

Unlocking Health Services for MSM and Transgender Women in San Salvador

STUDY OBJECTIVES

The goal of this research brief is to provide descriptive information on health seeking behavior and sexual orientation disclosure to a healthcare provider among MSM and TW in San Salvador. The first objective is to examine traditional dimensions of access that could potentially influence the decision to seek care (e.g., distance, health insurance, having a regular source of care), as well as factors specific to the experience of sexual minorities (e.g., fear of discrimination). The second objective is to describe public versus private service use and preference for MSM and TW, including an analysis of factors that influence preference for services in each sector. The final objective is to describe the frequency of sexual orientation disclosure to a healthcare provider and factors associated with disclosure in the healthcare setting.

STUDY METHODS

A cross-sectional survey was conducted among 670 MSM and TW in San Salvador who were recruited through respondent driven sampling (RDS) from November 2011 to February 2012. Recruitment chains were initiated by five seeds, purposely selected based on their social standing and wide social networks. Each participant was administered up to three recruitment coupons to distribute to social acquaintances who met study eligibility criteria. This included being 18 years of age or older, having had anal sex with a man or TW in the past 12 months, and having lived, worked or studied in San Salvador for a minimum of three months prior to the interview.

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Introduction

Sexual minorities including men who have sex with men (MSM) and transgender women (TW) are at increased risk for mental and physical health problems (Baral, S. Sifakis, F. Cleghorn, F. et al. 2007; King, Semlyen, Tai et al. 2008). Mitigating these health problems requires appropriate attention to MSM and TW by the healthcare system. Programmatic activities and research in Central America related to health service use have primarily focused on provider attitudes towards sexual minorities and associated quality of care (Ortiz 2008; URC 2008). It is also important to understand health seeking behavior from the perspective of potential clients, and the factors that affect how to “get clients in the door” of the health system for screening, care, and treatment of health problems. Furthermore, research from international settings demonstrates that providers who are aware of their patient’s sexual orientation are more likely to provide appropriate consultation specific to their health needs (Bernstein et al., 2008; Mimiaga, Reisner and Bland 2009). However, there is a gap in information about health seeking behavior and sexual orientation disclosure to healthcare providers among MSM and TW in low-and-middle income settings including El Salvador.

Key Findings

MSM who participated in this study

MSM in the study sample were young, with 69% of participants in the 18-24 year old age group. Most study participants had completed secondary school or had post-secondary education (62%). A substantial number of participants in the study were poor, with 27% reporting no monthly income, and 43% earning less than \$250 per month. Approximately half of the MSM in the study self-identified their sexual orientation as gay or homosexual (49%), or as bisexual or heterosexual (52%). The same percentage of MSM reported that they were either single (43%) or in a sexual relationship with another man or transgender woman (43%), while only 13% reported being in a partnership with a woman at the time of the study.

Access to healthcare services for MSM and transgender women

Health insurance and having a regular source of care are two factors commonly associated with health service utilization. As noted in the full report, 22% of participants were affiliated with or beneficiaries of public or private health insurance. A total of 24% had a regular doctor, nurse, or other healthcare provider, and 30% had access to a regular source of care through a health facility. Participants reporting use of health

STUDY METHODS *continued*

This study was approved by the Tulane University Biomedical Institutional Review Board and the National Committee for Ethics and Clinical Investigation in El Salvador. For details about the methods used in this study, including the scales referenced in this brief and item summaries, please see the full report at:

<http://www.measureevaluation.org/publications/tr-13-92>

ANALYSIS

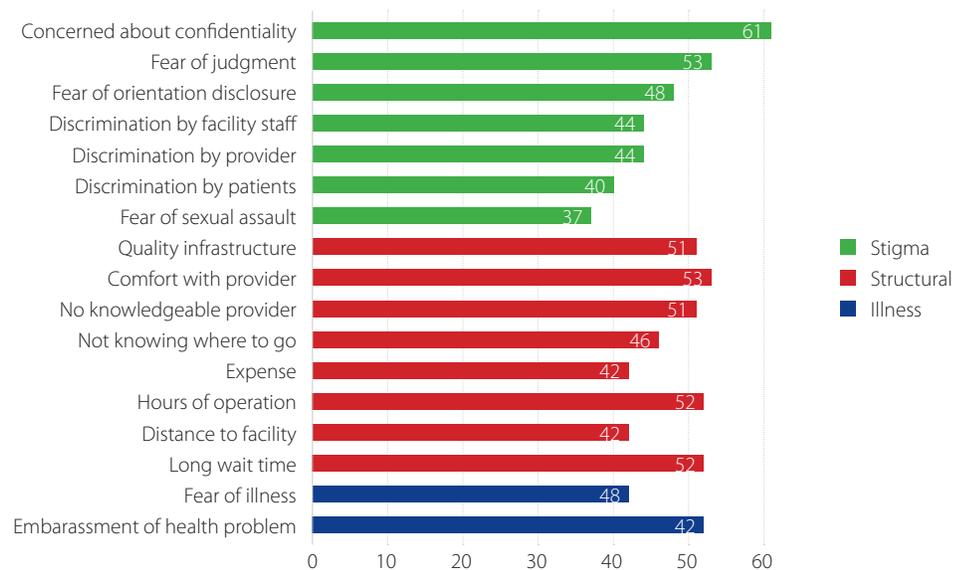
The data from the survey was entered into the statistical analysis program, Respondent Driven Sampling Analysis Tool 6.01 (RDSAT) (www.respondentdrivensampling.org). This program facilitated the use of weights to account for the non-random selection of participants in the calculation of frequencies. The data was then transferred to the statistical software package STATA SE version 12.0. Bivariate and multivariate analyses were conducted by weighting the outcome variable. A cutoff of $p < .05$ was used for statistical significance. The predicted probabilities based on logistic regression models are presented in the figures. Captions for each figure note control variables used in each model.

services in the last 12 months were more likely to have health insurance, a regular source of care, earn a monthly income, and be single (vs. partnered with a man or TW). Participants were more likely to have health insurance if they were 25–34 years old (versus 18–24 years), earned an income, and were MSM (versus a TW). Participants were more likely to have a regular source of care (provider or facility) if they were older than 24 years, MSM, or if they were single. In terms of health status, persons who used health services in the last year reported slightly better overall physical well-being. Overall mental well-being was slightly lower for participants who had a regular source of care.

Participants were asked to respond to a series of questions about factors that could potentially influence their decision to seek healthcare. These questions encompassed three categories of factors including structural, stigma, and illness. Structural barriers refer to traditional access barriers (e.g., long wait times, perceived technical skill of provider, perceived quality of facility, cost of service, etc.). Questions about stigma as a potential barrier referred specifically to fear of maltreatment due to sexual orientation such as judgment, discrimination, a lack of confidentiality and other concerns about sexual orientation disclosure and discrimination from providers, health facility staff, and other patients. Illness-related questions asked about aspects of the health condition that might influence the decision to seek healthcare such as embarrassment associated with the health problem or fear of gravity of the condition.

Participants were asked if each factor influenced their decision to seek healthcare “a lot,” “a little” or “not at all.” In Figure 1, the percentage of participants reporting that the factor influenced their decision to seek healthcare “a lot” is presented. The most commonly cited concern affecting the decision to seek healthcare was confidentiality (61%), followed by fear

Figure 1: Factors influencing the decision to seek healthcare among MSM and TW (%)



Percentages presented in Figure 1 are weighted percentages calculated using RDSAT software; $n=670$

of judgment (53%) and a lack of comfort with the provider (53%). The least commonly cited concerns affecting the decision to seek healthcare were fear of sexual assault (37%), fear of discrimination from other patients (40%), expense (42%), distance to facility (42%), and embarrassment of the health problem (42%).

