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Factors affecting healthcare-seeking behavior among men who have sex with men in Starehe sub-county, Nairobi City County

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Abstract
Men who have sex with men (MSM) are a marginalized population in Kenya. When seeking medical care, they usually encounter obstacles due to accusations and public discrimination. As a result, MSMs put themselves at risk of developing serious illnesses that would burden the economy. This study aims to identify the barriers and behaviors that influence MSM healthcare-seeking. A quantitative study was conducted in Nairobi's Starehe sub-county. The researcher randomly selected participants at a Support Widows and Orphan Programmers drop-in center. The investigation happened between December 13, 2021, to January 15, 2022. Participants were subjected to a self-administered questionnaire after consenting. Most respondents were youths (92.7%:190). MSM's who encountered discrimination while receiving treatment were three times more likely to be afraid to seek medical attention (UOR=3.2, 95% CI). The majority of MSMs preferred non-government institutions (56.1 %; 115). The MSMs who were denied medical care were more likely to be afraid to seek care (UOR=3.9, 95% CI (1.192, 12.434). MSMs showed confidence in disclosing their sexual orientation to a health provider (82.1%:133) compared to family members (18.3%:11). The study found that MSMs' have challenges and poor health-seeking behaviors that is due to lack of a strategy for providing medical care to MSMs. The Ministry of Health should plan on how to supply items like drugs and protective devices required in the treatment and prevention of diseases among MSMs. Participants in this study were selected at the centrally located site in Nairobi County. The selection at one center can contribute to sampling bias.

Introduction

The group of men who have sex with other men (MSM) is categorised as one of the key demographics by the HIV management program due to their increased risks of acquiring HIV and other sexually transmitted infections (Avert, 2017). Originally, the term (MSM) was initially developed by American epidemiologists who used the concept for studying disease risk rather than identity-based categories such as gay, bisexual, or straight. The term also refers that a man who self-identifies as gay or bisexual may not necessarily engage in sexual activity with men, and a man who self-identifies as straight may engage in sexual activity with men (LaGrone, 2016). Transgender people, people with disabilities,

people who inject drugs (PWID), sex workers, children, teenagers, and prisoners are other key populations where MSMs belong.

MSM behavior has been practiced since the Middle Ages. Although they have existed for that long, they are still a minority and a marginalised group. In Kenya, section 162 of the penal code puts a maximum 14-year sentence for homosexuality and section 165 classifies their sexual behavior as gross indecency, both carrying a lengthy jail sentence. These measures are harsh to the group, and they can propel the economic burden, leading to failure to meet WHO's goal of eradicating HIV by 2030 (Organization, 2016)

MSM has a high risk of spreading HIV, and when compared to other key populations, it is the group of people who inject drugs (PWID) and MSMs who have more than 24 times transmission risks(Macdonald et al., 2017). Sexual and romantic attraction between people of the same sex is referred to as homosexuality (Scheller et al., 2023). Usually, homosexual and gay terms are used interchangeably. Gay is a social identity and is typically preferred in social circumstances (Bhugra et al., 2022). A bisexual, otherwise referred to as pansexual, is someone who interacts romantically or sexually with individuals of different sexes or genders. This makes them more likely to contract and spread STDs/HIV within their network(Woensdregt & Nencel, 2020). Sexual contact between people who are not of the same gender typically results in less harm. This is possible because female organs typically generate sufficient lubricants to protect both from harm. Since the anal wall produces less lubricant than the vaginal walls, sexual partners who use anal and penis organs are prone to harm (Vélez et al., 2022). As a result, MSMs are more vulnerable to HIV and other sexually transmitted diseases (STDs) than the general population. MSMs need preventative services like pre-exposure prophylaxis (PrEp), hepatitis A and B vaccinations, and sexual protection devices(Reza et al., 2020). They also require medical attention for anal injuries and sexually transmitted illnesses such as gonorrhoea, giardiasis, syphilis, and human papillomaviruses. Furthermore, the group calls for the dissemination of health information on risk-reducing conduct and responsible sex behaviour(Joint United Nations Programme on HIV/AIDS, 2020b).

