

**UNIVERSITY OF NAIROBI**

**DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK**

**ACCESS OF HEALTH CARE SERVICES AMONG SEXUAL MINORITIES IN KENYA:  
A CASE STUDY OF WOMEN WHO HAVE SEX WITH WOMEN (WSWs) IN NAIROBI  
COUNTY, KENYA**

**BY**

**CATHERINE WAHU KARIUKI**

**(C50/77598/2015)**

**A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT FOR THE  
REQUIREMENTS OF THE AWARD OF MASTER OF ART IN (MEDICAL  
SOCIOLOGY)**

**2017**

**DECLARATION**

I, Kariuki Catherine, do declare that this project paper is my original work and has not been submitted to any other institution for an academic award.

**Name: Catherine Wahu Kariuki**

**Reg. No: C50/77598/2015**

Date:..... Signature:.....

**Declaration by Supervisor**

This research project has been submitted for examination with my approval as the University of Nairobi Supervisor.

**DR. ROBINSON MOSE OCHARO**

Date:..... Signature:.....

## **DEDICATION**

This study is dedicated to my late parents, Patterson Kariuki and Lucy Wambuu for their sacrifice and steady upbringing. May our good Lord rest your souls in his eternal peace.

To my partner and friend Isaac Waweru, for his patience and encouragement. To my children Barbara Nyambura and Sandra Wambuu, who often took a back seat as I delved into this research project, for your prayers and moral support. To my work colleagues who eased my workload to help me focus and also encouraged me along the way. To my friends, who tried hard to understand the nature of my project, but were too modest as not to ask too many questions, their blank stares and snide comments went a long way. To members of staff in the sociology department, their support and input was refreshing. And finally to all researchers who are courageous enough to take on unpopular and controversial topics for the love of knowledge

## **ACKNOWLEDGEMENTS**

I am grateful to my University supervisor, Dr. Robinson Ocharo for his patience and guidance through the development and implementation of this research.

Despite the initial hesitance, due to the open hostility faced by members of the SOGIE community from larger society, I am extremely indebted to the study's respondents in Nairobi County who openly expressed their thoughts and critical responses. They willingly gave their time and participated in the study. It is my sincere hope that the results from this study is of help to them.

Last and definitely not least I would like to offer my gratitude to my family; for their patience and behind the scene support as I took quality time off their lives to research and compile this work, and my employer for giving me time off when I required to carry out research on this project

## Table of Contents

<b>DECLARATION</b> .....	<b>i</b>
<b>DEDICATION</b> .....	<b>iii</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>iv</b>
<b>Abbreviations</b> .....	<b>x</b>
<b>Definition of Key Terms and Concepts</b> .....	<b>xi</b>
<b>ABSTRACT</b> .....	<b>xiii</b>
<b>Chapter One:Introduction</b> .....	<b>1</b>
1.1 Background Information .....	1
1.1.1 Concept of Sexual Minorities .....	4
1.1.2 Health Care Seeking practice in Kenya .....	6
1.3 Research Questions .....	13
1.4 Objectives of the Study .....	13
1.5 Significance of the Study .....	13
1.6 Scope and Limitations of the Study .....	14
<b>Chapter Two: Literature Review and Theoretical Framework</b> .....	<b>16</b>
2.1 Introduction.....	16
2.2 Empirical Literature .....	16
2.2.1 Overview of Sexual Minorities .....	16
2.2.2 The Identity of Women who have sex with Women (WSWs).....	20
2.2.3 Health Challenges among Sexual Minorities .....	23
2.2.3.1 Factors affecting WSWs Health.....	25
2.2.4 Factors affecting the Health Care System.....	27
2.2.5 Social and Cultural factors affecting Health .....	29
2.3 Theoretical Framework .....	33
2.4 Conceptual Framework .....	38
<b>Chapter Three: Research Methodology</b> .....	<b>40</b>
3.1 Introduction.....	40
3.2 Research Design.....	40
3.3 Site Selection .....	40
3.4 Unit of Analysis and Unit of Observation .....	42
3.4.1 Unit of analysis .....	42

