Sexually Transmitted Infection Risk and Health Service Access among Men Having Sex with Men in Addis Ababa, Ethiopia: A qualitative study

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Abstract

Abstract Background: Heterosexuality is the most common form of sexual orientation in the world. Other forms of sexual orientations such as homosexuality, bisexuality and asexuality are characterized as abnormal and viewed as deviations from normal sexuality. Sexually transmitted infections (STI) are comprised of numerous organisms, both viral and bacterial, that are transmitted primarily through sexual contact. Men having sex with men (MSM) have high risk of STI. Even if some studies were conducted in some African countries, there is no enough research in Ethiopia among men having sex with men. Hence, this study aimed to assess sexual transmitted infection (STI) risk and health service access among men sex with men in Addis Ababa. Methods: Qualitative study with phenomenological method was used to assess sexual transmitted infection risk among men having sex with men in Addis Ababa from June 16, 2017- August 10, 2017. Snowball sampling method was used to recruit the study participants. Data was analysed using Narrative Analysis method. Results: A total of 22 study participants were involved in the study. The main reasons cited to engage in to this life were the way they were raised, being a rape victim and believing that it is their nature. They were at high risk of STI due to having multiple sexual partners, not using condom, absence of anal condom, swapping of sexual partner and using substances. Some of the study participants preferred self-medication for fear of provider bias, fear of stigma and discrimination. There is no policy and guidelines that address STI risk among MSM. There are no STI prevention and treatment packages targeting this MARPs group. Conclusions: Though MSM are at higher risk of contracting STIs including HIV, prevention packages are not available. This poses risk to the general heterosexual public. There should be policy and guideline that protects the health of this population and promotes safe sexual practice. STI risk reduction programs should also target this particular population. Keywords: Men having sex with
men, sexual transmitted infection, Addis Ababa, Ethiopia.

Background

Heterosexuality is the most common form of sexual orientation in the world. Other forms of sexual orientations such as homosexuality, bisexuality and asexuality are characterized as abnormal and viewed as deviations from normal sexuality (1).

There has been a long-standing reluctance to acknowledge or accept the existence of homosexuality in Africa. Nowadays, homosexuality is better accepted and integrated in the social and legal systems of the Western nations than in Africa (2), where there are notable debates and discourses about the legal and social issues of accepting homosexuality. Even if such claims of non-existence are not as popular as before, these days, there is still an argument put forth by some groups of people in Africa that homosexuality is not African but is, instead, brought from a foreign culture and, particularly, that of the West (3).

In Ethiopia, homosexual practices are punishable by law. Both in the 1957 Penal Code and in the newly revised Criminal Code, homosexual practices are regarded as "indecent acts" and punishable by imprisonment. Article 629 of the Federal Criminal Code of Ethiopia states that whoever performs a homosexual act, or any other indecent act with another person of the same sex, is punishable with ‘simple imprisonment’, whereas Article 630 (b) prescribes “rigorous...imprisonment not less than 10 years where the person makes a profession of such activities (4).

While anyone who has sex, can get sexually transmitted disease (STD), sexually active gay, bisexual and other men who have sex with men (MSM) are at greater risk. In addition to having higher rates of syphilis, more than half of all new HIV infections occur among MSM. MSM are at increased risk for acquiring sexually-transmitted infections (STI) (5); and, STIs can increase the likelihood of acquiring HIV (6).
Sexually transmitted infections are comprised of numerous organisms, both viral and bacterial, that are transmitted primarily through sexual contact, including chlamydia, gonorrhea, syphilis, human papilloma virus and genital herpes. Chlamydia, gonorrhea, and syphilis are curable but re-infections can occur (7). Globally, the prevalence of HIV and STI is disproportionately higher among men who have sex with men than in the general population. Also in low and middle income countries, same-sex practising men have a greater risk of HIV infection than that which pertains to the general population. Yet, UNAIDS reports that the health service coverage for same-sex attracted men has been very low; only 12% of same-sex practicing men had been getting HIV related services in Africa until 2005 (8).

