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**PERCEPTIONS AND FACTORS INFLUENCING ACCESS
TO HEALTH CARE SERVICES OF MEN WHO HAVE
SEX WITH MEN IN KIGALI CITY**

Thesis submitted to the Faculty of
Arts, Media and Social Sciences in
partial fulfillment of the requirements
for the Master's Degree in
Development Studies from the
University of Rwanda

By
Eugenie INGABIRE

Supervisor: Dr. Simeon WIEHLER

Kigali, July 2014

DECLARATION

I do hereby declare that this thesis titled “**PERCEPTIONS AND FACTORS INFLUENCING ACCESS TO HEALTH CARE SERVICES OF MEN WHO HAVE SEX WITH MEN IN KIGALI CITY**” submitted in partial fulfillment of the requirement Masters of Development Studies, at University of Rwanda, is my own work and effort to the best of my knowledge; it has not been submitted anywhere for any award. Where other sources of information have been used, they have been acknowledged.

Signature:

Eugenie INGABIRE

Date:

APPROVAL

This is to certify that Eugenie INGABIRE has carried out a research work titled **“PERCEPTIONS AND FACTORS INFLUENCING ACCESS TO HEALTH CARE SERVICES TO MEN WHO HAVE SEX WITH MEN IN KIGALI CITY”**.

Signature:

Dr. Simeon WIEHLER

Research supervisor

Date.....

ABSTRACT

Men who have sex with men have unique experiences and circumstances that affect their physical and mental health needs as well as their access to high-quality health services. This study examines perceptions and factors influencing access to health care services available to men who have sex with men in Kigali City. The study explores also the attitudes of health care providers, perceived benefits and barriers to access to health services as well as strategies to enhance this access.

To make sure that the findings are robust, a participatory and anthropological methodology was used to build relationships of trust with 40 sampled men who have sex with men in Kigali City. Additionally, 20 health care providers were interviewed to compliment the information received from men who have sex with men. The ages of men who have sex with men ranged from 20 to 35 years.

The primary data showed that 55% of respondents reported having a secondary school level of education; 15% have had sex with other men for more than 10 years and only 27.5% report always using condoms, while 55% reported also being interested in having sex with women. In terms of factors influencing access to health care services, the findings revealed that stigma by other patients and health care providers was respectively 50% and 20%; 78.9% fear to be recognized as MSM when they access health services, and 40% complain about the long distance to reach an MSM-friendly health facility. In general, men who have sex with men are satisfied with the quality of health services (82.5%).

Results from the study contribute to the literature on men who have sex with men and support the need for scaling up health services to MSM and its integration in the existing health system in Rwanda.

DEDICATION

To the Almighty God for His unconditional love and mercies

To my late father

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ACRONYMS

AIDS	: Acquired Immunodeficiency Syndrome
ANC	: Ante Natal Care
APA	: American Psychological Association
ART	: Anti-Retroviral Therapy
CDC	: Centre for Disease Control and Prevention
CNLS	: Commission Nationale de Lutte contre le SIDA
DHS	: Demographic and Health Survey
DoH	: Department of Health
DRC	: Democratic Republic of Congo
FGD	: Focus Group Discussion
GBV	: Gender Based Violence
HBM	: Health Belief Model
HC	: Health Centre
HIV	: Human Immunodeficiency Virus
HMIS	: Health Management Information System
ICAP	: International Center for AIDS Care and Treatment Programs
IEC	: Information Education Communication
IGA	: Income Generating Activities
MDG	: Millennium Development Goal
MoH	: Ministry of Health
MSM	: Man who have sex with men
MSMGF	: Global Forum for men who have sex with men and HIV
NGO	: Non-Government Organization
NSP	: National Strategic Plan
RBC	: Rwanda Biomedical Center
RwF	: Rwandan Franc
SGBV	: Sexual and Gender-Based Violence
SRH	: Sexual and Reproductive Health
SRHR	: Sexual and Reproductive Health Rights

STIs : Sexually Transmitted Infections
TB : Tuberculosis
UNAIDS : Joint United Nations Programme on HIV and AIDS
VCT : Voluntary Counseling and Testing
WHO : World Health Organization

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CHAPTER I: INTRODUCTION

1.1 Background of the Study

1.1.1 Introduction

According to Maslow (1943), the needs of human beings can be ranked in a hierarchical order. Sexuality is one of the needs that human beings require to enjoy complete fulfillment. A state of wellbeing in relation to sexuality across life involves physical, emotional, mental, social, and spiritual dimensions. This is an inextricable element of human health and is based on a positive, equitable, and respectful approach to sexuality and to relationships.

People are oriented differently around sexual relationships, behaviours and practice sexuality in different ways. Some people are attracted to the opposite sex, others are attracted to the same sex, and yet others feel attractions to both. The existence of same-sex groups is rarely acknowledged by societies and in most cases; same sex individuals face stigma, discrimination and rejection.

This study focuses on perceptions and factors influencing access to health care services of men who have sex with men (MSM) in Kigali City. This marginalized group of same-sex individuals was surveyed to gather their views and stories in order to inform different stakeholders involved in decision making and health service provision.

1.1.2 Health and Development

Health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives. In that sense, health is an asset individuals possess, which has intrinsic value (being healthy is a very important source of well-being) as well as instrumental value (Lustig, 2004). Better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more. Many factors influence health status and a country's ability to provide quality health services for its people (Perkins et al, 2006).

Due to the dominance of heterosexual traditions, same sex practices are usually seen as

abnormal. However, there is a need to understand social experience, sexual behavior, risks, benefits, barriers and prevention of diseases to ensure the provision of improved health services to same sex individuals. This allows MSM to benefit from equal high quality of health services according to their health needs.

Healthy people build a wealthy nation. It implies that healthy populations live longer, are more productive, save more and can be catalysts of poverty reduction and sustainable economic progress and development.

1.1.3 Men who have sex with men (MSM)

MSM is a term coined in 1990 to describe men who engage in sex with other men. It encompasses an array of sexual identities, including gay, bisexual, transgendered, and self-identified heterosexual men who have sex with men (Young & Meyer, 2005), based on behavior rather than group identity.

According to Sifris et al. (2014), the term "MSM" focuses on behavior rather than cultural or social self-identification. This then provides a clearer picture of HIV prevalence (and a better understanding of the implications related to HIV prevention).

1.1.4 Men who have sex with men in Africa

Many African countries deny the presence of men who have sex with men or consider same sex practices as imported from West. On the other hand, they enact laws criminalizing same sex practices expecting to protect traditional values.

But many in Africa, including Bishop Desmond Tutu (2012) observe that men who have sex with men exist in all cultures and in every part of the world. Some people believe same sex behaviors were brought [to Africa] by the white man. But others note that it has always been here. What the white man brought was homophobia clothed in religious doctrines that we (Africans) did not have before (Alistair, 2006).

In May and June 1886 a large massacre of Christians, both Catholic and Protestant, took

place. Many were executed at Namugongo, the traditional execution site also used for the Muslim martyrs of 1876. The immediate cause for the killings was the Kabaka's anger at the disobedience of his Christian pages, in particular their refusal to engage in homosexual practices (Nthamburi, 1991).

Men may engage in same sex relationships because women are not available. This is the case of prisons or boarding schools.

1.1.5 Men who have sex with men and health

Studies and surveys have been carried out to better understand the HIV epidemic situation and identify where to put more attention. Many programs and initiatives on men who have sex with men (MSM) health in Sub Saharan Africa focus more on HIV prevention, care, treatment and support as this group is considered to be at higher risk of HIV infection and its spread. In the few Sub-Saharan African studies to date, MSM are estimated to have three to four times the HIV prevalence of the general population (UNAIDS, 2013).

On the other hand, many African countries put laws criminalizing same sex activities and this might affect access to health services and then has severe consequences on public health in general and the country development in particular.

The Government of Rwanda carried progress in improving health of Rwandan population in various areas (eg: malaria, tuberculosis, HIV, etc.). It is against this that Rwanda put MSM in the category of groups at high risk of HIV infection which need particular efforts and close monitoring for HIV prevention and surveillance. Through the Ministry of Health and its institutions, Rwanda has chosen to integrate health services for men who have sex with men into the existing health system, the first of its kind in the Sub Saharan Africa. It plays a key role to design strategies which facilitate the population accessing to better health quality services which leads to the country development. The National HIV Strategic Plan 2009-2012 targeted groups at a higher risk of HIV infection or key populations including men who have sex with men (CNLS, 2009).

1.2 Statement of the problem

The phenomenon of MSM is considered extremely marginal, closely associated with European or Western contamination, and there is a deep belief that it has no roots in traditional African society (McKenna 1996; Panos Institute 1990, cited by Population Council).

Men who have sex with men have shared unique experience and circumstance that affect their physical health and mental health needs as well as their ability to receive high-quality health services (CDC, 2011).

Homosexuality is socially a sensitive issue and this creates a barrier to MSM to seek health services as the rest of the population and a number of individual risk behaviors significantly contribute to the ongoing disparities in the sexual health of MSM. This situation can be associated with higher rates of sexually transmitted infections including HIV.

In 2009, the Rwanda Biomedical Center (RBC) conducted a qualitative exploratory study on “determinants of HIV risk behaviors among men who have sex with men (MSM) in Kigali” and shared its findings in 2011. The findings showed that the taboos manifest in perceived fears of stigma and discrimination that contribute to the secretive and hidden nature of MSM behavior (RBC, 2011).

ICAP (2013) through its program to support MSM accessing to HIV health services mentioned that the key challenge was the reluctance of MSM to seek services due to their fear of being stigmatized and discriminated against.

Factors related to emotional and social support can drive sexual risk taking among men who have sex with men such as multiple sexual partners, unsafe sex and sex work. Negative attitudes of community members and health care providers, lower economic status, geographic location and quality of health services also play a significant role.

When MSM remain hidden and do not access health services, they may also think that they do not have this right or they are damned as many of society members say. These attitudes will not also contribute to prevention measures and lead increase HIV transmission and other sexual and transmitted infections.

Despite the efforts made, men who have sex with men themselves do not feel free and comfortable to seek health services because of the strong cultural resistance so they fear stigma, rejection and even abuse from some radical society members and this leads to unsafe sexual behavior. Such behaviors could have public health implications and particularly on female sexual partners of MSM who are bisexual. In addition, this group expects specific health care needs which require trained health providers and friendly service environment. Bearing in mind that many physicians treat homosexual patients at least once in their medical career (Sanchez et al. 2006), and that homosexuals represent a significant part of the general population (Laumann et al. 1994), it is important to pay special attention to this group.

Attitudes of health professionals can influence the willingness to provide help to homosexual patients (Yen et al. 2007) and consequently the quality of health care and treatment. The researcher is sensitive to health care access by the key populations and particularly men who have sex with men and her motivation for this subject is that health services should not be seen as an issue of morality but as a basic right of all citizens.

1.3 Research questions

The study seeks to fill the information gap since there was no research carried out on perceptions and factors influencing access to health care services for men who have sex with men in Rwanda. The study aimed to answer to the following questions:

1. What are the background characteristics (socio-demographic and economic profile) of the respondents in terms of age, marital status, education, occupation, monthly income and religion?
2. What are the perceptions of men who have sex with men on seeking health care services?
3. Which factors could be associated to access or lack of access to health services of men who have sex with men?
4. What are the key barriers/challenges in accessing health care services by men who have sex with men?

5. Given the social and cultural context of men who have sex with men in Rwanda, what might be done to improve access to health care services for this population in Kigali City?

1.4 Objectives of the study

The main objective of this study was to explore the relationship between social experience, perceptions of men who have sex with men vis a vis health care services, attitudes of health care providers, perceived benefits and barriers to access to health services and other factors influencing this access.

The specific objectives of the study were:

- To explore relationship between the social experience and susceptibility of becoming men who have sex with men in Kigali City;
- To determine perceptions and factors that influence access to health care services of men who have sex with men;
- To explore barriers to access to health care services of men who have sex with men;
- To explore strategies that enhance access to health services for men who have sex with men.

1.5 Significance of the study

This study explored the understanding and experiences of men who have sex with Men in Kigali City. The findings of this study will benefit different stakeholders: MSM communities, health professionals, public, decision makers, universities and the Government of Rwanda. The benefit goes also to the researcher herself as this study allowed understanding of perceptions and factors influencing access to health care services of men who have sex with men.

The findings and recommendations of this study work will contribute to further research and other scientific works as secondary data and the outcomes will be also instrumental in reformulation of strategies and approaches for health service provision to men who have sex with men and as an important element to design and/or review program interventions for this specific hidden group.

1.6 Scope of the study

The study was on perceptions and factors influencing access to health care services of men who have sex with men. It was conducted in three districts of Kigali City. The data was collected by the researcher herself from men who have sex with men and health care providers using interviews, observation and secondary data analysis.

1.7 Limitations of the study

Due to the fact that men who have sex with men comprise a hidden group and are hard to reach, it was not possible to use a nationally representative sample. However, the selected study participants have closely reflected the majority of men who have sex with men and health care providers who have treated MSM in their professional career.

The small number of respondents and health care providers do not compromise the validity of the findings as the results of the qualitative data collection are not meant to be generalizable to the broader population but instead to provide information that will be used for particularistic knowledge generation and the program improvement and planning that is needed to extend human right principals to this population.

The researcher interviewed 40 men who have sex with men and 20 health care providers. Men who have sex with men were met through their social network's leaders and health care providers at their respective health facilities.

1.8 Theoretical Framework

The study was guided by the Health Belief Model (HBM). HBM is a psychological model that attempts to explain and predict health behaviors. The HBM was first developed in the 1950s by social scientists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services in response to the failure of free tuberculosis (TB) health screening program. Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS (Glanz et al, 2002). The HBM is based on the understanding that a person will take a health-related action (i.e.,

reduction of sexual partners) if that person:

- 1) feels that a negative health condition (i.e., TB) can be avoided,
- 2) has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e., avoidance of smoking will be effective at preventing TB), and
- 3) believes that he/she can successfully take a recommended health action (i.e., he/she can have good personal hygiene such as avoid coughing and sneezing at other persons).

The basic constructs of HBM were derived from the behavioral and psychological sciences and identified subjectively determined factors that influence individual compliance with health recommendations. In summary, the model posits that individual compliance with any given health behavior can be explained by six major concepts:

- 1) perceived susceptibility or the individual's subjective risk for contracting a disease,
- 2) Perceived severity or the perceptions an individual has of the seriousness of contracting a disease or of leaving the disease untreated,
- 3) Perceived benefits or the individual's beliefs of the effectiveness of available courses of action to reduce personal susceptibility to the disease,
- 4) Perceived barriers or the major costs believed to be associated with compliance to the recommended behavior,
- 5) Cues to action or specific stimuli necessary to trigger appropriate health behavior, and
- 6) self-efficacy or the individual's confidence in their ability to execute the recommended health behavior.

In addition, the HBM posits that in order for an individual to take preventive action, he would first need to believe he is susceptible to the disease and that consequences of the disease would be perceived as severe. These two concepts (perceived susceptibility and perceived severity), when combined, form a single construct, perceived threat or risk of developing the illness or condition. The HBM predicts that when an individual's perceived threat or risk of developing the disease or illness increases, the likelihood of taking preventive action increases as well.

As applied to the study, this theory links MSM background characteristics, social experience, perceptions and factors that influence access to health services on the following assumptions: a

MSM will take a health related action (i.e., seeking health services, reducing the number of sexual partners and use the safer sex practices) based on the Health Belief Model outlined above.

1.9 Conceptual Framework

Chinn and Kramer (1999) define a concept as a “complex mental formulation of experience”. The researcher designed this part to achieve the research objectives. In this work, there are two independent variables: the background of men who have sex with men and their sexual experience. The dependent variables are the perceptions and factors influencing access to health care services to men who have sex with men.

The diagram below shows the interconnection between variables:

Independent variables

Socio-demographic characteristics of men who have sex with men:

- Age
- Marital status
- Education
- Occupation
- Average monthly income
- Religious membership
- Degree of religiosity

Dependent variables

Factors influencing access to health services to men who have sex with men:

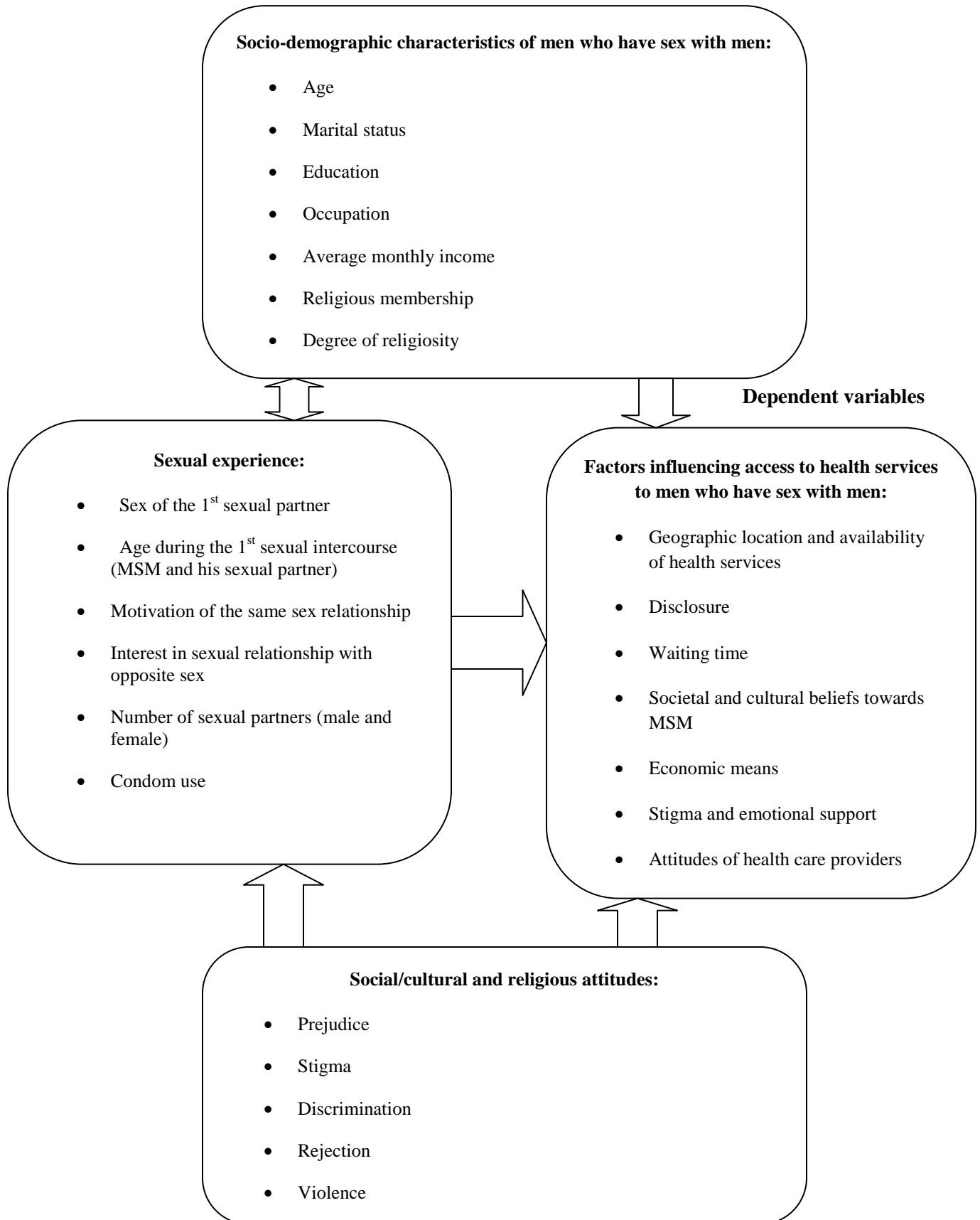
- Geographic location and availability of health services
- Disclosure
- Waiting time
- Societal and cultural beliefs towards MSM
- Economic means
- Stigma and emotional support
- Attitudes of health care providers

Sexual experience:

- Sex of the 1st sexual partner
- Age during the 1st sexual intercourse (MSM and his sexual partner)
- Motivation of the same sex relationship
- Interest in sexual relationship with opposite sex
- Number of sexual partners (male and female)
- Condom use

Social/cultural and religious attitudes:

- Prejudice
- Stigma
- Discrimination
- Rejection
- Violence



CHAPTER II: REVIEW OF LITERATURE

This chapter focuses on the review of literature related to the study. This includes books, journals, magazines, reports, websites and other relevant sources. The study was done on perceptions and factors influencing access to health care services of men who have sex with men in Kigali City.

For the purpose of this study, it is important to clearly understand some key concepts, an overview on men who have sex with men and health in other regions and Rwanda as well as the existing theories and analysis.

2.1 Operational definition of concepts

Homosexuality: The word homosexual is derived from the Greek word ‘homos’, meaning ‘same’. It refers to people who have sex with and/or sexual attraction to or desires for people of the same sex (UNAIDS, 2011).

Freud (1905) believed that homosexuality could be the natural outcome of normal development in some people. He noted that homosexuality could occur in individuals who had no other signs of deviation and no impairment in their functioning. However, he did not view homosexuality as a sign of illness, by which he meant a symptom arising from psychic conflict. Instead, he saw homosexuality as the unconflicted expression of an innate instinct.

MSM: Boellstorff (2011) begins by analyzing the scientific and bureaucratic assumptions underlying the creation of this cumbersome concept in the 1980s. Initiated as an attempt by public health workers, epidemiologists, and other health professionals to separate behavior (sexual activity) from identity, MSM was initially intended to expand HIV prevention efforts to men who have sex with men, but do not identify as “gay”- a term considered in some cases to be burdened by associations with Western, elite, white males. MSM thus began as a medicalized term for a “risk group” detached from identity and politics, based in the idea that “it is not who you are, it’s what you do.”

According to the UNAIDS Terminology Guidelines (2011), the term “*men who have sex with men*” describes males who have sex with males, regardless of whether or not they have sex with

women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men.

Sexual orientation: According to UNAIDS (2011). The term “sexual orientation” refers to each person’s profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different, the same, or both sexes. For Boellstorff (2010), a person’s sexual orientation is defined by the sex which he or she is sexually attracted. The person could be straight or heterosexual when he/she is attracted primarily or exclusively to members of the opposite sex. He/she is called gay or homosexual when is attracted primarily or exclusively to members of the same sex. The person is characterized as bisexual or pansexual when has strong, viable attraction for people of both male and female sexes. Sexual orientation has replaced the archaic term "sexual preference," which was predicated on the false belief that all people can choose to be viably attracted to people of either sex. People who have the ability to do so are, as noted above, bisexual.

For Grollman (2010), most people adopt a ***sexual identity*** that “matches” their sexual orientation: most heterosexually-oriented people identify as “heterosexual” or “straight”, most homosexually-oriented people identify as “lesbian” or “gay.” However, there is a sizable number of people for whom sexual orientation does not coincide with their sexual identity. We can define sexual identity as the label that people adopt to signify to others who they are as a sexual being, particularly regarding sexual orientation.

Stigmatization: “Stigma” is derived from the Greek meaning a mark or a stain. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy. When stigma is acted upon, the result is discrimination that may take the form of actions or omissions (UNAIDS, 2011). Stigma may also be defined as “a discrediting social label” (Wright et al. 2007). Stigma can be negative reactions to socially unacceptable characteristics (Chenard, 2007).

Discrimination: Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal

characteristic or perceived belonging to a particular group—in the case of AIDS, a person’s confirmed or suspected HIV-positive status—irrespective of whether or not there is any justification for these measures. The term ‘stigmatization and discrimination’ has been accepted in everyday speech and writing and may be treated as plural (UNAIDS, 2011). In this study, the particular group referred to men who have sex with men.

According to UNAIDS (2000), denial of sexual behavior between men, stigmatization or criminalization of MSM, difficulty in reaching MSM, inadequate epidemiological information on HIV transmission through male-to-male sex, inappropriate or inadequate health services, and the lack of donor funding are critical barriers to research and health service delivery. Recent studies from low and middle income countries indicate that MSM populations are up to 19 times more vulnerable to HIV than the general population due in part to unprotected anal intercourse and other high-risk behaviors. The risk is compounded wherever homophobia and criminalization drive MSM underground: social marginalization, stigma, and discrimination tend to both drive riskier behaviors and effectively limit men’s access to health services.

2.2 Same sex behaviors

Desmond Tutu HIV Foundation (2009) states that many people wonder what causes a person’s sexual orientation to be homosexual or gay. Most people believe that sexual orientation is either caused by a person’s genetics (something they are born with) or that it is a reflection of their behaviour (something that they learn). The fact is, however, that it is not known what causes sexual orientation, whether it is heterosexual, homosexual, or bisexual. Some studies suggest there are genetic influences, but not all researchers or experts agree with these research findings. Ultimately though, most researchers agree that sexual orientation is determined by biological (genetic) and social (environment, family, community) factors.

According to the American Psychological Association (APA), the psychological and scientific communities provide much speculation but few reliable answers about the causes of same-sex attraction. Our many years of experience suggest a clearer perspective. The official explanation from the APA says that there is no consensus about what causes homosexuality but observed eight predisposing factors that are common in the backgrounds of men with same sex attraction:

1. Unhealthy childhood relationships with females

Females can wound young boys by smothering, criticizing, controlling, and ignoring proper boundaries. Some boys who have experienced such wounding develop unhealthy relationships with women in adulthood in which they either push them too far away or hold them too close.

