Social Marginalization due to Sexual Orientation and Health Service Utilization among Men Who Have Sex with Men in San Salvador, El Salvador

Introduction:

Increasing access to quality health services among men who have sex with men and inclusive groups (gay, homosexual, or bisexual men, and transgender women (TW) is important from both a public health and human rights perspective. Provision of comprehensive and quality healthcare for MSM and TW, requires an understanding of how the reality of social exclusion and marginalization endured by this population affects their need and desire for services, their perception of available health services, and their experience seeking health services. The overall goal of this study was to describe current use of health services among MSM and TW, quality of services received, and modifiable factors along the care continuum influencing general health service utilization in El Salvador.

Methods:

A cross sectional study using respondent driven sampling (RDS) to recruit a representative sample of MSM and TW was conducted in the capital city of San Salvador, El Salvador from November 2011 – February 2012. A structured survey was administered to research participants by interviewers trained in appropriate methods for facilitating surveys including sexual risk behavior and other sensitive questions. The interview team was diverse in terms of sexual orientation, and included gay identified men, a transgender woman, and a heterosexual woman. Interviews were conducted in private rooms in a study office, located in a central location near shopping outlets and public transportation routes. Data was entered on personal digital assistants.

Study protocol followed standard techniques for RDS. Recruitment chains were initiated by seeds, purposely selected based on their social standing and wide social networks to increase the probability of successful referrals and recruitment chains. Seeds were also selected to increase the likelihood of sexual diversity in the study sample, and included two gay/homosexual men, two bisexual men, and one bisexual transgender women. Sexual orientation was based on self-report. Each participant was administered up to three recruitment coupons to distribute to social acquaintances seen in the last two weeks, and who met study eligibility criteria. This included being 18 years of age or older, anal sex with a man or transgender woman in the past 12 months, having lived, worked or studied in San Salvador for a minimum of three months prior to the interview, and being in possession of a recruitment coupon. A design effect of 2 was used in the sample size calculation that used the standard formula for estimating differences in population proportions set at a minimum of 15% detectable difference, with an alpha=.05, 80% power, and assuming a 10% non-response rate.

Data was cleaned and labeled in SAS, and converted to a text file for use in the statistical software package RDSAT. All univariate analyses and bivariate associations were conducted in

RDSAT to facilitate the appropriate application of item weights using the multiplicity estimator. Items found to be associated with the outcome variable using RDSAT were included in a multivariate logistic regression using STATA version 12. The item weight calculated in RDSAT for the outcome variable was exported to STATA and used in the multivariate analysis.

This study was approved by the Tulane University Biomedical Institutional Review Board and the National Committee for Ethics and Clinical Investigation in El Salvador.

Results

Table 1 presents select socio-demographic and other health related characteristics relevant for the examination of health service utilization. Study participants were relatively young, with 69.3% in the age group 18-24. The majority self-identified as bisexual or heterosexual men (43.7%), followed by gay or homosexual men (37.9%), heterosexual transgender women (14.3%), and bisexual or gay transgender women (4.1%). A majority of participants completed secondary school or had tertiary training (59.6%). However, a substantial number of participants were poor, with 27.8% earning no monthly income, and 43.5% earning less than $250 per month (results not shown).

A total of 30% of the sample reported visiting a doctor or other healthcare provider in the last 12 months. A total of 22.2% and 24.3% respectively had health insurance and a usual source of care. The majority were in excellent, very good or good health status based on self-report (89.4%). However, a substantial number (26.6%) also reported contemplating suicide at some point in their life, an indication of distress and mental health status.

Few participants were currently married or partnered with a women (10.6%), and approximately one third were in stable sexual relationships with a man or transgender woman (31.4%). The median number of lifetime number of sexual partners was 15, with 38.2% reporting 16 or more sexual partners in their life. A third of participants (33.5%) exchanged sex in order to receive money, drugs, food or a place to sleep in the 12 months prior to the interview. A smaller percentage reported being clients of sex workers in the last 12 months (17.7%). Use of illicit drugs in the past 30 days was reported by 15.3% of the sample (defined as marijuana, heroin, ecstasy, glue, crack, cocaine, or amphetamines). A majority of participants (60.5%) reported consuming five or more alcoholic beverages on at least one occasion in the past 30 days.