3.4.2 Unit of Observation.....	43
3.5 Target Population and Sample Population.....	43
3.5.1 Target population.....	43
3.5.2 Sample population.....	43
3.6 Sample Size and Sampling Procedure.....	43
3.6.1 Sample size.....	43
3.6.2 Sampling procedure and recruitment techniques.....	44
3.7 Ethical Consideration.....	44
3.8 Methods of Data Collection.....	44
3.8.1 Qualitative Data.....	45
3.8.2 Quantitative Data.....	45
3.9 Data Analysis.....	45
3.10 Validity of Instruments.....	45
3.11 Reliability of Instruments.....	45
<b>Chapter Four: Data Analysis, Presentation and Interpretation.....</b>	<b>46</b>
4.1 Introduction.....	46
4.2 Respondents Background Information.....	46
4.2.1 Respondents Age.....	46
4.2.2 Level of Education.....	47
4.2.3 Marital Status of Respondents.....	48
4.2.4 Religious affiliation.....	50
4.2.5 Respondents role in the WSWs relationship.....	51
4.3 Health needs that manifest among WSWs by virtue of their sexuality.....	52
4.3.1 Treatment availability for WSWs in the health care system.....	53
4.3.2 Reasons for negated health provision.....	54
4.4 Availability of health care services for WSWs.....	59
4.4.1 Services that WSWs would like to receive.....	60
4.5 Accessibility of Health Care Service by WSWs in Nairobi County.....	62
4.5.1 Health Centers offering non-discriminative health care services.....	63
4.5.2 Reasons for unfavorable attitude towards WSWs.....	64
4.6 Challenges that exist for WSWs in seeking health care services.....	71
4.6.1 Factors associated with challenges experienced.....	71

4.6.2 Challenges that exist for WSWs in their bid to seek health care services.....	75
4.7 Copying mechanisms employed by WSWs in seeking health care services.....	75
4.7.1 Copying mechanisms employed by WSWs .....	76
4.7.2 Mechanisms to ensure equal access to health services for WSWs .....	77
4.7.3 Kenya health care system in dealing with WSWs health needs.....	77
<b>Chapter Five: Summary, Conclusions and Recommendations .....</b>	<b>79</b>
5.1 Introduction.....	79
5.2 Summary of the Findings .....	79
5.2. Specific WSWs health needs by virtue of their sexual orientation .....	79
5.2.2 Availability of health care services by WSWs.....	80
5.2.3 Extent of accessibility of health care services.....	80
5.2.4 Health Challenges that exist for WSWs.....	81
5.2.5 Copying mechanisms employed by WSWs .....	81
5.3 Conclusion .....	82
5.4 Recommendations.....	82
5.4.1 Recommendations for Policy .....	82
5.4.2 Recommendations for Further Research.....	83
<b>References.....</b>	<b>84</b>
<b>APPENDICE .....</b>	<b>93</b>
Appendix I: Interview Schedule Questionnaire .....	93
Appendix II: Interview Guide for Key Informants .....	102

## LIST OF FIGURES

Figure 1 Conceptual Framework.....	39
Figure 2: Map of Kenya .....	41
Figure 3: Map of Nairobi .....	42
Figure 4: Respondent's Level of Education.....	48
Figure 5: Marital Status of Respondents.....	49
Figure 6: Religious affiliation of Respondents .....	50
Figure 7: Role of respondents in the WSWs relationship .....	51
Figure 8: Treatment availed to WSWs in health care centers .....	54
Figure 9: Availability of social support for WSWs .....	76
Figure 10: Kenya health system ability to deal with WSWs health needs.....	77

## LIST OF TABLES

Table 1: Age of the Respondents .....	46
Table 2: Nature of Health Needs.....	52
Table 3: Respondent opinion on negation of health service provision .....	55
Table 4: Guttman Scale: Negation of Health Service Provision.....	56
Table 5: List of health services WSWs would like to receive .....	60
Table 6: Cross Tabulation Table (Health needs as result of sexuality & Availability of Health care service).....	62
Table 7: Health Care Providers level of discrimination to WSWs by Sector .....	63
Table 8: Reasons for unfavorable attitude towards WSWs .....	64
Table 9: Challenges experienced by WSWs as a result of their sexual orientation .....	71

## **Abbreviations**

AI	Amnesty International
AIDs	Acquired Immune Deficiency Syndrome
GALCK	Gay and Lesbian Coalition of Kenya
HIV	Human Immuno-Deficiency Virus
HPV	Human Papillomavirus
KHP	Kenya Health Policy
KHRC	Kenya Human Rights Commission
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queers
LBQ	Lesbian, Bisexual and Queer
MDG	Millennium Development Goals
MSM	Men who have sex with men
NGOs	Non-Governmental Organizations
OSEA	Open Society of East Africa
OSEA	Other Sheep East Africa
PEMA	Persons Marginalized and Aggrieved
PCC	Population Control Council
PEP	Post Exposure Prophylaxis
SOGIE	Sexual orientation, gender identity and Expression
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infections
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
VCT	Voluntary Counseling and Testing
WSWs	Women who have sex with Women

