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Original Research Article

Healthcare Seeking Behavior among Women Who Have Sex with Women in Dar-es-Salaam, Tanzania: A Public Health Lens

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Abstract: Little is known about sexually minority women's health and wellbeing in the developing countries like Tanzania. Hence, there is limited knowledge of these women's health seeking behaviors and pathways they take to rectify their ill conditions. The study investigated on women who have sex with women's health seeking behaviors and pathways they take to remedy ill conditions they face. Data presented in this paper are part of a cross-sectional descriptive and retrospective formative qualitative study among women who have sex with women conducted in Dar-es-Salaam region. Researchers used focus group discussion, in-depth interviewing, observation and collecting women's life stories to generated data needed for this study. Women who have sex with women in Dar-es-Salaam come from all backgrounds and experience unique primary and specialized healthcare needs different from their counterparts. Social and legal strictures against homosexuality coupled with widespread heteronormativity put women who have sex with women at risk of overt or covert stigma and discrimination in the healthcare system. Illegal status of homosexuality in this country shapes differentiated health seeking behaviors and pathways among sexually minority women. Healthcare providers are reported discriminating and stigmatizing transgender men and tomboys forcing them to avoid vising public health facilities. I recommend the Ministry of health to initiate and support multidisciplinary, comprehensive and informative health research among women who have sex with women and use findings to facilitate improving women who have sex with women's health and healthcare professionals' ability to diagnose, treat, control, and prevent illnesses among this group.

Keywords: Women who have sex with women, lesbians, wellness behavior, health seeking behavior, women's health, qualitative research, Tanzania.

INTRODUCTION

A review of literature available indicates that globally, sexually minority women – lesbians and bisexual – encounter varied complex and interconnected barriers that limit them from accessing quality and equitable healthcare [1-8]. Some of the reported barriers these women face include, but not limited to: stigma, discrimination, prejudice, isolation, mental health, depression and anxiety [9]. The women who have sex with women (WSW), therefore, have worse health experiences (multiple health disparities) that have adverse impact on their healthcare access, health services uptake and health outcomes [9-12] and may delay healthcare seeking and screening [13].

Knight and Jarret [6] contend, "WSW face a variety of barriers to optimal health, including a history of negatively perceived interactions in clinical settings that lead them to delay or avoid healthcare and disparities can exist throughout the lifetime". In addition, lesbians, including WSW, are concerned with confidentiality and disclosure, discriminatory attitudes and treatment, and have limited understanding as to what their health risks may be [3]. Tadele and Made [8] 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" that could limit their access to proper healthcare services available.

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Researchers report WSW have lower rates of contraceptives use [10, 14]; are less likely to have health insurance than heterosexual women [6, 10, 15, 16]; and are at high risk of partner violence [6, 17]. In addition, WSW have low rates of healthcare services utilization available and when they do, they never disclose their sexual behaviors and practices to the healthcare providers [18]. Consequently, they miss diagnosis and treatment they dearly need [19].

It is clear that WSW have the same sexual and reproductive health needs as other women but they are at risk of STIs due to the risky behaviors they engage in and poor services received at healthcare facilities they visit [10]. WSW need access to regular sexual health checkups and HIV testing. In Tanzania, a little is known about factors that influence WSW's health seeking behaviors and lived experiences with healthcare system [19-21] and more so on their health needs, their engagement in wellness behaviors and utilization of healthcare services found in their areas. In this paper, therefore, I present WSW's reported health seeking behaviors and pathways they take for the sake of remedying ill conditions they face in Dar-es-Salaam, Tanzania.

METHODS AND MATERIALS

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 [22]. 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. Researchers used purposeful sampling method to recruit community leaders, community members and underground-operating NGOs/institutions' managers supporting lesbians, gay, bisexual and transgender men and women (LGBT) in the study area as they are knowledgeable of issues around female same-sex relationships in their areas. Eligible women who, after three visits, were not available for arranged interviews or unable to participate in the study due to health conditions 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 on motives, historical perspectives and same-sex sex experiences. The use of four methods of inquiry enabled the researchers to understand, recognize and appreciate female same-sex sex behaviors and practices from the WSW's perspective.