Many factors contribute to the higher rates of STDs among MSM: Higher rates of HIV and STDs among MSM increase a person’s risk of coming into contact with an infected partner and becoming infected them. Certain behaviors such as not using condoms regularly and having anal sex increase STD risk. Homophobia, stigma, and discrimination can negatively influence the health of gay, bisexual and other men who have sex with men (9). Although many STDs can have serious consequences if untreated, many people don't have symptoms. Most people don't know they are infected (10). Health care and access, another key social determinant, remains an important structural factor to create barriers or pathways to good health (11).

Worldwide, lesbian, gay, bisexual and transgender persons experience vast amounts of discrimination, harassment and victimization from society. Subsequent research explored the social stressors that placed gay (male) youth at high risk for physical and psychological problems (1). Some of the factors that may reinforce homophobia on a larger scale are moral, religious, and political beliefs of a dominant group (12).

The African continent is seen as a highly homophobic continent with low tolerance for
homosexuals and non-normative sexualities. In about 37 countries in Africa, homosexual acts are deemed illegal (1). Youths are at high risk for a number of negative health consequence associated with early and unsafe sexual activity including infection with human immune deficiency virus, and other sexually transmitted disease (13). Youths who engage in MSM sexual behavior are generally more vulnerable due to various individual, social and programmatic factors. They have limited access to reproductive health services that focus on the special needs of adolescents and these youths are at high risk for risky sexual behaviors. In reality however, various parties starts to express their worries regarding social malaise among the youth which leads to further deterioration of their morality. The youth are often faced by a number of challenges that are unique. These challenges differ between developed and developing countries. Studies of lesbian, gay, and bisexual youth find that 23% to 42% of their samples have attempted suicide at least once in their lifetime (14).

Many same-sex attracted men do not go to a health facility to seek remedy for certain types of health problems, mainly because they fear discrimination from health care workers and the leaking of information about their sexual status (15). Because of the complex nature of the problem, reproductive health strategies demand a multi-sector and integrated approach on risky sexual behavior. A study conducted in Addis Ababa explored the extent of the practice and pattern of MSM’s sexual behavior and the risk behaviors of MSM which predispose to HIV/AIDS (16). Homosexuality in Addis Ababa seems to have increased without being noticed. That homosexual acts are illegal and culturally stigmatized may have contributed to it being practiced covertly. As some MSM are bisexual, engaging in heterosexual intercourse, there may be cross bridging of the transmission of sexually transmitted infections, including HIV (17).

However, even if some studies were conducted in some African countries, there is no
enough research in Ethiopia that explored the risks of STIs and health service access among men having sex with men. The finding of this study will provide information for concerned stakeholders to design intervention to reduce the risks of STI and improve health service access. Therefore, this study aimed to assess sexual transmitted infection risk and health service access among men having sex with men in Addis Ababa.

Methods

Study setting, period and design

The study was conducted in Addis Ababa, the capital city of Ethiopia from June 16, 2017-August 10, 2017. Addis Ababa has ten sub-cities and a total of 3,048,631 projected population in 2013. Qualitative study with phenomenological study design was conducted to assess sexual transmitted infection risk and health service access among men having sex with men in Addis Ababa.

Study population

The study population was those who were accessible male having sex with male during data collection in Addis Ababa.

Sample size determination and sampling procedures

The sample size was determined during data collection based on information saturation. The sample size was 22 male study participants who had sex with men. Key informants were selected from Ministry of Health, Health Bureau and Consortium of Reproductive Health Association (one key informant from each organization). Study participants were selected using snowball technique until information saturation. Key informants were selected from Federal Ministry of Health and Addis Ababa Health Bureau who have roles and responsibilities on reproductive health service and/program (one key informant from each organization).

Data collection tools, procedures and quality assurance
The data were collected using semi-structured questionnaires from in-depth interviews and key informant interviews. Quality of data collection was maintained through selecting silent and comfortable place as to allow maximum concentration and interest in the topic. Participants were well informed to give a true answer through explaining the purpose and importance of the study and assuring the confidentiality of the data they are going to provide.

Data management and analysis

The tape-recorded qualitative data obtained from in-depth interviews and key informant interviews were familiarized through reviewing, reading and listening. The data were carefully read, line-by-line, and divided into meaningful analytical units. Audio recorded and notes of interviews were transcribed using non-verbatim transcription technique. The transcribed data were translated from Amharic into English language. The transcribed scripts were intensively read and data were synthesized. The data were analysed using Narrative Analysis method.