As of 2016, MSM was illegal in many countries worldwide, with penalties including death, significant fines, and lengthy prison terms. About 50% of Americans supported same-sex unions in 2014, a decision which was upheld in 2015 by the Supreme Court (McCarthy, 2014). Even though the LGBT community is legal in the USA, they are disadvantaged because of the increased violence and homicide they experience (Zhang, 2018). In countries with low socioeconomic levels, like Sub-Saharan Africa (SSA), just 14% of MSM can access services (Arreola et al., 2015). In Africa, the Middle East, and Russia, males who engage in sexual activity with other men still have their human rights neglected and violated, except in South Africa (Mendos, 2019) (Rodríguez-Álvarez et al., 2018). Kenya is one of the nations involved in many court cases that oppose same-sex unions; as a result, the WHO's objective of eliminating HIV by 2030 may be hampered (Woensdregt & Nencel, 2022). Due to the ongoing discrimination and stigma, there is little likelihood that the pandemic will be eradicated from the world, making it cyclical (Kenworthy et al., 2018; Mendos, 2019).

Literature review

Because of their underlying ethnic backgrounds, social level, sexual preference, and gender identity, MSMs frequently face significant stigma and discrimination (Cabal, 2017). According to Horanieh et al. (2020), institutions, organisations, the community, and policymakers reject the majority of KPs. Previous studies were conducted in Kenya to address challenges related to HIV testing and treatment optimisation. The results showed that 28.0% of MSMs had been denied services as a result of their same-sex activities (Shaver et al., 2017). Health professionals occasionally dissuade MSMs from

seeking medical care because of their prejudice, discrimination, social-cultural ideology, and judgmental thoughts and beliefs. This result is consistent with a study conducted in India, which discovered that the discriminating actions of healthcare professionals facilitated MSM and transgender people's poor health-seeking behaviour (Rao et al., 2020). According to a survey by the Joint United Nations Programme on HIV/AIDS (2016) , 15% of MSM in 20 countries are heterosexual and HIV positive. In Kenya, MSMs are far more likely to have HIV than other men, as indicated by the HIV/AIDS Report 2011, which estimated the prevalence of HIV among MSM to be 18.2% as compared to the general public, with 5.9% (Avert, 2017). This research aims to understand the challenges MSM in the Starehe sub-county encounter when seeking healthcare services and identify the factors influencing their behaviour.

Materials and methods

The study was done at the Starehe sub-county, one of the Seventeen sub-counties that comprise Nairobi City County. This location has a drop-in centre called the SWOP city clinic that serves MSMs and other key population groups. Most people served at this drop-in facility commute daily from nearby sub-counties to this centrally located sub-county in the central business district with a population of varying socioeconomic status.

Research design and sampling

A cross-sectional quantitative research methodology was used in this study. Two hundred five respondents participated in this study; a sample size was determined through Fisher et al.'s formulae. According to the Key Population Mapping and Size Estimate National Report 2019 (NASCOP, 2019), 10,209 MSMs reside within this county.

Men who reported having intercourse with other men within the previous six months were identified before study enrolment was done using the Key Population's Ministry of a standard health questionnaire. The study ensured that participants were at least 18, lived in Nairobi, and willingly signed an informed consent form. Participants under 18 years, mentally challenged, or those who could not consent were also excluded from the study. The selection criteria ensured that participants represented a variety of social and behavioural traits and reported sexual orientations that included gay, bisexual, and heterosexual, as well as marital patterns.