Focus group discussion (FGD):

A focus group is a small-group (of between six 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 FGDs conducted and guided by the three research assistants (RAs) (a moderator, a time keeper and a recorder) and were conducted in Kiswahili, the Tanzania national language known and spoken by the participants. Questions on the FGD guide focused on WSW's issues including their profiles, public's perceptions of WSW; and the WSW's lived experienced within the Tanzania context. The RAs conducted the FGDs in Kinondoni District because it was reported harboring several recreational places frequented by and residence of majority of WSW [22]. 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 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 [23]. Same-sex relationship, and female same-sex 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 supporting all-WSW groups in the study area identified by a previous study on men who have sex with men (MSM) [24]. Through these initial interviews, researchers were able to identify FGDs participants 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, life stories and observations. The average duration of the IDIs was one and half hours. However, as 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 they were interested to understanding 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 [25]. 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 FGDs, IDIs and life stories. 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 [26, 27], the HIV Behavioral and Biological Surveillance Survey among Female Sex Workers in Dar-es-Salaam, 2010 [22] 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. 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 FGDs, IDIs and life stories 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 [28, 29]; 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.

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, IDIs and life stories were audio recorded. Due to the illegal status of female same-sex 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

Profiles 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. Of the seven WSW interviewed, five reported never married, 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 seeking behaviors

During FGDs and IDIs researcher asked participants to discuss on what they do when they feel unwell or having ill-health. 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 … Whenever we fall sick, we seek for care provided at public and private health facilities in the city"* (IDI_B, 35 years, 2021).

A participant 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 … Whenever we feel unwell, we seek care from facilities in this area … Those who can afford go to private facilities [names]… For example, I attend clinic at a public facility [name] for malaria, fevers, stomachaches, headaches and sometimes magonjwa ya zinaa [STIs] … I also access family planning services [male condoms and pills (Pre-exposure prophylaxis, PrEP)]at this facility [name]"* (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 … So, whenever we fall sick, we visit public facilities in the city* (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] and seek healthcare at public or private health facilities as other women do"* (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 and seek healthcare the same way other women do"* (IDI_I, 43 years, 2021).

A participant aged 35, divorced, a FSW and started engaging in same sex at the age of 19 reported,

> "*Whenever we feel unwell, we visit the nearby [public] health facility [name] for treatment … You know we are not different from other women in this country … Look at me, I dress and behave feminine, hence, no one can associate my appearance with female same-sex relationship … So, we receive healthcare like any woman … I have never experienced any problem at the facilities I have visited … It is only when the doctors and nurses identify your sexual orientation, they discriminate against you"* (IDI_B, 35 years, 2021).

Discussing on the category of WSW that faces discrimination at the health facilities, the same participant reported, *"However, the transgender men and tomboys report facing discrimination from the doctors and nurses due to their physical appearance and behaviors [dress and present masculine] that make them easily detected by the healthcare providers … To avoid such embarrassments, the tomboys opt for self-medication, buying medicine from nearby pharmacies or visit private health facilities [names]"* (IDI_B, 35 years, 2021).

A participant aged 26, never married, a university graduate, and present a transman reported,

> *"We [the tomboys and transgender men] face a lot of problems whenever we visit the public health facilities like [names] … The healthcare providers openly discriminate against us from our appearance [dressing]…. Sometimes a doctor or a nurse calls colleagues to witness the case he or she has encountered …. Often, they speak the language [probably English] we do not understand … So, to do away with such embarrassments, whenever we are unwell, we wait for the pain to go away … If pain persists, we buy medicines from the pharmacies or visit the private hospitals [names] where the doctors and nurses have no time to discuss*

their clients' appearances" (IDI_ F, 26 years, 2021).