Results

Socio-demographic characteristics of respondents

A total of 22 study participants involved in the study. From the total study participants 14 (63.6%) were in the age group of 21-25 years and more than half of them had secondary school educational level. Majority of the study participants were Orthodox Christian followers and not employed. Place of birth of 19 (86.4%) of the study participants were in Addis Ababa. According to the role as a sexual partner half of the study participants were bottom (Table 1).

Respondents nature of bringing up and reasons to engage in MSM life for those who are receptive

The majority of the respondents responded that they were brought up by their mothers.
More specifically the participants replied that they were grown up with a single parent i.e. their mothers due to a number of reasons. For example, some of the respondents said that they don’t even know their fathers because they are deceased, divorced or separated death or divorce when they were young.

A 24 years old participant said “I was brought up led me to engage in such a life. I lost my dad so early and then it was only my mother who grew me up. Hence, when I was growing I usually looking what my mother was doing at home. So, I used to mimic her at home and used to engage in any activity performed by females. Even now I do activities which are womanish including dressing like a woman and using cosmetics of entirely womanish. Eventually, I got married to a man and left home as a whole. Furthermore, I go out at night to do a business just taking make ups and so on.”

Most respondents share similar feelings towards their family. They don’t have the feeling of love towards their fathers. Some of the respondents specifically said that they adopt their mothers’ behavior early in their lives. In other words, they claim absence of a father figure from the family as a reason for their gay life.

When asked if the way they were brought up had any contribution for MSM life and the majority of the respondents said that their early life has the biggest contribution for them to engage in the activity. Being treated like a girl for strong desire of having a female child in male dominated family was cited as reason by some of the participants. The last male child is given the name of a daughter while attaching every gender stereotypes associated to females. Then the last baby boy who is given such a character starts to develop the character starts to develop acting like a woman which eventually growth to engage in MSM life. Such life which begins from home is then widened to the life of neighborhood and peer mates. A boy who is raised in such family when he is with his peers is expected to behave like a girl.
Their first sexual encounter is with those who they very close to them including their relatives, teachers, their peers from their neighbors. Still a single participant said that friend of his father made him to start such a life. According to this respondent a friend of his father used to frequently visit him after the death of his father and gradually drew him into gay life.

Some experienced the life after reading books, fictions and movies which arose their curiosity and then remained caught up. Few respondents claimed they started the life after being a victim of rape. Still a significant number of respondents replied that being a gay is natural. They believe certain men naturally possess female hormone of female they make them get attracted to men.

A 25 years old participant replied that “How do you ask such a question it is very natural people the level of noticing the feeling it is natural to man and this is my nature”. He continued to say that “had this not been natural, I could have been out of this life, I tried to stop it a number of times but I couldn’t and I believe that his is a natural phenomenon”.

Social network

The researcher further presented participants of the study a question concerning whether there are social networks which strength their life bond. As far as their reply to this item is concerned, the following responses were obtained.

They already created a social network which constitutes such categories as the ‘top’ category constituting four and members the ‘bottom’ category which is composed of 11 members and their ‘verse’ category which constitutes of members. Specifically speaking the verse and bottom categories depend on their life on this activity is that they earn money on both roles mentioned individuals from those two categories spend together chatting their experience the type of men they spent with, the money they earned, chewing chat and so on. In fact, they like this network for a number of reasons such as
they help each other, they love each other it is the place where they find their true identity and at times they exchange their sexual partners who they are not comfortable with. Moreover, they arrange such social gatherings them frequently meet as birth day parties and marriage ceremonies. Even during hard times such as illness, it is this network who they get help from better than their parents and family members.

One respondent said “This social network is a place where I can find my true identity. It is a place where each of us spends based on our own interest including our own dressing style further more I don’t want to spend with a straight to refer a man who is not gay. In the meantime, we can find member who introduce their own partners and say I have someone with me who is a nice onion to be sold in an exchange where we share the disease in us alike.” They also add that “even though the government and the community don’t accept us we have our own social network to spend a fantastic gathering”.