Data collection process and analysis

The primary population drop-in center register was picked explicitly for this study, it contained more than 1000 active members involved in men-to-men sexual relationships. The participants were recruited randomly from the centre's daily register, which reported 30 to 40 MSMs daily. Every fourth MSM attending the clinic was selected from the register. The eligible participants were informed about the study's goal before being requested to sign an informed consent form voluntarily. Finally, the selected participants were requested to complete a self-administered structured questionnaire. This tool evaluated the sociodemographic traits, health-seeking behaviour, and challenges MSMs encounter while seeking medical attention. The exercise was done in a private, safe study center within the drop-in center.

Before the study began in Starehe Sub-County, ten MSM from Kasarani Sub-County, far from the study location, were subjected to the questionnaire. After getting permission from the facility supervisor to conduct the study, ten members were picked randomly from a daily register. The purpose of the study was explained to them, and they consented to participate. By putting the instrument of the study to the test, we could ascertain the validity and reliability of the tool. Uncertain questions were rephrased to make them more straightforward, while unclear questions were changed

to make them explicit. The questionnaire and consent forms were translated into Kiswahili for those who had trouble reading English. After carefully reviewing and validating the form's content, the department chair permitted the researchers to start, stop, or continue their investigation.

Data was collected between December 13, 2021, and January 15, 2022. The questionnaire was completed by the participants in approximately 30 to 45 minutes. The research assistants were always present to assist participants in filling out the forms accurately. During the research investigation, we provided personal protection equipment (PPEs) because it was COVID-19 pandemic season, and Standard Operating Procedures (SOPs) were strictly followed.

The data acquired for this investigation was stored on an encrypted computer, and only authorised researchers had access to the lockable locker where the questionnaire survey forms were kept. Before and after the data collection exercise, no one had access to the information on the data obtained that may be linked to the specific participants. The collected data were coded and entered into SPSS version 24.0, an electronic database. Tables and graphs were used to present the univariate, bivariate, and multivariate data analysis results. Multivariate data were placed in categorical variables to ascertain the association between one dependent binary variable and other independent factors, and regression analysis was examined by logistic regression. By using a statistical inference of 5%, relationships between categorical variables of the data were analysed using chi-square.

Ethical Considerations

The Aga Khan University Department Review Committee (DRC) for the School of Nursing and Midwifery received and reviewed and approved the study proposal. Then, the National Council of Science and Technology Institution (NACOSTI) authorised the research to start after obtaining ethical approval from the University's Institutional Ethics Review Committee (IERC). The participant's confidentiality and privacy were appropriately safeguarded when collecting data by conducting data collection exercises in a private room within the drop-in centre. The participants signed a consent form before commencing the questionnaire in the presence of an investigator, and this was obtained in writing before any data was obtained. In cases where the participant was illiterate, the MSM participant could designate a peer with no personal interest in the study's outcome to watch as the researcher explained the process. The witness countersigned when the participant substituted their fingerprint for a signature. If a participant in the study experienced significant difficulties in obtaining health services, the researcher gave them access to a comprehensive list of MSM-friendly hospitals.

Results

The study results were analyses based on the objectives of the investigation: healthcare-seeking behaviour and challenges of MSMs while they sought healthcare services.

Health-seeking behaviour

Demographic characteristics based on health-seeking behaviour.

The study involved 205 participants, or 100% participation. Table 1 below displays the respondents' demographic information. The respondents were between the ages of 18 and 50. Youth between the ages of 18 and 35 made up the majority (92.7%:190). Many participants preferred to be identified as a gay, bisexual, or gay person (97.9%; 189). Most respondents (83.9%:172) were single at the moment of study. The same proportion of respondents had basic and higher education (49.8%:102) and (50.2%:103), respectively. Age, educational level, and monthly income did not impact health-seeking behaviour ($\chi2$= (4.03, 4) p= 0.401)., $\chi2$ (4.80, 3), p=0.187, $\chi2$ (5.16, 4) p=0.271, respectively.