## Definition of Key Terms and Concepts

Bottom/Femme/Stem	A term used by lesbians to signify the role played by a submissive partner
Bisexual:	Sexual orientation of a person who is sexually and romantically attracted to both men and women
Effeminate man:	word used to describe a man whose behavior and mannerisms mirror that of women
Gay:	Synonym in many parts of the world for homosexual; used here to refer to the sexual orientation of a man whose primary sexual and romantic attraction is toward other men.
Gender:	Social and cultural codes (as opposed to biological sex) used to distinguish between what a society considers “masculine” and “feminine” conduct.
Gender identity:	Person’s internal, deeply felt sense of being female or male, both or something other than female and male. It does not necessarily correspond to the biological sex assigned at birth.
Gender non-conforming:	Behaving and appearing in ways that do not fully conform to social expectations based on one’s assigned sex
Homophobic Tendencies:	Dislike of or prejudice against homosexual people. Irrational fear of, aversion to, or discrimination against homosexuality or homosexuals.
Homosexuality:	A person who is exclusively or almost exclusively romantically attracted to members of his/her own sex.
Homosexual orientation:	Sexual orientation which is characterized by romantic desires towards members of the same sex.
Intercrural Sex:	A type of intercourse generally regarded as non-penetrative in which a male partner places his penis between a male or females thigh’s
Intersex:	A person born with reproductive or sexual anatomy that does not seem to fit the typical definitions of “female” or “male”
Lesbian:	Sexual orientation of a woman whose primary sexual and romantic attraction is toward other women

Outted:	To have one's orientation (often gay or lesbian) revealed to one's family, colleagues or public or to openly and publicly state one's sexual orientation
SDGs:	Sustainable Millennium Goals are a new universal set of goals, targets and indicators that UN member states will be expected to use to frame their agendas and political policies over the next 15 years. They are a call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity.
Sexual Minorities:	A group whose sexual identity, orientation or practices differ from the majority of the surrounding society. It can also refer to transgender, genderqueer (including third gender) or intersex individuals. The term is primarily used to refer to lesbian, gay, bisexual, transgender, and intersex individuals, particularly gay people.
Sexual orientation:	Refers to each person's capacity for profound emotional affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender
SOGIE:	Sexual Orientation Gender Identity and Expression: Describes to whom a person is sexually attracted. Some people are attracted to people of a particular gender; others are attracted to people of more than one gender. Some are not attracted to anyone.
Top/Stud/Tommy	A term used by lesbians to signify the role played by a dominant partner
Transgender:	The gender identity of people whose birth gender (which they were declared to have upon birth) does not conform to their lived gender (the gender that they are most comfortable with expressing or would express given a choice). A transgender person usually adopts, or would prefer to adopt, a gender expression in consonance with their preferred gender, but may or may not desire to permanently alter their bodily characteristics in order to conform to their preferred gender.

## **ABSTRACT**

Studies on the SOGIE worldwide and specifically in Kenya are unpopular mainly because homosexuality has been criminalized by law. As a result members of the LGBTIQ community are afraid of coming out regarding their sexual orientation and this is especially so when they need to seek out health care services. Considering that health care is a fundamental right enshrined in the constitution, it becomes a tough balance so seek out health services as a right and to risk exposure of their sexual orientation which is criminalized by the same constitution. Using the descriptive survey design, the main objective of this research was to examine the access of health care services among Women who have sex with Women (WSWs) in Nairobi County. In order to achieve this, the specific objectives were: to find out the specific health care needs WSWs are faced with by virtue of their sexual orientation; to establish the availability of health care services sought by WSWs; to examine the extent of accessibility of health care services by WSWs in Nairobi County; to investigate challenges that exists for WSWs in seeking health care services; and to identify coping mechanisms employed by WSWs in their seeking health care endeavors.

The study established that the top three health needs among women who have sex with women are STI and STI testing, psychological issues and HIV testing. Treatment however of these conditions while available at no cost in public health centers is often not sought out by LGBTIQ individuals because of experiences of past discrimination or perceived homophobia within the prevailing health care system. Majority of the respondents reported to having unmet health needs, while a smaller percentage reported to having their health needs met in spite of their sexual orientation. The research established that majority of the respondents had not received treatment in health care centers when the health personnel discovered their sexual orientation while a few reported to have received treatment despite their sexual orientation. Some of the challenges that WSWs reported to have experienced in their bid to seek out health care services were listed as follows: discrimination, stigmatization, homophobia among health personnel and punitive laws against homosexuality. Due to the challenges experienced by WSWs in their health seeking endeavors, the study established that majority sought social support from organizations that champion homosexuals' right, social media platforms among sexual minorities, ideas shared by other stakeholders through networks and seminars, health forums that accord open discussions and dialogue, social support offered by peers and other sexual minorities.

## **Chapter One: Introduction**

### **1.1 Background Information**

At present Kenya is at crossroads, on the one hand the Lesbian, Gay, Bisexual, Transgender, Intersex and Queers (LGBTIQ) organizations have become more visible and are increasingly recognized by state institutions, on the other hand tension around LGBTIQ are also on the rise within government and the public domain. Accordingly this crossroads underpins the urgent need to gain more insights into the live experiences of LGBTIQ people and LBQ women also referred to as WSW in particular. (GALCK, 2016).