2. Distorted concepts of gender

Unhealthy childhood relationships with females can distort a man's view of the female gender, affect how he sees himself in relation to women, damage his sense of masculinity, and prevent the natural development of a sense of genderedness. This can leave the individual without a sense of the opposite sex as complementary and attractive.

3. Feeling incongruent with one's own gender

Feeling incongruent with what a man believes his gender requires may create a psychologically unstable situation, resulting in the unconscious mind compensating through fixations or attractions toward males and masculinity.

4. Problems in relationships with other males

During childhood, some boys disconnect from other males due to negative experiences with males, negative stereotypes about males, and fear of being seen as strange. This leaves their normal needs for same-sex connection and bonding unmet, resulting in longings and cravings for male closeness.

5. Sexual conditioning

Sexual desire can be conditioned through pairing specific stimuli with sexual arousal. Male-on-male sexual abuse and early exposure to male pornography may create or intensify homosexual arousal for some boys.

6. Sexual abuse

In addition to its potential role in conditioning sexual arousal, sexual abuse can create or intensify gender incongruity, disaffiliation from other males, and if the perpetrator is female, fear or hatred of women. It may also create repetitive patterns of compulsive sexual behavior.

7. Certain biological and physical issues

Research on direct biological and genetic causes of homosexuality is inconclusive. But our experience suggests that certain biological factors can have an important indirect impact by affecting other parts of the developmental pathway.

8. Certain emotional and psychological problems

Certain emotional and psychological issues may increase the likelihood of developing homosexuality. These issues probably don't play a causal role, but may intensify the effect of other predisposing factors, particularly gender incongruity, same-sex disaffiliation, sexual conditioning, and sexual abuse.

Whitehead (1999) quoted that ... "Surveys of adult homosexuals show conspicuous deficits in several of these developmental stages – showing that homosexuality is cultural and environmental rather than genetic."

The statement from American Psychological Association (APA) shows that "there is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles; most people experience little or no sense of choice about their sexual orientation" (APA, 2013).

In 2004, Frankowski stated sexual orientation probably is not determined by any one factor but by a combination of genetic, hormonal and environmental influences. In recent decades, biologically based theories have been favored by experts. Although, there is no scientific

evidence that abnormal parenting, sexual abuse or other adverse life events influence sexual orientation. Current knowledge suggests that sexual orientation is usually established during early childhood.

The religious statement in the Christian anthropology by Teltamanzi (1999), the Archbishop of Genoa in Italy, said that we must pay primary, continual and undeniable attention to the person and his primordial dignity: his "type" of sexuality, with its concrete forms of realization, never deprives the person of that basic dignity which is inherent in his very being as a creature of God. Here we are speaking of personal dignity in the objective and ontological sense rather than the subjective and moral sense, i.e., relative to moral conduct that can be defined as being in accordance with or not in accordance with the values and demands proper to one's dignity as a person. And to complement this, Pope Jean Paul II cited by Teltamanzi, continued that "Now we should move from a general statement about the "value" of the person to a particular one about the value of the person's sexuality, beginning with the basic *logos* of loving and being loved with specific reference to the masculinity and femininity of the person. We are helped in this regard by the profound and thought-provoking "theology of the body" which John Paul II developed in the catechesis he gave from 1979 to 1984, especially regarding the *nuptial meaning of the human body*. As he said, for example, in his address of 16 January 1980: "The human body, with its sex, and its masculinity and femininity, seen in the very mystery of creation, is not only a source of fruitfulness and procreation, as in the whole natural order, but includes right 'from the beginning' the 'nuptial' attribute, that is *the capacity of expressing love*".

Religious intolerance and rejection negatively affects the health and well-being of men who have sex with men. During the press conference on July 29th, 2013 while on way from the 28th Youth Festival in Rio de Janeiro, the Pope Francis said: "If a person is gay and seeks God and has good will, who am I to judge them? Gay people should not be marginalized but integrated into society." (BBC, 2013).

2.3 Men who have sex with men and African society

About same sex practices in Africa, Meersman (2012) stated that there are many discussions around the fact that homosexuality is un-African. Many African countries let know

that homosexuality was imported by Westerners through colonialism and religious doctrines. On the other hand, some anthropologists assert that homosexuality has its origin in Africa. Possibly the oldest evidence of homosexuality is in Africa. In Egypt stands the 4390-year-old Saqqara tomb (near Giza) of Niankhkhnum and Khnumhotep, two men buried together for the afterlife. On the walls are several depictions of them in intimate embrace and nose-kissing, the form of kissing favoured by heterosexuals too in ancient Egypt.

The fact of the matter is that there is a long history of diverse African peoples engaging in same-sex relations. Indeed, evidence suggests that it was the historical processes of colonization and missionization that consistently altered African sexual practices. Virulent homophobia may be the real western perversion at work here. Moreover, there is growing evidence that African men and women are being actively persecuted on the basis of their sexual practices and identities (Amory, 1997). Same-sex sexual experimentation before marriage or in adolescence has been reported, and in some areas male-to-male sex is a necessary component of certain traditional practices (Murray & Roscoe, 2001).

In pre-colonial African societies same-sex relationships were often constituted through informal rites of passage. Murray and Roscoe report that the *Yan Daudu* societies of the Hausa described such relations in terms connoting frivolity and irresponsibility, such as *wasa* (to play), thus allowing same-sex relations to be ignored or surrounded with a sense of invisibility. Furthermore, spiritual leaders in Zimbabwe believed sexuality to be related to spiritual powers and possession. Men involved within same-sex relationships were left alone, as they could return as an “*ngozi*”, an avenging spirit, which could cause greater havoc to the community’s procreation. In many cases in Zimbabwean traditional healers regarded same-sex relationships as respectable if caused by certain types of spirit possession, rather than the offence and usurpation of natural order they are deemed to be today.

In the anthropological literature, there are several references to the existence of male homosexuality in different parts of Africa (Tauxier 1912; Evans-Pritchard 1929; Werner 1987 cited by Niang, 2003). In Senegal, Crowder (1959) described its existence in Wolof society and concluded that the phenomenon is well entrenched within this society. Pritchard (1970) also recorded that male Azande warriors in the Northern Congo routinely took on young male lovers between the ages of twelve and twenty, who helped with household tasks and participated in

intercultural sex with their older husbands. The practice had died out by the early 20th century, after Europeans had gained control of African countries, but was recounted to Evans-Pritchard by the elders to whom he spoke.

Nowadays, in many cases, policymakers and health leaders know a little about men who have sex with men; some actively deny the existence of MSM within their countries. This was exacerbated by the lack of data about men who have sex with men and of course about their health needs and all related consequences.

The study conducted in Kenya by Onyango et al. (2006) in 500 Kenyan men who have sex with men found that over two-thirds of the sample (69 percent) report ever having sex with a woman; even percent of respondents are currently married and seven percent are divorced/separated/widowed. Twenty-two percent have at least one child. Many respondents remain sexually active with women; 20 percent of those who have ever had sex with a woman (n=344) report having vaginal sex in the past month, and 7 percent report having anal sex with a woman in the past month. When asked to describe their sexual identity, nearly a fourth (23 percent) say they are bisexual. The same study mentioned the risk of having multiple sexual partners and some respondents “could not remember the actual number” of partners. However, there is a substantial subgroup of men (21 percent) who report having only one partner in the previous year.

In a study conducted by Simooya et al. 2001, cited by Niang (2002), in Zambia, 8.4 percent of prisoners reported homosexual intercourse, although indirect questioning imply a much higher figure. Interviews with prisoners in Nigeria suggest the existence of widespread male-to-male intercourse (Orubuloye et al.1995). But beyond research conducted with prison populations, there has been little work by African researchers on the identity and behavior of MSM with the goal of developing HIV prevention and care programs that meet the needs of MSM.

Another study conducted in Rwanda in Kimironko prison, The most commonly discussed sexual practice was “ubufilawoni”, the term refers to men having anal sex with other men either as active or passive partners. The qualitative data do not allow quantifying how prevalent the practice is. However, the number of stories and accounts appearing in the interviews, and the detail with which it is described, strongly suggest it is very widespread (Rolfe et al. 2007).

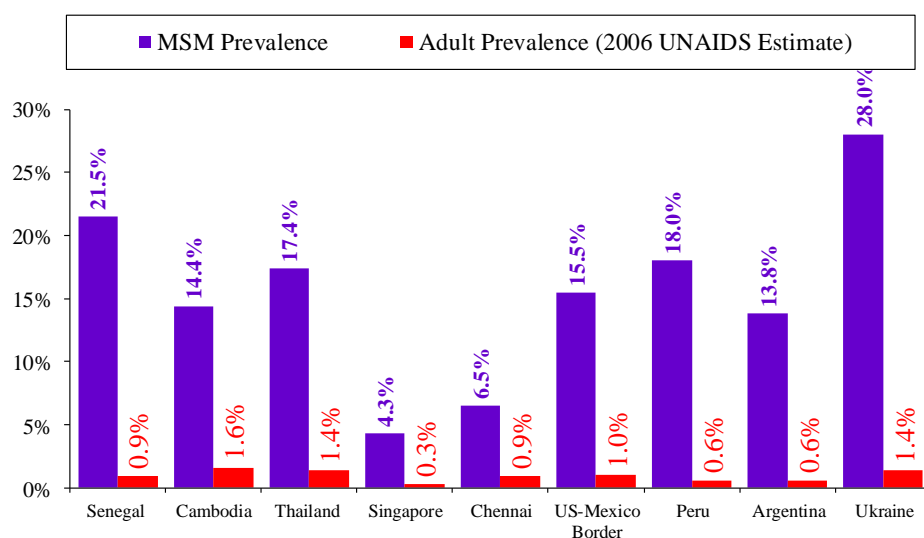
2.4 Men who have sex with men and health risks

In Africa, very few social and behavioral studies exist on men who have sex with men. Discussions and debates over newspapers, religious fora and some legislations show that a number of society members do not tolerate the same sex practices. This creates prejudice stigma, discrimination, rejection and violence towards men who have sex with men. On the other hand, social pressure to get married and have children deteriorates the situation because men who have sex with men get married in order to be seen as men in society while they continue the sexual relationships with other males.

People with marginalized sexual or gender identities or behaviors sometimes lack the ability or desire to protect themselves from infection, due to structural factors including self-stigmatization, discrimination and lack of access to information and services. In certain studies, HIV prevalence among men who have sex with men has been found to be as high as 25% in Ghana, 30% in Jamaica, 43% in coastal Kenya and 25% in Thailand (UNAIDS, 2009).

In 2007, the Global HIV Prevention Working Group, convened by the Bill & Melinda Gates Foundation and the Henry J. Kaiser Family Foundation, estimated that HIV prevention services reach only 9% of men who have sex with men. UNAIDS has estimated that at least 5 to 10 percent of all HIV infections globally occur through male-to-male sexual activity. Important conclusions from behavioral studies of African MSM are that unprotected anal sex is commonplace, knowledge and access to appropriate risk prevention measures are inadequate, and that, in some contexts, many MSM engage in transactional sex. Stigma, violence, detention, and lack of safe social and health resources are widely reported (UNAIDS, 2009).

Figure 1: HIV prevalence in MSM (Worldwide)



Source: UNAIDS (2006)

Table 1: Estimates of HIV prevalence from studies in sub-Saharan African men who have sex with men, 2009

Country	Sample Size	MSM Prevalence (95% CI)	15+ HIV Prevalence
Senegal	943	21.6 (19.0-24.3)	0.88%
South Africa	574	15.3 (12.4-18.3)	15.89%
Zambia	641	32.9 (29.3-36.6)	15.72%
Kenya	1125	15.6 (13.5-17.7)	7.49%
Tanzania	509	12.4 (9.5-15.2)	5.88%
Malawi	201	21.4 (15.7-27.1)	11.46%
Nigeria	1961	13.5 (12.0-15.0)	2.88%
Sudan	1119	8.8 (7.1-10.4)	1.26%
Egypt	340	5.3 (2.9-7.7)	0.02%
Total	6470	15.7 (14.9-16.5)	5.00%

Source: Baral et al. (2009)

2.5 Men who have sex with men and health services in sub-Saharan Africa

Due to these attitudes, men who have sex with men face fear to be recognized as MSM. Lane et al. (2011) reported that verbal abuse targeting MSM from health care workers in

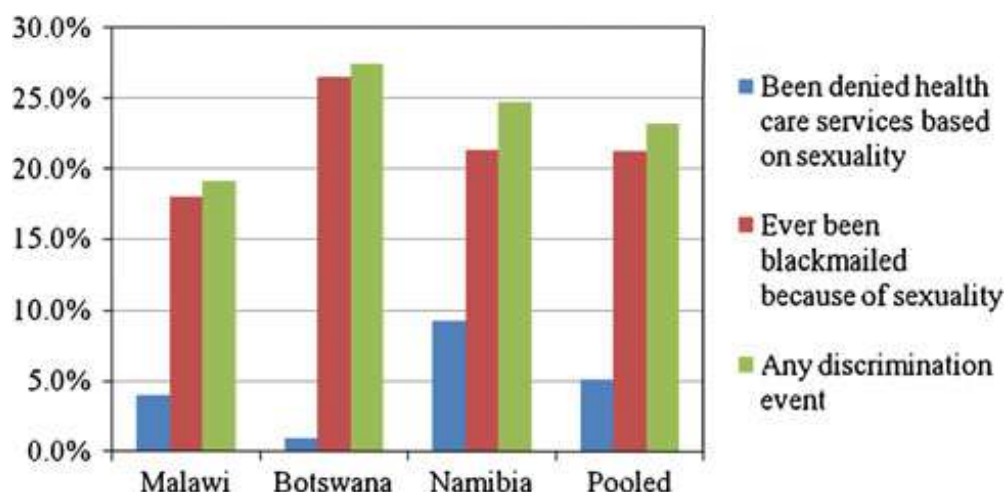
South Africa had a negative influence on the appropriate use of health care services and then denied services and this still make them hidden.

The nature of hiddenness is the breach for risk behaviors including unprotected sex, multiple sexual partners (males and females) and the spread of HIV infection and other transmitted infections.

The vulnerability of MSM is further increased by structural factors such as a lack of funding for MSM-appropriate services, lack of specific skills training of health providers, and institutionalized stigma within the public healthcare sector. MSM patients generally avoid being identified as MSM, culminating in their elevated risk of HIV acquisition, transmission being overlooked, and a lack of counseling about the risks associated with unprotected anal sex (Rebe, 2011). He continues and says that marketing MSM-appropriate services is challenging, especially in areas where MSM do not disclose their sexual behaviours and remain hidden to the healthcare system. It has taken time for MSM groups to develop trust in the clinic and the most effective marketing has occurred by word of mouth via clients who have had a positive health-affirming experience at the clinic.

According to Smith et al. (2009) "... Globally, men who have sex with men (MSM) continue to bear a high burden of HIV infection. In sub-Saharan Africa, same-sex behaviors have been largely neglected by HIV research up to now. The results from recent studies, however, indicate the widespread existence of MSM groups across Africa, and high rates of HIV infection, HIV risk behavior, and evidence of behavioral links between MSM and heterosexual networks have been reported. Yet most African MSM have no safe access to relevant HIV/AIDS information and services, and many African states have not begun to recognize or address the needs of these men in the context of national HIV/AIDS prevention and control programmes. The HIV/AIDS community now has considerable challenges in clarifying and addressing the needs of MSM in sub-Saharan Africa; homosexuality is illegal in most countries, and political and social hostility are endemic. MSM who disclose their orientation, through choice or necessity, report family rejection, public humiliation, harassment by authorities, and ridicule by health-care workers. The consequences of stigma on HIV risk, and access to prevention and care for African MSM are unknown.

Figure 2 : Experiences of discrimination on the basis of sexuality among MSM in Malawi, Botswana and Namibia



Source: Fay et al. (2011)

Other key finding from Onyango et al. (2006) show that men who have sex with men report having difficulty finding providers trained to meet their specific sexual health needs. Respondents prefer to receive STI treatment and/or HIV counseling in private clinics because they are perceived to provide greater confidentiality, the most important factor they cite when choosing a health facility. Other criteria include affordability and close access to quality care.

In recent years, however, changes are made and national and international organizations are conducting researches and surveys to inform the policy makers and health professionals on men who have sex with men health. Some countries are also committed to develop inclusive policies and strategies to address HIV prevention, care and treatment to all citizens with particular attention to key populations including men who have sex with men.

In his statement, the Executive Director of UNAIDS, Michel Sidibe cited by Ayala (2009), said that "... The failure to respond effectively has allowed HIV to reach crisis levels in many communities of men who have sex with men and transgender people. Efforts to reverse this crisis must be evidence informed, grounded in human rights and underpinned by the decriminalization of homosexuality...we must work together to end homophobia and ensure the barriers that stop access to HIV services are removed."

An effective response to HIV/AIDS requires improved strategic information about all risk groups, including MSM. The belated response to MSM with HIV infection needs rapid and sustained national and international commitment to the development of appropriate interventions and action to reduce structural and social barriers to make these accessible (Smith, 2009).

2.6 Rwanda and men who have sex with men

Rwanda is among one of the low-income countries in the world with a total population of 10,537,222 people (Rwanda Population Census, 2012). As many of other African countries, Rwanda is known for its strong family tradition, which might increase feelings of intolerance, stigma towards men who have sex with men.

Rwanda's law is silent on the issue of homosexuality: neither the 2003 Constitution nor the 1977 Penal Code make mention of any crime related to homosexuality. Sexual offenses are outlined in the 1977 Penal Code, and include rape, rape of children, sexual torture, adultery, prostitution, and exhibitionism. While homosexual acts involving either sex are punishable if one participant is under the age of 18 and the other is older, as provided in section 362 of the Penal Code, no provision exists for the criminalization of sexual acts between consenting adults. Article 26 of the 2003 Constitution does limit the right to marriage to heterosexual couples, stating that, "Only civil monogamous marriage between a man and a woman is recognized." Some advocates of laws to criminalize homosexuality argue that the state should prohibit the practice as part of the state's obligation to protect the values and cultural traditions of the country. Proponents of this limitation argue that homosexuality is not a part of Rwanda's cultural heritage, and as a result, it should not be accepted. This argument, apart from erroneously claiming that homosexuality has not always existed within the culture, also overlooks the state's obligation to ensure that the traditions it promotes adhere to the human rights principles and fundamental freedoms guaranteed within the Constitution (HOCA, 2007).

It is important to determine whether individuals experiencing stigma related to their sexual orientation report any social or cultural influences on the level of their stigma and its effects on health outcomes and access to care. Health professionals went beyond the human right context

and developed strategic interventions considering and offering health services to key populations including men who have sex with men. According to Binagwaho et al. (2009) “Internationally men who have sex with men (MSM) have been identified as a high risk group for HIV acquisition. This is due to a tendency towards higher risk sexual behaviors (including, penetrative anal intercourse) and greater numbers of casual (and often commercial) sexual partners. MSM are often referred to as a “bridging population” for HIV transmission between behaviorally bisexual and behaviorally heterosexual populations. Studies of MSM in Africa have documented high rates of previous and current bisexual behavior, and many MSM respondents report being married.

Furthermore, according to the same author, a meta-analysis of research in sub-Saharan Africa on MSM and HIV risk reported that African MSM bear a considerably higher burden of HIV than do behaviorally heterosexual men. Prevalence of HIV among MSM in other East African countries is over 17%. A recent Modes of Transmission modeling exercise conducted in Rwanda found that 15% of new infections may be among MSM. Despite the growing body of evidence on the existence of MSM and their relatively high HIV risk, the HIV prevention needs of MSM are still largely ignored in many African societies due in part to religious and moral convictions and related stigma, and in part to ignorance around the existence of MSM, and the importance of providing services and support for MSM as a vital means of fighting the epidemic. Key results from the 2009 research in Rwanda (Binagwaho, 2009) include:

- Men reported an average of two male sexual partners in the 12 months prior to survey.
- 37 respondents reported casual sex in the one month prior to survey and 18 of these men reported unprotected sex with a casual sex partner in this timeframe.
- MSM have wide sexual networks. One-quarter of respondents reported sex with a woman in the year prior to survey.
- A high proportion of MSM in Kigali may engage in commercial and/or transactional sex: one in ten respondents reported exchanging sex for money in the year prior to survey.
- 27 respondents reported experiencing at least one STI symptom previously and 13 respondents reported a prior STI diagnosis.

The results of this exploratory study show that MSM in Kigali are at elevated risk for HIV

infection compared to the general population, and require specific HIV/STI prevention services/support. Data on HIV prevalence among this population are not available so far.

The same study demonstrated the need for sensitive and targeted interventions for this risk group. As a result of this emerging evidence, the Rwanda National Strategic Plan on HIV and AIDS 2009-2012 (NSP) has identified MSM as a priority group for HIV prevention services, setting a national target of reaching 60% of MSM with a minimum package of HIV prevention services by 2012. Though some national and international organizations are providing “MSM-friendly” HIV services, a nationally-agreed, evidence-based, minimum package of HIV prevention services targeted to MSM has not yet been established and no implementing partners are directly targeting MSM for interventions (CNLS, 2009).

It is against this that the Government of Rwanda made big advances in terms of developing policies, guidelines and strategies for integrated and inclusive health interventions with a particular attention to men who have sex with men through its universal access approach. Some national and international partners responded to the call and some started their activities in the area of supporting health services to men who have sex with men.

Since 2010, ICAP has collaborated with the Government of Rwanda and its Rwanda Biomedical Center (RBC) on an innovative project to increase MSM’s access to and utilization of quality, MSM-friendly HIV prevention, care, and treatment services in the nation’s capital, Kigali. Following a rapid assessment of Kigali health facilities and the MSM-related knowledge, attitudes, and practices among health workers at these facilities, three clinics—Kabusunzu, Rugarama, and Carrefour— were selected to pilot a multi-pronged intervention focused on MSM (ICAP, 2013). Other partners such as Society for Family Health (SFH) and Health Development Initiative (HDI) are focusing their interventions on HIV prevention among men who have sex with men.

Gupta (2014) said that Rwanda is taking the lead by providing antiretroviral medications to groups that did not previously receive them: pregnant women, young children, female sex workers, men who have sex with men, and those with sexual partners who are not infected. He added that while many countries continue to approach the HIV epidemic in isolation, Rwanda

has managed to integrate its response to HIV within its broader platform for social and economic development.

Given the systematic review of distinctive characteristics of men who have sex with men and the existing theories, the literature has clearly shown that men who have sex with men face social, cultural, religious and political challenges and at the same time suggested that inclusive strategies should be developed in order to reduce the spread of HIV infection.

CHAPTER III: METHODOLOGY

This chapter explains the overall procedure used by the researcher to collect, analyze and interpret the data collected from the field.

This chapter also describes targeted population and further describes the methods and techniques that were used in the study. It comprises: Research design, population, sample size and sampling procedure, research instruments, data collection procedures, ethical considerations and data analysis.

3.1 Research design

This is an exploratory and qualitative study. The methodology used was participatory and anthropological which built on a relationship of trust, particularly when it comes to working with a hidden group like MSM. This helped to understand their sexual behaviors and experiences as well as health provider's attitudes and actions. Descriptive design was used to describe the situations as they are, aiming at providing a description of the socio-demographic characteristics of the sampled MSM, their sexual experience and the attitudes of health care providers.

3.2 Locale and Population of the study

The study was conducted in Gasabo, Kicukiro and Nyarugenge districts in Kigali City, Rwanda. Kigali City is the capital city of Rwanda and has a population of 1,135,428 habitants among them 585,379 male and 550,049 female. The population density is 1,557 per sq.km (Rwanda Population Census, 2012).

Figure 3 : Map of Kigali City



Source: <http://www.enjoyrwanda.info/where-to-stay/kigali>

The target population of this study was 40 men who have sex with men aged between 20-35 years and 20 health care providers. All respondents were Rwandese.

3.3 Sample size and Sampling procedure

Given that the population of men who have sex with men is both unknown in size and is hidden, 40 men who have sex with men and 20 health care providers were recruited from their social networks and health facilities respectively. Sample size for data collection methods was chosen based on feasibility, time and funds available for the study, as well as best practices in qualitative data collection in other settings. The small size was due to the hidden target population and hard to reach, but this would not compromise the validity of the conclusions, as the results of the qualitative data are not meant to be generalizable to the broader population but

instead to 1) inform the interpretation of the collected information and 2) provide actionable information on program design and decision making.

The researcher was a former employee of International Center for AIDS Care and Treatment Programs (ICAP) and the latter initiated a program supporting access to clinical HIV services for men who have sex with men and the researcher was leading this program (ICAP, 2012). This experience allowed the researcher to interact with men who have sex with men and build up a large number of relationships and used multiple contact points to recruit participants. She also used the snowball sampling for MSM involving peer recruitment from the MSM network leaders and the purposive sampling for health care providers. Participant recruitment and inclusion criteria for the study were elaborated as follows: being MSM and aged of 18 years old and above, consenting to participate in the study and having received any health service as MSM. For the 20 health providers, consenting to participate and having treated a man having sex with other men in their professional career. The health care providers were interviewed to compliment the information received from the main respondents (MSM).

3.4 Research instruments

The researcher developed and used some instruments to obtain information from all the respondents. The language used between the researcher and men who have sex with men was Kinyarwanda and all the tools were translated from English into Kinyarwanda to facilitate understanding.