Table 1: Demographic characteristics based on health-seeking behavior

		Health-seeking behaviour			
Demographic Factors	***Total***	***Yes***	***No***	***Test (value, df)***	***p***
Age group					
18-20 Years	***15(7.3%)***	***4(26.7%)***	***11(73.3%)***	***χ2 (4.03, 4)***	***0.401***
21--25 Years	***108(52.7%)***	***15(13.9%)***	***93(86.1%)***		
26-30 Years	***47(22.9%)***	***11(23.4%)***	***36(76.6%)***		
31-35 Years	***20(9.8%)***	***5(25.0%)***	***15(75.0%)***		
Above 36 Years	***15(7.3%)***	***4(26.7%)***	***11(73.3%)***		
Marital status					
Unmarried	***161(78.5%)***	***27(16.8%)***	***134(83.2%)***	***χ2 (5.62, 2)***	***0.06***
Married	***33(16.1%)***	***7(21.2%)***	***26(78.8%)***		
Divorced	***11(5.4%)***	***5(45.5%)***	***6(54.5%)***		
Education					
Primary	***8(3.9%)***	***2(25.0%)***	***6(75.0%)***	***χ2 (4.80, 3)***	***0.187***
Secondary	***94(45.9%)***	***14(14.9%)***	***80(85.1%)***		
College	***68(33.2%)***	***12(17.6%)***	***56(82.4%)***		
University	***35(17.1%)***	***11(31.4%)***	***24(68.6%)***		
Monthly Income					
Less than 5000	***69(36.7%)***	***15(21.7%)***	***54(78.3%)***	***χ2 (5.16, 4)***	***0.271***
6000-10000	***70(37.2%)***	***13(18.6%)***	***57(81.4%)***		
11000-30000	***39(20.7%)***	***6(15.4%)***	***33(84.6%)***		
31000-49000	***4(2.1%)***	***0***	***4(100%)***		
Above 50000	***6(3.2%)***	***3(50.0%)***	***3(50.0%)***		

Challenges of health-seeking behaviour

The study investigated challenges of health-seeking behavior among the MSMs through accessibility and health-seeking behavior, availability and level of satisfaction, and affordability factors. The findings from the study are shared below.

Accessibility and health-seeking behaviour

Fear of seeking medical care was associated with whether MSMs had experienced discrimination based on their sexual orientation ((χ2 (17.43, 1), ρ<0.001)). Five times as many of those who were denied were likely to develop a fear of seeking medical care (Unadjusted Odds Ratio (UOR)=5.3, 95% Confidence Interval (CI) (2.283, 12.075). In a similar vein, fear of obtaining medical attention was related to experiencing discrimination based on sexual orientation ((χ2= (7.60,1), ρ<0.006)). Three times, respondents (UOR=2.9, 95% CI (1.330, 6.247)) reported mistreatment. Fear of seeking medical care was related to experiencing prejudice based on sexuality when obtaining treatment or in society (((2= (10.20,1), 0.001)), (2= (5.40, 1), p=0.02)). MSM who said they experienced prejudice during treatment were three times more likely to be frightened to seek out medical care (UOR=3.2, 95% CI) (1.531, 6.619). Likewise, fear of obtaining medical care was twice as prevalent in people who experienced social prejudice (UOR=2.3, 95% CI) (1.127, 4.64). The relationship between the accessibility of health services and health-seeking behaviour is shown in Table 2 below.