A participants aged 27, has O-level education, and has sex with men stated, *"I have no difficulties visiting any health facility in this area because I present and appear feminine [dressing and appearance] No one can tell I am a lesbian … I have never disclosed my sexual behaviors [orientation] to any health worker or relative … So, I am free to visit any health facility"* (IDI, A, 27 years, 2021). Presenting on the category of WSW that faces some difficulties visiting public health facilities, the same participant said,

> *"The situation is quite different for the tomboys and transgender men … They report facing embarrassments and discrimination from healthcare workers …. For example, if a tomboy has a boil on the outer vagina [labium majus or labium minus] will have to undress for the doctor's examination … The doctor will notice the mismatch between the patient's appearance and the sex [appears male, but is a female] … Some doctors and nurse would pretend to lecture and judge them [yielding and blaming] on their bad behaviors [transitioning] … Some doctors go a country mile calling their colleagues to witness the case at hand … Such words and actions from the health workers strongly embarrass the tomboys … Some [tomboys and transgender men] leave the premises without completing treatment cycle [lab tests or collecting medicines from the pharmacy, for example] … As a result, the tomboys and transgender men rarely visit public health facilities … When they fall sick, they either treat themselves, buy medicines from the pharmacies … Those who can afford, visit private hospitals like [names]"* (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, *"Whenever I fall sick, I visit the public health facility [name] … I present a female, so no doctor or nurse can doubt my behaviors … I never tell them I am a lesbian … So, they handle me as any other citizen"* (IDI_E, 28 years, 2021). Discussing the tomboy's and transgender men's experiences, the same participant narrated,

> *"It is a pity, the tomboys and transgender men face difficulties utilizing healthcare service available at public facilities …. Once the doctors and nurses recognize they are females transitioning to men, they develop hatred against them … Sometimes they [doctors and nurses] yell at them and openly present discriminatory behaviors towards them [tomboys and transgender men] …. Tomboys and transgender men, therefore, rarely visit these facilities [names] … They depend on self-medication, buy medicines from the pharmacies or seek services from private facilities [names]"* (IDI_E, 28 years, 2021).

A community leader interviewed in Kinondoni observed, *"As I have told you, WSW are not different from us [straight/heterosexual women] … I am sure when they fall sick, they go to the nearby public health facility [name]; buy medication from the pharmacies [names]and those who can afford, go to the private hospitals like [names]"* (IDI_K, 60 years, 2021). A religious leader interviewed noted, *"I hope whenever they [WSW] fall sick, they seek help from any source [self-medication, pharmacy, health facility] given the nature of the [health] problem they face"* (IDI_I, 43 years, 2021).

DISCUSSION

WSW defined and Tanzania context

Globally, WSW are recognized belonging to different categories depending on the context within which reference is made [30-35]. In Tanzania, WSW are collectively and commonly referred to as "*wasagaji*" or lesbian [20, 36-38]. In this study, however, 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 [5, 20]. This definition is preferred because the focus is on WSW's behaviors and practices rather than labels [6] 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 [5, 39, 40]. 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" [41].

Homosexuality or same-sex relationships are illegal in Tanzania [19, 20, 37, 42]. Thus, same-sex relationships or 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 [43, 44]. WSW, therefore, conduct their behaviors underground keeping their homosexuality hidden and rarely reported on [19, 20, 42].

The illegal status of female relationships has adverse effects to the WSW's health, healthcare and livelihoods [19, 45] and terror of utilizing healthcare services available in the country is high among the transgender men and the tomboys [21, 46]. In addition, violence, rape (including WSW correction rape), social exclusion (denial, rejection, stigma, and isolation), and

discrimination characterize the daily life of individuals engaged in same-sex relationships in this country. Unfortunately, WSW rarely seek medical support for these conditions [17, 19, 42].

WSW's health seeking behaviors pathways

Health or care seeking behavior is any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy [47, 48]. In this perspective, therefore, health seeking behavior is preceded by a decision-making process that is further governed by individuals and/or behavior, community norms, and expectations as well as provider-related characteristics and behavior [49]. Consequently, client-based factors, provider-based factors, caretaker perceptions; social and demographic factors, cost, social networks, biological signs and symptoms, community connectedness [1, 9] work synergistically to produce a pattern of health seeking behavior. For this reason, the nature of care seeking is not homogenous depending on cognitive and noncognitive factors that call for a contextual analysis of care seeking behavior. Context may be a factor of cognition or awareness, sociocultural as well as economic factors [50].