Data collection

In this study, the collection of data took place between February and April 2014. The interviews were held in restaurants/bars or coffee shops from the choice of men who have sex with men for their privacy. The interviews with health care providers took place at their respective health facilities. The researcher provided a verbal introduction about the purpose of study. Interviews were administrated after the participants have accepted and signed their consent to participate in the study. Confidentiality was assured as the participant's right and was respected at all stages of the study process. Each questionnaire package was numbered to ensure accuracy for data entry and analysis. All records used were kept confidential.

In-depth interviews

This refers to the semi-structured interview guide was developed to collect information from MSM and health care providers. The questionnaire was pre-tested in 3 men who have sex with men and 1 health care provider before data collection.

The questionnaire included the information on the background of the respondents, sexual and social experience, perceptions and factors influencing access to and use of health services, potential effects of stigma towards health services and recommendations to enhance access and use of health services. The interviews went beyond the rhetoric of interview and the researcher collected also some stories about MSM social experience.

Observation

This technique allowed the researcher to use the senses to perceive and understand the experiences of men who have sex with men. She spent hours sitting, chatting, participating in social events and eating with men who have sex with men and this allowed her to see what they actually do live and to experience the kind of interactions between them and the rest of the community members.

3.5 Reliability of the instrument

Reliability is the degree of consistency and precision in which the meaning of instruments is demonstrated (Amin, 2005). It is defined also as a degree to which an assessment tool produces stable and consistent results. The aim was to pre-test the questionnaire with the view of ensuring that respondents understood well the questions and provided appropriate responses and to check whether administration of the survey procedure as a whole went smoothly.

3.6 Data analysis

The data analysis took place between February and June 2014. Data was analyzed using the Statistical Package for the Social Sciences (SPSS) version 16 for Windows in a password-protected computer. The double entry method was used to ensure accuracy of transcribed data.

To measure the relationship between variables Odds ratios and 95% confidence intervals were calculated. These were the primary methods of comparing factors contributing to men who have sex with men access to health services.

3.7 Ethical considerations

3.7.1 Protocol approval

Prior to the data collection process, the researcher submitted the study protocol and all developed tools for data collection to University of Rwanda for approval.

3.7.2 Informed consent

Men who have sex with men and health care providers who agreed to participate in the semi-structured interviews were asked for written informed consent. All subjects have signed a consent form to confirm their willingness to participate after having/being read a detailed information sheet outlining the research purpose, study procedures, risks, benefits, sources for additional information about the study and their rights as study participants. Participants were informed of their right not to participate in the review or to withdraw at any time without suffering any negative consequences. The informed consent was initially developed in English and was then translated into Kinyarwanda.

3.7.3 Compensation and justification

Men who have sex with men and health care providers participating in interviews were receiving Rwfs 2,000 and Rwfs 1,000 respectively to compensate for their time participating in the study.

3.7.4 Confidentiality

Individual interviews were held in a private space to best protect subjects' confidentiality. All data collected during interviews with men who have sex with men and health care providers were identified and labeled with a sequential unique study ID number. The written consent form, containing the participant name and signature were the only document with subject identifier but there was no way to link this with the data collected in the interviews. All completed

questionnaires and forms were stored in a secure location with limited access. All paper-based study documents will be destroyed three years after completion of the study.

3.7.5 Potential Benefits

There is unlikely to be any direct benefit to subjects for their participation in this study. However, the information gathered during the study will be used to inform the public health and development sectors from which participants benefit.

3.7.6 Potential risks

The risks to study participants are expected to be minimal. There was no administration or use of invasive procedures. The use of study identification numbers and signature of the informed consent have no link to participants. Some of the questions during the interviews may make participants uncomfortable. If such a situation, participants were given the alternative of skipping the questions or stopping the interview.

CHAPTER IV: FINDINGS AND DISCUSSIONS

This chapter presents the results of the study using tables, graphs and charts. The interpretation of the findings is made following the stated objectives.

4.1 Background characteristics of participant MSM

The first objective of the study was to find out the background characteristics of the sampled men who have sex with men of the study (Socio-demographic and economic profile of respondents). This section presents the background characteristics of the respondents in terms of residence, age, marital status, education, occupation, average monthly income and religion. Descriptive statistics (frequencies and percentages) were used to analyze the socio-demographic and economic profile of the respondents as presented in Table 2.

Table 2: Descriptive data of MSM participant (N=40)

Variable	Modalities	N	%
District	Gasabo	13	32.5
	Kicukiro	14	35.0
	Nyarugenge	13	32.5
Age group	20-25 years	14	35.0
	26-30 years	19	47.5
	31-35 years	7	17.5
Marital Status	Single	36	90.0
	Married	1	2.5
	Divorced	1	2.5
	Cohabited	2	5.0
Level of education	No education	1	2.5
	Primary	11	27.5
	TVET	4	10.0
	Secondary	22	55.0
	University	2	5.0
Profession	Student	6	15.0
	Not employed	7	17.5
	Small business Employee	13	32.5
	Public Sector Employee	8	20.0

Variable	Modalities	N	%
	NGO's Employee	1	2.5
	Others	5	12.5
Level of income per month in RwF	Less than 15,000	10	25.0
	15,000-20,000	2	5.0
	21,000-50,000	14	35.0
	51,000-100,000	6	15.0
	> 100,000	8	20.0
Religion	None	1	2.5
	Roman Catholic	19	47.5
	Protestant	8	20.0
	Adventist	7	17.5
	Muslim	3	7.5
	Other Religions	2	5.0
Level of religiosity	Moderate	12	30.0
	Little	17	42.5
	None	10	25.0
	No response	1	2.5

Source: Primary Data, 2014

District of residence

The distribution of MSM in the three districts (32% in Gasabo, 35% in Kicukiro and 33% in Nyarugenge) was explained by the fact that Kigali City is homogenous in terms of its inhabitant's social life style, free movements facilitated by common means of transport and with easy and accessible entertainment opportunities. Also, men who have sex with men in Kigali City are very connected and the communication among them is easy and quick.

Age

Considering the age of interviewed MSM, Table 2 shows that the majority of respondents (19) 47.5% were aged between 26-30 years old; 14 respondents (35%) are aged between 20-25 years old and 7 respondents (17.5%) are aged between 31-35 years old. The high proportion of age group (26-30) was associated with the maturity and independence of the respondents to leave out of their parent's homes and share small rent houses with their peers. At

this age, many people finish their studies, want to feel free and manage their life without the influence of the parents or other family members. The findings differ from the Onyango's ones (2006) which confirmed that almost men who have sex with men (in Kenya) are young.

Marital status

As regards to marital status of the respondents, 36 (90%) were single; 1 (2.5%) was married; 1 (2.5%) divorced and 2 (5%) cohabited. This finding let know that the social pressure of getting married is not significant in Kigali City so men who have sex with men are free to stay single. The study differs from the study results conducted in Ghana by the Boston University's Center for Global Health and Development and the Kwame Nkrumah University of Science and Technology (KNUST), in collaboration with the FHI 360 in 2013 where thirty-nine percent of participants were married; a similar proportion (40%) were single. The remaining 20% (9 participants) reported cohabitating with someone.

Education

According to the results in Table 2, 22 respondents (55%) had a secondary level of education; 11 respondents (27.5%) had a primary level; 4 (10%) went to TVET; 2 (5%) went to higher education and 1 (2.5%) never went to school. This implies in this study that the majority of men who have sex with men are literate. The high proportion of education was associated with the less prejudice which allows MSM to resist from societal and cultural stigma. Another interpretation was that some men who have sex with men started homosexual practices while in boarding schools as mentioned by one. He stated: *"When I was in boarding school, I used to be approached by a colleague when we were watching movies because it was always night and he used to touch my genital organs and after I became familiar with. We were doing anal sex regularly. After I realized that I'm more attracted by males than females"* (A 21 years MSM from Nyarugenge district).

The findings concord with the results from a survey conducted by Hladik et al. (2012) in Uganda where about three quarters of men who have sex with men in Kampala had attended secondary school or higher.

Occupation

The results of Table 2 show that 13 respondents (32.5%) were employees in small business such as hairdressers, music studio, handcraft and selling merchandise; 8 (20%) worked in public sector; 7 (17.5%) had no paid job; 6 (15%) were students, 5 (12.5%) were small business owners while 1 (2.5%) worked for NGO. This means that 67.5% of MSM in Kigali City have paid jobs. The findings concord with the results of the study conducted in Ghana in 2013 by the Boston University's Center for Global Health and Development and the Kwame Nkrumah University of Science and Technology (KNUST), in collaboration with FHI 360. Among study MSM participants, 64% were employed. The findings were associated with the fact that men who have sex with men do face public humiliation and prefer to work in small businesses. We assumed also that small businesses facilitate contact and connections between MSM from different areas within and outside Kigali City.

Income

The results of Table 2 show that 14 respondents (35%) earned between USD 30-72/month; 10 (25%) earned less than USD 21.7/month; 8 (20%) earned more than USD 145/month; 6 (15%) earned between USD 74-144/month and 2 (5%) earned between USD 22-72/month. The findings imply that the majority of men who have sex with men could have an average monthly income above USD 1.25 international poverty line.

The results underline that same sex practices in Kigali City are much more likely linked with inborn behavior instead of means of gaining money. The level of monthly income is associated with the employment where 32.5% of MSM work as small business employees.

Religion

Table 2 shows that 19 respondents (47.5%) were Roman Christians; 8 (20%) were Protestant Christians; 7 (17.5%) were Adventists; 3 (7.5%) were Muslims; 2 (5%) belong to other religions while 1 (2.5%) did not belong to any religion. As the majority was Christians, the findings concord with the DHS 2010 results which show that Christians constituted 93% of the Rwandan population.

The level of religiosity of men who have sex with men (little at 42%, moderate at 30%, not at all at 25%) was associated with the attitudes of religious leaders. The involvement of men

who have sex with men in churches or mosques is limited with fear to be judged, humiliated, punished or rejected. The results concord with the study conducted by Niang et al. (2002) where a Muslim dignitary explained, “*Since the Muslim religion forbids homosexuality, we cannot accept homosexuals either in our homes or in our mosques*”. Another cleric explained that when a Muslim shakes hands with a homosexual, a certain number of prayers are required for his purification and yet MSM behavior is common in Saudi Arabia, Palestna and other Muslim countries.

During the interview, one MSM testified: “*Since I was young, I was serving in my Catholic church in every Sunday mass until I was about 17 years old. After, I continued to take different responsibilities in church. Recently the head of our basic community discovered that I am MSM; he approached me and said that it’s known that I’m MSM and he advised me to no never take any responsibility again while I’m still being homosexual otherwise I could bring hell or any other devil to the whole community*”(A 28 years MSM from Nyarugenge district).

Table 3: Descriptive data of health care Providers (N=20)

Variable	Modalities	N	%
District of work	Nyarugenge	14	70.0
	Kicukiro	5	25.0
	Gasabo	1	5.0
Sex	Female	12	60.0
	Male	8	40.0
Marital status	Single	3	15.0
	Married	16	80.0
	Widow	1	5.0
Position/title	Nurse	12	60.0
	Social worker	4	20.0
	Medical doctor	3	15.0
	Lab Technician	1	5.0
Religion	Roman Catholic	11	55.0
	Protestant	7	35.0
	Adventist	2	10.0
Degree of religiosity	Very religious	12	60.0
	Moderate	7	35.0
	Little religious	1	5.0

Source: Primary data, 2014

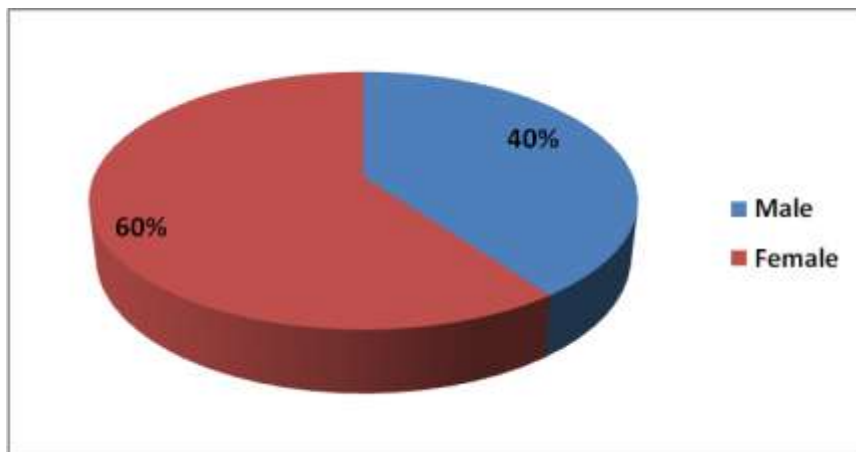
4.2 Social experience of MSM

Social experience deals with age at the first sex, age and number of sexual partners, motivation facts to make same sex relationship, time period of having sex with other men, matters of identification of MSM, condom use, disclosure, feelings of the sexual orientation, stimuli to decide to disclose and reactions from the community towards men who have sex with men.

4.2.1 Age at the first sexual intercourse versus age and sex of the first sexual partner

The researcher found out that twenty four men who have sex with men out of 40 had their first sex with females. The figure 4 below provides details:

Figure 4 : Proportion of sex of the first sexual partners of MSM (N=40)

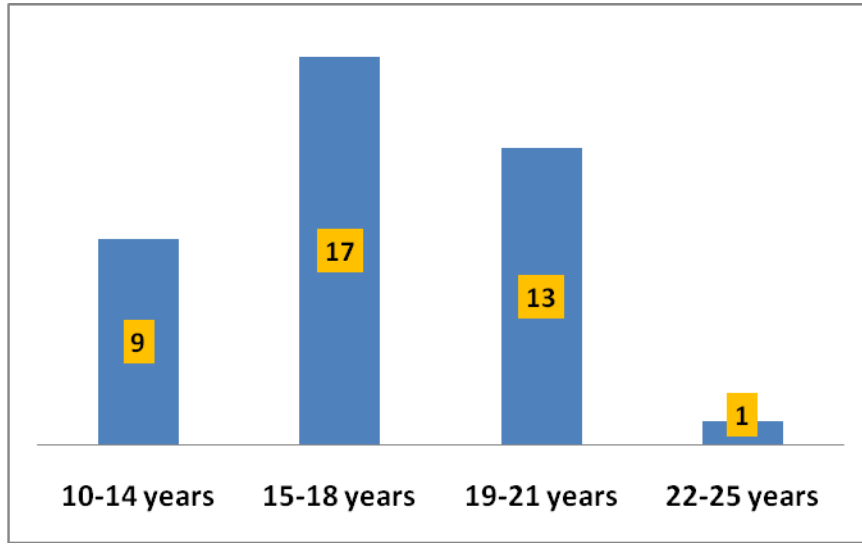


Source: Primary data, 2014

The results of Figure 4 show that 60% of men who have sex with men had their first sex with females and 40% with males. This implies that the majority of the respondents are bisexuals; it means they are attracted to and/or has sex with both men and women. In absence of any intervention to prevent or reduce HIV transmission and other sexual transmitted infections, the risk would be high in both males and females. The findings agree with the results of the study conducted by Hladik (2012) indicating that three-quarters of MSM in Kampala had ever had sex with women. They also complement the statement of Bouchier (2012) who said that bisexual

concurrency is common, and as a result, a high rate of HIV among this group has implications for bridging to the wider community.

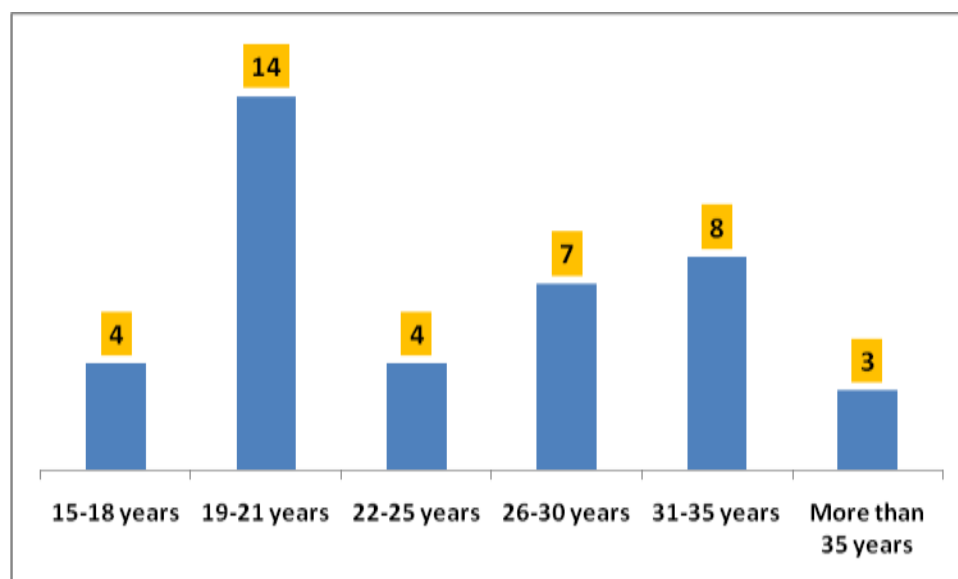
Figure 5 : Age group at the first sex (N=40)



Source: Primary data, 2014

The results of Figure 5 show that 9 respondents (22.5%) were aged between 10-14 years old; 17 respondents (42.5%) were aged between 15-18 years; 13 (32.5%) were aged between 19-21 years and 1 (2.5%) was aged between 22-25 years old. This implies that men who have sex with men had their first sex while they are still young. The age at the first sex is an important indicator to predict the risk of exposure to HIV and other sexual transmitted infections during the young age. The Rwanda national policy on family planning shows that the reproductive age among Rwanda population is between 15 and 49 years old (MOH, 2012). A non-negligible proportion of 22.5% had their first sex when they were aged between 10 and 14 years old. This complements the study conducted by Murray and Roscoe (2001) which reported same sex experimentation in adolescence.

Figure 6 : Age group of the first sexual partner (N=40)



Source: Primary data, 2014

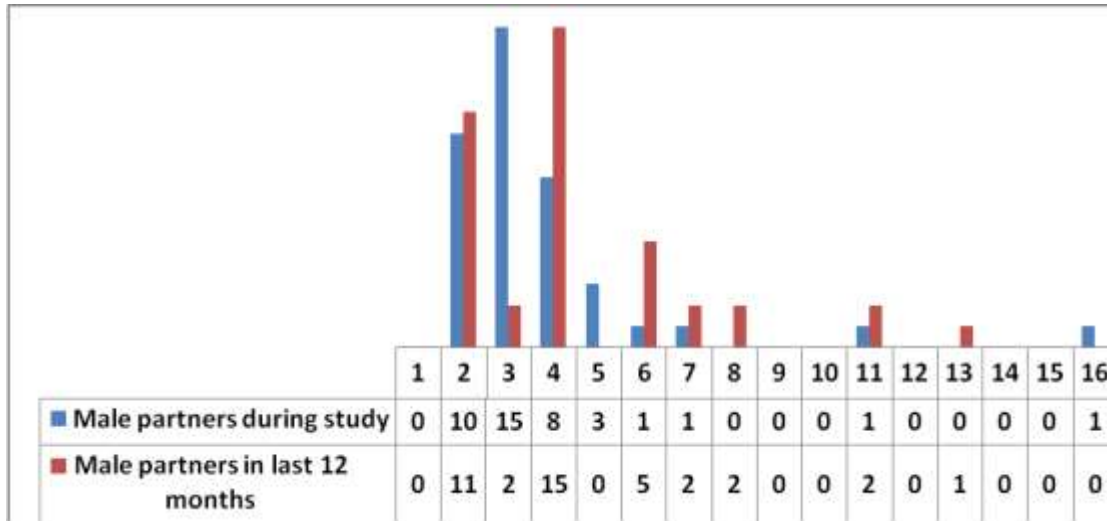
Table 6 shows that 4 sexual partners (10%) of men who have sex with men were aged between 15-18 years old; 14 (35%) aged between 19-21 years; 4 (10%) aged between 22-25 years old; 7 (17.5%) aged between 26-30 years; 8 (20%) aged between 31-35 years old and 3 (7.5%) aged over 35 years old. The results imply that the majority of sexual partners of men who have sex with men in Kigali City were older than the respondents.

During the interview, one respondent testified: *“When an older sexual partner negotiates and insists to have sex with you, it’s not easy to refuse as he insists and sometime he proposes a financial compensation while you are in need”* (A 20 years MSM from Kicukiro district). This story lets understand that some sex intercourses with men who have sex with men are influenced by financial compensation. Consequently, such situation might be difficult for men who have sex with men to negotiate safer sex with their older sexual partners which increase the risk of exposure to different infections including HIV.

An element misses precision here to know how men who have sex with men in Kigali City are either engaged in receptive or insertive anal intercourses.

4.2.2 Men and women as sexual partners of MSM

Figure 7 : Number of male sexual partners of MSM (N=40)



Source: Primary data, 2014

The results of the figure above show that number of male sexual partners during the study period varied between one and fifteen while in 12 months preceding the study, it varied between one and twelve. The findings raise concerns about the less perceived risk of having multiple and casual sexual partners with low use of condom and the severity of HIV and other sexual transmitted infections. The analysis brought again the issue of process of changing risky behaviors among men who have sex with men.

The general interpretation of the figure shows the slight decrease in number of sexual partners which could be attributed to regular educational sessions on HIV by health care providers focusing on HIV prevention including the reduction of sexual partners.

Figure 8 : Numbers of female sexual partners of MSM during the study

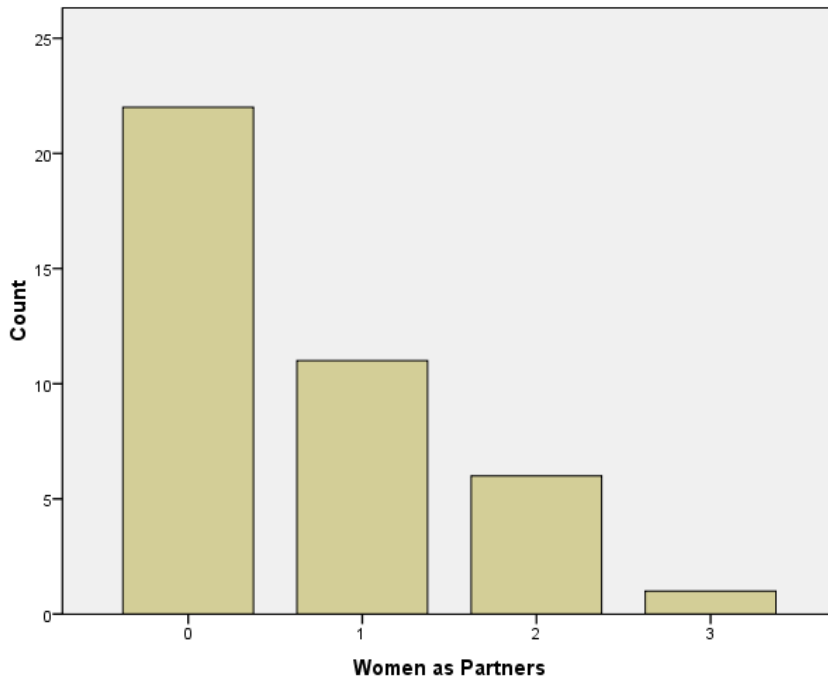
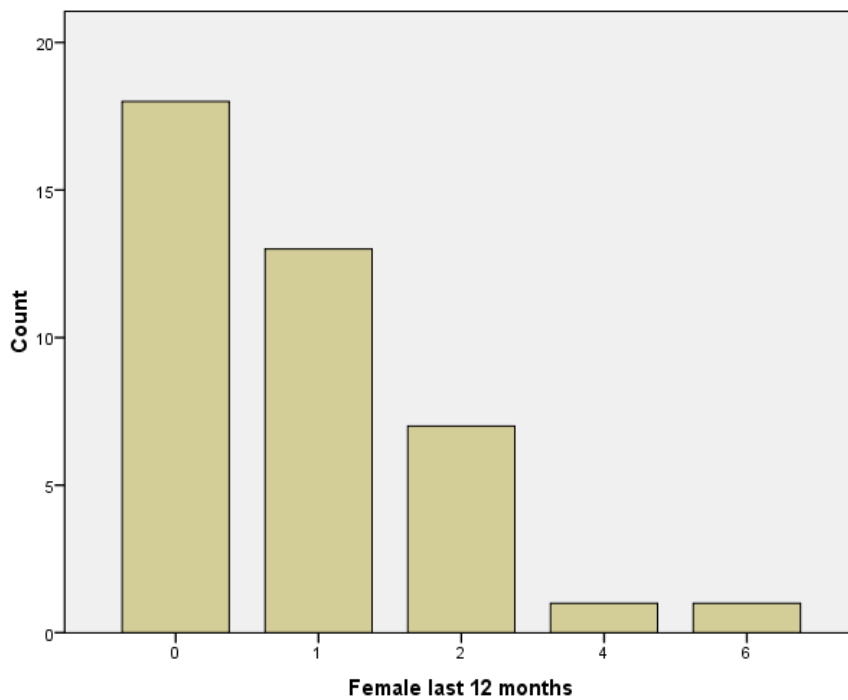


Figure 9 : Number of female sexual partners of MSM in the last 12 months



Source: Primary data, 2014

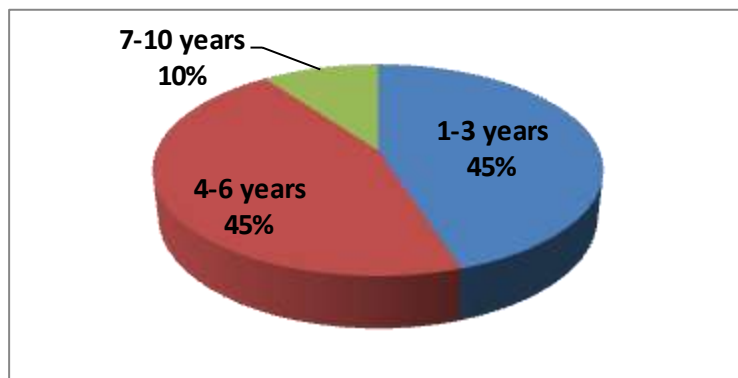
As the Figure 8 draws, men who have sex with men have also sexual relationships with women. The researcher found out that during the study period, 18 MSM (45%) didn't have any female sexual partner, 13 (32.5%) had one female sexual partner each, 7 (17.5%) had two sexual partners each and the two remaining had respectively four and six female sexual partners.