When asked their meeting places, the majority of the respondents met their partners at Piassa such as Cinema Ethiopia, National Theater, Filwiha, Megnanga and Bole night clubs. They use code languages to communicate. Social media such as Facebook are platforms for interested members to get introduced. Individual members also play key role in introducing new members to the group.

A 24 years old participant said “By this time I go out with (laugh......where should I say to you ...emm... you can find them everywhere. Even these days instead of us to go to them, they have become very closer to us”.

Another 42-year-old man said “Some years back from now we usually meet at cinemas, clubs and some confined places which were only disclosed to the members of the group but when these places were noticed by other people we used to shift to other places. The other regular place is Filwiha but now we find each other through telephone friends, using the groups code at public open toilet, we tell words of appreciation and say your dick is so
attractive then we exchange more information and for further relation so that we recruit new comers. I am pleased when I recruit new members and make them join the group furthermore the respondents mention that there are members from every walk of life such as artists, singers, politicians, famous people and so on”.

**Respondents’ response about their future in MSM life**

The respondents were presented with a question which asked them if they want to stay in this life or want to leave it. To this item the majority of the participants want to leave from this life. The reasons they provided to leave this life include religion, interested to have normal life and engage in a formal marriage to have children. Furthermore, they also mentioned that in this life the majority of the community discriminates them and hence, to get acceptance from the society. Unlike the majority some respondents said that they want to stay in the life for some reasons. Their reasons for staying in the life include it is the source for staying in the life include it is the source of income for their life. Moreover, they mentioned that they can’t establish a relationship with opposite sex, and fear of disease were cited as reasons for staying in the life.

A 23 years old participants said that “I invested a maximum effort to get out of this life. Even I went to sorcery and witchcraft houses looking for a solution to get out of the life. Some individuals tell me that they go out of such life, but I wondered how they managed to get out of the life. But for me I found really difficult to get out of the life. I naturally accept that there is a female with in me”.

Another participant who is 24 years old also gave the following witness to the above question “I really hate this life, I don’t have the desired social life. All my life has been spoiled. Even from religions point of view, I can’t imagine how God would see me because everybody around me hates me. But for I earn money through this job, I couldn’t go out of it”.
There were also some respondents who said they really love this life. Their reason is that this is the means of earning money and some said they even love the sex life itself. They said they really enjoy making sex with males and they also love males. According to one participant who is 25-year-old “I am offended against you even for asking to get out of this life. I am crazy about the life.”

**Sexual Practice**

**Multiple sexual partnerships**

In an effort to know the situation of sexual partner, participants were presented a question about whether or not they have sexual partners. To this end all of the respondents said that they don't have steady sexual partners. According to the participants, in this life it is inconceivable to have a steady sexual partner. They further added that it is very common these among groups to look for new members as what they say to recruit straights. Due to reasons of recruiting new members, they usually go out with different individuals; probably they may go out with different with 3 different individuals in a single day. According to the respondents within a year it is difficult to remember the number of individuals they slept with. Hence, they said that they had sex with innumerable number of individuals. Each has his own reasons for having sex with many persons. For example, for some particularly those who are bottom MSM, their reason is, it is the source of income for their living hence, their life depends on it. They also said they don't like to have a steady sexual partner. They are interested to have multiple sexual partners. Those with steady sexual partners had to go out with other person to satisfy their financial desire though they want to have a single partner.

One of the participants mentioned “In such a life to have a steady sexual partner is unthinkable. The life by itself doesn’t allow you to stay with a single regular sexual partner. It rather demands you to give
various partners who have new ones. For example, in the last one year I had sex with many. As a matter of fact, I could have sex with 3 different individuals. For example, I have steady sexual partner right now he is my third sexual partner, I want to stay with him because I love him. However, I go out with others because I need money for a living. To this end, I had to go out with more than 60 individuals in a year."

A participant said, “I have a regular sexual partner by now. You can see I have a ring on my finger however, I didn’t get married formally, and it is just a ring which is a promise. I have a regular sexual partner because I was a fistula patient, but after went to hospital and was recovered from it, I had a regular sexual partner”. Concerning their experience of using condom the study participant replied as follows. The majority of the respondents responded that they don’t use condom during sexual intercourse for a number of reason. In the first place, they hate condom they experience pain if they use it, during intoxication, they also prefer a bare sex for the better satisfaction. Moreover, their clients ask them to make sex without condom and the promise to add a money on which they negotiate. Then, they agree with their clients provided that they got extra amount. In addition, if they got someone who they prefer to date or having sex they want to had the sex without condom for their own gratification. As a testimony, participants who is 42 years old “I have never used condom while making sex, I don’t get any satisfaction. Moreover, in my experience no body requested me to have a sex with condom.”