Combined measures of structural, stigma, and illness factors were created, so that persons reporting more factors as issues affecting their decision to seek healthcare had a higher score for each category of barrier. Participants were categorized as having either a “high” or “low” level of the access barrier relative to other respondents in the study using a median split. Each category was examined in relation to whether the participant postponed healthcare when they needed it in the last year. Thirty-three percent (33%) of participants needed healthcare in the last year. Out of those who needed care, 48% postponed healthcare but eventually got it.¹

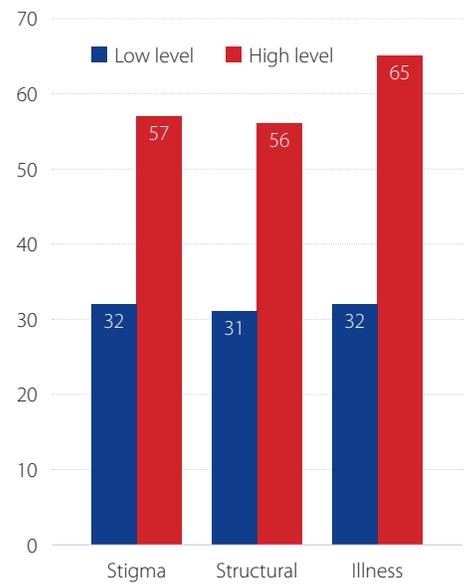
Figure 2 shows the relationship between each type of access barrier and participant’s postponement of healthcare, among those who needed care in the last year. Each type of barrier was statistically significantly related to postponement of healthcare after controlling for socio-demographic characteristics. Fifty-seven percent (57%) of participants who reported a high level of stigma barriers postponed care, compared to only 32% of participants reporting a low level of stigma barriers. Fifty-six percent (56%) of participants who reported a high level of structural barriers postponed healthcare, compared to only 31% of participants reporting a low level of structural barriers. Finally, 65% of participants who reported a high level of illness barriers postponed healthcare, compared to only 32% of participants who reported a low level of illness barriers.

Public and private healthcare services

Use of healthcare was examined by public and private services (Figure 3). Participants who used health services in the last 12 months were asked to report the type of facility they used. The categories of facilities included MINSAL hospital/clinic, ISSS hospital/clinic, private hospital/clinic, or other (such as pharmacy and mobile unit). For the current assessment the analysis was restricted to participants reporting MINSAL, ISSS, or private facility use.

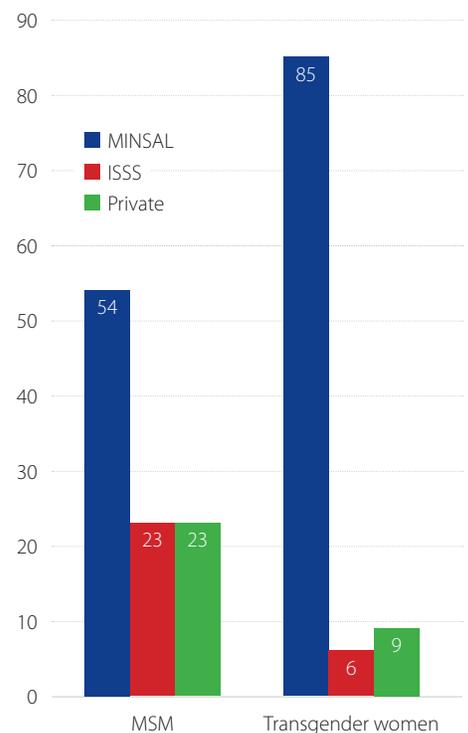
MINSAL facilities were the most common type of facilities used by both MSM and TW. However, the percentage of TW (85%) using MINSAL facilities was significantly higher compared to MSM (54%). Among MSM, approximately one in four reported using ISSS (23%) and private (23%) facilities. Among TW, only 6% used ISSS facilities and 9% used private facilities in the last 12 months. The percent difference in use of a MINSAL compared to ISSS and private between MSM and TW was statistically significant after controlling for socio-demographic characteristics.