Health is the most basic fundamental human right guaranteed to every individual as a means to safe guard and maintain life. The bill of rights under article 43. (1) states that “Every person has the right (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care”. (Constitution of Kenya, 2010). Studies by human rights groups indicate that the LGBTIQ community lack comprehensive services and in addition have poor access to health care. (KHRC, 2011). LGBTIQ Kenyans in seeking treatment for STIs, counseling and HIV testing and transgender and intersex persons attempting to access general care are often afraid of honestly responding to medical interviews due to the fear that it will lead to rebuke, arrest or both. They are often more worried about exposure to the status of their sexual orientation as well as health care professional’s reaction than in getting treatment and as a result only seek health care when their condition has deteriorated. (KHRC 2011).

Furthermore, the constitution of Kenya promulgated in 2010 offers equal rights for all citizens under the bill of rights. Article 27 (1) states that “Every person is equal before the law and has the right to equal protection and equal benefit of the law”. Additionally, article 27 (4) states that “The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, color, age, disability, religion, conscience, belief, culture, dress, language or birth.” (Constitution of Kenya, 2010). These rights however are not enjoyed equally by all Kenyans; studies by human rights groups on the LGBTIQ community report violations of the above rights enshrined in the constitution such as harassment by state officials, denial of health care services, ridicule by health care professionals, blackmail from ex-spouses and other professionals familiar with the

individuals sexual identity, social stigma and being ostracized by family and society, physical violence and threats of deaths and expulsions from learning institutions. (KHRC, 2010).

The World Health Organization (WHO), in its working definition defines universal access of sexual reproductive health to include “preventive care, ailment diagnosis, counseling, treatment and reproductive health care services relating to: antenatal, prenatal, postpartum, newborn care; family planning services including infertility, contraception; elimination of unsafe abortions; prevention and treatment of STIs/HIV etc and the promotion of healthy sexuality.” (WHO, 2011) According the Kenya Health Policy 2014-2030, the constitution of Kenya 2010, provides the overarching legal framework to ensure a comprehensive rights-based approach to health services delivery. In view of this, it is imperative to review the access of health care services for sexual minorities against the rights and need based approach, as provided for in the Kenya health policy.

In view of the above rights, LGBTIQ persons face hindrances in availing quality health care services such as among others voluntary couple counseling and testing (VCT) and testing as well as treatment for STIs, including HIV and AIDs. (National Aids Council 2009). This increases their vulnerability to HIV infections and also hampers researchers attempts to reach out to them in attempts to investigate their HIV risk, behavior and prevalence rates (National Aids Council 2009). Due to lack of data, the SOGIE individuals are not considered a priority target group by HIV and AIDs program planners and health care providers. The lack of legal recognition for the LGBTIQ persons in Kenya has remained a stumbling block to meeting their health needs. According to the National Aids Control Council (NACC, 2009), HIV prevalence among sexual minorities such as MSMs is higher than that of other sexual groups. 1,500 MSMs get infected with HIV each year with 60% of them engaging in heterosexual relationships, while about 9,000 females are exposed to the AIDs causing virus (NACC 2010).

Despite existing laws that discriminate against sexual and gender minorities leading to outlawing of same-sex relations on one hand, homosexuality being illegal in Kenya, and considered taboo among majority of ethnic groups on the other hand, evidence exists that indicates its prevalence and growth in the country. (KHRC 2011). Kenya has a growing number of women who identify as LBQ. The issues faced by this cohort include physical violence, undetected mental health,

home evictions, social stigmatization, isolation and poverty. Homosexuals exist and have formed support groups that champion for their rights. Majority of these groups are registered as human rights and/or civil society organizations, and hence highlight their social and psychological needs on the human and civil rights platform. These organizations have representation country wide with majority of them concentrated in urban areas. (GALCK Publication 2016)

Every individual in Kenya has the right to the highest attainable standard of health, which includes reproductive health right (Constitution of Kenya, Bill of Rights, 2010).. Additionally the constitution obligates the state and every state organ to observe, respect, protect, promote and fulfill the rights in the constitution. (Constitution of Kenya, 2010). Public officers as well as varying state organs have a constitutional obligation to deal with the needs of the vulnerable groups in society and to domesticate the provisions of any and every relevant international treaty and convention that Kenya has rectified. (Universal Declaration of Human Rights, UDHR, 2010). The state has further obligation under Article 46 of the constitution to protect consumer rights, including the protection of health and safety and economic interests. (Constitution of Kenya, 2010). Kenya's progressive new constitution promulgated in 2010, guarantees all Kenyans the right to privacy, dignity, and non-discrimination. It articulates a set of national values that includes "human rights, non-discrimination and protection of the marginalized." Further the constitution integrates international law, including treaties ratified by Kenya that prohibit discrimination on the grounds of sexual orientation into Kenyan law. (Constitution of Kenya, 2010). One of the treaties that Kenya rectified is the Yogyakarta principles; this addresses the application of International Human Rights Law in relation to Sexual Orientation and Gender Identity and Expression. These principles were crafted in 2006, in response to documented abuse patterns, this led to an intellectual and re-known group of international human rights experts put their minds together while in Indonesia resulting in an outline a set of international principles relating to SOGIE. This resulted in the (Yogyakarta principles, 2006), legal standards that are a universal guide to human rights, that requires compliance by all states. The end result would preferably be a different and brighter future where all people are born free and equal in dignity and rights and hence allow individuals the opportunity to fulfil that precious birthright. This study will hence focus on access of health care services among sexual minorities singling out WSWs because health is of great importance in sustaining and maintaining human health.