In addition to the above response a participant who is 24 years old said that “I have never used condom; because when we intended to go to sex, we get intoxicated with alcohol and other drugs. Most of the people who are in such a life doesn’t need condom. But when some married men come to us and ask us to do it with condom. Even this is done not to miss the money.”
A testimony from a third participant was also sought and the researcher made a request about his experience of using condom. Accordingly, he replied as follows “I haven’t ever used condom. In the first place using condoms for an intercourse with the same sex is inconceivable. The already existing condom is to be used for opposite sex partners. Moreover, the condom is not made for same sex so it’s very painful while we have sex. It’s painful even without condom; hence, having sex with condom is more painful. It’s only with western nations which I probably use condom because they may ask me to do it with condom”.

Contrary to the above respondents, only five respondents said that they sometimes use condom. However, even those who use it avoid using it with certain pre-conditions such as if someone with a nice gesture comes to them they prefer to do it without. Furthermore, if someone again asks them to pay them more they also avoid it. Still when they make sex with condom they say that it is always torn so, it is not possible to say that they are using it safely. Forgetting to use condom due to drunk has also been mentioned by these participants. In response to this question the researcher came across a participant who is 23 years old he said that “I sometimes use condom but when I am drunk, I forget to use it and have sex bare. However, after watching the status of the man whom I am having sex, and if I feel something odd about him physically, I may use condom.”

Another participant who is 25 years old also provided me with the following response “More or less I use condom but if someone asks me to do it without condom and promised to pay more, I don’t use condom. Moreover, if I came across a person a person of my type who is comfortable, I don’t also use condom our life is just the life of prostitutes. Even they get some rest at day time. But zegas are everywhere in churches, buses, hospital and so on, the country is in mess. I don’t care anymore because when I decided not to engage in this activity and leave home an inviting condition happens. They may go away from me
if I ask him to get condom.”

**Use of condom**

When asked about using condom during sexual intercourse, majority of the participants don’t use condom in most of their sexual encounters. Few respondents know about anal condom. They came to know during their encounters with foreign nationals.

**Use of substance**

When participants were asked about their experience of addictive substances, all of them said that they are addicted to a number of substances such as cigarette, alcohol, chat and drug. They claim they abuse substances to hide themselves and got disinhibited as they may be forced to do things either they are comfortable about and suppress the guilt. At times they have pressure from their peers, hence, one way or the other; they can’t escape the addiction easily.

A 26-year-old said “I usually take alcohols, smoke cigarette and chew chat so that I get intoxicated. I am strongly addicted to chewing chat and smoking when I go out for job called it, jirrera that means business I usually use these addictive substances. I have also lesbian friends who I regularly spend the day time with.”

**STI risk and health seeking behavior**

Among the study participants 19 claimed to have symptoms of STI and anal fissure, bleeding and pain. Three were HIV positive. Sixteen out of 19 study participants have visited health center and treated for their problem. The rest three of them prefer to treat them at home getting the medicine from pharmacy based on the symptoms of their health problems. They prefer to do this because of fear of stigma and discrimination from the health care providers.

Those health professionals who examined the MSM individuals with some STI identify believes that they catch from other opposite sexual partners and hence, they don’t ask
them for further investigation. In relation to the above responses, some participants were asked for further testimony and their response are presented as follows:

A participant who is 22 years old says that “I was examined for being told to have sexually transmitted infection two or three times. I also faced anal bleeding and fissure but for both problems I used hot water salt at home and treated myself. However, for the STI, I visited health center and received treatment from professionals. The health professionals assumed to be sure that I developed the disease from female sexual partner and didn’t ask me anything about how I encounter with it. But if he were asked I could have told him the truth. Currently I am HIV positive and taking the medicine.”