Figure 9 shows the number of female sexual partners of MSM during 12 months prior to the study. In that period, 22 out of 40 MSM (55%) didn't have any female sexual partner, 11 (27.5%) had 1 female sexual partner, 6 (15%) had two female sexual partners each and one of them (2.5%) had one female sexual partner

As it can be read in Figures 8 and 9, there is a bisexuality aspect among men who have sex with men in Kigali City. This is an important indicator for prevention strategies and programmes to support men who have sex with men and their sexual partners, male and female, while targeting the entire population.

The statement of one health care provider from Kicukiro district highlighted his concern about the issue: "... Another challenging issue is that men who have sex with men have the sex with female partners also. Among these female sexual partners, some are single and others married and they have sexual intercourses with other men apart from MSM! You can't imagine how this situation is alarming to the public health world..." (Primary data, 2014).

Figure 10 : Number of years in treating MSM by health care providers (N=20)



Source: Primary data, 2014

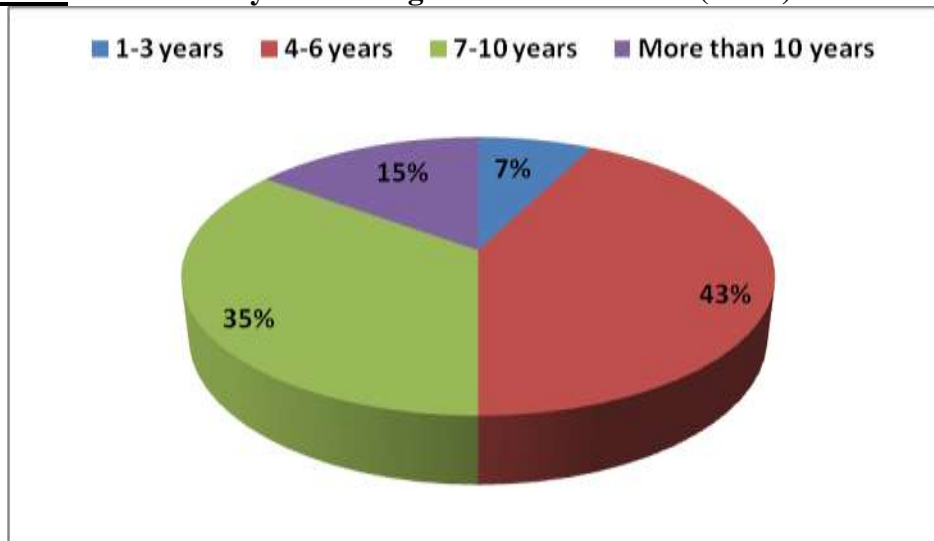
The results of Figure 10 show that the majority of health care providers (90%) had treated men who have sex with men for about six years. This implies time when the Government of Rwanda through the Ministry of Health developed the national strategic plan for HIV 2009-2012 considering men who have sex with men as a group at high risk of HIV infection in the category of key populations. In addition, it was the period when ICAP initiated HIV clinical services for men who have sex with men in Kigali City.

Only 10% of health providers had treated men who have sex with men between 7-10 years ago. The findings show that among these health providers some work for private clinics where MSM went before the initiation of health services for MSM in public health facilities. Some men who have sex with men were able to disclose their homosexual status to the health personnel.

4.2.3 Time period and motivation facts of having sex with other men versus interest of having sex with the opposite sex

Figure 11 shows responses of men who have sex with men regarding the time period they have sex with other men and the motivating factors.

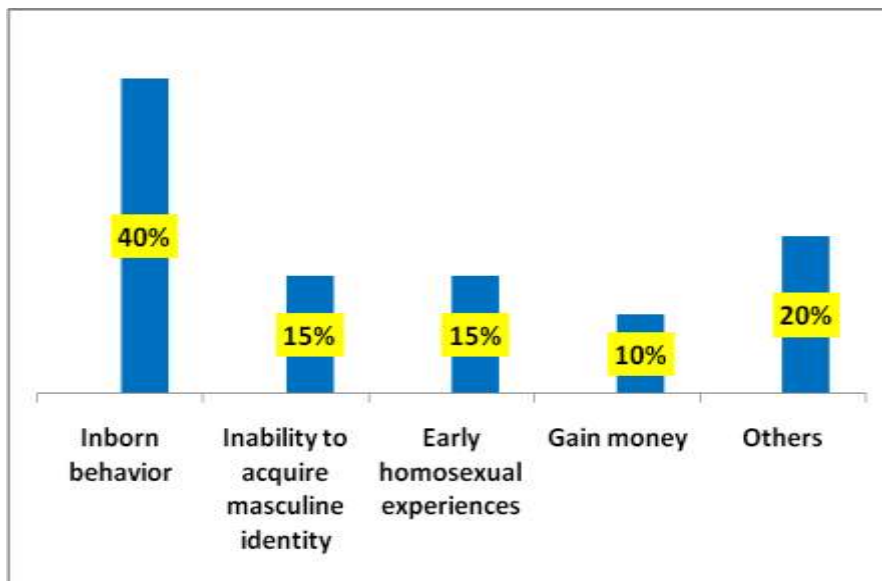
Figure 11 : Number of years having sex with other men (N=40)



Source: Primary data, 2014

The big proportion of respondents (85%) had sex with other men since between 1-10 years. In 2008, the National AIDS Control Commission conducted the first study on MSM in Rwanda and this implies that the study gave the opportunity to MSM to disclose their homosexual status. Few years after, the strategic plan on HIV recognized the risk behaviors among MSM and some health care providers were trained to deal with men who have sex with men.

Figure 12 : Motivation factors of having sex with other men (N=40)



Source: Primary data, 2014

The results of Figure 12 show the factors that motivate MSM to have sex with other men that include inborn behavior at 40%, inability to acquire masculinity at 15%, early homosexual experiences at 15%, way to gain money at 20% and other facts at 20%. Other facts include curiosity to discover same sex, influence from friends and use of alcohol.

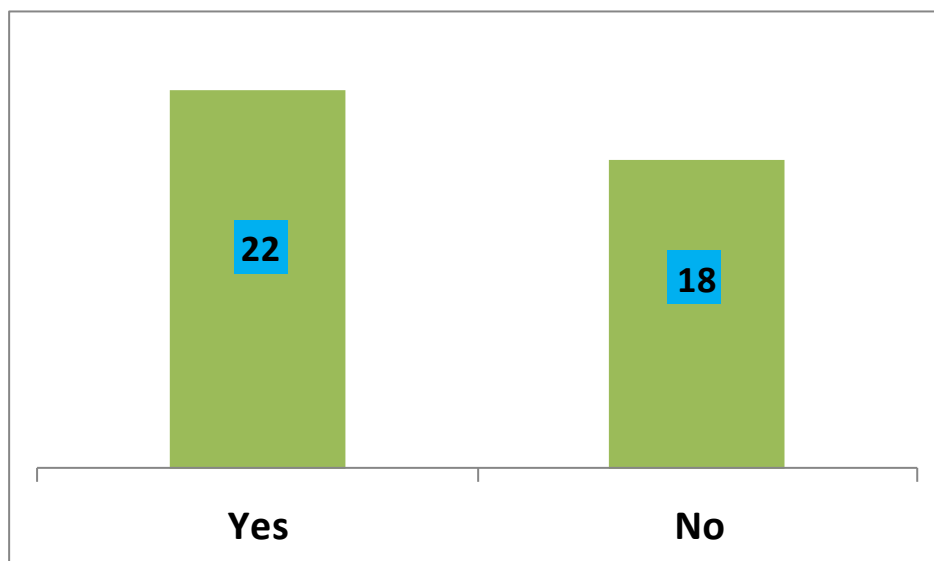
Friedman and Downey (2002) explained that some studies hint at a biological component, but have not proven that same-sex attraction is an inborn or biologically-determined characteristic. Likewise, there are theories that claim biological predispositions influence the development of homosexual attractions when other life experiences are also present. However, professionals agree that environment influences a child in significant ways: your family, friends, society, and experiences influence how you feel, how you view life, and how you act. To complete this,

Oaks (1995) said that "some kinds of feelings seem to be inborn...all of us have some feelings we did not choose..."

The findings coincide with those in Senegal where, according to Niang et al. (2002), "sex with men is driven by many reasons, including love, pleasure, and economic exchange."

During the interview, one respondent talked about his same sex story: "When I was born I was told that my mother was expecting to have a girl because she had already three boys and then she has prepared a baby girl layette set. More I was growing, more she was telling me that she would be happier if I was a girl. Through this important message I started to adopt feminine behavior in order to make her happy..." (A 22 years MSM from Kicukiro).

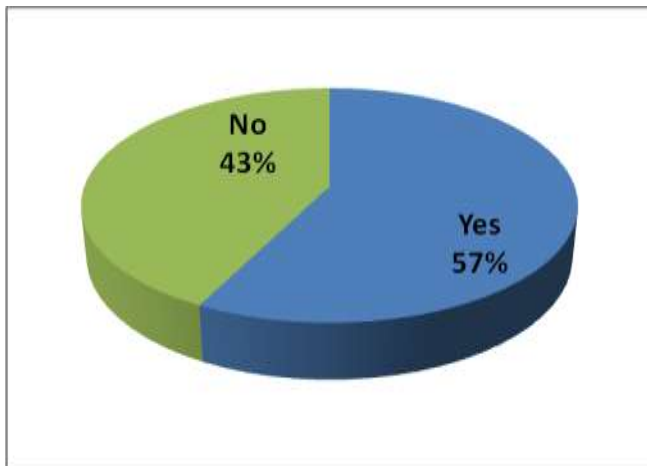
Figure 13 : Interest in having sex with the opposite sex



Source: Primary data, 2014

Figure 13 shows that 55% (22/40) expressed the interest in having sex with the opposite sex while 45 didn't. The findings confirm the results of Figure 4 and imply the attraction by both male and female.

Figure 14 : Identification of MSM by appearance or mannerism



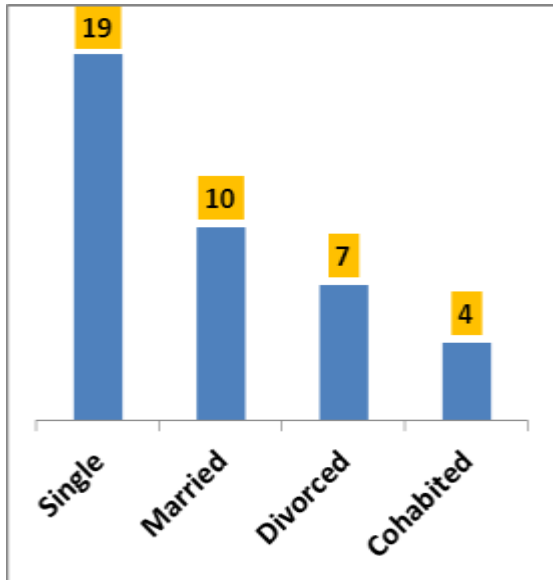
Source: Primary data, 2014

The results of Figure 14 show that 57% of the respondents confirm that men who have sex with men can be identified by their appearance or mannerism in the ways such as dressing, hair style, walking, speaking and looking. These findings inform that men who have sex with men can easily identify their similar which facilitate the networking among them.

Niang et al. (2002) described the receptive MSM as more likely to adopt feminine mannerism and be less dominant in sexual interactions. MSM have distinct identities and social roles that go beyond sexual practices.

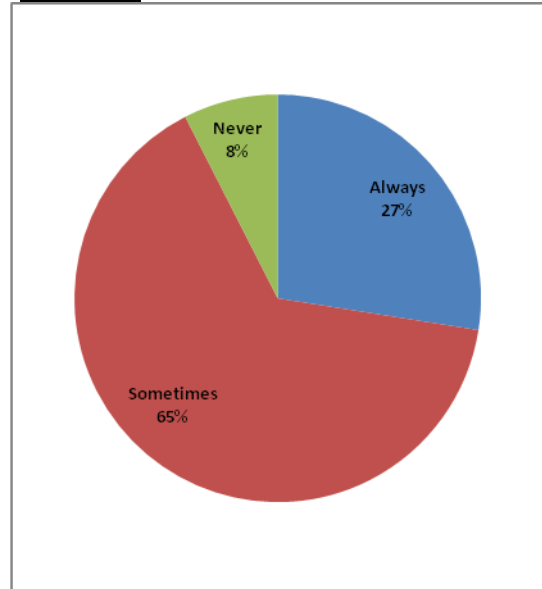
4.2.4 Marital status of current male sexual partner, condom use, feeling about sexual orientation and motivation of disclosure and society reactions on MSM

Figure 15 : Marital status of current male partners



Source: Primary data, 2014

Figure 16 : Level of condom use



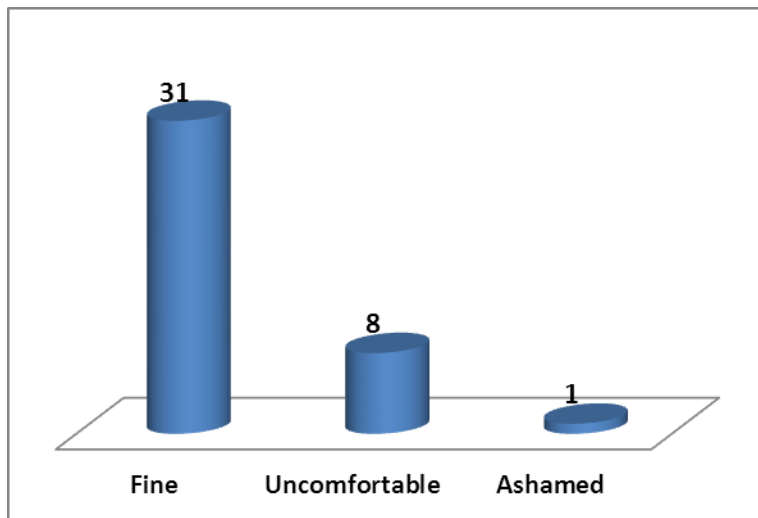
Source: Primary data, 2014

Results of Figure 15 show the marital status of current sexual partners of men who have sex with men in Kigali. The results imply a number of 19 (47.5%) sexual partners are single; 10 (25%) are married; 7 (17.5%) are divorced while 4 (10%) cohabite. No widower sexual partner was mentioned in the study. The findings of Figure 13 complement the Table 1 that shows 90% of MSM in Kigali City are single. This might facilitate sex negotiation among men who have sex with men within their social networks.

Figure 16 complements Figure 10 in terms of risk behavior among men who have sex with men and their sexual partners. The proportion of 25% of MSM sexual partners are married and condom is always and consistently used only at 27%. This implies the high proportion of unprotected sex with MSM in most of their sexual intercourses (65%). Men who have sex with men have sex with married men and at the same time with women, and both with a lower use of condom; this show the channel of spreading HIV and other sexual transmitted infections in heterosexual and same sex couples.

The findings concord with the study conducted in Rwanda in 2009 whose findings showed that condom use among MSM in Kigali was low (24%). Thirty-four respondents reported that they had never previously used a condom with a male or female sexual partner.

Figure 17 : Feelings of MSM about their sexual orientation



Source: Primary data, 2014

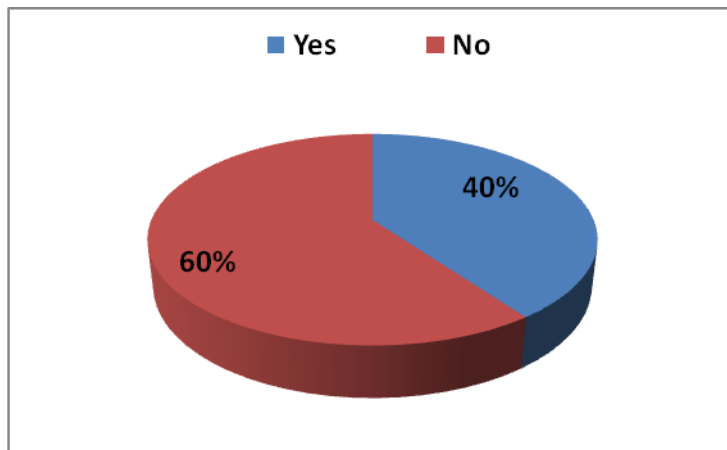
The results of Figure 17 show that 77.5% (31) of men who have sex with men feel fine with their sexual orientation; 20% feel uncomfortable and 2.5% feel ashamed. The feelings are associated with the results of Table 2 about the level of education. When MSM have a certain level of education they feel less prejudiced. Another analysis is that the social and political environment of the country is less discriminating. The health system is more protecting and supportive which make MSM more comfortable and open.

The following stories from MSM confirmed the analysis: *“I am really grateful to our Government that protects its citizens without discrimination as stipulated in the National Constitution. Initiation of health services to men who have sex with is a good example to other neighboring countries. When I go to Uganda to visit my friends, I have pity on MSM from there because they cannot disclose their same sex status with fear of persecution or imprisonment. Of course they resist from seeking health services while in Rwanda the health providers sensitize us to come and benefit services as others”* (MSM from Gasabo district).

Another man who has sex with men said: “I feel more open because there is no law criminalizing us. I really appreciate the support from the Ministry of Health to train health care providers who take good care of us. I particularly appreciate the sessions related to HIV and STI prevention and behavior change. Before, I was not aware of the risk of unprotected anal sex” (A 28 years old MSM from Kicukiro).

During this time, relationships are developed, self-confidence is gained, and many old homophobic beliefs are questioned and re-evaluated. As gay men become more committed to their homosexuality, they begin to be more disclosing to a broader range of individuals in a greater number of social situations and express their homosexual identity more often in public (Cass, 1984).

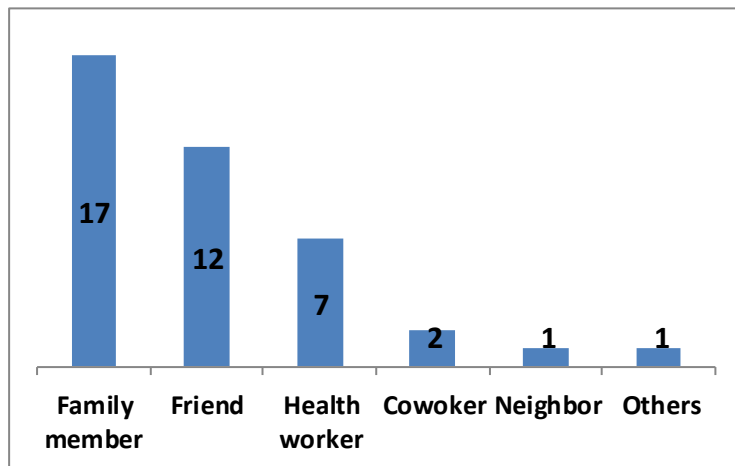
Figure 18 : Desire of having children by MSM (N=40)



Source: Primary data, 2014

As it can be read on the figure above, 16 respondents (40%) do desire having children while 24 (60%) do not. Among the respondents who desire to have children, 87.5% (14/16) do not wish their kids know that their fathers are MSM. The results show that the majority of respondents don't want to have children or more for who already have them.

Figure 19 : The person to whom was first disclosed the sexual identity



Source: Primary data, 2014

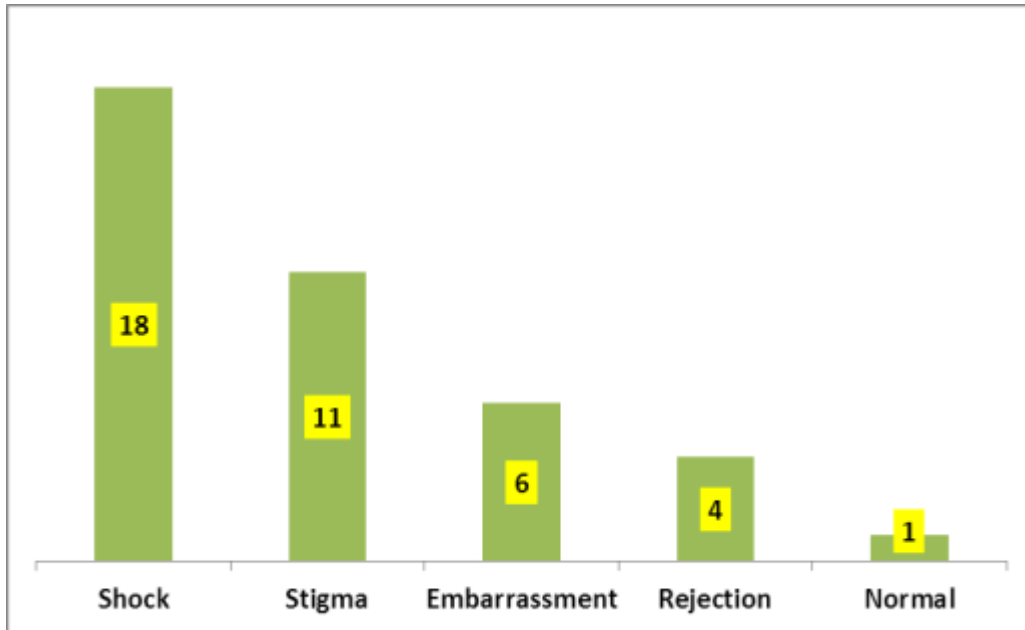
The results of Figure 19 imply the first person to whom men who have sex with men disclosed their sexual identity. Family members rank the first with 17 MSM (42.5%); 12 MSM (30%) disclosed to their friends; 7 MSM (17.5%) disclosed to health care workers; 2 MSM (5%) disclosed to their coworkers while 2 disclosed respectively to a neighbor and another person.

The findings imply the key role of family in the life of children and the complicity among family members. Men who have sex with men feel more comfortable with their family members than others. This informs that families of men who have sex with men in Kigali City are supportive to their sons and are open to discuss with their children about sexual issues including sexual orientation.

Friends are another category of trusted people by men who have sex with men. In the interview, friends were understood as other men who have sex with men and sexual partners. This implies close friendship to share the sexual identity and other sexual issues among peers and sexual partners, especially same sex partners. One man who has sex with other men testified during the interview: *“I have male and female sexual partners, but I do all my best to not be discovered by my girlfriend that I also do sex with other men. I worry she can stop the relationship or tell this to everyone who know me”* (a 22 years MSM from Nyarugenge district).

The findings agree with results of the study conducted in Kigali on MSM (Binagwaho, 2009) where nine men (9%) reported that their families were aware of their homo- or bisexuality (N=99). Seven of these nine respondents had discussed their homo- or bisexuality with their families.

Figure 20 : Society reactions towards MSM (N=40)



Source: Primary data, 2014

Figure 20 shows that the reactions of society are less tolerant to same sex practices. This implies the sensitivity of the issue among society members which limit men who have sex with to disclose their sexual identity and then make them hidden with fear of being stigmatized or rejected. Only one respondent reported normal reaction from society members.

4.3 Perceptions and key attributes of access to health services of MSM

In terms of perceptions and factors that contribute or limit access to health services, different aspects of influence were discussed with men who have sex with men, including availability and utilization of health services, disclosure of their sexual orientation to

providers, waiting time appreciation at health facility, types of services mostly looked for, attitudes and beliefs of providers, society and religious towards MSM and key challenges faced while accessing to health services.

4.3.1 Availability and utilization of health services

Table 4: Availability and utilization of health services, waiting time appreciation and most visited health services (N=40)

Variable	Modalities	N	%
Availability and utilization of health care services	Knowing any health facility offering specific health services to MSM	34	85.0
	Going to any health facility when sick	37	92.5
	Going to the nearest health facility when sick	21	52.5
	Disclosure to health providers of being MSM	32	80.0
Last visit time to the health facility	Between 1-15 days	6	15.0
	Between 16-30 days	6	15.0
	Between 1-3 months	14	35.0
	More than 3 months	13	32.5
	No answer	1	2.5
Waiting time before being seen by a health provider	Between 1-20 min	18	45.0
	Between 21-40 min	13	32.5
	Between 41-60 min	4	10.0
	Over one hour	5	12.5
Waiting time appreciation	Short	16	40.0
	Fair	16	40.0
	Long	8	20.0
Most visited health service as MSM	VCT	21	52.5
	STI	17	42.5
	General consultation	15	37.5
	General counseling	1	2.5

Source: Primary data, 2014

Availability of health services for MSM

The results of Table 2 show that more than eight out of ten (85%) know health facilities offering specific health services to MSM in Kigali City. They mentioned three health facilities: Kabusunzu and Rugarama health centers in Nyarugenge district and Carrefour Polyclinic in Kicukiro district. In 2010, the three facilities initiated health services for men who have sex with the support of ICAP in collaboration with RBC.