Table 2: Accessibility and Health-Seeking Behavior

		Afraid of seeking Health services			
Accessibility Factors	***Total***	***Yes***	***No***	***Test (value, df)***	***p-value***
Preferred type of health facility					
Government hospital	***34(16.6%)***	***4(11.8%)***	***30(88.2%)***	***χ2 (9.57, 5)***	***0.088***
Faith-based hospitals	***3(1.5%)***	***2(66.7%)***	***1(33.3%)***		
Private hospitals	***23(11.2%)***	***7(30.4%)***	***16(69.6%)***		
Chemists	***5(2.4%)***	***1(20.0%)***	***4(80.0%)***		
NGOs health programs	***115(56.1%)***	***23(20.0%)***	***92(80.0%)***		
Outreach program	***25(12.2%)***	***2(8.0%)***	***23(92.0%)***		
Accessible health service encourages seeking medical services.					
Yes	***143(70.1%)***	***28(19.6%)***	***115(80.4%)***	***χ2 (0.066, 1)***	***0.797***
No	***61(29.9%)***	***11(18.0%)***	***50(82.0%)***		
How friendly are Government facility					
Not friendly	***102(64.2%)***	***23(22.5%)***	***79(77.5%)***	***χ2 (1.68, 1)***	***0.194***
Friendly	***57(35.8%)***	***8(14.0%)***	***49(86.0%)***		
How friendly is a private facility					
Not friendly	***25(15.5%)***	***2(8.0%)***	***23(92.0%)***	***χ2 (2.20, 1)***	***0.137***
friendly	***136(84.5%)***	***28(20.6%)***	***108(79.4%)***		
How friendly are Faith based facility					
Not friendly	***26(27.1%)***	***5(19.2%)***	***21(80.8%)***	***χ2 (0.16, 1)***	***0.681***
Friendly	***70(72.9%)***	***11(15.7%)***	***59(84.3%)***		
How friendly are NGO facility					
Not friendly	***8***	***1(12.5%)***	***7(87.5%)***	***χ2 (0.20, 1)***	***0.654***
Friendly	***181(95.8%)***	***34(18.8%)***	***147(81.2%)***		

Availability and level of satisfaction

According to the study, there was no correlation between the degree of satisfaction with services and their availability at both government and private facilities ($\chi 2$ (3.99, 2), p=0.135), ($\chi 2$ (3.99, 2), p=0.135), respectively. Although most respondents in the study indicated that they feel more satisfied with NGOs $\chi 2(2.27,2)$, p= 0.256, compared to Government facility $\chi 2(0.31,2)$, p= 0.855 Table 3 below illustrates this.

Table 3: Availability and level of satisfaction

		Afraid of Seeking HIV Services			
Availability Factors	***Total***	***Yes***	***No***	***Test (value, df)***	***p-value***
Satisfaction at the Government facility					
Satisfied	***36(17.7%)***	***7(19.4%)***	***29(80.6%)***	***χ2 (0.31, 2)***	***0.855***
Neutral	***95(46.8%)***	***19(20.0%)***	***76(80.0%)***		
Not Satisfied	***72(35.5%)***	***12(16.7%)***	***60(83.3%)***		
Satisfaction at the private facility					
Satisfied	***106(52.2%)***	***17(16.0%)***	***89(84.0%)***	***χ2 (3.99, 2)***	***0.135***
Neutral	***75(36.9%)***	***19(25.3%)***	***56(74.7%)***		
Not Satisfied	***22(10.8%)***	***2(9.1%)***	***20(90.9%)***		
Satisfaction at the Faith-based facility					
Satisfied	***42(21.0%)***	***7(16.7%)***	***35(83.3%)***	***χ2 (2.79, 2)***	***0.247***
Neutral	***103(51.5%)***	***24(23.3%)***	***79(76.7%)***		
Not Satisfied	***55(27.5%)***	***7(12.7%)***	***48(87.3%)***		
Satisfaction at the NGO facility					
Satisfied	***175(85.8%)***	***32(18.3%)***	***143(81.7%)***	***χ2 (2.72, 2)***	***0.256***
Neutral	***25(12.3%)***	***4(16.0%)***	***21(84.0%)***		
Not Satisfied	***4(100%)***	***2(50.0%)***	***2(50.0%)***		

Affordability factor

Most respondents (63.2%:129) said they utilise medical services because they are cost-effective. However, reasonable respondents (36.8%:75) never indicated that the cost of healthcare was a barrier to seeking healthcare. Health-seeking behaviour was unaffected by the affordability of services$\chi 2$ (0.74, 1), p=0.388).