In a similar way, other participant presented the same testimony as specified above which including anal bleeding fracture. More particularly a participant who is 22 years said that “I encountered penial discharge for which I went to hospital received treatment from professionals however, the health professional did not have any idea about my situation and asked me if I had unsafe sexual intercourse and I said yes, because I didn’t want to tell him for the fact that if I told him, I feel that he would discriminate me or prescribe a medicine which I felt could hurt me. The Doctors may not faithful to their oath they pledged during as he promised during their graduation.”

This participant is 22 years old and made the following response “He said that some years back I went to hospital with friend and while my friend was on a treatment I told to the health professional that I am a gay and asked if we don’t use condom when we make sex, how likely are we prone to HIV/AIDS and he gave me the following response It would be good if you use condom but if you don’t use its just like splashing of the sperm on your skin. His response gave me more confidence to continue to have sex without condom. Now look at me, at the age of 22, I am living with the virus.”

**Stigma and discrimination**
Most said they get discriminated and stigmatized by their families, neighbors and society. They usually face problems of social isolation, insulation and even beating by part of the society.

A 25 years old participant said that “the community at his surrounding usually calls me names such words as “bushti” even those who were close to me after they know that I am a gay. Thus, I usually stay at home all day through and go out at night. At this time my family doesn’t say anything to me because they have already convinced themselves.”

**Stakeholders involvement**

One of the key informants stated that globally there is acknowledgment concerning to MSM including on their health service access, but in Ethiopian context there is any special program that address the needs of this group. In the meantime, they don’t have any information about their number, their risk for STI and HIV and also where to trace them. There is no any special policy or programs that address STI risk among MSM. The informant claims these group can get the service in health facilities without any discrimination.

One of the key informant said “we don’t believe that MSM exist in Ethiopia. So, we don’t believe it needs a special program or policy. We have a reproductive health strategy including family planning, sexual behavior education and others but there is no so called MSM on reproductive health”. He continued saying “this group of population are criminals so we can not avail this service. But, if there are compelling evidence which shows the magnitude of STI risk, programs can be considered in the future”.

The other key informant indicated that, we believe that this group needs special program because STI is aggravating factor for HIV. Previously the STI guideline did not address MARPS group but now they considered other risky population like commercial sex workers, long road drivers and daily laborer. We do not have STI prevention package or partner
organization that works among MSM. Moreover, health care providers are trained on how to treat STI but not specifically for MSM. We don’t have training for health care providers that helps to treat STI among MSM.

Discussion

According to the participants, it is impossible to have a steady sexual partner. A National Internet-based Cross-sectional Survey conducted in Viet Nam on multiple and concurrent sexual partnerships among men who have sex with men indicated that from 1695 MSM study participants, 69.5% of them had multiple sexual partner in the last six months (18) which supports the findings of this study.

The majority of the respondents don’t use condom during sexual intercourse for a number of reasons. The reasons cited include not accessing condoms, partner influence especially if it transactional. A study in Uganda reported similar finding. The major barriers identified were with condom use such as difficulties with using condoms, access challenges, lack of knowledge and misinformation about condom use, partner and relationship related issues, financial incentives and socio-economic vulnerability, and alcohol consumption (19).

All of the study participants said that they are addicted to a number of substances such as cigarette, alcohol, chewing chat and drug. Their life itself made them prone to all sorts of addictive substances which made them more prone to risky sexual behavior including engaging in practice of unprotected sex. Similarly, a study conducted in South Africa related to drug use among MSM indicated that 11% of men described having sex while under the influence of drugs (20).

According to the findings of this study MSMs were at high risk of STI due to having multiple sexual partners, not using condom, absence of anal condom, swapping of sexual partner, intoxication and using other drugs. According to UNAIDS Action Framework, the
prevalence of STI is disproportionately higher among men who have sex with men than in the general population. Also in low and middle income countries, same-sex practising men have a greater risk of STI infection than that which pertains to the general population (8). In Europe, men who have sex with men (MSM) are disproportionately affected by STIs (21), and there has been an increasing trend in syphilis, with close to half (48%) of new syphilis cases in the EU/EEA in 2012 reported among MSM (22). Reported gonorrhoea cases are also increasing with 38% of cases in 2012 reported among MSM (23).