Only half of participants had revealed their sexual orientation to a family member (52.9%). A minority of participants (7.7%) had ever revealed their sexual orientation to a healthcare provider. A total of 21.6% reported experiencing physical or verbal abuse because of their sexual orientation in the past 12 months (defined as hitting, punching, threats, scolding, or shaming), and 20.8% reported having been sexually assaulted (forced to have sexual intercourse) ever in their life.

Bivariate analysis comparing point estimates and 95% confidence intervals (CI) calculated in RDSAT, indicate that the percentage of participants using health services in the past 12 months is significantly higher for participants who: earn any monthly income versus no income, are not a heterosexual transgender woman, have health insurance, have a regular healthcare provider, have ever contemplated suicide, have a stable partner who is male or transgender, have sold or bought sex in the last 12 months, have disclosed their sexual orientation to a family member or healthcare provider, have been mistreated because of their sexual orientation in the past 12 months, or have ever been victims of sexual assault.

In Table 2, constructs related social marginalization due to sexual orientation experienced within the healthcare setting are presented. The first construct was adapted from measures of discrimination based on race in studies conducted in the United States, and captures experienced discrimination based on sexual orientation when receiving care from a healthcare provider. Affirmative responses, indicating an experience of discrimination based on sexual orientation ranged from 55.4% to 62.0% across the five items. Internal consistency of the items was high (Cronbachs' alpha =0.89). Item responses were on a 3-point likert scale (always, sometimes, never). Responses were summed and the aggregate score was divided at the median to create a dichotomous variable to indicate high versus low intensity of discrimination used in multivariate analysis.

The second construct presented in Table 2, captures characteristics of healthcare providers that are important with respect to their treatment of patients who are sexual minorities, and the quality of services provided to the MSM and Transgender populations. These items were developed based on research literature, and initial consultation with MSM and Transgender advocacy groups in San Salvador. Affirmative responses across the six items ranged from 32.6% - 38.8%. Internal consistency of the items was high (Cronbach's alpha = 0.96). A dichotomous variable was created for participants who reported access to a healthcare provider with one or more of the characteristics (48.9 %) in contrast to participants who reported not having access to a healthcare provider with any of the characteristics presented.

Summary variables for both constructs were examined in relation to health service utilization in the last 12 months. A bivariate association was detected at the .05 level of significance, such that the percentage of persons using health services in the past 12 months was lower for participants who experienced high levels of discrimination, and higher for participants reporting access to a healthcare provider supportive towards sexual minorities.

In Table 3, the adjusted odds ratios are presented for variables included in a multivariate logistic regression model. Socio-demographic characteristics and variables significantly associated with health service utilization in bivariate analysis from tables 1 and 2 were included in the model. When controlling for other variables (including health status), a relationship remained between income, insurance, usual source of care, disclosure, discrimination, provider supportive of sexual minorities, and the weighted outcome variable of health service utilization in the last 12 months.

Specifically, participants earning any income (Adjusted Odds Ratio (aOR) 2.99, 95% CI: 1.10-8.08) those with health insurance (aOR4.00, 95% CI: 2.01 – 7.96) or a usual source of healthcare (aOR 3.84, 95% CI: 1.99-7.41) were more likely to use healthcare in the last 12 months. Persons who had disclosed their sexual orientation were also more likely to use health services including participants who had disclosed to a family member (aOR 2.84, 95% CI: 1.54-5.26) or a healthcare provider (aOR 3.53, 95% CI: 1.28-9.72). Experiences within the healthcare setting were also important to healthservice utilization. Participants who reported access to a provider with characteristics supportive of the health needs of MSM and TW were more likely to use health services (aOR 3.30, 95% CI: 1.64-6.64), while participants who experienced more discrimination related to their sexual orientation from a healthcare provider were markedly less likely to have used services (aOR 0.42, 95% CI: 0.22-0.80).