The findings imply the wide information sharing among men who have sex with men social networks about the availability of health services for them in Kigali City. A testimony of a MSM about the availability of services: *“I remember the first time I heard that there are health centers that offer services to MSM... I could not quickly understand this and I checked the information with another MSM who confirmed this. He even told me that he is very sure because he talked to someone from RBC. From then, we started share the good news with our peers”* (MSM from Nyarugenge district).

Utilization of health services

Table 2 shows that 92.5% of men who have sex with men (37/40) visit a health facility when they are sick. The utilization was associated with the information and availability of health services for MSM. The proportion of 92.5% show that men who have sex with men were in need of such services and especially as this initiative was the first in the country.

However, only 52.5% of the respondents go to the nearest health facility while 47.5% prefer to go far from their homes. This implies the fear of being recognized by the health providers and other patients from the same zone. They feel more comfortable with the health providers of the three health facilities mentioned above and that offer health services with a particular attention to the specific group of MSM.

The high level of utilization of services was also due to outreach activities organized by the three health facilities to sensitize men who have sex with men in order to increase their access to HIV clinical services as highlighted by ICAP (2013).

Disclosure of sexual orientation to health care providers

Table 2 shows that 80% of the respondents have disclosed their sexual orientation to the health care providers. This implies the level of trust between health care providers and men who have sex with men. Men who have sex with men know that it's from disclosing their sexual orientation that health providers will help them in health care process. On the side of health care providers (N=20), trust is associated with training offered to health providers to deal with men who have sex with men.

The findings differ from the results of the study conducted by Risher et al. (2013) in Swaziland where disclosure of sexual orientation to health care providers was at 31.2%.

Appreciation of waiting time at health facility

Table 2 shows that 80% of the respondents appreciate positively (short and fair) the time they wait before they are seen by health care providers. The waiting time varies between one minute and one hour. This implies the rapidity of health service provision and attention given to MSM when arrived to the health facilities. The results on waiting time were associated with the level of health service utilization by men who have sex with men.

The most visited services

The findings show that men who have sex with men use mostly VCT (Voluntary Counseling and Testing for HIV) and screening and treatment of sexual and transmitted infections (STIs). In Table 4, the number of respondents is greater than 40 because respondents were given the choice to mention two or more services (if needed) they seek mostly.

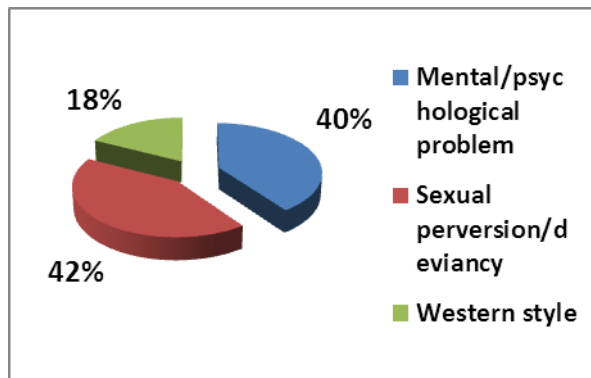
The results were confirmed by health care providers where they mentioned VCT at 75% and STI at 50%. This was associated with the HIV main focus of ICAP and RBC while initiating health services for men who have sex with men.

Furthermore, the findings inform the lack of full integration of services for MSM in the existing services at health facility level. This is observed in the low use of general consultation at 37.5% as the main entry point for all patients.

4.3.2 Societal/cultural and religious beliefs towards MSM

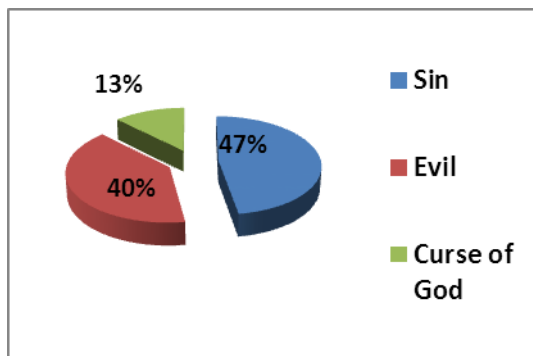
The researcher was interested to know the views regarding what men who have sex with men believe society think about their sexual orientation.

Figure 21 : Societal/cultural beliefs towards same sex practices



Source: Primary data, 2014

Figure 22 : Religious beliefs towards same sex practices



Source: Primary data, 2014

As depicted in Figures 21 and 22, a significant proportion of society and religious members have negative views about same sex practices:

- Society members consider men who have sex with men as mental patients (40%); as sexual deviants (42.5%) or consider this as imitating western style (17.5%). These different views are associated with the attitudes of stigma, rejection and sometimes violence.

The information from Figure 21 is an indicator of knowing how MSM are considered and how this could negatively affect the wellbeing and inhibit access to health services.

Between 1948 and 1990, the World Health organization classified homosexuality as a mental handicap. On 17th May 1990, the General Assembly of the World Health Organization (WHO) removed homosexuality from the list of mental illnesses after a statement that homosexuality is not a disease, a disturbance or a perversion. Dr. Mirta Roses Periago (Director of Pan American Health Organization) to complete this said: “*Since homosexuality is not a disorder or a disease, it doesn’t require a cure. There is no medical indication for changing sexual orientation*”. Since 2004, the date of 17th May was conceived as an **International Day Against Homophobia (IDAHO)** (Boersma, 2012),

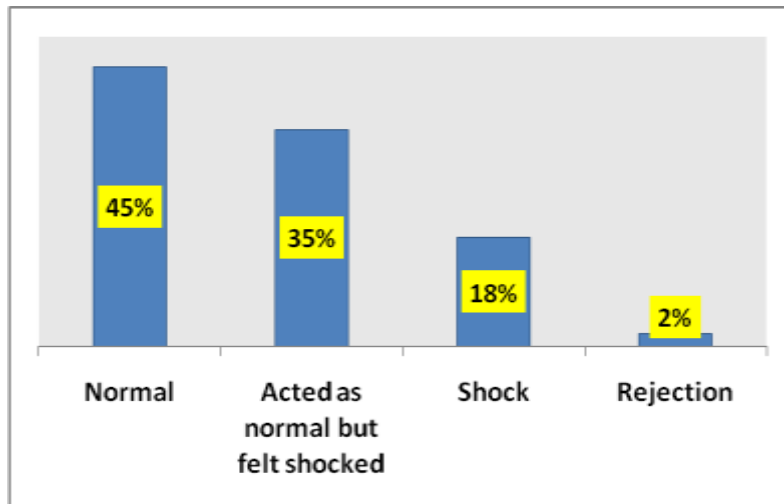
- On the side of religious, Figure 22 shows that men who have sex with men are viewed as sinners (47.5%), as evil (40%) or as cursed by God (12.5%). The findings complete the results of Table 2 about the low level of religiosity of MSM. This means the above judgments make MSM feel guilty and reluctant to churches/mosques activities. In addition, this situation creates barrier in disclosure, then in accessing to health services and prevention of HIV and other sexual transmitted infections.

To summarize this section, societal/cultural and religious beliefs towards same sex practices have implications on access to and use of health services for men who have sex with men. At the end, the same society and religious community are the ones to cope with consequences that are caused by the lack of access to health services. These consequences include morbidity, low productivity and mortality.

4.3.3 Attitudes of health care providers when treating MSM

Figure 23 : Attitudes of health care providers when meeting

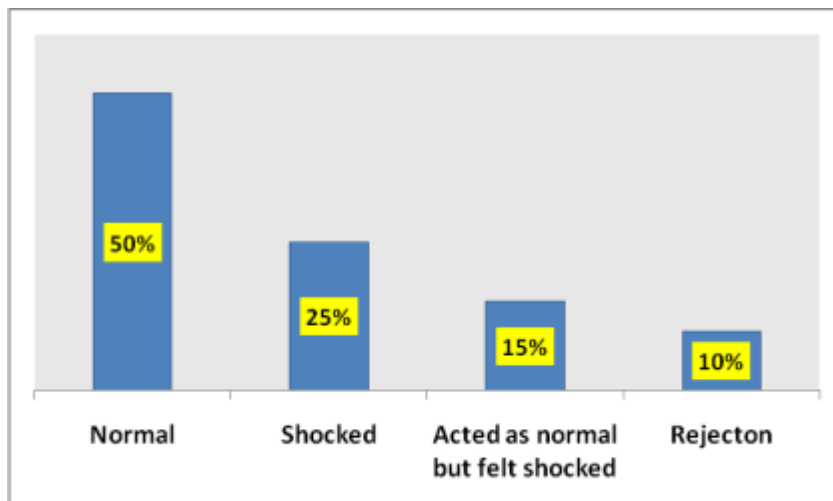
MSM for the first time as interpreted by MSM (N=40)



Source: Primary data, 2014

Figure 24 : Attitudes of health care providers when meeting

MSM for the first time as stated by health providers (N=20)



Source: Primary data, 2014

Figures 23 and 24 show how health providers reacted when they met men who have sex with men for the first time as interpreted respectively by MSM and themselves. 45% and 50% of providers took the issue as normal, 35% and 15% acted as normal but they were feeling shocked, 18% and 25% were openly shocked while 2% and 10% rejected MSM.

Health care providers (45% and 50%) adopted a good attitude about no stigmatization as health professionals. This was emphasized during the training they received on MSM clinical management and 75% of the interviewed health care providers were trained. Training played a great role in avoiding stigmatization as this phenomenon was revealed in some other countries. Indeed, according to Rebe et al. (2013, p.53) "...Clinic staff has received extensive sensitivity and competency training and are accepting of the diversity of MSM. They have become accustomed to providing service to MSM with either a feminine or masculine gender-identity, as well as to transgendered individuals".

Some health care providers (35% and 15%) acted as normal but they were really feeling shocked. They managed to control the shock and bore they are called to treat all patients without any discrimination. They were also trained but this reaction was explained by the social context in which they grew in. A certain number of health care providers (18% and 25%) were shocked because it was their first time to see a man who has sex with other men and could not hide their reaction. One provider testified: *"During discussions with my colleagues about homosexuality, I thought this was simple and theoretical stores from Europe and America. The first time a MSM disclosed to me he has sex with men, I was extremely shocked and I could not believe that. I asked him many questions and I am sure I made him uncomfortable..."* (A social worker from Nyarugenge district).

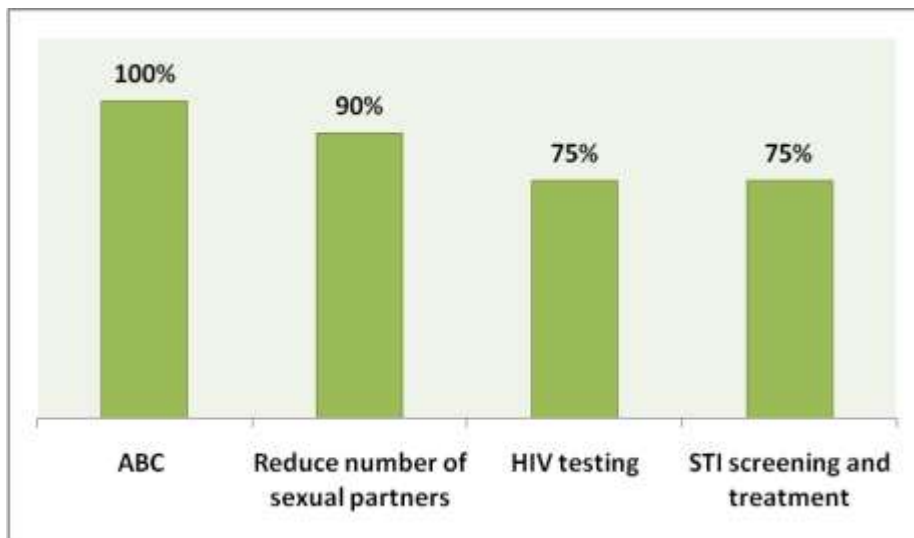
Another proportion of health providers (2% and 10%) rejected MSM who came to the health facility. They said they felt they were taken by devil, like they were dreaming and some even said they escaped the consultation room and left the MSM because they could not treat them. This rejection was associated with lack of training and missing to the code of medical ethics.

The findings concord with the study conducted by Dahan et al. (2007) that said that medical students, during their studies, as well as young doctors, during their residency, often do not

receive comprehensive education on different sexual orientations. In addition, senior doctors lack practical skills in addressing unique health care needs of homosexual patients, which are often minimized or ignored.

4.3.4 Key educational messages provided to MSM

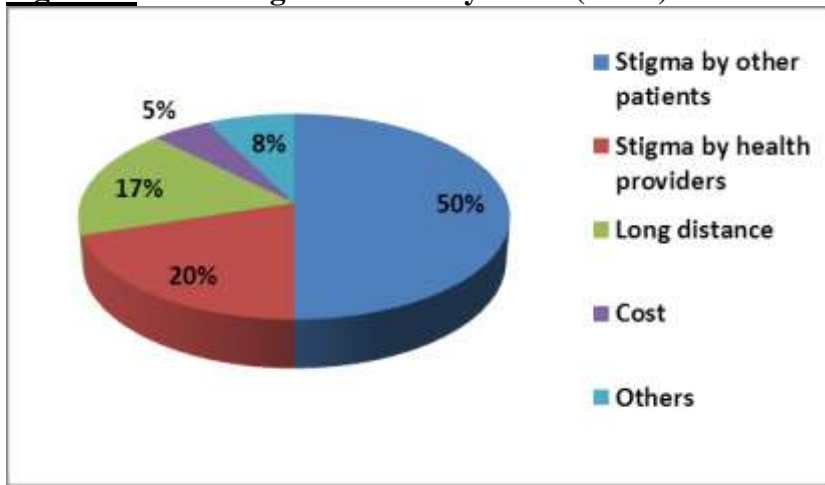
Figure 25 : Key messages on HIV and STIs (N=20)



Source: Primary data, 2014

4.3.5 Key challenges in accessing to health services

Figure 26 : Challenges as stated by MSM (N=40)

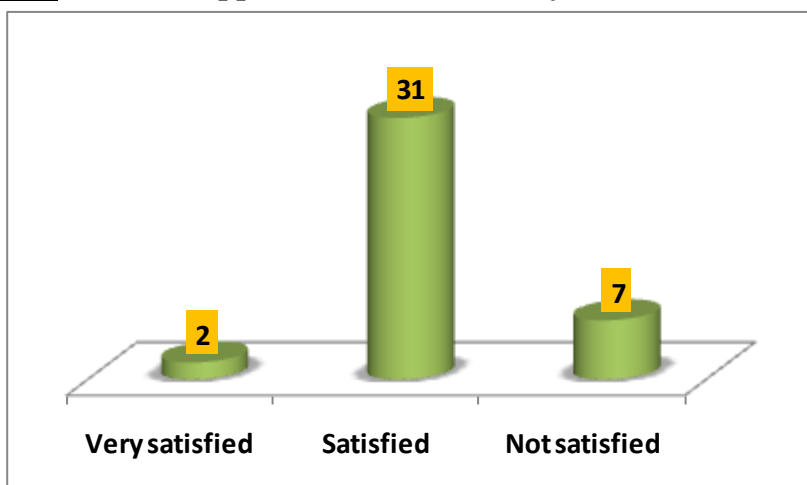


Source: Primary data, 2014

Figure 26 shows the challenges by men who have sex with men while accessing to health services. A half of respondents (50%) mentioned stigma by other patients at health facility, 20% face stigma by health providers, 17% do long distance to reach health facilities that offer health services to MSM, 5% mentioned the cost problem when it comes to pay some medicines when diagnosed any other disease and 8% face other challenges.

4.3.6 General appreciation of health services offered to MSM

Figure 27 : General appreciation of services by MSM



Source: Primary data, 2014

4.3.7 Potential effects of stigma towards health services to MSM

The researcher noticed that 13 out of 20 (65%) health staff interviewed have sensed some kind of frustration, stigma or reticence felt by MSM in accessing health services. Among them, only two health staff (15.3%) presented their excuses while a half of them (50%) send them to a counselor. More so, one health staff confirmed that these psychological effects lead to taking drugs. Those unfriendly and prejudiced services are observed in other countries. Indeed, in Ghana, according to Rebe et al. (2013, p.52), study findings revealed that "...Powerful reminder of the level of stigma, discrimination and human rights abuses that these men face in their everyday lives, including, being denied healthcare, ... or being afraid to seek health care services. MSM experience mainstream state sector healthcare services as unfriendly and prejudiced, which creates a barrier to accessing such services.

4.4 Strategies to enhancing access to health services for MSM

In order to increase access to health care services for MSM, services, activities and strategies were proposed by men who have sex with men to be carried out at national, health facility, community and individual levels.

4.4.1 National Health Policy and Strategic Plan to support MSM

For the national level, men who have sex with men proposed to build the capacity of health care providers, to develop activities for economic empowerment of MSM, to scale up and equip health facilities for MSM services and to provide guidelines on health service provision for MSM. The table below provides more details:

Table 5: Proposed services and activities to be included in the National Policy and Strategic Plan (N=40 and multiple selection permitted)

Variable	Modalities	N	%
Proposed activities and services to support MSM at National level	Scale up health services at all health facilities	22	55.0
	Knowledge on sexual and reproductive health for MSM	14	35.0
	Training of health care providers to remove stigmatizing attitudes towards MSM	16	40.0
	Economic empowerment of MSM	8	20.0
	Avail all necessary equipment and materials to provide friendly health services to MSM	8	20.0
	Guidelines on health service provision for MSM	7	17.5
	Peer education	3	7.5
	Knowledge on MSM risky behavior	3	7.5

Source: Primary data, 2014

The great proportion of men who have sex with men (55%) proposed the scale-up of health services for them because such services are offered at three health facilities and only in Kigali City while other MSM across the country are in need. Another significant proportion (40%) proposed training of health care providers in order to remove stigmatizing attitudes towards MSM. The findings were associated with the results of figures above regarding stigma by health care providers. The interviewed MSM mentioned also education on sexual and reproductive health (35%), economic empowerment (20%), equipment of health facilities (20%), peer education (7.5%) and knowledge on risky behavior (7.5%).

Indeed, according to Rebe et al. (2013), "...for a health provision site to be considered MSM-appropriate, a number of criteria need to be met. Firstly, most MSM require more than a friendly service (often incorrectly referred to as an MSM-sensitized service); they expect competence regarding their specific sexual healthcare needs. Services therefore need to be both sensitive and competent if they are to attract and retain MSM in care."

This model assists in providing an enabling space that promotes feelings of anonymity regarding the reason for attendance, and allays fears of being identified as gay or HIV-infected when attending the clinic. Clinic staff has received extensive sensitivity and competency training and are accepting of the diversity of MSM. Since MSM are at an elevated risk of acquiring and transmitting HIV, prevention technologies assume particular importance.

For health staff, proposed activities are almost the same as proposed above but in different proportions. Table 19 below provides details:

Table 6: Proposed activities and services by health staff to support MSM at National level (N=20 and multiple selection permitted)

Variable	Modalities	N	%
Proposed activities and services to support MSM at National level	Scale up health services at all health facilities	16	80.0
	Training of health care providers to remove stigmatizing attitudes towards MSM	9	45.0
	Knowledge on sexual and reproductive health for MSM	7	35.0
	Knowledge on MSM risky behavior	3	15.0
	Economic Empowerment of MSM	1	5.0
	Avail all necessary equipment and materials to provide friendly health services to MSM	1	5.0

Source: Primary data, 2014

4.4.2 Community, individual and health facility support to MSM

At community, health facility and individual levels, men who have sex with men proposed some services and activities to be developed and integrated in the package to enhance access to health care services. The table below provides more details:

Table 7: Proposed activities and services to support MSM at community, health facility and individual levels (N=40 and multiple selection permitted)

Variable	Modalities	N	%
Proposed activities and services to support MSM at community level	Psychological support	24	60.0
	Peer education	9	22.5
	Knowledge on MSM risky behavior	3	7.5
Proposed activities and services to support MSM at individual level	Peer education	25	62.5
	Knowledge on sexual and reproductive health	10	25.0
	Knowledge on MSM risky behavior	5	12.5
Proposed activities and services to support MSM at health facility level	Friendly services to MSM	22	55.0
	Remove stigmatizing attitudes towards MSM	20	50.0
	Knowledge on MSM risky behavior	1	2.5
	Support group	1	2.5

Source: Primary data, 2014

As it can be read in Table 5, there are several services/activities proposed by men who have sex with men to be developed in order to increase access to health care services.

Support from community

The majority (60%) of respondents wishes the support from community members in terms of psychological; 22.5% mentioned peer education while 7.5% want community members to be educated on risky behavior of men who have sex with men. MSM proposed the above services because they know that if the community is educated on how to deal with men who have sex with men, it will avoid the negative attitudes of community members that include stigma, discrimination and rejection toward them.

In addition, education and peer education will allow community members to understand the reasons for same sex feelings instead of being seen inappropriate. It will also facilitate to promote tolerance and positive beliefs toward diverse sexual orientations.

Support from MSM themselves

At individual level, men who have sex with men proposed peer education (62.5%), knowledge on sexual and reproductive health (25%) knowledge on risky behavior (12.5%) to be incorporated in the package.

Men who have sex with men know how important is their involvement in the implementation of the national health policy to develop self confidence, improve quality of services and enhance prevention messages through peer education. Once considered in the national response, they will have positive attitudes and greater level of disclosure regarding their sexual orientation and self-esteem.

Support from health personnel

Respondents were asked to propose what would be done at health facility level to enhance access to health care services by men who have sex with men. Then, 55% that propose health facility should offer friendly services; 50% to remove stigmatizing attitudes of health care providers; 2.5% to increase knowledge on risky behaviors while 2.5% propose initiation of support groups.

The nature of homosexual practices seems inappropriate because of the heterosexual traditions. This doesn't facilitate men who have sex with men to disclose easily their sexual orientation and to lead health care providers to discomfort or uneasiness when confronted by a patient to be MSM and called to do anal sex examination. Men who have sex with men propose friendly services and remove of stigmatizing attitudes in order to promote open and free space for MSM to seek health services, build trust and confidence between provider and MSM and then improve adherence to health care services.

Indeed, according to Rebe et al. (2013), "... for a health provision site to be considered MSM-appropriate, a number of criteria need to be met. Firstly, most MSM require more than a

friendly service (often incorrectly referred to as an MSM-sensitized service); they expect competence regarding their specific sexual healthcare needs. Services therefore need to be both sensitive and competent if they are to attract and retain MSM in care... It has taken time for MSM groups to develop trust in the clinic and the most effective marketing has occurred by word of mouth via clients who have had a positive health-affirming experience at the clinic.”

Yen et al. (2007) said also that attitudes of health professionals can influence the willingness to provide help to homosexual patients and consequently the quality of health care and treatment.

CHAPTER V: SUMMARY CONCLUSION AND RECOMMENDATIONS

This chapter refers to the presented and analyzed data in the preceding chapter. The summary and conclusion are drawn from discussed findings in accordance with the objectives of the study. Recommendations and areas for further research were suggested.

Based on multiple case study approach, the findings provide good picture of what has been brought from the field and rich and in-depth insights which confirm the usefulness of the research framework used in this work.

The research work sought to explore perceptions and factors influencing access to health care services of men who have sex with men in Kigali City, Rwanda. A sample of 40 respondents was used. The data was analyzed descriptively and qualitative approach explored traits of individuals and settings that could not be easily described numerically. Quantitative approach was also used because numerical data was applied.

5.1 Summary

5.1.1 MSM social experience

The findings revealed that 60% of respondents had their first sex intercourses with female; 40% had female sexual partners during the study period. This means that the majority of men who have sex with men in Kigali City are bisexuals. The results of this study are consistent with the previous findings that reported a significant proportion (69%) of bisexuals in Kenya (Onyango et al., 2006).

The study results indicate that 22.5% of respondents had their first sex intercourses when aged between 10-14 years old. The age at the first sex is below the reproductive age as mentioned in the national family planning policy. The results would call health professionals and decision makers to review the sexual and reproductive health age policy and consequently develop strategies to prevent sexual transmitted diseases and unwanted pregnancies during adolescence. Having the first sex during when young was also revealed in the study conducted by Murray

and Roscoe (2011) that same sex is experimented in adolescence.

The large percentage of respondents in this study indicates that 75% had more than one male sexual partner during the study period; 25% of their sexual partners are married men and only 27.5% always use condom and consistently. This means that strategies for sexual risk reduction are yet far to be reached. Furthermore, sexual transmitted infections including HIV would increase among homosexual and heterosexual couples. The same idea was advanced by Niang et al. (2002), many MSM are at high risk of HIV because of unprotected sex, a history of STI symptoms, and poor knowledge of STIs. When asked about condom use at last sex, only 23 percent of those reporting insertive anal sex said they used a condom. The figure for receptive anal sex was much lower: 14 percent. Condom use with women was also low: 37 percent said they used a condom the last time they had sex with a woman.

The results of this study made it known that 40% were motivated to have sex with other men by inborn behavior. Although most researchers agree that sexual orientation is determined by biological (genetic) and social (environment, family, community) factors.