Though some of the study participants sought medical care at health centers, others preferred to treat themselves at home for fear of stigma. Similarly, a study conducted in Addis Ababa indicated that many same-sex attracted men do not go to a health facility to seek remedy for certain types of health problems, mainly because they fear discrimination from health care workers and the leaking of information about their sexual status (15).

Though the country has reproductive health strategy including for family planning, sexual behavior education and others, there is no any special program and/ or policy that address STI risk among MSM. Most countries in the EU/EEA ensure that their national STI prevention policies and plans have some specific focus on MSM. Across the EU/EEA, MSM are identified as a priority group for the promotion of STIs testing, condoms and targeted information on risk reduction (24). Stigma reduction and STI testing and treatment among MSM are also common national priorities. However, implementation and coverage of programme services often do not meet policy aspirations (25).

Moreover, while STI programmes across Europe include MSM to varying extents, very few settings provide services tailored to the needs of MSM. Fewer still comprehensively address men’s needs for health promotion to empower sexual health decision-making, STI testing, treatment, and prevention. More challenging is that due to stigma and fear of discrimination, significant numbers of men in parts of Europe do not disclose their sexual
orientation to others.

In this study, none of those participants visiting health facilities had disclosed their sexual practice to the health providers for fear of rejection. A recent survey conducted by the EU Fundamental Rights Agency found that 38% of gay male respondents said that none of their healthcare providers were aware of their sexual orientation (26).

Conclusions

There is same sex practice in Addis. Because of fear of stigma and discrimination and illegality of the practice, they don’t disclose their sexual orientation to people including health care providers. MSMs were at high risk of STI due to having multiple sexual partners, not using condom, absence of anal condom, swapping of sexual partner, intoxication and using other drugs. This poses risk to the general heterosexual public. Some of the study participants preferred self-medication for fear of provider bias, fear of stigma and discrimination. They perceive health care providers are not prepared on how to communicate issues related to sexual orientation and culturally sensitive sexual practices and provide service for special population including MSM.

There was no policy and guidelines that address STI risk among MSM. There were no STI prevention and treatment packages targeting this MARPs group. Therefore, the needs of this special group of population and their sexual rights should be acknowledged by the health policy makers and there should be policies and guidelines that targets the health need of MSM in the country.

Abbreviations

AIDS Acquired immunodeficiency syndrome
HIH Human immunodeficiency virus
MSM Men having sex with men
Declarations

Ethics approval and consent to participate

Ethical clearance was obtained from GAMBY Medical and Business College. Written consent was obtained from all study participants. The confidentiality of participant related data were maintained by avoiding possible identifiers such as name, only identification number was used as a reference then after the whole data collection process, recorded and documented interviews were kept safe throughout the whole process of the research work.

Availability of data and materials

All relevant data are available within the manuscript

Competing interests

The authors have declared that they have no competing interests.

Consent for publication

The consent for publication was obtained from each study participant during data collection.

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Authors’ contributions

All authors meet the ICMJE criteria for co-authorship, providing substantial intellectual contributions for the manuscript. All authors contributed to data analysis, drafting and revising the article, gave final approval of the version to be published, and agree to be accountable for all aspects of the work.

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Tables

Table 1: Socio-demographic characteristics of study participants, Addis Ababa, 2017 (n=22)
| Variables                  | Frequency | Percent (%) |
|---------------------------|-----------|-------------|
| Age                       |           |             |
| 21-25                     | 14        | 63.6        |
| 26-30                     | 6         | 27.3        |
| >30                       | 2         | 9.1         |
| Educational level         |           |             |
| Primary (1-8)             | 4         | 18.2        |
| Secondary (9-12)          | 13        | 59.1        |
| Diploma and Above         | 5         | 22.7        |
| Religion                  |           |             |
| Orthodox                  | 20        | 90.9%       |
| Protestant                | 2         | 9.1%        |
| Occupation Employed       |           |             |
| Employed                  | 2         | 9.1%        |
| Not employed              | 20        | 90.9%       |
| Place of birth            |           |             |
| Addis Ababa               | 19        | 86.4        |
| Out of Addis Ababa        | 3         | 13.6        |
| Role as a sexual partner  |           |             |
| Bottom                    | 11        | 50.0        |
| Top                       | 4         | 18.2%       |
| Verse                     | 7         | 31.8%       |