Multivariate Analysis

The study's multivariate findings are displayed in (Table 4 below). After adjusting for variables, whether being denied access to healthcare, whether being mistreated by healthcare workers based on sexual orientation, whether experiencing sexual discrimination based on sexuality, and whether experiencing discrimination from a society based on sexual orientation. Due to their sexual behaviour, MSM who denied receiving medical care based on their sexual orientation were approximately four times more likely to be afraid to do so (UOR=3.9, 95% CI (1.192, 12.434)). As a result, there was a correlation between seeking health care and being denied healthcare services because of sexual orientation.

Table 4: Multivariate Analysis

		Afraid of seeking HIV services		UOR	95% C.I.for UOR		AOR	95% C.I.for AOR	
Accessibility Factors	**Total**	**Yes**	**No**		**Lower**	**Upper**		**Lower**	**Upper**
Denied health services due to sexual orientation									
Yes	30(14.6%)	14(46.7%)	16(53.3%)	5.25	2.283	12.075	3.85	1.192	12.434
No (Ref)	175(85.4%)	25(14.3%)	150(85.7%)	1			1		
Encountered mistreatment from a Health Provider based on sexuality									
Yes	41(20.0%)	14(34.1%)	27(65.9%)	2.883	1.33	6.247	0.804	0.238	2.712
No (Ref)	164(80.0%)	25(15.2%)	139(84.8%)	1			1		
Faced discrimination while receiving treatment based on sexuality									
Yes	53(26.0%)	18(34.0%)	35(66.0%)	3.184	1.531	6.619	1.601	0.571	4.489
No (Ref)	151(74.0%)	21(13.9%)	130(86.1%)	1			1		
Faced discrimination from a society based on sexual orientation									
Yes	82(40.0%)	22(26.8%)	60(73.2%)	2.286	1.127	4.64	1.53	0.688	3.402
No (Ref)	123(60.0%)	17(13.8%)	106(86.2%)	1			1		

		Afraid of seeking HIV services		UOR	95% C.I.for UOR		AOR	95% C.I.for AOR	
Accessibility Factors	**Total**	**Yes**	**No**		**Lower**	**Upper**		**Lower**	**Upper**
Denied health services due to sexual orientation									
Yes	*30(14.6%)*	*14(46.7%)*	*16(53.3%)*	*5.25*	*2.283*	*12.075*	*3.85*	*1.192*	*12.434*
No (Ref)	*175(85.4%)*	*25(14.3%)*	*150(85.7%)*	*1*			*1*		
Encountered mistreatment from a Health Provider based on sexuality									
Yes	*41(20.0%)*	*14(34.1%)*	*27(65.9%)*	*2.883*	*1.33*	*6.247*	*0.804*	*0.238*	*2.712*
No (Ref)	*164(80.0%)*	*25(15.2%)*	*139(84.8%)*	*1*			*1*		
Faced discrimination while receiving treatment based on sexuality									
Yes	*53(26.0%)*	*18(34.0%)*	*35(66.0%)*	*3.184*	*1.531*	*6.619*	*1.601*	*0.571*	*4.489*
No (Ref)	*151(74.0%)*	*21(13.9%)*	*130(86.1%)*	*1*			*1*		
Faced discrimination from a society based on sexual orientation									
Yes	*82(40.0%)*	*22(26.8%)*	*60(73.2%)*	*2.286*	*1.127*	*4.64*	*1.53*	*0.688*	*3.402*
No (Ref)	*123(60.0%)*	*17(13.8%)*	*106(86.2%)*	*1*			*1*		

Discussion

The study examined the challenges and MSMs' behaviours that affect their health-seeking. This study showed that no demographic characteristics, including age, marital status, educational attainment, and monthly income, affected how MSM sought health care. MSM's reluctance to seek medical assistance was correlated with the prejudice they encountered because of their sexual orientation. There was a five-fold higher chance that those rejected would later acquire a phobia of seeking medical attention. Three times as many respondents said that mistreatment prevented them from getting medical attention. Similar to these findings, due to the stigma and fear of discrimination that MSM experience, the uptake of HIV services among them is still unsatisfactory (Kiplagat, 2016).