Figure 2: Percentage of MSM and TW who postponed healthcare by level-of-access barrier



Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, gender identity, and sexual orientation. $p \leq .05$; $n=212$

Figure 3: Percentage of MSM and TW who used MINSAL, ISSS, or private healthcare facilities in the last 12 months



Percentages presented are converted from the predicted probabilities calculated using multinomial logistic regression models that controlled for age, education, income, relationship status. $p \leq .05$; $n=240$

1) Only 34 participants reported needing care and not receiving it in the last year. For this reason, postponement of care was selected as the outcome variable examined

Income is one factor that is commonly thought to influence use of public versus private services. In this study use of MINSAL, ISSS, and private facilities was assessed by level of income including persons who earned no monthly income, those who earned US\$250 or less, and those who earned more than US\$250. No statistically significant difference in type of service use by income was found in bivariate analysis. The exception was a marginal statistically significant difference such that participants earning more than US\$250 per month compared to those earning no income were more likely to use private rather than MINSAL services. When controlling for gender identity, age, education and relationship status, participants earning income, and higher levels of income, were more likely to use private and ISSS services than MINSAL services.

All participants were asked to report the type of facility where they preferred to receive health services (see Figure 4). The same response categories were applied as those described for health service use. Slightly more than half of both MSM (53%) and TW (57%) report that they prefer a private health facility. Slightly less than half of MSM (42%) and TW (40%) report that they prefer a MINSAL health facility. Few MSM (5%) or TW (3%) stated a preference for an ISSS facility. A higher percent of TW preferred a private versus MINSAL facility compared to MSM, after controlling for socio-demographic characteristics.

Several factors were associated with a preference for a specific type of health facility. Participants who had a regular provider were more likely to prefer MINSAL health facilities. Familiarity with a particular type of health facility was also important. Participants who reported using MINSAL facilities in the last 12 months were more likely to report a preference for a MINSAL facility. Similarly, participants who used private health facilities were more likely to prefer private facilities. These associations were statistically significant after controlling for socio-demographic characteristics.

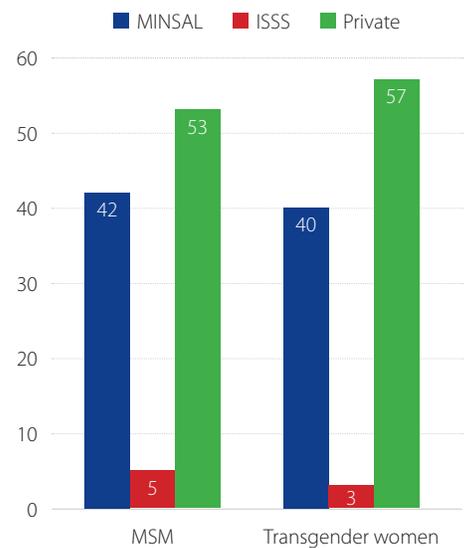
Disclosure of sexual orientation to healthcare providers

In this analysis, disclosure of sexual orientation to a healthcare provider was measured using participant’s response to the question: “When you have received medical care, how often did you inform the healthcare provider that you had sex with men or TW?” Response categories included “always,” “sometimes,” and “never.” Sixty percent (60%) of participants responded that they “always” or “sometimes” inform their healthcare provider of their sexual orientation. This percentage was significantly higher for TW compared to MSM, after controlling for socio-demographic characteristics. Only 57% of MSM “always” or “sometimes” disclosed their sexual orientation to their healthcare provider, while 77% of TW did so (see Figure 5).