5.1.2 Perceptions and attributes of access to health care services

The study found out that 92.5% of respondents go to health facility when they are sick and among them, 52.5% go to the nearest health facility. This indicates how men who have sex with men prefer to go far from their homes because they fear to be recognized as MSM by their neighbors of patients and health care providers. Such situation might be challenging to men who have sex with men adherence once enrolled into care and other health services due to the long distance they have to do.

Among 40 participants in the study, 80% had disclosed their sexual orientation to health care providers. This result indicates the level of confidence and trust between men who have sex with men and health care providers. These findings differ from other studies (Knight, 2004) that found men who have sex with men often do not reveal their sexual practices or sexual orientation to their physician. Risher et al. (2013) found that a minority (31.2%) of participants reported having disclosed sexual practices with other men to a healthcare provider.

The results indicate also that men who have sex with men seek more services related to voluntary and counseling of HIV test (VCT) at 52.5% and screening and treatment of sexual and transmitted diseases (STIs) at 42.5%. This was associated with the low use of condom and MSM want to check regularly if they are not infected to HIV or another STI. The presence of specific HIV related services for men who have sex with men are explained by their vulnerability to HIV infection. The same idea was early advanced by other researchers who noted that HIV infection rates among MSM are substantially higher than those of general population adult males in every epidemic assessed (Beyrer et al. 2012); MSM are often referred to as a “bridging population” for HIV transmission between behaviorally bisexual and behaviorally heterosexual populations (Asiimwe et al. 2011); globally, men who have sex with men (MSM) continue to bear a high burden of HIV infection (Smith et al. 2009).

Results of the study indicated that society members think men who have sex with men have mental problems (40%) or sexual perversion (42%). These societal beliefs explain the negative attitudes towards men who have sex with men. The findings indicate that 45% of society members manifest shock and 27.5% stigma towards men who have sex with men.

The study results revealed that 45% (mentioned by MSM) and 50% (mentioned by health care providers) of health care providers adopt positive attitudes towards men who have sex with men. The above attitudes were associated with the training on sensitivity and management of MSM. Similar findings from a study conducted in Kenya revealed that scaling up MSM sensitivity training for African health care workers is likely to be a timely, effective and practical means to improve relevant sexual health knowledge and reduce personal homophobia sentiment among health care workers involved in HIV prevention, testing and care in Sub-Saharan Africa.

5.1.3 Barriers to accessing health care services

Among 40 participants in the study, 50% reported having been stigmatized by other patients at health facility. In addition, among 20 health care providers interviewed, 65% mentioned stigma of MSM by community members in general. The similar results were shown by Ayala et al. (2013) saying that due to stigma, discrimination, and criminalization, the HIV

epidemic among MSM continues to go largely unaddressed in many parts of the world. As of December 2011, 93 countries had failed to report any data on HIV prevalence among MSM over the previous 5 years, and recent reports indicate that less than 2% of global HIV prevention funding is directed toward MSM.

5.2 Conclusion

The study findings show that access to health services of men who have sex with men is attributed to multiple factors. These include characteristic background, social experience, social and cultural beliefs, religious beliefs, availability and affordability of specific health services, attitudes of health care providers as well as psychosocial and structural factors.

The significant level of access to health services by men who have sex with men in Kigali City was more attributed to the national commitment to integrate services for key populations including men who have sex with men, availability of such services at three health facilities of Kigali and improved attitudes of health care providers. In addition, the study results indicated that family members are more supportive towards men who have sex with men.

Understanding of challenges faced by men who have sex with men in accessing health services is essential to guide interventions and strategies to better inform and support men who have sex with men. The beliefs about same-sex practices are combined with stigma and discrimination that keep men who have sex with men hidden; spreads HIV and other sexual transmitted diseases and increases morbidity.

The study findings support the need for targeted health services for men who have sex with men and further prevention strategies should be consider both heterosexuals and homosexuals for effective outcomes.

Based on the principles of medical ethics and the right to health, health services should be inclusive and easily available to all population as well as men who have sex with men. This requires strategies to sensitize and educate providers and other staff members in health care and social service settings in order to underline the principle of non-discrimination for the community health and well-being. Access to health services should be seen in a social justice

way as a right to human life and dignity.

5.2 Recommendations

The following recommendations were given based on the study findings:

Government of Rwanda and Ministry of Health

- The Government has a critical role in ensuring the provision of health care services to all citizens. As a first step, implementation of the National Strategic Plan and the revision of health policy and HIV guidelines and programs to meet the needs of men who have sex with men would go a long way towards addressing health service gaps
- There is a need of ongoing professional development and in-service training programs focusing on sensitivity for health care providers
- As many MSM feel more comfortable using dedicated services, establish centers of excellence and support private health services to integrate them.

Kigali City

- Explore and reach networks of men who have sex with men and their sexual partners engaged in commercial sex work and organize education sessions to improve knowledge regarding the impact of sexual risk behaviors and behavior change.

Men who have sex with men in Kigali City

- Reinforce condom use during every sexual intercourse
- Participate actively in outreach efforts to reach men who have sex with men through peer education.

5.4 Suggested areas for further research

In view of study findings, the following areas were suggested for further research and may focus on:

- Comparison between heterosexual and homosexual individuals living with HIV in terms of their adherence to care and treatment program
- Psychological and sexual health of female sexual partners of men who have sex with men.

REFERENCES

- Alistair, B-Evans (2006). *Homosexuality as Part of Pre-Colonial Africa*, About.com African History. Retrieved from <http://africanhistory.about.com/b/2006/11/07/homosexuality-as-part-of-pre-colonial-africa.htm>
- American Psychological Association (2013). *Resources for LDS Leaders, Families and Friends of those with same sex attraction*, Center for Gender Wholeness, USA
- Amory, Deborah P. (1997). "Homosexuality" in *Africa: Issues and Debates*, Published by African Studies Association. Retrieved from <http://www.jstor.org/stable/1166238>
- Asiimwe A; Chapman J; Basominger C; Kragu S; Kyampof K; Koleros A (2011). *Determinants of HIV risk behaviors among men who have sex with men in Kigali, Rwanda*, Rwanda Biomedical Center
- Ayala, G. (2009). *Social Discrimination Against Men Who Have Sex With Men (MSM). Implications for HIV Policy and Programs*, Global Forum on MSM and HIV (MSMGF), Oakland, CA 94612, United States
- Ayala et al. (2013). *Access to Basic HIV-Related Services and PrEP Acceptability among Men Who Have sex with Men Worldwide: Barriers, Facilitators, and Implications for Combination Prevention*, Journal of Sexual Transmitted Diseases, Volume 2013, Article ID 953123
- Baral, S., Trapence, G., Motimedi, F. et al. (2009). *HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana*. PLoS One, 4, e4997
- Beyrer et al. (2012). *Global epidemiology of HIV infection in men who have sex with men*, The Lancet. Retrieved from http://www.amfar.org/uploadedFiles/_amfarorg/On_the_Hill/SummaryPtsLancet2012.pdf
- Binagwaho, Dr. Agnes; Chapman, Jenifer; Koleros, Andrew; Utazirubanda; Yves; Pegurri, Elisabetta; Gahire, Rose (2009). *Exploring HIV risk among MSM in Kigali, Rwanda*, MEASURE Evaluation, Carolina Population Center, University of North Carolina at Chapel Hill, 206 W. Franklin Street, TR-09-72
- Boellstroff, Tom (2011). *But Do Not Identify as Gay: A Proleptic Genealogy of the MSM Category*. Retrieved from

- <http://culanth.org/articles/36-but-do-not-identify-as-gay-a-proleptic-genealogy>
- Boersma Nik (2012). *World health Organization issues statement condemning LGBT conversion therapies* Global Alliance for LGBT Education. Retrieved from http://www.lgbt-education.info/en/news/global_news/news?id=572
- Bourchier, L (2012). *Getting to Zero in Sub-Saharan Africa: Providing HIV services to men who have sex with men*, UNAIDS. Retrieved from <http://www.unaids.org/en/aboutunaids/unaidstrategygoalsby2015/>
- Cass, Vivienne C. (1984), *Homosexual Identity Formation: Testing a Theoretical Model*, The Journal of Sex Research, Vol. 20, NO 2. Retrieved from: <http://www.jstor.org/discover/10.2307/3812348?uid=3738944&uid=2129&uid=2&uid=70&uid=4&sid=21104422278053>
- Center for Diseases Control and Prevention (CDC). *Gay, Bisexual and Men's Health*, 1600 Clifton Rd. Atlanta, GA 30333, USA
- Chenard, C. (2007). The impact of stigma on the self-care behaviors of HIV-positive gay men striving for normalcy. *Journal of the Association of Nurses in AIDS Care*, 18 (3) [\[PubMed\]](#), [\[Web of Science ®\]](#)
- Chinn, P.L., Kramer, M.K. (1999). *Theory and Nursing Development* (5th ed.), Mosby Inc. St Louis
- Dahan R, Feldman R, & Hermoni D (2007). *The importance of sexual orientation in the medical consultation*. *Harefuah*; 146:626-30, 644
- Desmond Tutu HIV Foundation (2011). *Men who have sex with men: An Introductory Guide for Health Workers in Africa*, South Africa
- Ekwo, Emmanuel (2010). *Homosexuality: Explaining the Zeitgeist*, Author House 1663Liberty Drive Bloomington, IN 47403. Retrieved from www.authorhouse.com
- Fay H, Baral SD, Trapence G, Motimedi F, Umar E, Iiping S, et al. (2011). *Stigma, Health Aare Access, and HIV Knowledge Among Men Who Have Sex With Men in Malawi, Namibia, and Botswana*. *AIDS Behav.* 2011;15:1088–97. PubMed Abstract | Publisher Full Text
- Frankowski, BL (2004). *Sexual orientation and Adolescents*, American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 847-434-4000

- Friedman RC, Downey JI (2002), *Sexual Orientation and Psychoanalysis: Sexual Science and Clinical Practice*, Columbia University Press, ISBN 0231120567, 9780231120562
- Glanz, K., Rimer, B.K. & Lewis, FM. (2002). *Health Behavior and Health Education. Theory, Research and Practice*, San Francisco: Wiley & Sons
- Greenberg, David (1988). *The Construction of Homosexuality*, University of Chicago Press, ISBN: 97802263062851427
- Grollman, EA (2010). *What Is "Sexual Identity"? Is It The Same As Sexual Orientation?* Kinsey Institute, USA
- Gupta, Dr. Neil (2013). *One of the World's Tiniest, Poorest Countries Is Redefining HIV Care*, The Atlantic. Retrieved from <http://www.theatlantic.com/international/archive/2013/12/one-of-the-worlds-tiniest-poorest-countries-is-redefining-hiv-care/281937/>
- Head, Tom (2010), *About.com Civil Liberties*. Retrieved from http://civilliberty.about.com/od/gendersexuality/g/sex_orientation.htm
- Hladik W, Barker J, Ssenkusu JM, Opio A, Tappero JW, et al. (2012). *HIV infection among Men Who Have Sex with Men in Kampala, Uganda – A Respondent Driven Sampling Survey*. PLoS ONE 7 (5): e38143. Doi: 10.1371/journal.pone.0038143
- Horizon Community Association (2007). *Rwanda: Situation Update - The Treatment of LGBT Individuals in Rwandan Law and Society*, International Gay and Lesbian Human Rights Commission. Retrieved from <http://iglhrc.org/content/rwanda-situation-update-treatment-lgbt-individuals-rwandan-law-and-society>
- ICAP (2012). *Enhancing HIV Prevention for the MSM Population in Mali, South Africa, and Rwanda*. Retrieved from <http://icap.columbia.edu/news-events/detail/enhancing-hiv-prevention-for-the-msm-population-in-mali-south-africa-and-rw>
- ICAP (2012), *Enhancing HIV Prevention for the MSM Population in Mali, South Africa, and Rwanda*. Retrieved from <http://icap.columbia.edu/news-events/detail/enhancing-hiv-prevention-for-the-msm-population-in-mali-south-africa-and-rw>
- ICAP (2013). *Reaching MSM with HIV Prevention, Care and Treatment Services in Rwanda*, Columbia Mailman School of Public Health. Retrieved from

<http://icap.columbia.edu/news-events/detail/reaching-msm-with-hiv-prevention-care-and-treatment-services-in-rwanda>

- Jellison, William A. (2003). *The Mediating Effects of Attitudes Toward Homosexuality Between Secure Attachment and Disclosure Outcomes Among Gay Men*, The Haworth Press, Inc. 10.1300/J082v46n01_05. Retrieved from <http://www.haworthpress.com/store/product.asp?sku=J082>
- Knight, Daniel (2004). *Health Care Screening for Men Who Have Sex with Men*, American Family Physician, Little Rock, Arkansas. Retrieved from <http://www.aafp.org/afp/2004/0501/p2149.html>
- Lane, T, Raymond HF, Dladla S, Rasethe J, Struthers H, Mcfarland W, McIntyre J. (2011). *High HIV prevalence among men who have sex with men in Soweto, South Africa: results from the Soweto Men's study*. AIDS Behav. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/19662523>
- Laumann EO, Gangnon JH, Michel RT, Michaels S. (1994). *The social organization of sexuality: Sexual Practices in the United States*, University of Chicago Press, Chicago, USA
- Lustig, N (2004). *Macroeconomics and Health: Investing in Health for Economic Development*, Mexican Commission on Macroeconomics and Health, Santa Catarina Mártir, Cholula, 72820 Puebla, México, ISBN 968-6254-66-8
- Maslow, Abraham (1943). *A Theory of Human Motivation*, Psychological Review #50, p.370-396
- Meersman, Brent (2012). *Homosexuality is African*, Mail and Guardian. Retrieved from <http://www.thoughtleader.co.za/brentmeersman/2012/03/26/homosexuality-is-african/>
- Murray and Roscoe (2001). *Boys Wives and Female Husbands, Studies of African Homosexualities*, Palgrave Macmillan, New York, USA
- National AIDS Control Commission (2009). *Rwanda National HIV Strategic Plan for HIV 2009-2012*, Kigali, Rwanda
- National AIDS Control Commission (2009). *Rwanda National Strategic Plan on HIV and AIDS 2009-2012*, Ministry of Health, Kigali Rwanda

- National AIDS Control Commission (2010). *United Nations General Assembly Special Session on HIV and AIDS. Country Progress Report January 2008 - December 2009*, Republic of Rwanda, Kigali
- National Institute of Statistics of Rwanda (2012). *4th Rwanda Population Census*. Retrieved from <http://www.statistics.gov.rw>
- Niang, Cheikh Ibrahima et al. (2002). *Meeting the Sexual Health Needs of Men Who Have Sex With Men in Senegal*, Institute of Environmental Sciences, Cheikh Anta Diop University, Senegal
- Niang, Cheikh Ibrahima et al. (2003). « *It's raining stones* »: *Stigma, violence and HIV vulnerability among men who have sex with men in Dakar*, Senegal
- Nthamburi, Z. (1991). *From mission to church: a handbook of Christianity in East Africa*, Uzima Press, Nairobi, Kenya
- Oaks ED (2002), *Same-Gender Attraction*, The Church of Jesus Christ of Latter-Day Saints. Retrieved from <https://www.lds.org/ensign/1995/10/same-gender-attraction?lang=eng>
- Olubuloye, IO; Omoniyi OP; Shokunbi, WA (1995). *Sexual networking, STDs and HIV/AIDS in four urban goals in Nigeria*, Health Transition Review, Supplement to Volume 5, 1995, 123-129
- Onyango-Ouma, W.; Birungi, Harriet and Scott Geibel (2006). *Understanding the HIV/STI prevention needs of men who have sex with men in Kenya*, Horizons Research Summary. Washington, D.C. Population Council
- Perkins, Dwight H. et al, (2006). *Economics of Development*, W. W. Norton & Company; 6th edition
- Pope Francis (2013). “*Who Am I to judge Gay People*”? BBC. Retrieved from <http://www.bbc.co.uk/news/world-europe-23489702>
- Population Council (2002); McKenna (1996); Panos Institute (1990). *Meeting the Sexual Health Needs of Men Who Have Sex With Men in Senegal*. Retrieved from <http://www.popcouncil.org/pdfs/horizons/msmsenegal.pdf>
- Population Council (2012). *MARPS Sensitization: A Diversity Training Guide for Health Care Providers in Nigeria. Series 1: Working with Men who have Sex with Men (MSM)*. Retrieved from

http://www.popcouncil.org/uploads/pdfs/2012HIV_ENR-MARPsSensitization.pdf

- Pritchard, EE Evans (1970). *Sexual Inversion among the Azande*. American Anthropologist, American Anthropological Association, New Series, Vol. 72, N0. 6
- Rebe, K B et al. (2003). *Towards 'men who have sex with men- appropriate' health services in South Africa*, June 2013, Vol. 14, No. 2 SAJHIV MED
- Rebe, K B et al. (2013). *Towards 'men who have sex with men- appropriate' health services in South Africa*. Retrieved from <http://www.sajhivmed.org.za/index.php/sajhivmed/rt/printerFriendly/841/822>
- Rebe K B, Struthers H, De Swardt G, McIntyre JA (2011). *HIV Prevention and treatment for South African men who have sex with men*. S Afr Med J 2011;101(10):708-710
- Risher et al. (2013). *Sexual stigma and discrimination as barriers of seeking appropriate healthcare among men who have sex with men in Swaziland*, Journal of the International AIDS Society. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3833105/>
- Rolfe B, Binagwaho A, Gahima I, Marara IK, Rugamba ER and Rusagara F (2007). *Learning from Prisoners. Understanding risk to prevent HIV infection among prisoners and wider community. A case study of Kimironko prison in Kigali, Rwanda*, United States Agency for International Development, Rwanda
- Roscoe W, Murray SO, editors. (1998). *Boy-wives and female-husbands: Studies in African Homosexualities*, New York: PALGRAVE
- Rwanda Biomedical Center (2011). *Determinants of HIV risk behaviors among men who have sex with men (MSM) in Kigali, Rwanda*
- Rwanda National Institute of Statistics (2012). *Rwanda Demographic and Health Survey 2010*, Ministry of Finance and Economic Planning, Kigali, Rwanda
- Sifris, Dennis; Myhre, James (2014). *Men Who Have Sex with Men (MSM)-HIV/AIDS*, About.com AIDS/HIV
- Sigmund, Freud (1953). *Three Essays on the Theory of Sexuality*, In J. Strachey (Ed.&Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 7, pp. 123–246). London: Hogarth Press (Original work published 1905)

- Smith, Adrian D et al. (2009). *Men who have sex with men and HIV/AIDS in Sub-Saharan Africa*, The Lancet, Volume 374, Issue 9687. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)61118-1/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61118-1/abstract)
- Teltamanzi D (1997). *Christian Anthropology and Homosexuality – 1- Homosexuality in the context of Christian anthropology*, The Cathedral Foundation, L'Osservatore Romano English Edition, Baltimore, MD 21201, (410) 547-5380
- UNAIDS (2006). *Report on the Global AIDS epidemic: Executive Summary. A UNAIDS 10th Anniversary Special Edition*, UNAIDS/06.20E, ISBN 92 9 173511 6
- UNAIDS (2009). *UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People*, UNAIDS/09.22E – JC1720E
- UNAIDS (2010). *A Hidden Epidemic: HIV, Men Who Have Sex with Men and Transgender People in Eastern Europe and Central Asia Regional Consultation*, UNAIDS, Ukraine
- UNAIDS (2011). *UNAIDS Terminology Guidelines*, UNAIDS, Switzerland
- UNAIDS (2012). *HIV and Outreach Programmes with Men Who Have Sex with Men in the Middle East and North Africa. From A Process of Raising Awareness to A Process of Commitment*, Cairo, Egypt. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/20120920_MSM_MENA_en.pdf
- UNAIDS (2013). *Report on Global AIDS Epidemic*. Retrieved from <http://www.unaids.org/en/resources/campaigns/globalreport2013/globalreport/>
- Weinberg G. (1972). *Society & and the healthy homosexual*. New York: St Martin's Press
- Whitehead, Neil E., PhD. (1999). *My Genes Made Me Do It!* Huntington House Pub.
- Wright, K., Naar King, S., am, P., Templin, T., Frey, M. (2007). *Stigma Scale Revised: Reliability and Validity of a Brief Measure of Stigma For HIV+ Youth*, National Institute of Health,
- Yen CF et al. (2007). Attitudes toward gay men and lesbians and related factors among nurses in Southern Taiwan. *Public Health* 2007; 121:73-79
- Young, RM & Meyer, IH (2005). *The trouble with “MSM” and “WSW”: Erasure of the sexual minority person in public health discourse*. *American Journal of Public Health*, 95: 1144-1149

APPENDICES

APPENDIX 1

CONSENT FORM FOR PARTICIPATION

Introduction

Thank you. My name is Eugenie INGABIRE, we are conducting a study to assess the perceptions and factors influencing access to health care services of men who have sex with men in Kigali City. We need your contribution to know and understand these perceptions and factors. Your answers to these questions today will help better understanding.

Description of procedures

We would like to invite you to participate in this study by taking part in an individual life history. The interview consists of both short answer and more open-ended questions that will take less than 40 min to complete. I will take notes of your story during the interview to be able to remember what you said when I will write report.

Risks and inconveniences

Your name will not be written on your interview notes or included in any summary or report. No one outside the study will read the notes from your interview.

As already noted, we will do everything we can to keep your data secure, and the information you will give me will be kept strictly confidential.

Benefits

You may not benefit directly from this study, but we expect you as well as people you know in the near future, particularly men who have sex with men to be given much more attention in health service provision.

Confidentiality

Your name will not be recorded on the interview form. Instead the form will have a study number. Everything you say during this interview will be held confidential and the information

you give during this interview will not in any way be used against you or your family. Your name will never appear in any written report.

Only myself and my study supervisor will be able to look at and copy your research records.

Voluntary participation

Your participation in this interview is voluntary and you do not have to answer any question you are not comfortable with. You can decide to end your participation in the interview at any time. Ending the interview will have no impact on your life. However, your participation is very important and we welcome your ideas and suggestions.

Please feel free to ask any questions you may have about your participation in this study or in the interview process.

Compensation or financial consideration

You will be provided with an honorarium of 2000 RWF to compensate for your time.

APPENDIX 2

INTRODUCTION TO THE INTERVIEW

Thank you again for agreeing to participate in our study. Keep in mind that all comments are valued and there are no wrong answers or opinions. You can choose not to answer any questions that you do not want to. You may also ask me to explain questions if you do not understand them. You may also stop the interview at any time if you decide no longer want to participate. Please remember that your responses to our questions are identified only by number and will be kept confidential. Your name does not appear on this questionnaire.

As I told you, we are conducting a study to assess the perceptions and factors influencing access to health care services of men who have sex with men. We need your contribution to know and understand these perceptions and factors. Your answers to these questions today will help better understanding.

- Participation in this study is voluntary and you are not obliged to respond to a question if you do not want to.
- We will handle all information you provide as strictly confidential
- Before we begin, please review this consent agreement (*Give copy of agreement*)
- If you sign this agreement, it means that you agree to participate in this discussion.
- We will give you a copy of the signed agreement and we will keep one for our records.

APPENDIX 3

PARTICIPANT CONSENT

I understand the purpose of the study. I also understand that my participation in this study is voluntary. It has been made clear to me that I may decide at any time to stop participating in the study. It has also been explained to me that I will not suffer any penalty; neither will I lose any benefits. I am willing to participate in this study on my own free will.

Yes, I would like to participate in this study

No, I do not want to participate in this study

Name and signature of participant

.....

APPENDIX 4

QUESTIONNAIRE FOR MSM/IBIBAZO BIBAZWA ABAGABO BAKORA IMIBONANO MPUZABITSINA N'ABANDI BAGABO

Questionnaire ID :

Date of interview/*Itariki y'ibazwa*:/...../.....