Discussion

A number of studies have explored attitudes towards MSM/TW among healthcare providers, with the goal of developing interventions to mitigate discrimination experienced by sexual minorities within the healthcare system. There is also mounting empirical evidence of the detrimental effect of internal feelings of shame related to sexual orientation on wellbeing, and in relation to sexual risk behavior. The findings of this study add to this literature in several important ways. First, these findings provide descriptive information on health seeking behavior and experience receiving health services from the perspective of a representative sample of MSM in San, Salvador. Second, the findings demonstrate the influence of wider community norms related to sexual orientation as important and detrimental to health seeking behavior, but that may not be directly related to the health system. Finally, findings reveal significant areas for improvement required within the health system to increase health service utilization, including specific important characteristics for a supportive healthcare provider serving MSM/TW populations.

Only half of participants had disclosed their sexual orientation to a family member, and only 7.7% had ever disclosed their sexual orientation to a healthcare provider. In both cases, disclosure was related to increased use of health service. Participants in this sample were generally young, and may still be in the process of developing their sense of self and sexual orientation, as the majority of men also reported their sexual orientation as bisexual. Internal acceptance of sexual orientation is a necessary precursor to disclosure, and may be a difficult process for individuals situated in a heteronormative environment. Fear of social rejection may also serve as a barrier to disclosure. However, the data from this study indicate that increased engagement with the health system will require a change in social norms related to sexuality, including efforts to promote self-acceptance among MSM/TW, and to promote accepting attitudes among family and social relations of MSM/TW. These wider social efforts are necessary to get clients "in the door" of the health system.

Once MSM/TW engage with the health system, it is important that they are accepted and treated with dignity and respect by healthcare providers. This requires that all parts of the health system are involved, not only those related to treating STIs and HIV. A significant effort has been strategically placed on HIV services for MSM/TW; however, it is important that providers begin to understand MSM/TW health needs as not isolated to their sexuality. Existing within a context of social marginalization also influences the mental health of MSM/TW, as captured in the current data by a high percentage of participants who had ever contemplated suicide. Similarly, a substantial number of participants reported experiencing physical and verbal abuse, and being victims of sexual assault. Substance use was also high, with 60% of participants reporting binge drinking in the past 30 days and 15% reporting use of illicit substances. Clearly, the health needs of this population are not limited to sexual health. Specialized services should be coupled with broader training of healthcare providers, beginning with medical curriculum, in the specific health needs of this population, and techniques for building rapport and confidence in services among this group.

Table 1. Socio-demographic and health related characteristics among men who have sex with men in San Salvador, El Salvador, 2011-2012

Characteristic	N	Weighted %	95% CI
Socio-demographics			
Self-reported sexual identity and orientation			
Man, gay or homosexual man	279	37.9	32.1-43.4
Man, bisexual or heterosexual	227	43.7	38.0-50.7
Transgender women, heterosexual	136	14.3*	10.5-18.1
Transgender woman, bisexual or gay	28	4.1	2.0-6.0
Age			
18-24	426	69.3	63.8-75.3
25-65	244	30.7	24.7-36.2
Education			
Incomplete secondary or less	270	40.4	34.6-46.3
Complete secondary through tertiary	397	59.6	53.7-65.4
No monthly income	141	27.8*	23.0-32.4
Health service utilization, health insurance, usual source of care, and health status			
Visited a doctor or other healthcare provider in the last 12 months.	250	30.2	25.7-35.1
Beneficiary of health insurance	155	22.2*	17.7-27.4
Has a regular healthcare provider	199	24.3	20.2-28.7
Overall health status excellent, very good, or good (self-report)	586	89.4*	85.9-92.6
Ever contemplated suicide	214	26.6*	22.2-31.5
Sexual behavior and substance use			
Currently married or partnered with a woman	62	10.6	7.3-14.2
Current stable partner who is male or transgender	233	31.4*	26.4-36.1
≥16 lifetime number of sexual partners	313	38.2*	32.9-43.8
Exchanged sex for resources, last 12 months (received) (n=623)	270	33.5*	28.9-38.5
Exchanged resources for sex, last 12 months (client) (n=623)	161	17.7*	14.0-21.4
Consumed illicit drugs in the last 30 days	133	15.3	11.8-19.1
Consumed five or more alcoholic beverages on one occasion, last 30 days	410	60.5	55.5-65.8
Disclosure of sexual orientation			
Disclosed sexual orientation to family	398	52.9*	47.8-58.1
Disclosed sexual orientation to healthcare provider	66	7.7*	5.1-10.4
Abuse			
Physically or verbally abused because of sexual orientation, last 12 months	185	21.6*	18.0-25.6
Survivor of sexual assault	173	20.8*	17.1-25.0