Several factors were associated with participants’ disclosure of sexual orientation to a healthcare provider.² Disclosure was more likely among participants who reported access to a healthcare provider with at least one

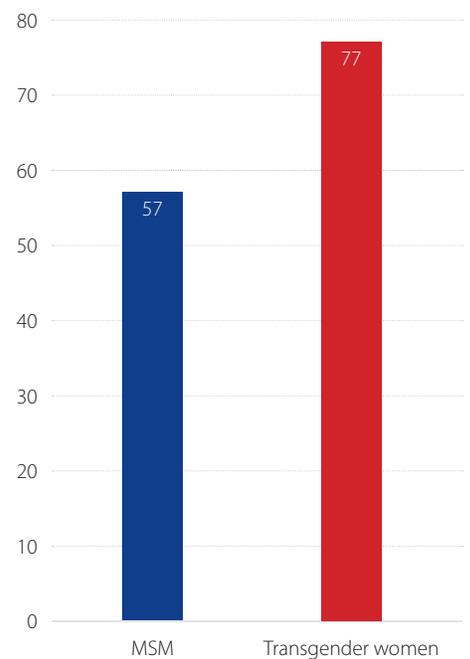
2) A separate analysis was conducted limited to MSM participants and yielded similar results in terms of factors identified as important and the direction of their association with sexual orientation disclosure to a healthcare provider.

Figure 4: Percentage of MSM and TW who prefer MINSAL, ISSS, or private healthcare facilities



Percentages presented are converted from the predicted probabilities calculated using multinomial logistic regression models that controlled for age, education, income, relationship status. $p \leq .05$; $n=624$

Figure 5: Disclosure of sexual orientation to a healthcare provider by gender identity (%)



Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for sexual orientation, age, education, income, and relationship status. $p \leq .05$; $n=661$

characteristic supportive of sexual minorities (see Box 1). Among participants with access to a healthcare provider with at least one of these characteristics, 69% had disclosed their sexual orientation to a healthcare provider. In contrast, only 53% of participants without access to a provider with these qualities had disclosed (see Figure 6).

Box 1: Item summary for measure of access to a provider supportive of MSM and TW	
Description: Each participant was asked to respond to a series of questions after being read the prompt: "If you needed care, do you have access to a health care provider who..." The response categories were "yes" and "no." The percent responding "yes" are presented below.	
<i>Individual item</i>	<i>Weighted % (95% confidence interval)</i>
Treats you with dignity and respect	58 (49–65)
Does not judge you negatively	57 (48–65)
Has sufficient knowledge about the health needs of MSM and TW	67 (50–93)
Maintains the confidentiality of patients	51 (43–59)
Maintains an environment in which the patient feels comfortable asking questions about sexual behavior	51 (43–59)
Access to a provider with at least one supportive characteristics	50 (43–57)

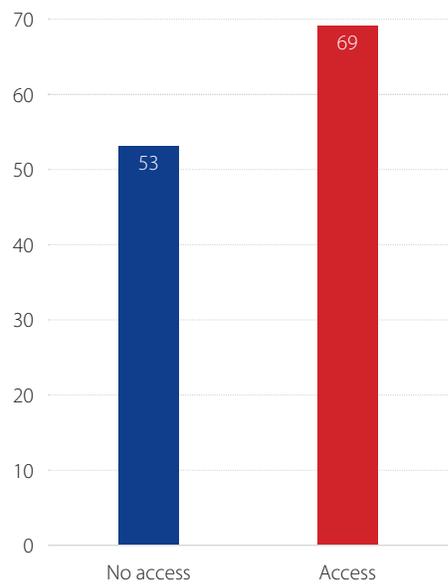
Participants who “always” or “sometimes” disclosed their sexual orientation to their healthcare provider were also more likely to report a high level of discrimination from a healthcare provider,³ after controlling for socio-demographic characteristics. Eighty-one percent (81%) of participants with a high level of perceived provider discrimination had disclosed their sexual orientation to a healthcare provider. In contrast, only 39% with a low level of perceived provider discrimination had disclosed (see Figure 7). Higher levels of internalized homonegativity were also associated with disclosure to a healthcare provider.⁴

Disclosure of sexual orientation was also related to type of service use, after controlling for socio-demographic

3) Perceived provider discrimination was based on the participants’ report of the following due to their sexual orientation when seeking healthcare: being treated with less respect, receiving poorer quality service, being discriminated against, being refused service, and feeling they had to pretend to be heterosexual. High and low categories relative to other participants in the sample were created using a median split.