### **1.1.1 Concept of Sexual Minorities**

It is commonly believed that the act of homosexuality is a degenerate conformist first world innovation forced on colonized third world Africa by white men, or alternatively, by Islamic slave-traders. It is considered exogenous to the history of the African people. (National Annual Conference of Traditional Leaders, 2005, as cited in Reid, 2010, p. 44). Same-sex behavior however existed in Africa long before the westerners arrived. Political leaders around Africa have entrenched the notion that homosexuality is ‘alien’ to the African culture and an import of the depraved West. (Morgan & Wieringa, 2005, P17). While drawing on heterosexist discourse, African Presidents have labeled same-sex practices as going ‘against African tradition’ and construct homosexuality as originating in European and Western contexts which they say fosters “the deepest level of depravity” (Times of Zambia, 1998 as cited in Reddy, 2002, p. 170).

The former President of Kenya Daniel Arap Moi, claimed that “Homosexuality is against African Norms and traditions” (Morgan & Wieringa 2005, p. 25). The current sitting Kenyan President Uhuru Kenyatta, just like the third Kenyan president His Excellency Mwai Kibaki has kept mum where public debates centering on LGBTIQ rights are involved. In July 2015, however Kenyatta who appeared pushed to a corner made the first public statement on these rights at a press conference in the context of a visit from US President Barack Obama, calling gay rights a “non-issue” in an apparent effort to avoid heated debate. The Kenyan Deputy President William Ruto on the other hand has repeatedly and openly, made his position on the issue known. He has expressed his views overtly that leaves homophobic tastes in our collective mouths. Prior to assuming his current position, Mr. Ruto as the member of parliament representing Eldoret North was on the front line in opposing the proposed Kenya’s progressive new constitution in 2010, claiming that the constitution’s equality provisions being snaked in were an attempt to legalize same-sex marriage. During the country side televised 2013 deputy presidential debate, Mr. Ruto did not hesitate in comparing homosexuals to “dogs”. In another forum, just after a court judgment compelling the NGO board to register the National Gay and Lesbian Human Rights Commission, he stated while invited to speak during a church service in May 2015 that “There is no room for gays and those others in Kenya”. Additionally, same sex marriages were given equal rights in a ruling in the US Supreme Court, the deputy president strongly spoke against the ruling while attending yet another church service, and was quoted as

saying “We hear that America has legalized homosexuality and other dirty things” (GALCK, 2016).

In Nigeria former President Olusegun Obasanjo, declared same-sex unions as ‘unnatural and unAfrican’ while traditional leaders in South Africa have claimed that same-sex marriage goes ‘against most of African beliefs, cultures, customs and traditions (National Annual Conference of Traditional leaders, 2005, as cited by Reid, 2010 p. 44). Leaders in Uganda, Zimbabwe, Nigeria and Namibia have publicly vocalized their repugnance of homosexuality and constructed it as a ‘sinful’ act which appears to go against Christian beliefs. (Ratele, 2006).

Same-sex unions have been constructed as ‘unchristian’ in that they are ‘non-procreative’, and therefore they go against Biblical teachings around reproduction (Reid, 2010, p 40). Notably in some African cultures where same-sex marriages are practiced for instance in the Kikuyu, Kamba, and Kalenjin tribes in Kenya, same-sex sexuality within these marriages are considered taboo owing to both cultural and Christian religious beliefs that structure the Kenyan Society (Baraka & Morgan, 2005). African leaders and those who draw on the ‘unAfrican’ discourse regularly construct homosexuality – a western import as unchristian and thereby appropriating a western religion to criticize foreign practices. (Horn, 2006; Reddy, 2002. Reid, 2010). Laws that criminalize and/or outlaw homosexuality or ‘unnatural sex’ use the discourse of homosexuality as unchristian and un-Biblical which are both colonial imports (Horn, 2006, p. 13). Both the Catholic and Protestant religious leaders have supported the construction of homosexuality as a sin (Baraka & Morgan 2005).