District/*Akarere atuyemo*:

Province/*Intara*:

A. SOCIO-DEMOGRAPHIC CHARACTERISTICS

N0	Questions/ <i>Ibibazo</i>	Responses/ <i>Ibisubizo</i>
A1	Date of birth/ <i>Itariki y'amavuko</i>	DD/MM/YY/ <i>Umunsi/Ukwezi/Umwaka</i>
A2	What is your marital status/ <i>Ni iyihe rangamimerere yawe?</i>	<ol style="list-style-type: none"> 1. Single/<i>Ingaragu</i> 2. Married/<i>Yashyingiwe mu mategeko</i> 3. Cohabited/<i>Afite uwo babana nk'abashakanye</i> 4. Separated/<i>Batandukanye n'uwo bashakanye bitaremezwa n'amategek</i> 5. Divorced/<i>Yatandukanye n'uwo bashakanye mu mategeko</i> 6. Widower/<i>Umupfakazi</i>
A3	What is you level of education/ <i>Wize amashuri angahe?</i>	<ol style="list-style-type: none"> 1. None/<i>Ntayo</i> 2. Primary/<i>Abanza</i> 3. Adult literacy/<i>Ayo gusoma no kwandika ku bakuru</i> 4. TVET/<i>Imyuga</i> 5. Secondary/<i>Ayisumbuye</i> 6. University/<i>Amakuru/kaminuza</i> 7. Other/specify/<i>Andi/Sobanura</i>
A4	What is your occupation/ <i>Ukora iki?</i>	<ol style="list-style-type: none"> 1. Student/<i>Umunyeshuri</i> 2. Not employed/<i>Nta kazi</i> 3. Small business employee/<i>Nkorera abandi mu bucuruzi</i> 4. Small business owner/<i>Mfite ubucuruzi bwanjye</i> 5. Public sector employee/<i>Nkorera ikigo cya leta</i> 6. NGO's employee/<i>Nkorera umuryango utegamiye kuri leta</i>

		Other/specify/ <i>Ibindi/ sobanura</i>
A5	What is your monthly income (in Rwf)/ <i>Winjiza amafaranga angahe ku kwezi?</i>	<ol style="list-style-type: none"> 1. Less than 15.000/<i>Munsi ya 15 000</i> 2. Between 15.000 na 20.000/<i>Hagati ya 15.000-20.000</i> 3. Between 21.000-50.000/<i>Hagati ya 21.000-50.000</i> 4. Between 51.000-100.000/<i>Hagati ya 50.000-100.000</i> 5. More than 100.000/<i>Hejuru ya 100.000</i>
A6	Do you attend church/mosque? Which denomination/ <i>Usengera mu rihe torero?</i>	<ol style="list-style-type: none"> 1. None/<i>Ntaryo</i> 2. Roman Catholic/<i>Umugaturika</i> 3. Protestant/<i>Umuporoso</i> 4. Adventist/<i>Umudivantisite</i> 5. Muslim/<i>Umuyisilamu</i> 6. Other/specify/<i>Irindi/Rivuge</i>
A7	How religious are you/ <i>Witabira ute aho usengera?</i>	<ol style="list-style-type: none"> 1. Very/<i>Cyane</i> 2. Moderate/<i>Bigereranije</i> 3. Little/<i>Buhoro</i> 4. None/<i>Sinitabira</i>

B. SEXUAL EXPERIENCE/AMAKURU KU MIBONANO MPUZABITSINA

N0	Questions/<i>Ibibazo</i>	Responses/<i>Ibisubizo</i>
B1	Of which sex did you have sex for the first time/ <i>Umuntu mwakoranye imibonano mpuzabitsina bwa mbere ni uw'ikihe gitsina?</i>	<ol style="list-style-type: none"> 1. Male/<i>Gabo</i> 2. Female/<i>Gore</i>
B2	How old were you when you had your first sexual intercourse/ <i>Wari ufite imyaka ingahe ukora imibonano mpuzabitsina bwa mbere?</i>	<ol style="list-style-type: none"> 1. Between 10-14/<i>Hagati ya 10-14</i> 2. Between 15-18/<i>Hagati ya 15-18</i> 3. Between 19-21/<i>Hagati ya 19-21</i> 4. Between 22-25/<i>Hagati ya 26-30</i> 5. Between 26-30/<i>Hagati ya 26-30</i> 6. Between 31-40/<i>Hagati ya 31-35</i> 7. <i>Between 41-50/Hagati ya 41-50</i> 8. More than 50/<i>Hejuru ya 50</i>
B3	How old was your sexual partner/ <i>Uwo mwakoranye imibonano mpuzabitsina we yari afite imyaka ingahe?</i>	<ol style="list-style-type: none"> 1. Between 10-14/<i>Hagati ya 10-14</i> 2. Between 15-18/<i>Hagati ya 15-18</i> 3. Between 19-21/<i>Hagati ya 19-21</i> 4. Between 22-25/<i>Hagati ya 26-30</i> 5. Between 26-30/<i>Hagati ya 26-30</i> 6. Between 31-40/<i>Hagati ya 31-35</i> 7. <i>Between 41-50/Hagati ya 41-50</i> 8. More than 50/<i>Hejuru ya 50</i>

B4	What do you think was the motivation to have sex with other man/men/ <i>Ni iki utekereza cyaba cyaraguteye guhitamo gukora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Inborn behavior/<i>Niko navutse</i> 2. Inability to acquire masculine identity/<i>Numvaga ntifitemo ubugabo muri jye</i> 3. Early homosexual experiences/<i>Nakoranye imibonano mpuzabitsina n'abandi bagabo ndi muto</i> 4. Gain money/<i>Nashakaga amafaranga</i> 5. Other/specify/<i>Ikindi/sobanura</i>
B5	Do you ever feel interested in having sex with the opposite sex/ <i>Ujya wumva ufite ubushake bwo gukora imibonano mpuzabitsina n'umuntu mudahuje igitsina (gore)?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
B6	How long do you have sex with other men/ <i>Hashize igihe kingana gute ukora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Between 1-6 months/<i>Hagati y'amezi 1-6</i> 2. Between 7-12 months/<i>Hagati y'amezi 7-12</i> 3. Between 1-3 years/<i>Hagati y'imyaka 1-3</i> 4. Between 4-6 years/<i>Hagati y'imyaka 4-6</i> 5. Between 7-10 years/<i>Hagati y'imyaka 7-10</i> 6. More than 10 years/<i>Hejuru y'imyaka 10</i>
B7	Can MSM be identifiable by their appearance or mannerism/ <i>Ese umugabo ukora imibonano mpuzabitsina umuntu ashobora kumureba agahita amumenya ahereye ku myitwarire n'imigirire ye?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
B8	If yes, what are the characteristics that differ from other men/ <i>Niba ari yego, ni ibiki bimuranga bitandukanye n'iby'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Dressing/<i>Imyambarire</i> 2. Hair style/<i>Uko asokoza</i> 3. Walking/<i>Uko agenda</i> 4. Speaking/<i>Imivugire</i> 5. Others/specify/<i>Ibindi/sobanura</i>
B9	How many male and female sexual partners do you have now/ <i>Ubu waba ufite abantu b'igitsina gabo n'igitsina gore bangahe mujya mukorana imibonano mpuzabitsina?</i>	<ol style="list-style-type: none"> 1. Male/<i>Abagabo:</i> 2. Female/<i>Abagore:</i>
B10	How many male and female sexual partners did you have in the past 12 months/ <i>Mu meze 12 ashize waba waragize abantu b'igitsina gabo n'igitsina gore bangahe mwakoranye imibonano mpuzabitsina?</i>	<ol style="list-style-type: none"> 1. Male/<i>Abagabo:</i> 2. Female/<i>Abagore:</i>

B11	What is the current marital status of your male sexual partners(s)/Uwo/abo mukorana imibonano mpuzabitsina b'igitsina gabo bafite iyihe rangamimerere?	<ol style="list-style-type: none"> 1. Single/ <i>Ingaragu</i> 2. Married/<i>Yashyingiwe mu mategeko</i> 3. Divorced/<i>Yatandukanye n' uwo bashakanye</i> 4. Widower/ <i>Umupfakazi</i> 5. Cohabited/<i>Afite uwo babana nk' abashakanye</i> 6. Don't know/<i>Simbizi</i>
B12	What is the current profession of your male sexual partner(s)/Uwo/abo mukorana imibonano mpuzabitsina b'igitsina gabo bakora iki (akazi)?	<ol style="list-style-type: none"> 1. Student/<i>Umunyeshuri</i> 2. Public sector employee/<i>Umukozi wa leta</i> 3. NGO sector employee/<i>Umukozi mu muryango utegamiye kuri leta</i> 4. Business person/<i>Umucuruzi</i> 5. Teacher/<i>Umwariimu</i> 6. Other/<i>Specify/Undi/muvuge</i>
B13	How often do you use condom (and lubricant) during your sexual intercourses with male partners/ <i>Ukoresha agakingirizo kangaha iyo ukora imibonano n' abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Always/<i>Buri gihe</i> 2. Sometimes/<i>Rimwe na rimwe</i> 3. Never/<i>Nta na rimwe</i> 4. Don't know/<i>Simbizi</i>
B14	How do you feel about your sexual orientation as MSM/ <i>Ese wiyumva gute muri wowe kuba ukora imibonano mpuzabitsina n' abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Fine/comfortable/<i>Neza</i> 2. Uncomfortable/<i>Siniyumva neza</i> 3. Ashamed/<i>Numva mfite ikimwaro</i> 4. Frustrated /<i>Numva mfite ipfunwe</i> 5. Other/<i>specify/ikindi/sobanura</i>
B15	To whom did you disclose first your sexual identity/ <i>Ninde wabwiye bwa mbere ko ukora imibonano mpuzabitsina n' abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Family member/<i>Uwo mu muryango</i> 2. Friend/<i>Inshuti</i> 3. Neighbor/<i>Umuturanyi</i> 4. Coworker/<i>Uwo dukorana</i> 5. Health worker/<i>Umukozi wo kwa muganga</i> 6. Peer educator/<i>Umukangurambaga</i> 7. Religious leader/<i>Umuyobozi mu idini</i> 8. <i>Other/specify/Abandi/sobanura</i>
B16	According to you, what usually prompts MSM to decide to disclose they are MSM/ <i>Ku bwawe, utekereza ko ari iki gituma umugabo ukora imibonano mpuzabitsina n' abandi bagabo afata icyemezo cyo kubivuga?</i>	<ol style="list-style-type: none"> 1. To access to services/<i>Kugira ngo mbashe kubona ubufasha</i> 2. To a potential sexual partner/<i>Kuwo ntekereza ko twakorana imibonano mpuzabitsina</i> 3. To respond to an asked question/<i>Kugira ngo nsubize ikibazo nabajijweniba nkora imibonano mpuzabitsina n' abandi bagabo</i> 4. To my peer because I'm comfortable with him/<i>Kuwo duhuje gukora imibonano mpuzabitsina n' abandi bagabo</i> 5. Others/<i>specify/Indi mpamvu/sobanura</i>

B17	What are the reactions of the society (family members, neighbors, service providers or people in general) when they noticed that someone is MSM/ <i>Ese ubona aho mutuye/sosiyete (abo mu muryango, abaturanyi, abaganga n'abandi bose muri rusange) bagaragaza iki nk'imyifatire iyo bamenye ko ukora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Shock/<i>Gukubitwa n'inkuba</i> 2. Embarrassed/<i>Babuze uko bagira</i> 3. Rejection/<i>Numvise ntamwakira</i> 4. Stigma/<i>Akato</i> 5. Normal/<i>Nk'ibisanzwe</i> 6. Support/<i>Barushaho kutwitaho</i> 7. Others/specify/<i>Ikindi/sobanura</i>
B18	Did/do you ever face any violence because you are MSM/ <i>Waba warigeze uhohoterwa mu buryo ubwo ari bwo bwose kubera ko ukora imibanano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
B19	If yes, how have you been violated <i>/Niba ari yego, waba warahohotewe ute?</i>	<ol style="list-style-type: none"> 1. Stigmatized/<i>Nahawe akato</i> 2. Beaten/<i>Narakubiswe</i> 3. Slapped/<i>Nakubiswe inshyi</i> 4. Shouted/<i>Natewe imigeri</i> 5. Raped/<i>Nafashwe ku ngufu</i> 6. Others/specify/<i>Ibindi/sobanura</i>
B20	Do you plan to have or do you have children/ <i>Wumva wifuza kugira cyangwa waba ufite abana?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
B21	If yes, do you want your kids to know you are MSM/ <i>Niba ari yego, wumva abana bawe bamenya ko ukora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>

C. PERCEPTIONS AND FACTORS INFLUENCING ACCESS TO AND USE OF HEALTH SERVICES FOR MSM/IMPAMVU ZITERA KUBONA/KUTABONA NDETSE NO GUKORESHA/KUDAKORESHA UBUFASHA BW'UBUVUZI BUGENEWE ABAGABO BAKORA IMIBONANO MPUZABITSINA N'ABANDI BAGABO

N0	Questions/Ibibazo	Responses/Ibisubizo
C1	When you are sick or need any health service, do you go to any health facility/ <i>Waba ujya kwa muganga iyo urwaye cyangwa ukeneye ubundi bufasha bw'ubuvuzi?</i>	<ol style="list-style-type: none"> 1. Yes/Yego 2. No/Oya
C2	Do you go to the nearest health facility when you are seek or need any health service/ <i>Ujya ku ivuriro riri hafi yawe iyo urwaye cyangwa ukeneye ubundi bufasha bw'ubuvuzi?</i>	<ol style="list-style-type: none"> 1. Yes/Yego 2. No/Oya
C3	If not, why do you prefer to go far from you home/ <i>Niba ari oya, kuki uhitamo kujya kure y'aho utuye?</i>	<ol style="list-style-type: none"> 1. Availability of health services /<i>Niho hari ubufasha bugenewe abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i> 2. Fear to be seen by people who know me/<i>Ntinya ko abantu banzi bambona</i> 3. Allow me to meet other MSM/<i>Bimfasha guhura n'abandi bagabo bakora imibonano mpuzabitsina n'abandi bagabo</i> 4. Others/specify/<i>Ibindi/sobanura</i>
C4	Do you know if there are any health facilities offering specific health services to MSM/ <i>Waba izi niba hari amavuriro afasha akanatanga ubufasha bw'ubuvuzi ku bagabo bakora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Yes/Yego 2. No/Oya
C5	If yes, how did you come to find out the health services available for MSM/ <i>Wamenye ute ko hari ubufasha bw'ubuvuzi bugenewe abagabo bakora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. By a friend/<i>Inshuti</i> 2. By peer educator/<i>Umukangurambaga</i> 3. By a family member/<i>Uwo mu muryango</i> 4. By a coworker/<i>Uwo dukorana</i> 5. By health worker/<i>Umukozi wo kwa muganga</i> 6. By radio/TV/<i>Radiyo/televiziyo</i> 7. By newspaper/magazine/<i>Ikiyamakuru</i> 8. Other/specify/<i>Ukundi/kuvuge</i>

C6	Did you disclose to health care providers that you are MSM/Waba hari abakozi bo kwa muganga wabwiye ko ukora imibonano mpuzabitsina n'abandi bagabo?	<ol style="list-style-type: none"> 1. Yes/Yego 2. No/Oya
C7	If yes, how comfortable were you/ Niba ari yego, wumvaga umeze ute?	<ol style="list-style-type: none"> 1. Very comfortable/ Nisanzuye cyane 2. Comfortable/Nisanzuye 3. Not comfortable/Ntisanzuye 4. Not comfortable at all/Ntisanzuye na gato
C8	When is your last time you have visited the clinician/Ni ryari uheruka kujya kwa muganga?	<ol style="list-style-type: none"> 1. Between 1-15 days/ Hagati y'iminsi 1-15 2. Between 16-30 days/ Hagati y'iminsi 16-30 3. Between 1-3 months/ Hagati y'ameze 1-3 4. More than 3 months/ Hejuru y'amezi 3
C9	The last time you have visited the clinic, how long did you have to wait before you are seen by a clinician? /Ubwo uheruka kwa muganga, wategereje igihe kingana gute kugira ngo ubonane n'umuganga?	<ol style="list-style-type: none"> 1. Between 1-20 min/Iminota 1-20 2. Between 21-40 min/Iminota 21-40 3. Between 41-60 min/Iminota 41-60 4. Up to 1 hour/Hejuru y'isaha
C10	How do you appreciate this waiting time/Icyo gihe ubona kingana gute kuri wowe?	<ol style="list-style-type: none"> 1. Short/Gito 2. Long/Kinini 3. Fair/Kirakwiye
C11	Which health service do you seek the most/Ni ubuhe bufasha ukenera kenshi/inshuro nyinshi kwa muganga?	<ol style="list-style-type: none"> 1. General consultation/ Kwisuzumisha muri rusange 2. Counseling/Ubujyanama 3. VCT/Kwipimisha virusi itera Sida ku bushake 4. STI/Kwisuzumisha no kwivuzza indwara zifata imyanya ndangagitsina 5. TB/Kwipimisha no kwivuzza igituntu 6. Other/specify/Ibindi/sobanura
C12	With whom do you feel more comfortable to talk to about your health problems/Ninde wumva wisanzuyeho cyane igihe uvuga ibibazo bijyanye n'ubuzima bwawe	<ol style="list-style-type: none"> 1. Family member/Uwo mu muryango 2. Friend/Inshuti 3. Health worker/Umukozi wo kwa muganga 4. Peer educator/Umukangurambaga 5. Other MSM/MSM mugenzi wanjye 6. Others/specify/Undi/Muvuge
C13	What do you think are the societal and cultural beliefs towards MSM/ Ni iki utekereza nk'imyumvire ya sosiyete n'umuco ku birebana n'abagabo bakora imibonano mpuzabitsina n'abandi bagabo?	<ol style="list-style-type: none"> 1. Mental/Psychological problem/Ikibazo/uburwayi bwo mu mutwe 2. Sexual perversion/ Imibonano mpuzabitsina inyuranije n'umuco 3. Western style/Iby'abanyaburayi 4. Others/specify/Ibindi/sobanura

C14	What is religious beliefs towards MSM/ <i>Ese mu rwego rw'idini ubona imyumvire ku bagabo bakora imibonano mpuzabitsina n'abandi bagabo yo imeze ite?</i>	<ol style="list-style-type: none"> 1. Sin/Icyaha 2. Evil/Imyuka mibi 3. Curse of God/Umuvumo 4. Others/specify/Ibindi/sobanura
C15	Do you get any psychological harm in life due to your sexual orientation/ <i>Mu buzima bwawe hari ibibazo ugira mu mitekerereze yawe cyangwa biguhungabanya bitewe n'uko ukora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Yes/Yego 2. No/Oya
C16	Do you ever feel stigmatized as MSM/ <i>Byigeze kukubaho ko uhabwa akato kubera ko ukora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Yes/Yego 2. No/Oya
C17	If yes, what do you do in such case/ <i>Niba ari yego ubytwaramo ute icyo gihe?</i>	<ol style="list-style-type: none"> 1. I feel unhappy/Birambabaza 2. I isolate myself/Ndigunga 3. I feel sad/Ngira agahinda 4. I feel angry/Ndarakara 5. I feel furious/Ngira umujinya 6. Other/specify/Ikindi/sobanura
C18	Who gives you emotional support/ <i>Ninde uguha ubufasha/ugukomeza iyo wumva wahungabanye?</i>	<ol style="list-style-type: none"> 1. None/Ntawe 2. Family members/Uwo mu muryango 3. Friend/Inshuti 4. Neighbor/Umururanyi 5. Coworker/Uwo dukorana 6. Health worker/Umuganga 7. Peer educator/Umukangurambaga 8. Religious leader/Umuyobozi mu idini 9. Other/specify/Undi muntu/sobanura
C19	Do you ever take drugs/ <i>Waba warigeze gufata ibiyobwabwenge?</i>	<ol style="list-style-type: none"> 1. Yes/Yego 2. No/Oya
C20	If yes, what is the motivation around this drug use/ <i>Niba ari yego watubwira impamvu yatumye ubifata?</i>	<ol style="list-style-type: none"> 1. Stress/Kudatekana 2. Loss of self-esteem/Kutigirira icyizere 3. Peer pressure/Kwigana abandi 4. Others/specify/Ibindi/sobanura

C21	How do clinicians respond once they identify you as MSM/ <i>Ubona abaganga babyakira gute iyo bamenye ko ukora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Shocked/<i>Bakubitwa n'inkuba</i> 2. Resigned/<i>Babura uko bagira</i> 3. Normal/<i>Nk'ibisanzwe</i> 4. Supportive/ <i>Batwitaho kurushaho</i> 5. Reject us/<i>Banga kutwakira</i> 6. Others/specify/<i>Ikindi/sobanura</i>
C22	Do clinicians speak to you about how to prevent from HIV and other sexual transmitted infections/ <i>Abaganga babaganiriza ku buryo bwo kwirinda agakoko gatera Sida n'izindi ndwara zifata imyanya ndangagitsina?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
C23	Are there changes or improvements that have been made in providing health services to MSM/ <i>Ese haba hari impinduka zabaye mu guha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ubufasha bw'ubuvuzi?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
C24	What are things you liked more about health care services/ <i>Ni iki wakunze kurusha ibindi ku bijyanye n'ubufasha bw'ubuvuzi?</i>	<ol style="list-style-type: none"> 1. Welcome/custom care/<i>Uburyo bwo kwakira abarwayi</i> 2. Quality of services/<i>Uburyo bwiza ubufasha butangwamo</i> 3. Availability of MSM services/<i>Kuba hari ubufasha bugenewe aba MSM</i> 4. Infrastructures/<i>Inyubako zimeze neza</i> 5. Others/specify/<i>Ibindi/sobanura</i>
C25	What are things you did not like about health care services/ <i>Ni iki utakunze ku bijyanye n'ubufasha bw'ubuvuzi?</i>	<ol style="list-style-type: none"> 1. Welcome/custom care/<i>Uburyo bwo kwakira abarwayi</i> 2. Quality of services/<i>Uburyo butari bwiza ubufasha butangwamo</i> 3. Infrastructures/<i>Inyubako zitameze neza</i> 4. Others/specify/<i>Ibindi/sobanura</i>
C26	How do you appreciate the quality of services you get from health care providers in general/ <i>Muri rusange, ni gute mwishimira uburyo muhabwa ubufasha bugenewe abagabo bakora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Very satisfied/<i>Ndabyishimiye cyane</i> 2. Satisfied/<i>Ndabyishimiye</i> 3. Not satisfied/<i>Simbyishimiye</i> 4. Not satisfied at all/<i>Simbyishimiye na gato</i>

C27	Would you send other MSM to health facilities for services/ <i>Wumva washishikariza abandi bagabo bakora imibonano mpuzabitsina n'abandi bagabo kujya kwa muganga guhabwa ubufasha bw'ubuvuzi</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
C28	What are the barriers or challenges do you face as MSM in accessing to health services/ <i>Ni izihe nzitizi cyangwa imbogamizi muhura nazo mu kwitabira ubufasha bwo kwa muganga?</i>	<ol style="list-style-type: none"> 1. Stigma/<i>Akato</i> 2. Rejection/<i>Gucibwa/gutereranwa</i> 3. Poverty/<i>Ubukene</i> 4. Long distance to reach the health facility/<i>Urugendo rurerure</i> 5. Others/specify/<i>Ibindi/sobanura</i>
C29	Do you manage to afford health services easily/ <i>Ese ubasha kubona/kwiyishyurira serivise zo kwa muganga ku buryo bworoshye?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
C30	If not, how do you get support/ <i>Niba ari oya icyo gihe ninde ugufasha?</i>	<ol style="list-style-type: none"> 1. Social service/<i>Abafasha abatishoboye</i> 2. Friend/<i>Inshuti</i> 3. Parents/<i>Ababyeyi</i> 4. Sister/brother/<i>Umuwandimwe</i> 5. NGO/<i>Umuryango utegamiye kuri leta</i> 6. Other/specify/<i>Undi/sobanura</i>
C31	What has been the most difficult experience concerning your life as MSM you have faced so far in accessing health services/ <i>Nk'umugabo ukora imibonano mpuzabitsina n'abandi bagabo, kugeza ubu ni iki cyakugoye/cyagukomerereye kurusha ibindi mu kubona ubufasha bw'ubuvuzi?</i>	<ol style="list-style-type: none"> 1. Stigma by a health care provider/ <i>Nahawe akato n'abaganga</i> 2. Stigma by other patients/<i>Nahawe akato n'abandi barwayi</i> 3. The cost/<i>Igiciro cy'ubufasha</i> 4. The long distance/<i>Urugendo rurerure</i> 5. Other/specify/<i>Ibindi/sobanura</i>
C32	While accessing health care services, are you facing problems related to geographical location/ <i>Iyo ukeneye ubufasha bwo kwa muganga hari inzitizi zijyane n'aho ubufasha buherereye ugira?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>

D. WHAT CAN BE DONE TO ENHANCE ACCESS TO HEALTH SERVICES BY MEN WHO HAVE SEX WITH MEN IN RWANDA/ NI IKI CYAKORWA NGO ABAGABO BAKORA IMIBONANO MPUZABITSINA N'ABANDI BAGABO MU RWANDA BARUSHEHO KWITABIRA GAHUNDA ZO KWA MUGANGA?