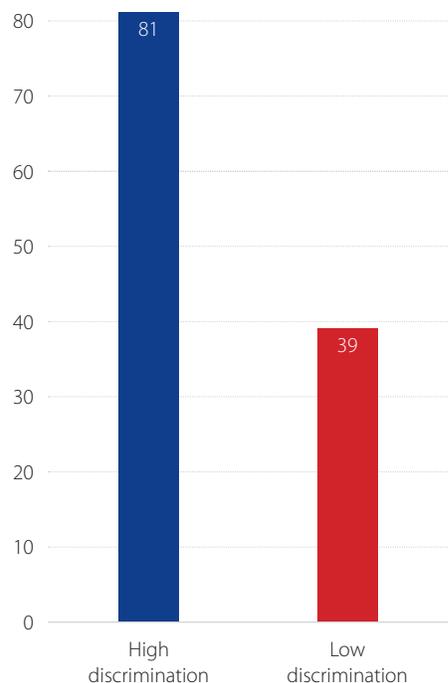
4) For details about internalized homonegativity and its correlates please see the research brief “Internalized Homonegativity and Its Health-Related Consequences for MSM in El Salvador,” available at URL: <http://www.cpc.unc.edu/measure/publications/fs-14-96>

Figure 6: Percentage of MSM and TW who had disclosed their sexual orientation to a healthcare provider by access to a supportive provider



Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, and sexual identity and orientation. $p \leq .01$; $n=661$

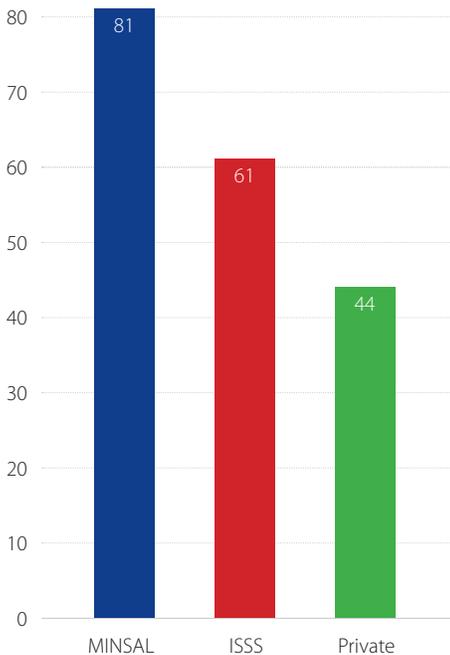
Figure 7: Disclosure of sexual orientation by level of perceived provider discrimination (%)



Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, and sexual identity and orientation. $p \leq .001$; $n=646$

characteristics. Among participants who used MINSAL facilities in the last 12 months, 81% had disclosed their sexual orientation to a healthcare provider. In contrast, only 61% who used ISSS and 44% who used private facilities disclosed their sexual orientation to a healthcare provider (see Figure 8).