France decriminalized homosexuality in 1791. The United Kingdom and Wales equally abolished the law criminalizing consensual same-sex sexual conduct in 1967. (Amnesty International Publication, 2013). Homosexuality has also being decriminalized and is hence practiced in some Africa countries, South Africa allowed joint adoption of children by declared homosexual couples in 2002, while at it introduction of legal statues on legal gender recognition in 2014 consequently led to allowance for same-sex marriage in 2006. (Amnesty International Publication, 2013). Similarly, Cape Verde in 2004, did away with offences related to homosexual activity. Mauritius in 2009, committed to decriminalize homosexuality, Sao Tome and Principe in the year 2011 along with Seychelles committed to appealing laws that discriminate against homosexuality (Amnesty International Publication, 2013).

Homosexuality is therefore not un-African. According to a recent research carried out in Nairobi, 97% of MSMs indicated that they had had their first homosexual encounter experience with another Kenyan, among others they named: fellow students, neighbors or extended family members. (Johnson, 2007). A similar research carried out in the coastal town of Mombasa which bares the tag of being a holiday destination for homosexual men originating from western hemisphere, at least 80% of male sex workers' said that majority of their male clients were fellow Kenyans. (Population Control Council 2009). To further this claim, as part of his academic study namely: "Homosexuality in Traditional Sub-Saharan Africa", Re-known Sociologist (Stephen O. Murray 1998) highlights a large number of cultural practices that encompass the continent of Africa and that brings out the fact that homosexuality was practiced by African's before white imperialism. Additional studies on homosexuality have discovered that sexual relationships between men and boys were often practiced throughout African history, and even though they were not always widely accepted or institutionalized, they were often tolerated. (Stephen O. Murray 199)

The LGBTIQ individuals face a number of challenges as a result of their sexual orientation. These challenges are structural, religious, cultural, social, political and psychological. (Diamond, 2008). The health status of these individuals, a prerequisite for survival, is affected by these challenges and hence the need to interrogate these issues in totality.

### **1.1.2 Health Care Seeking practice in Kenya**

Anand Grove; an individual who served as the United Nations Special Rapporteur and specifically who dealt with the right of all humanity accessibility to the highest attainable standard of mental and physical health, reported in April 2010 that legislature outlawing sexual behavior between same sex homosexual adults who do so in agreement and are of sound mind acts as a barrier to HIV education and efforts to prevent its spread, in addition these are not compatible with the right to health. The Joint United Nations Program on HIV and AIDs commonly known as UNAIDs hold a similar view. (UNAIDs Publication, 2014). SOGIE individuals and WSWs in particular face difficulties in and out of the health care system that are unique to this cohort. Unfortunately, these difficulties often lead to less than ideal mental and physical challenges. The medical fraternity through no fault of their own have not been open

enough to these medical experiences to understand the specific health care needs of lesbians. (GALCK, 2016).

According to (Arthur Kleinmann 1980), there exists within societies a variety of health systems that overlap and coexist among each other. Each sector uniquely explains disease and treats health related problems, determines the healer(s), and the patient and the ways in which they interact and fixes in the course of treatment. One of these is the professional sector that consists of organized, legally sanctioned healing professionals. (Kleinmann 1980) emphasizes that the professional sector is so dominant that the modern medicine profession in health care systems in most societies, is equated with the entire health care systems when studies on health are carried out. This sector includes physicians in each sector and those who assist them such as nurses, technicians, midwives, clinical officers among others. It describes anyone acknowledged or perceived in a culture as belonging to a professional group. (Thorne & Robinson, 1988). In many cultures, professional healers are those recognized by law and enjoying the power of a medical establishment behind them, but in some cultures no formal licensure exists (Weaver & Wilson, 1984). The professional sector in Kenya is fully established and a source of consultation for many individuals. The legality of this sector builds confidence in the citizenry and as such is widely visited when ailments arise. The SOGIE individuals consult this sector due to exiting legality, popularity, and trust built over a number of years. The uniqueness of the health seeking situation of this cohort also determines their reliance on this sector, as the most possible solution to the aforementioned uniqueness.

Another sector is the folk sector, where healers are non-professionals, non-bureaucratic specialists who have received little or no training in professional medicine. (Kleinmann 1980) Their knowledge of healing often comes from serving as an apprentice to another folk healer. They are viewed as important healers because they have an inborn or special healing power and/or have been the recipient of their masters' knowledge. Folk healers according to (Kleinmann 1980) are classified into secular and sacred but these are blurred in practice and often overlap. These healers approach healing in a holistic way dealing with a person's interactions with the natural and the supernatural realms and with a person's physical, emotional and even spiritual problems. They practice herbalism and concoct recipes consisting of plant and animal and mineral substances as some are herbalists and root cutters. In addition they use

traditional surgical and manipulative treatments recommend special systems of exercise and advocate “special non sacred healing”. The sacred healer however who also falls in the folk sector emphasis on the patient’s faith and belief system for healing. (Kleinmann,1985, p. 149). There exists a strong and trusting relationship between the healer and the patient. Kenya being a highly religious state, many individuals subscribe to this form of healing and its popularity is openly acknowledged and accepted. The SOGIE individuals may be reluctant to seek health related services from this sector due to religious based homophobic tendencies. There is however reprieve in the existence of the Other Sheep a SOGIE friendly religious establishment that offers spiritual guidance and hence devoid of homophobic tendencies.