N0	Questions/Ibibazo	Responses/Ibisubizo
D1	<p>What services and activities should be included in a National Health Policy and Strategic Plan to support MSM/ Ni ibihe bikorwa byakongerwa muri politike n'igenamigambi by'ubuzima mu rwego rwo gufasha abagabo bakora imibonano mpuzabitsina n'abandi bagabo?</p>	<ol style="list-style-type: none"> 1. Training of health care providers to remove stigmatizing attitudes towards MSM/ <i>Kwigisha abaganga guhindura imyitwarire ishyira mu kato abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i> 2. Knowledge on sexual and reproductive health for MSM/ <i>Kwigisha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ku buzima bw'imyororokere</i> 3. Knowledge on MSM risky behavior/<i>Kwigisha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ku myitwarire yabashyira mu kaga</i> 4. Peer education/ <i>Ubukangurambaga</i> 5. Support group/<i>Amatsinda y'ubufatanye</i> 6. Economic empowerment of MSM/<i>Gufasha abagabo bakora imibonano mpuzabitsina n'abandi bagabo kwiteza imbere mu bukungu</i> 7. Other/specify/<i>Ibindi/sobanura</i>
D2	<p>What can be done at individual level/ Ni iki cyakorwa ku rwego rw'abagabo bakora imibonano mpuzabitsina n'abandi bagabo kugira ngo barusheho kwitabira no kugoresha ubufasha bw'ubuvuzi?</p>	<ol style="list-style-type: none"> 1. Peer education/ <i>Ubukangurambaga</i> 2. Knowledge on sexual and reproductive health for MSM/ <i>Inyigisho ku buzima bw'imyororokere y'abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i> 3. Knowledge on MSM risky behavior/<i>Inyigisho ku myitwarire yabashyira mu kaga abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i> 4. Others/specify/<i>Ibindi/sobanura</i>
D3	<p>What about the community level/Ni iki cyakorwa ku rwego rw'abaturage kugira ngo abagabo bakora imibonano mpuzabitsina n'abandi bagabo barusheho kwitabira no</p>	<ol style="list-style-type: none"> 1. Peer education/ <i>Ubukangurambaga</i> 2. Knowledge on MSM risky behavior/<i>Inyigisho ku myitwarire yabashyira mu kaga abagabo bakora</i>

	<i>kugoresha ubufasha bw'ubuvuzi?</i>	<p><i>imibonano mpuzabitsina n'abandi bagabo</i></p> <p>3. Psychosocial support to MSM/ <i>Guha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ubufasha mu mitekerereze</i></p> <p>4. Others/specify/<i>Ibindi/sobanura</i></p>
D4	<p>What about service level (hospital and health center level)/ <i>Ni iki cyakorwa ku rwego rw'ivuriro (ibitaro n'ibigo nderabuzima) kugira ngo abagabo bakora imibonano mpuzabitsina n'abandi bagabo barusheho kwitabira no kugoresha ubufasha bw'ubuvuzi?</i></p>	<p>1. Remove stigmatizing attitudes of health care providers towards MSM/<i>Guhindura imyitwarire y'abaganga ishyira mu kato abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>2. Friendly services for MSM/ <i>Ubufasha bunogeye abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>3. Knowledge on sexual and reproductive health for MSM/ <i>Kwigisha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ku buzima bw'imyororokere</i></p> <p>4. Knowledge on MSM risky behavior/<i>Kwigisha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ku myitwarire yabashyira mu kaga</i></p> <p>5. Support group/ <i>Amatsinda y'ubufatanye</i></p> <p>6. Others/specify/<i>Ibindi/sobanura</i></p>
D5	<p>What can be done by the Ministry of Health/ <i>Ni iki cyakorwa ku rwego rwa Minisiteri y'Ubuzima kugira ngo abagabo bakora imibonano mpuzabitsina n'abandi bagabo barusheho kwitabira no kugoresha ubufasha bw'ubuvuzi?</i></p>	<p>1. Guidelines on health service provision for MSM/ <i>Imirongo ngenderwaho mu gutanga ubufasha bw'ubuvuzi ku bagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>2. Scale-up health services at all health facilities/ <i>Kugeza ubufasha bw'ubuvuzi bugenewe abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>3. Avail all necessary equipment and materials to provide friendly health services to MSM/<i>Kugena ibikoresho byose bikenewe kugira ngo abagabo bakora imibonano mpuzabitsina n'abandi bagabo bahabwe ubufasha bw'ubuvuzi bunoze</i></p> <p>4. Training of health care providers to remove</p>

		<p>stigmatizing attitudes towards MSM/<i>Kwigisha abaganga guhindura imyitwarire ishyira mu kato abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>5. Others/specify/<i>Ibindi/sobanura</i></p>
D6	<p>Do you have any other thoughts about health services for MSM/ <i>Hari ibindi bitekerezo ufite ku bufasha bw'ubuvuzi buhanbwa abagabo bakora imibonano mpuzabitsina n'abandi bagabo?</i></p>	<p>1. Yes/<i>Yego</i> 2. No/<i>Oya</i></p>
D7	<p>If yes, please list your suggestions/ <i>Niba ari yego, vuga ibyo bitekerezo</i></p>	<p>- - - - -</p>

APPENDIX 6

QUESTIONNAIRE FOR HEALTH CARE PROVIDERS/*IBIBAZO*

BIBAZWA ABAKOZI BO KWA MUGANGA

Questionnaire ID :

Date of interview/*Itariki y'ibazwa*:/...../.....

Health facility/*Ivuriro*:

Position/title/*Icyo ukora/ushinzwe*:

District/*Akarere*:

Province/*Intara*:

A. SOCIO-DEMOGRAPHIC CHARACTERISTICS

N0	Questions/ <i>Ibibazo</i>	Responses/ <i>Ibisubizo</i>
A1	Sex/ <i>Igitsina</i>	<ol style="list-style-type: none"> 1. Male/<i>Gabo</i> 2. Female/<i>Gore</i>
A2	How old are you/ <i>Ufite imyaka ingahe?</i>	
A3	What is your marital status/ <i>Ni iyihe rangamimerere yawe?</i>	<ol style="list-style-type: none"> 1. Single/<i>Ingaragu</i> 2. Married/<i>Yashyingiwe mu buryo bwemewe n'amategeko</i> 3. Divorced/<i>Yatandukanye n'uwo bashakanye</i> 4. Widower/<i>Umupfakazi</i> 5. Cohabited/<i>Afite uwo babana nk'abashakanye</i>
A4	Do you attend church/mosque? Which denomination/ <i>Usengera mu rihe torero?</i>	<ol style="list-style-type: none"> 1. None/<i>Ntaryo</i> 2. Roman Catholic/<i>Umugaturika</i> 3. Protestant/<i>Umuporoso</i> 4. Adventist/<i>Umudivantisite</i> 5. Muslim/<i>Umuyisilamu</i> 6. Other/specify/<i>Irindi/Rivuge</i>
A5	How religious are you/ <i>Witabira ute aho usengera?</i>	<ol style="list-style-type: none"> 1. Very/<i>Cyane</i> 2. Moderate/<i>Bigereranije</i> 3. Little/<i>Buhoro</i> 4. None/<i>Sinitabira</i>
A6	Have you worked outside Rwanda/ <i>Waba</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>

	<i>warigeze gukora hanze y'u Rwanda?</i>	
A7	If yes, where/ <i>Niba ari yego, mwakoze hehe?</i>	
A8	If yes, for how long/ <i>Niba ari yego, mwahakoze igihe kingana gute?</i>	<ol style="list-style-type: none"> 1. Between 1-6 months/ <i>Hagati y'amazi 1-6</i> 2. Between 7-12 months/ <i>Hagati y'amezi 7-12</i> 3. Between 1-3 years/ <i>Hagati y'imyaka 1-3</i> 4. Between 4-6 years/ <i>Hagati y'imyaka 4-6</i> 5. Between 7-10 years/ <i>Hagati y'imyaka 7-10</i> 6. More than 10 years/ <i>Hejuru y'imyaka 10</i>

B. GENERAL QUESTIONS/IBIBAZO RUSANGE

N0	Questions/Ibibazo	Responses/Ibisubizo
B1	When did you meet MSM for the first time in your professional career/ <i>Kuva utangiye akazi, ni ryari wahuye n'umugabo ukora imibonano mpuzabitsina n'abandi bagabo bwa mbere?</i>	<ol style="list-style-type: none"> 1. Between 1-6 months/ <i>Hagati y'amazi 1-6</i> 2. Between 7-12 months/ <i>Hagati y'amezi 7-12</i> 3. Between 1-3 years/ <i>Hagati y'imyaka 1-3</i> 4. Between 4-6 years/ <i>Hagati y'imyaka 4-6</i> 5. Between 7-10 years/ <i>Hagati y'imyaka 7-10</i> 6. More than 10 years/ <i>Hejuru y'imyaka 10</i>
B2	What was your first reaction when meeting him/them/ <i>Ubwa mbere uhuye n'abagabo bakora imibonano mpuzabitsina wifashe ute ukibyumva?</i>	<ol style="list-style-type: none"> 1. Shocked/<i>Nakubiswe n'inkuba</i> 2. Resigned/<i>Nabuze uko ngira</i> 3. Normal/<i>Nk'ibisanzwe</i> 4. Supportive/<i>Narushijeho kubitaho</i> 5. Rejection/<i>Numvise ntamwakira</i> 6. Others/specify/<i>Ikindi/sobanura</i>
B3	Why did you react in that way/ <i>Kuki wumvise ubaye gutyo?</i>	<ol style="list-style-type: none"> 1. It was the first time to hear that/ <i>Ni ubwa nari mbyumvise</i> 2. I could not tolerate this/ <i>Sinashoboraga kubyihanganira</i> 3. I could not understand/<i>Numvaga ntabyuma</i> 4. Others/specify/<i>Ikindi/sobanura</i>
B4	What usually prompts MSM to decide to disclose they are MSM/ <i>Utekereza ko ari iki gituma ba MSM bafata icyemezo cyo kuvuga ko ari ba MSM?</i>	<ol style="list-style-type: none"> 1. To access to services/<i>Kugira ngo mbashe kubona ubufasha</i> 2. To a potential sexual partner/<i>Kuwo ntekereza ko twakorana imibonano mpuzabitsina</i> 3. To respond to an asked question/<i>Kugira ngo nsubize ikibazo nabajijweniba nkora imibonano mpuzabitsina n'abandi bagabo</i> 4. To a peer because he is comfortable with him/<i>Kuwo duhuje gukora imibonano mpuzabitsina n'abandi bagabo</i> 5. Others/specify/<i>Indi mpamvu/sobanura</i>

B5	From which entry points are MSM seen at the health facility/ <i>Ni izihe serivise aba MSM binjiriramo iyo bakeneye ubufasha?</i>	<ol style="list-style-type: none"> 1. General consultation/<i>Isuzuma rusange</i> 2. VCT/<i>Aho bapimira ku bushake virusi itera Sida</i> 3. STI/<i>Aho basuzumira bakanavura indwara zifata imyanya ndangagitsina</i> 4. TB/<i>Aho basuzumira bakanavura igituntu</i> 5. Other/specify/<i>Ahandi/sobanura</i>
B6	How do you consider MSM/ <i>Ese utekereza iki ku ba MSM?</i>	<ol style="list-style-type: none"> 1. As other people/<i>Nk'abandi bose</i> 2. As mental patients/<i>Abarwayi bo mu mutwe</i> 3. As sexual deviants/<i>Abantu bayobye</i> 4. As sinners/<i>Abanyabyaha</i> 5. As cursed by God/<i>Ibivume</i> 6. Other/specify/<i>Abandi/sobanura</i>
B7	How do you feel vis-à-vis MSM's behavior in social life/ <i>Ese ubona ute imyitwarire y'aba MSM mu buzima busanzwe?</i>	<ol style="list-style-type: none"> 1. Like other people/<i>Nk'abandi bose</i> 2. Differently/<i>Baratandukanye</i> 3. In a western style/<i>Bitwara nk'abazungu</i> 4. Other/specify/<i>Abandi/sobanura</i>
B8	Do you think MSM, bisexual and heterogeneous behave differently/ <i>Utekereza ko ba MSM, abakora imibonano mpuzabitsina n'abo badahuje ibitsina bitwara mu buryo butandukanye?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>

C. PERCEPTIONS AND FACTORS INFLUENCING ACCESS TO AND USE OF HEALTH SERVICES FOR MSM/IMPAMVU ZITERA KUBONA/KUTABONA NDETSE NO GUKORESHA/KUDAKORESHA UBUFASHA BW'UBUVUZI BUGENEWE ABAGABO BAKORA IMIBONANO MPUZABITSINA N'ABANDI BAGABO

N0	Questions/Ibibazo	Responses/Ibisubizo
C1	Do MSM face any psychological problems/ <i>Aba MSM baba bahura n'ibibazo by'ihungabana?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
C2	If yes, how does this affect their mental health/ <i>Niba ari yego, ni gute bigira ingaruka ku buzima bwo mu mutwe?</i>	<ol style="list-style-type: none"> 1. Frustration/<i>Ipfunwe</i> 2. Isolation/<i>Kwigunga</i> 3. Drug abuse/<i>Gufata ibiyobyabwenge</i> 4. Lack of self-esteem/<i>Kutigirira icyizere</i>

		<p>5. Lack of confidence/ <i>Kutagira uwo yizera</i></p> <p>6. Others/specify/<i>Ibindi/sobanura</i></p>
C3	Is there an HIV risk assessment done for all MSM who come at the health facility/ <i>Haba hari uburyo bwo kumenya uko aba MSM bose baza ku ivuriro bahagaze ku birebana na virusi itera Sida?</i>	<p>1. Yes/<i>Yego</i></p> <p>2. No/<i>Oya</i></p>
C4	What age is mostly affected/ <i>Ni ikihe cyiciro cyanduye virusi itera Sida kurusha ibindi byiciro?</i>	<p>1. Young/<i>Abakiri bato</i></p> <p>2. Adults/<i>Abakuru</i></p> <p>3. Old/<i>Abakuze/Abasaza</i></p>
C5	Is there a room specific and organized for MSM services/ <i>Haba hari icyumba cyihariye cyagenewe gutangirwamo ubufasha ku ba MSM?</i>	<p>1. Yes/<i>Yego</i></p> <p>2. No/<i>Oya</i></p>
C6	Are MSM affected by other diseases/ <i>Aba MSM baba bibasirwa n'izindi ndwara?</i>	<p>1. Yes/<i>Yego</i></p> <p>2. No/<i>Oya</i></p>
C7	If yes, what does mostly affect them/ <i>Niba ari yego, ni izihe zindi bakunze kurwara cyane?</i>	<p>1. Malaria/<i>Malariya</i></p> <p>2. TB/<i>Igituntu</i></p> <p>3. STI/<i>Indwara zifata imyanya ndangagitsina</i></p> <p>4. Others/specify/<i>Ibindi/sobanura</i></p>
C8	What are the common sexual transmitted infections that affect MSM/ <i>Mu ndwara zifata imyanya ndangagitsina ni izihe abagabo bakora imibonano mpuzabitsina n'abandi bagabo bakunze kurwara?</i>	<p>1. Syphilis</p> <p>2. Gonorrhea</p> <p>3. Chlamydia</p> <p>4. Pubic lice</p> <p>5. Others/specify</p>
C9	Are they educated on how to prevent the aforesaid diseases/ <i>Ese mwaba mubigisha uburyo bashobora kwirinda ziriya ndwara zose mwavuze?</i>	<p>1. Yes/<i>Yego</i></p> <p>2. No/<i>Oya</i></p>
C10	If yes, how often do you do it/ <i>Niba ari yego, mubigisha kangahe?</i>	<p>1. Once a week/ <i>Rimwe mu cyumweru</i></p> <p>2. Once a month/<i>Rimwe mu kwezi</i></p>

		<ol style="list-style-type: none"> 3. Twice a month/<i>Kabiri mu kwezi</i> 4. Once a quarter/<i>Rimwe mu gihembwe</i> 5. Once a year/<i>Rimwe mu mwaka</i> 6. Other/specify/<i>Ibindi/sobanura</i>
C11	What measures of prevention are taught/ <i>Ni izihe ngamba zo kwirinda mubigisha?</i>	<ol style="list-style-type: none"> 1. Abstinence/<i>Kwifata</i> 2. To be faith/<i>Ubudahemuka</i> 3. Condom use/<i>Agakingirizo</i> 4. Other/specify/<i>Ikindi/sobanura</i>
C12	What are the key messages provided by health staff for MSM during medical visits/ <i>Ni ubuhe butumwa bw'ingenzi abaganga baha abagabo bakora imibonano mpuzabitsina n'abandi bagabo iyo baje ku ivuriro?</i>	<ol style="list-style-type: none"> 1. HIV testing/<i>Kwipimisha virusi itera Sida</i> 2. HIV care and treatment/<i>Kwitabira gahunda zifasha ababana na virusi itera Sida</i> 3. STI screening and treatment/<i>Kwisuzumusha no kwivuza igituntu</i> 4. Reduce number of sexual partners/<i>Kugabanya umubare w'abo bakorana imibonano mpuzabitsina</i> 5. Always use condom and consistently/<i>Gukoresha agakingirizo buri gihe kandi neza</i> 6. To be in support group/<i>Kujya mu itsinda ry'ubufatanye</i> 7. To seek counseling/<i>Gusaba ubujyanama mu ihungabana</i> 8. Others/specify/<i>Ibindi/sobanura</i>
C13	Are health care providers trained in providing services to MSM/ <i>Hari abaganga bahuguwe by'umwihariko ku gutanga ubufasha bw'ubuvuzi ku ba MSM?</i>	<ol style="list-style-type: none"> 1. Yes/<i>yego</i> 2. No/<i>Oya</i>

C14	What are the barriers and challenges have you so far faced while treating MSM/ <i>Kugeza ubu ni izihe mbogamizi muhura nazo mu kuvura aba MSM?</i>	<ol style="list-style-type: none"> 1. Self-stigma/<i>Kwiha akato</i> 2. Stigma by community/<i>Akato bahabwa n'abandi</i> 3. No respect of clinical appointments/<i>Kutubahiriza</i>
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		<p><i>gahunda zo kwa muganga</i></p> <p>4. No health insurance/<i>Nta bwishingizi mu kwivuza</i></p> <p>5. Limited knowledge about health/<i>Kutagira ubumenyi buhagije ku buzima</i></p> <p>6. Others/specify/<i>Izindi/sobanura</i></p>
C15	Is your department equipped with all the necessary requirements to provide health services to MSM/ <i>Mufite ibyangombwa byose bikenewe kugira ngo mutange ubufasha bw'ubuvuzi ku ba MSM?</i>	<p>1. Yes/<i>Yego</i></p> <p>2. No/<i>Oya</i></p>
C16	Is there any cost associated with services offered to MSM/ <i>Ubwo bufasha mubaha burishyurwa?</i>	<p>1. Yes/<i>Yego</i></p> <p>2. No/<i>Oya</i></p>
C17	If yes, do MSM afford them easily/ <i>Niba ari yego, aba MSM babasha kwishyura mu buryo bworoshye?</i>	<p>1. Yes/<i>Yego</i></p> <p>2. No/<i>Oya</i></p>
C18	Is this issue of MSM known by all health professionals/ providers/ <i>Ese abaganga bose baba bazi ba MSM?</i>	<p>1. Yes/<i>Yego</i></p> <p>2. No/<i>Oya</i></p>
C19	How do you appreciate the issue of MSM/ <i>Ese wumva ute aba MSM?</i>	<p>1. Familiar/<i>Ndabimenyereye</i></p> <p>2. Strange/<i>Simbimenyereye</i></p> <p>3. Devil/<i>Amashitani</i></p> <p>4. End of the earth/<i>Imperuka</i></p> <p>5. Others/specify/<i>Ibindi/sobanur</i></p>
C20	If familiar to you, does this issue need to be publicized at a wide range/ <i>Niba wumva ubimenyereye, utekereza ko byatangazwa ku rwego rwo kubimenyekanisha?</i>	<p>1. Yes/<i>Yego</i></p> <p>2. No/<i>Oya</i></p>

**D. POTENTIAL EFFECTS OF STIGMA TOWARDS HEALTH SERVICES TO MSM/
INGARUKA Z'AKATO KU BUFASHA BW'UBUVUZI BUHABWA ABAGABO
BAKORA IMIBONANO MPUZABITSINA N'ABANDI BAGABO**

N0	Questions/Ibibazo	Responses/Ibisubizo
D1	Have you sensed any frustration, stigma or reticence felt by MSM in accessing health service/ <i>Waba warigeze ubona umu MSM afite ipfunwe cyangwa yahawe akato igihe aje gushaka ubufasha bw'ubuvuzi?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
D2	If yes, what did you do in such a case/ <i>Niba ari yego, wabigenje ute?</i>	<ol style="list-style-type: none"> 1. Present excuses/<i>Kumwiseguraho</i> 2. Refer him to a counselor/<i>Kumwohereza ku mujyanama mu ku ihungabana</i> 3. Do counseling/<i>Kumukorera ubujyanama ku ihungabana</i> 4. Ask him to proof it/<i>Kumubaza niba hari gihamya cyangwa ikimenyetso</i> 5. Others/specify/<i>Ikindi/sobanura</i>
D3	Did these psychological effects lead to taking drugs/ <i>Ese iryo hungabana ryaba ritera gufata ibiyobyabwenge?</i>	<ol style="list-style-type: none"> 1. Yes/<i>Yego</i> 2. No/<i>Oya</i>
D4	If yes, what are other side effects/ <i>Niba ari yego, ni izihe ngaruka bitera?</i>	<ol style="list-style-type: none"> 1. Headaches/<i>Umutwe</i> 2. Nausea/vomiting/<i>Iseseme/Kuruka</i> 3. High blood pressure/<i>Umuvuduko ukabije w'amaraso</i> 4. Liver disease/<i>Indwara y'umwijima</i> 5. Cancer/<i>Kanseri</i> 6. Others/specify/<i>Ikindi/sobanura</i>

E. WHAT CAN BE DONE TO ENHANCE ACCESS TO HEALTH SERVICES BY MEN WHO HAVE SEX WITH MEN IN RWANDA/ NI IKI CYAKORWA NGO ABAGABO BAKORA IMIBONANO MPUZABITSINA N'ABANDI BAGABO MU RWANDA BARUSHEHO KWITABIRA GAHUNDA ZO KWA MUGANGA?

N0	Questions/Ibibazo	Responses/Ibisubizo
E1	What services and activities should be included in a National Health Policy and Strategic Plan to support MSM/ <i>Ni ibihe bikorwa byakongerwa muri politike n'igenamigambi by'ubuzima mu rwego rwo gufasha abagabo bakora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Training of health care providers to remove stigmatizing attitudes towards MSM/ <i>Kwigisha abaganga guhindura imyitwarire ishyira mu kato abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i> 2. Knowledge on sexual and reproductive health for MSM/ <i>Kwigisha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ku buzima bw'imyororokere</i> 3. Knowledge on MSM risky behavior/<i>Kwigisha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ku myitwarire yabashyira mu kaga</i> 4. Peer education/ <i>Ubukangurambaga</i> 5. Support group/<i>Amatsinda y'ubufatanye</i> 6. Economic empowerment of MSM/<i>Gufasha abagabo bakora imibonano mpuzabitsina n'abandi bagabo kwiteza imbere mu bukungu</i> 7. Other/specify/<i>Ibindi/sobanura</i>
E2	What can be done at individual level/ <i>Ni iki cyakorwa ku rwego rw'abagabo bakora imibonano mpuzabitsina n'abandi bagabo?</i>	<ol style="list-style-type: none"> 1. Peer education/ <i>Ubukangurambaga</i> 2. Knowledge on sexual and reproductive health for MSM/ <i>Inyigisho ku buzima bw'imyororokere y'abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i> 3. Knowledge on MSM risky behavior/<i>Inyigisho ku myitwarire yabashyira mu kaga abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i> 4. Others/specify/<i>Ibindi/sobanura</i>
E3	What about the community level/ <i>Ni iki cyakorwa ku rwego rw'abaturage?</i>	<ol style="list-style-type: none"> 1. Peer education/ <i>Ubukangurambaga</i> 2. Knowledge on MSM risky behavior/<i>Inyigisho ku</i>

		<p><i>myitwarire yabashyira mu kaga abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>3. Psychosocial support to MSM/ <i>Guha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ubufasha mu mitekerereze</i></p> <p>4. Others/specify/<i>Ibindi/sobanura</i></p>
E4	<p>What about service level (hospital and health center level)/ <i>Ni iki cyakorwa ku rwego rw'ivuriro)ibitaro n'ibigo nderabuzima)</i></p>	<p>1. Remove stigmatizing attitudes of health care providers towards MSM/<i>Guhindura imyitwarire y'abaganga ishyira mu kato abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>2. Friendly services for MSM/ <i>Ubufasha bunogeye abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>3. Knowledge on sexual and reproductive health for MSM/ <i>Kwigisha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ku buzima bw'imyororokere</i></p> <p>4. Knowledge on MSM risky behavior/ <i>Kwigisha abagabo bakora imibonano mpuzabitsina n'abandi bagabo ku myitwarire yabashyira mu kaga</i></p> <p>5. Support group/ <i>Amatsinda y'ubufatanye</i></p> <p>6. Others/specify/<i>Ibindi/sobanura</i></p>
E5	<p>What can be done by the Ministry of Health/ <i>Ni iki cyakorwa ku rwego rwa Minisiteri y'Ubuzima?</i></p>	<p>1. Guidelines on health service provision for MSM/ <i>Imirongo ngenderwaho mu gutanga ubufasha bw'ubuvuzi ku bagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>2. Scale-up health services at all health facilities/ <i>Kugeza ubufasha bw'ubuvuzi bugenewe abagabo bakora imibonano mpuzabitsina n'abandi bagabo</i></p> <p>3. Avail all necessary equipment and materials to provide friendly health services to MSM/<i>Kugena ibikoresho byose bikenewe kugira ngo abagabo bakora imibonano mpuzabitsina n'abandi bagabo bahabwe ubufasha bw'ubuvuzi bunoze</i></p> <p>4. Training of health care providers to remove stigmatizing attitudes towards MSM/<i>Kwigisha abaganga guhindura imyitwarire ishyira mu kato abagabo bakora imibonano mpuzabitsina n'abandi</i></p>

		<i>bagabo</i> 5. Others/specify/ <i>Ibindi/sobanura</i>
E6	Do you have any other thoughts about health services for MSM? / <i>Hari ibindi bitekereza ufite ku bufasha bw'ubuvuzi buhanbwa abagabo bakora imibonano mpuzabitsina n'abandi bagabo?</i>	1. Yes/ <i>Yego</i> 2. No/ <i>Oya</i>
E7	If yes, please list your suggestions/ <i>Niba bihari bivuge</i>	- - -

APPENDIX 5

CLOSING THE INTREVIEW

Thank you for taking part in this study. The information you shared will be very helpful. I asked a lot of personal questions and some of them may have upset you. If there is something you would like to discuss with me, please let me know (*pause here*).

Please remember that all of the information you shared will be kept strictly confidential.