Figure 8: Disclosure of sexual orientation by type of healthcare facility used in the last 12 months (%)

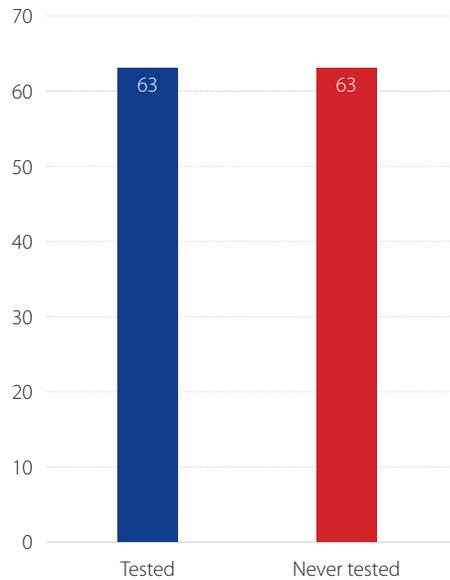


Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, gender identity, and sexual orientation. $p \leq .01$ for private versus MINSAL; $n=240$

There was no difference in HIV testing history by disclosure status. For both participants who had tested for HIV, and those who had never tested for HIV, 63% reported “always” or “sometimes” disclosing their sexual orientation to a healthcare provider. Similar results were found when examining disclosure by HIV testing in the last 12 months (see Figure 9).

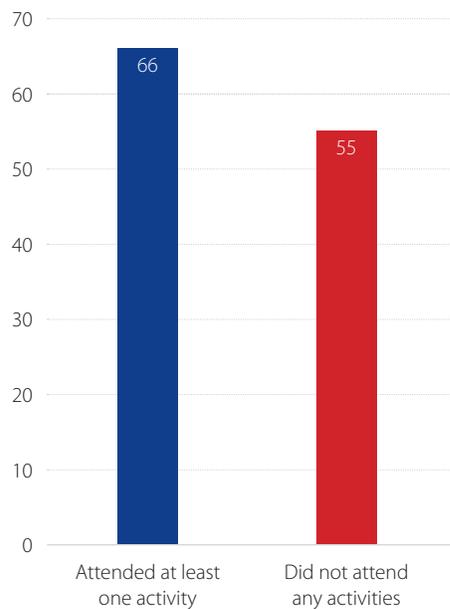
Disclosure of sexual orientation to a healthcare provider was significantly more common among participants who reported participating in at least one HIV educational activity in the last 12 months, after controlling for socio-demographic characteristics (see Figure 10). Sixty-six percent (66%) of these participants “always” or “sometimes” disclosed their sexual orientation to a healthcare provider, compared to only 55% of participants who had not attended an HIV educational activity.

Figure 9: Disclosure of sexual orientation by HIV testing history (%)



Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, gender identity, and sexual orientation. $n=638$

Figure 10: Percentage disclosing sexual orientation to a healthcare provider by attendance at an HIV educational activity in the last 12 months



Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, gender identity, and sexual orientation. $p \leq .05$; $n=640$

Summary

Health service utilization was more common among participants who had health insurance and a regular facility or provider. Concerns related to confidentiality, judgment, and comfort with the provider, were important factors influencing the decision to seek healthcare. Structural, stigma, and illness-related barriers were all related to postponement of healthcare. Most participants use MINSAL facilities when they need healthcare. This is particularly true for TW. However, slightly more than half report a preference for private services. Disclosure of sexual orientation to a healthcare provider was more common among TW compared to MSM. It was also more common among participants with access to a healthcare provider supportive of MSM and TW, and participants who used MINSAL versus private services.

Alarming, disclosure of sexual orientation to a healthcare provider was associated with a higher level of perceived provider discrimination by the participant. There was no difference in HIV service use (measured by HIV testing history), among participants who had disclosed their sexual orientation to a healthcare provider. However, participants with established links to the HIV prevention community (measured by attendance at an HIV educational activity in the past year) were more likely to have disclosed their sexual orientation to a healthcare provider.

Recommendations

Traditional factors influencing health service use among heterosexual population (health insurance, having a regular provider, etc.) are also important to consider for MSM and TW populations. However, in addition to these traditional factors, this study indicates that sexual minorities face unique barriers related to fear of discrimination due to sexual orientation. Efforts to mitigate the damaging effect of stigma related to sexual orientation should be promoted at the level of individual MSM and TW, their social network, and structural and cultural features of the social environment in San Salvador.⁵ Particular attention

should also be directed towards the health system. Given the level of service use and preference across types of health facilities, it is necessary to address barriers in the public sector (MINSAL/ISSS) while concurrently supporting access to private health services.