The third sector is the popular sector, whose characteristics are non-professional and non-specialist. It is also very popular in the Kenyan setup. It is at this sector where medical problems and ill health are first recognized and defined. The client and their families do not simply develop their own illness beliefs and perceptions within a vacuum but they are modeled by everyday social interactions (Marks, Murray, Evans, Wilig, Woodall & Sykes, 2005). This sector includes all the healing options that people freely make use of without recourse to folk healers or medical professionals. (Kleinmann, 1985), points out that most illnesses are self-diagnosed and methods for treating them are based on this self-assessment, or on the advice of a relative, friend or neighbor. The main arena of health care in the popular sector is the family and it is where most illness (70 – 90%) are evaluated and treated usually by women folk (mothers and grandmothers). This sector is often overlooked by medical literature, but for many cultures this is the predominant form of care and first therapeutic intervention. (Kleinmann, 1985). Sick people often learn healthy lifestyles through informants at this level; what foods to eat and which ones to avoid, appropriate levels of water to drink, sleeping, waking and the role of spirituality and interpersonal relationships. The use of magical charms to ward off disease and ill health are acceptable in this sector if they can be used to maintain good health. (Kleinmann, 1980). The SOGIE individuals may be attracted to this sector as it forms part of their social networks. Experiences are shared and what works and does not work, which establishments are friendly to the LGBTIQ community, is exchanged and acted upon appropriately. The decision on which sector to visit is also interrogated and made in this sector. (Kleinmann, 1980)

As a result of technological advancement, a fourth sector has arisen and is widely consulted as a form of self-treatment. This sector is the google doctor, where patients use the internet to seek diagnosis and treatment for their symptoms. Treatment is then sought over the counter in friendly pharmacies that are not strict on prescription presentation. Once self-treatment fails, the sick individual makes a choice at family or individual level on whom in the three sectors to consult. It is also common for sick individuals to consult all the sectors at the same time. (Jablonski, 2004). For instance after self-treatment fails; one may seek help from a medical doctor while also seeing a priest if the source of illness is viewed by the individual as stemming from supernatural sources. The same individual may also choose to consult the secular folk healer if they feel let down by the other two sectors.

The decision on which sector to consult is driven by a number of factors, a healer in one sector may diagnose or offer therapeutics that seem nonsensical to the patient or run contrary to their expectation and hence the next best option is sought. Other deciding factors may include but not limited to unavailability of the preferred sector at the time illness strikes, lack of economic means, the real or imagined success and reputation of the healer; or the patients self-assessment of the problem or the self-assessment of the problem by others.(Kleinmann 1980).

Whatever option a patient seeks, the government through the ministry of health has adopted the (Kenya Health Policy 2014 – 2030) that is geared towards the achievement of standards of health that are at their highest for all its citizenry. The policy document provides a road map that serves to ensure recognizable improvement in the health status of all Kenyans.

## **1.2 Statement of the Problem**

Even on a whim, a clear description of who is a lesbian or WSWs is not possible; however as a starting point common descriptive features may include attraction to women, women to women sexual behavior or self-declaration or outing as a lesbian/WSWs. (Chandra et al 2008). Lesbian relationships are not static and are known to move from one end point to another. In these kind of instances, a woman may totally out of choice not be completely heterosexual or completely homosexual or she may over a duration of unmeasurable time develop a lesbian orientation. (Chandra et al 2008). A woman who defines herself as bisexual will therefore find herself attracted to and/or engages in sexual behavior with both males and female individuals and she

will therefore identify herself as bisexual. Sexual orientation has not been definitively found to be directly determined by any particular factor or factors, and the time at which it comes forth, its recognition and/or identification, and expression of one's sexual orientation varies among individuals from time to time. (Chandra et al 2008). In whatever manner an individual identifies with a particular sexual orientation, the LGTBIQ and particularly lesbian and women who engage in sexual encounters with both men and women come across hurdles in gaining health care services that are not limited to worries/concerns about confidentiality and disclosure a right in the health care system, being looked down upon and stigmatization/discriminatory attitudes and treatment, limited access to health care and health insurance, and often a limited understanding as to what their health risks may be. (GALCK, 2016)

