts or breaks in the vagina or anus lining.

Similarly, WSW studied are at risk of a number of STIs (Gillepsie & Capriotti, 2016) including: thrush, BV, genital warts, trichomonas vaginalis (TV), chlamydia, gonorrhea, herpes, crabs, pubic lice, syphilis and hepatitis. Women-to-women transmission of these STIs can occur through: skin-to-skin contact, mucous membrane contact, vaginal fluids, menstrual blood, sharing sex toys and semen from STI/HIV- infected male donor. The implication is that WSW in Tanzania need steady screening for genital, oral or oropharyngeal HPV infection, genital herpes, BV, Chlamydia trachomatis, Neisseria gonorrhea, trichomoniasis, and HIV. In addition, given the illegal status of female same-sex relationship in the country, WSW hesitate seeking and utilizing healthcare service available. As a result, they lack regular Pap-tests increases risks of cervical cancer; lack regular mental health diagnosis and treatment; lack regular mammograms that increases risk of breast cancer and checkups for other forms of cancer. Kamazima, *et al.*, (2021d) reported that for varied reasons, WSW practice vaginal douching (VD) that involves flushing out the inside of the vagina with water or a solution of water mixed with vinegar, baking soda, iodine, lime/lemon juice, yogurt or homemade concoctions. VD researchers have presented this practice has adverse effects to women's health and

wellbeing that could need specialized care and skills to treat/cure.

Similarly, due to stigma, discrimination; and criminalization of female same-sex activities in the country, put WSW at risk of violence, depression, suicide, anxiety, substance (drugs and alcohol) use and abuse, smoking and sedentary behaviors that lead to overweight or obesity. More important, perhaps is that healthcare providers may lack professional skills to handle WSW's health needs. WSW, therefore, miss diagnosis, specialized care and psychotherapy they dearly need.

Some of the WSW studied reported were at various stages of gender transition and struggled to identify with one of the WSW-identified categories. Some expressed themselves as a sex different from that assigned at birth (Gillepsie & Capriotti, 2016). One of them was a transsexual individual (had undergone a permanent, surgical sex change). Others identify transman [born female who has undergone hormonal and/or surgical treatment for sex reassignment as a male, (FtM)]. Some identify transwoman [born male who has undergone hormonal and/or surgical treatment for sex reassignment as a female, (MtF)]. Transgender persons, therefore, lack specialized care providers to offer them specific types of surgical procedures and hormonal treatment they need, which force them to cross borders to Kenya, South Africa, Europe and the USA to access (very expensive) treatment and procedures.

CONCLUSION AND RECOMMENDATIONS

Our qualitative formative study was an eyeopener and the first one in Tanzania focusing on WSW's existence and wellbeing. Our study just scratched the surface of the enquiry on women sexuality in this country. Homosexuality is illegal in this country and behaviors and practices associated with same-sex sex are crimes punishable on conviction by life imprisonment, which explains limited studies conducted among these women in the country. A deep-rooted belief that WSW area at low risk of HIV and other STIs' woman-to-woman transmission coupled with a lack of awareness of the link between female same-sex practices and diseases, informed the poor risk perception demonstrated by WSW studied and limited investment in studies with this group in this country.

Only the transgender men and tomboys reported having unique health needs: they need specialized and expensive surgeries and hormonal treatments that are not available in the country. Transgender men seek these services outside the country in Kenya, South African, USA and Europe. Similarly, transgender men lack trusted specialists and psychotherapists to assist them in the gender transitioning process. Like WSW in other parts of the globe, WSW in Tanzania perceived female same-sex sex risk-free and did not associate health problems they face with their sexual risk behaviors. Findings from our study are not exhaustive to allow us to conclusively present WSW's health needs.

However, inferring from studies conducted in the developed world suggest that WSW in this country have specific health need well and above those of their counterparts in terms of both (inclusive, equitable and cost-effective) primary (including health promotion, disease prevention, diagnosis, treatment, rehabilitation, palliative care and reproductive health) and specialized (hormone therapy, gender-affirming surgery) care. To reach this goal, I recommend the Ministry of Health (MoH) to initiate, support and encourage larger ethnographic and multidisciplinary (longitudinal/cohort) studies, with different designs and nationally representative samples to assess WSW's health needs and wellbeing in the Tanzania context.

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