The findings of this study reinforce conclusions from several guidance documents on the provision of healthcare for sexual minorities (PAHO 2010; IOM 2011). Unfortunately, the data from this study indicate that changes in the health system are only slowly evolving, and MSM and TW continue to face many of the same barriers highlighted in these earlier documents. Data from other international settings indicate that disclosure of sexual orientation to a healthcare provider as positive step towards improved healthcare for sexual minority clients (Bernstein et al 2008; Petroll & Mosack 2007). However, in this study, participants who had disclosed their sexual orientation were more likely to report provider discrimination, and were not any more likely to have ever tested for HIV. If disclosure events were followed by appropriate attention to the specific health needs of MSM and TW, we would expect to see higher rates of HIV testing among those who had disclosed.

A limitation of the study is the cross-sectional design, which makes it impossible to discern if participants perceived higher levels of provider discrimination as a result of sexual orientation disclosure or vice versa. Nevertheless, the association between these two factors is concerning and merits further investigation.

In addition to supporting the use of private health services, efforts to reduce provider discrimination through trainings have occurred regionally, and more recently in El Salvador focusing on the transgender population (Corona & Arango 2013). These training are important and should continue, and should include a focus on MSM as well as TW. The development and integration of curriculum in universities and training programs specific to the healthcare needs of MSM and TW, should be promoted for medical, nursing, pharmacy, and other health professions. Resources for this type of training and curriculum development could be adapted for Central America from those available through the Fenway Institute (thefenwayinstitute.org/) and other international sources.

5) For detailed recommendations on a multi-level approach to reduce sexual minority stigma see the research brief "Internalized Homonegativity and Its Health-Related Consequences for MSM in El Salvador," available at URL: www.cpc.unc.edu/measure/publications/fs-14-96

In addition to eliminating overt provider discrimination, it is also important that providers are equipped with the skills to provide appropriate care and referrals for MSM and TW, who are at higher risk than heterosexual populations for suicide, anxiety and depressive disorders, HIV, STI, and hepatitis B and C (Baral, S. Sifakis, F. Cleghorn, F. et al. 2007; King, Semlyan, and Tai et al., 2008). One important resource to meet this goal is the document “Blueprint for the Provision of Care to Gay Men and Other Men Who Have Sex with Men (MSM) in Latin American and the Caribbean” (PAHO 2012). This document includes annexes with flow charts that indicate the appropriate steps for counseling a client who is MSM and at higher risk for certain health conditions.

There are several findings from this study that merit further exploration and should be incorporated as part of a research agenda for MSM and TW in the Central America region. First, participants who used MINSAL services were more likely to disclose their sexual orientation to their healthcare provider. The reasons for increased disclosure in the public versus private sector need to be further examined. One possibility is that persons seeking particular types of services (for example, free HIV testing), may be more likely

to attend public services. They may be more likely to disclose their sexual orientation because sexual behavior relates to the specific health problem motivating service use. However, in this study, there was no difference in HIV testing history based on service use or preference. Second, the association between experienced provider discrimination and preference for private services should be further examined.

While it is possible that persons are more likely to disclose their sexual orientation in the public sector, leading to increased discrimination, and subsequent preference for private services, this cannot be determined because of the cross sectional nature of the data. Longitudinal quantitative and ethnographic studies that capture important events in the sequence of decision making, disclosure of sexual orientation, and health seeking behavior would help fill this explanatory gap. Finally, research into the development of innovative and novel techniques to decrease provider discrimination is warranted. While literature from international settings suggests disclosure to a healthcare provider as leading to a supportive environment for MSM and TW, the data from this study indicate that the reverse may be true in San Salvador.

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