The study participants reported different actions they take whenever they experience ill-health. Some WSW wait for the symptoms to go away, turn to self-medication; or buy medicines from the pharmacies. When symptoms persist, some WSW seek care from public health facilities in their areas. The transgender men and tomboys reported opting for self-medication, buying medicines from trusted pharmacies and seeking care at private facilities and by a trusted practitioner. The transgender men and tomboys reported experiencing discrimination and negative attitudes from the nurses and doctors at public facilities they visit [21], which forces them to shun from visiting these facilities in the future.

Healthcare providers' negative attitude to the WSW reported could be attributed to the lack of skills (from medical college and on-the-job trainings) to handle WSW's unique health needs, the heteronormativity influence, and adherence to homosexual legal and social normative. Indeed, the illegal nature of female same-sex in the country explains, in part, why there is limited public research among this group in this country and poor healthcare professionals' understanding of these women's health needs and their health seeking behaviors. As Hughes and Evans [51] correctly observed, lack of information on WSW has contributed to "A lack of awareness among healthcare professionals about these [WSW's healthcare] needs [that] may lead to ill-informed advice and missed opportunities for the prevention of illness."

The public health importance of WSW's health seeking behaviors

Similar to The Institute of Medicine [1] observation, this study confirmed that WSW or lesbians in Tanzania are found among all subpopulations of women. Lesbians are as diverse as the general population of all women, and they are represented in all regions of this country, all socioeconomic strata, and all ages [20]. In the author's view, and as observed from this study, there is no single type of family, community, culture, or demographic category characteristic of WSW/lesbian women in this country. The public health importance and medical consequence of risky behaviors the WSW engage in have been detailed in studies like Rapid Response [4]; McNair & Bush [9]; Saronga, *et al*., [21]; Mayer [52]; Cloete, *et al*., [53]; Xu, *et al*., [54]; Eowyn [55]; ASHA [56]; Kamazima *et al*., [57]; Saronga, *et al*., [58]; Mbishi, *et al*., [59].

It suffices to note that from the public health perspective, there is need for all [(public) health professionals, policy makers and the public] to recognize the existence of WSW or lesbians and their varied primary and specialized health needs (sexual, reproductive and mental health, hormonal and gender confirming surgeries, for example), health seeking behaviors and service utilization and link them to appropriate and WSW-sensitive healthcare and pyscho-social services (including HIV, STIs and other health problems) for disease prevention, control and treatment.

CONCLUSION AND RECOMMENDATIONS

This qualitative formative study was an eyeopener and the first one in Tanzania focusing on WSW's existence and wellbeing. The study just scratched the surface of the enquiry on women's sexuality in this country. Homosexuality is illegal in this Tanzania and behaviors and practices associated with same-sex sex are crimes punishable on conviction by life imprisonment. Indeed, the illegal nature of female same-sex in the country explains, in part, why there is limited (public) research among this group in this country and poor healthcare professionals' understanding of these women's health needs. Social and legal strictures against homosexuality coupled with widespread heteronormativity in the health system make WSW (the transgender and tomboys in particular), one of the most marginalized at-risk groups in Tanzania. Poor healthcare providers' knowledge of their sexual orientations would jeopardize the quality of care for WSW.

Only the transgender men and tomboys reported having unique health needs and face difficulties accessing and utilizing healthcare services available in their areas. 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 behaviors. WSW who present feminine reported accessing and utilizing healthcare

services like other women in the country. Findings from this study are not exhaustive to allow us to conclusively present WSW's health seeking behaviors shaped by the context within which healthcare decisions are made in this country.

To reach this goal, I recommend further multidisciplinary, comprehensive, and informative (public) health research among WSW to generate data that would facilitate improving healthcare professionals' ability to diagnose, treat, control, and prevent illnesses among WSW in the Tanzania context. In addition, these studies could focus on testing the applicability of health seeking behavior theories including: the health belief model (HBM), theory of planned behavior, trans-theoretical model, and the theory of care seeking behavior that may explain factors affecting WSW's health seeking behaviors thus informing the varied pathways they take, which public health personnel and primary healthcare providers should recognize for improved healthcare for WSW in the Tanzania context.

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