n=670 unless otherwise indicated; *indicates significance at .05 in bivariate analysis with health service utilization in the last 12 months

Table 2. Experienced provider discrimination and access to a healthcare provider supportive of sexual minorities, among men who have sex with men, San Salvador, El Salvador, 2011-2012.

	N	Weighted %	95% CI
Experienced discrimination in the healthcare setting: *When getting medical care have you experienced the following because the provider knew or suspected that you had sex with men or transgender women (yes)?*			
You were treated with less respect than other people	356	55.4	50.5-60.3
You received poorer quality services than other people	376	59.3	54.7-64.1
You experienced discrimination	410	62.0	57.2-66.7
You were refused services	364	57.8	52.7-62.5
You felt it was necessary to pretend or explicitly say that you were heterosexual	388	57.7	52.8-62.5
Cronbach's alpha 0.89			
Access to a healthcare provider who demonstrates support towards sexual minorities; *If you needed care, do you have access to a healthcare provider (yes):*			
	N	**Weighted %**	**95% CI**
Who treats you with dignity and respect	302	38.8	33.9-44.0
Who does not judge you negatively	278	35.6	30.6-40.8
Who has sufficient knowledge about the health needs of MSM and transgender women	260	32.6	27.7-37.5
Who maintains patient confidentiality	296	36.8	31.5-42.0
With whom you feel comfortable asking questions about HIV and other STI	283	36.8	31.9-42.1
With whom you feel comfortable asking questions about sexual behavior	289	36.9	32.3-42.5
Cronbach's alpha 0.96			

Table 3. Factors associated with health service utilization in the last 12 months among men who have sex with men in San Salvador, El Salvador, 2011-2012.

Characteristic or construct	**Adjusted odds ratio**	**95% CI**
Age (ref = 18-24)	0.62	0.31-1.22
Education (ref = less than secondary)	1.58	0.78-3.19
Self-reported sexual identity and orientation		
Man, gay or homosexual man (ref)	--	--
Man, bisexual or heterosexual	0.79	0.39-1.59
Transgender woman, heterosexual	0.55	0.26-1.17
Transgender woman, bisexual or gay	0.44	0.10-1.87
Monthly income (ref = no income , vs. any)	2.99*	1.10-8.08
Beneficiary of health insurance (ref = no)	4.00***	2.01-7.96
Has a regular healthcare provider (ref = no)	3.84***	1.99-7.41
Self-reported health status (ref= excellent, very good, or good, vs. fair/poor)	0.62	0.28-1.38
Ever contemplated suicide (ref = no)	1.66	0.84-3.25
Current stable partner who is male or transgender (ref = no)	1.34	0.74-2.40
≥16 lifetime number of sexual partners (ref = <15)	1.79	0.86-3.71
Exchanged sex for resources, last 12 months (received, ref = no)	1.47	0.67-3.20
Exchanged resources for sex, last 12 months (client, ref = no)	1.01	0.43-2.34
Disclosed sexual orientation to family (ref = no)	2.84***	1.54-5.26
Disclosed sexual orientation to healthcare provider (ref = no)	3.53**	1.28-9.72
Physically or verbally abused because of sexual orientation, last 12 months (ref = no)	1.94*	0.99-3.79
Survivor of sexual assault (ref = no)	1.81	0.84-3.92
Experienced healthcare provider discrimination (ref = low)	0.42**	0.22-0.80
Access to healthcare provider supportive of sexual minorities (ref = no)	3.30***	1.64-6.64

*p<.05, ** p<.01, ***p <.001, n=632