According to this survey, there is a significant link between respondents' overall satisfaction with NGOs and the accessibility of their services. This suggests that NGOs are the only institutions in Kenya with a thorough strategy that considers key demographics like MSM. This is due to their 24-hour hotline, hired paralegals, security training for their members, operation of a rescue centre for victims of violence, and being part of a vast support system that includes other sex worker-led organisations and a few helpful police officers. Guidelines for treating MSM populations in public and

private health institutions must be developed, and healthcare professionals must be trained to deal with vulnerable groups like MSMs (Knight & Jarrett, 2015). Under a health promotion approach incorporating MSM in the care delivery team, peer navigators working with health teams may assist in mobilising social capital for patients who might otherwise be marginalised and foster a sense of shared ownership (Micheni et al., 2017).

Compared to their close friends and relatives, MSMs felt more at ease discussing their sexual orientation with a health professional (82.1%:133). According to Nguyen et al. (2020) stigma and prejudice are common obstacles to providing care for MSM in South Africa, working towards eliminating this obstacle through educating the general public about the crucial populations can lessen the burden of care. The MSM's preferences for health education, service delivery strategies, and privacy issues should be considered when designing and implementing future eHealth interventions. This is crucial to maximising the efficacy of such interventions (Avert, 2017) .

Our study found a link between fear of medical treatment and prejudice based on sexual orientation. The proportion of respondents who said they were reluctant to seek medical care was more than three times higher (UOR=2.9, 95%, CI). This may be related to the unfavourable treatment of MSM by healthcare professionals. The absence of healthcare professionals with specialised training in male sexual health and lack of providers who have been sensitised to deliver respectful, patient-centered treatment was one of the specific barriers to access for MSM patients (Micheni et al., 2017). For instance, qualitative research at Kisumu and Coastal, Kenya, discovered that MSMs were likelier to seek medical care from providers they thought were amiable, polite, judgment-free, private, and attentive to their needs (Okall et al., 2014). Staff frequently stated they feared the repercussions of providing MSM with risk reduction or sexual health therapies. Privacy concerns should be considered to increase the effectiveness of such initiatives (Nguyen et al., 2020). Many participants in this survey use health services because they are economical (63.2%). Similar studies found that the cost of using health services did not significantly affect how frequently people used them (Abuduxike et al., 2020).

It was advantageous that the sample for this study was picked in a metropolitan sub-county, and most participants came from surrounding sub-counties. The data collected from such a diverse range of demographics is significant for analysis. However, the sample selection may be biased because this study was conducted in a drop-in centre primarily catering to MSM who visit a medical facility independently.

Conclusion

Many issues accompany how MSM behave when seeking medical care. The MSMs' poor service-seeking behaviour was influenced mainly by the availability of services and their level of satisfaction. A persistent shortage of essential services deters MSMs from seeking such medical assistance. Building staff capacity and maintaining a constant supply of MSMs' necessities can also help change how they use services. The government should work towards developing and implementing MSM-specific measures through the Ministry of Health. However, MSMs frequently endure maltreatment and prejudice from those around them, including when they receive medical care in hospitals. This mistreatment makes MSMs more hesitant to seek medical help. Improvements in their service-seeking behavior may result from working on methods of reducing these influences. The study concludes that preventing physical inaccessibility, ensuring the availability of necessary supplies, and protecting individuals' privacy inside the facility can all aid in scaling up service utilisation among MSMs.

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Conflict of interest
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