According to (KHRC 2011), sexual minorities including WSWs, face barriers whose rights are protected in the constitution such as, harassment by state officials by being held in prisons and detention centers way above the constitutionally allowed period appearing before judicial officials, presentation in court on cooked up charges (Chapter 63, Laws of Kenya), compromised police officers who do not shy away from blackmail. LGBTIQ individuals with arrest threats and imprisonment should they refuse to surrender bribes (David K., 2010). Professional LGBTIQ individuals have been known to face blackmail situation by work colleagues, former partners, and security personnel who do so with assistance of other LGBTIQ individuals who are knowledgeable of the professionals' sexual identity. Bisexuals also face blackmail from ex-spouses in child custody battles as they are deemed unfit to raise children due to their sexuality. In other cases financial and educational support is withdrawn by family and guardians once LGBTIQ individuals 'out' themselves or are 'outed' by others. These tactics are aimed at blackmailing the LGBTIQ individual to reform. (KHRC 2011)

Stigma and exclusion by family and society is another barrier LGBTIQ individuals face. Failure to bring out humanity in sexual orientation and gender identity has led to SOGIE individuals being regarded as taboo and by extent inviting repulsion and stigma (KHRC 2011). Outlawing homosexuality is linked to stigmatized health care service provision considering that many providers find it difficult to provide services that do not appear stigmatizing to clients seen to be engaging in what can be described as illegal behavior. (KACC, 2009). Expulsions from learning institutions are yet another barrier individuals who identify as LGBTIQ tackle. They are often

marked and eventually sent away from school on grounds of perceived, actual or suspected sexual orientation or gender identity. Various news media have in the past presented reports of girls being chased from secondary schools on the suspicion of practicing lesbianism (KHRC 2011).

Physical violence and threats of death are yet another challenge individuals who identify as SOGIE face. Violence includes and is does not stop at harassment, mob justice, lynching, riots and beatings. Publications that are hateful in nature such as: text messages, posters, books, printed and online publications which constitute hate speech, a vice outlawed in the Kenyan Constitution article 33 (2) that states “The right to freedom of expression does not extend to (a) propaganda for war, (b) incitement to violence (c) hate speech; or (d) advocacy of hatred that (i) constitutes ethnic incitement, vilification of other or incitement to cause harm or (ii) is based on any ground of discrimination specified or contemplated in Article 27 (4). (Constitution of Kenya, 2010). The LGBTIQ are also faced with gang rape targeted at both gay and lesbians with the intention of straightening them out. (KHRC 2011).

The illegality of homosexual relationships and the social and structural reactions within the Kenyan society towards the SOGIE community and WSWs in particular, creates uncertainty and fear whenever the latter need to seek health care services in the health care system. (Kodero et al, 2011). The homosexual individuals face health risks and social problems not inherent in sexual orientation itself, but rather due to society’s responses to their sexuality. (O’Hanlan et al 1996). Public health and clinical researchers across a number of countries agree that there is now strong evidence to show that as a population, the homosexual, and by extension WSWs as a community experience health challenges due to the presentation of unique illnesses associated with their sexuality that include and not limited to increased risks for chronic disease and mental health concerns. (Croucher, 2002). LGBTIQ individuals present unique health issues, not commonly seen in the heterosexual community such as anal sores, STIs in the throat area, VCT same-sex couples counseling, higher prevalence of HIV/AIDs, invasive questioning, unnecessary tests like pregnancy tests for lesbians, need for water based lubricants, and leaking of fecal matter due to loosened anal muscles. Transgender individuals require hormonal injections, reconstruction

surgery, emotional therapy and counseling, while intersex individuals require genital reconstruction surgery and psychological therapy and counseling. (Boehmer, U., 2002).

Sociologists have long recognized that societies have powerful patterns, rules and regulations governing sexual behavior. Laws, religions and family systems all seek to control sexual activity and behavior. Foucault's *History of Sexuality* (1979), was an influential starting point in sociology to have particular ways in which we perceive sex which then becomes organized as part of the power relations in society, such as those based on gender. Heterosexuality has been seen as the norm in society with the nature of the roles women and men play in heterosexual relationships as driven largely by 'nature'. During the most part of the twentieth century, homosexual behavior was punishable by law in most European countries and the USA. Homosexuality in Africa, including Kenya is illegal and punishable by law, but this has not eradicated the existence of the homosexual community; and in particular WSWs. This has led to increased curiosity within social sciences to carry out various studies surrounding this group. Plummer was one of the early researchers into the field with his ground breaking *Sexual Stigma* (1975) and *The Making of the Modern Homosexual* (1981). Plummer has carried out other studies on life histories and accounts of the experiences of homosexual individuals in 'coming out' (Plummer, 1992, 1995).

The illegality and outlawed nature of homosexuality in Kenya, creates strain when the individuals are required to openly seek services that are a right and are necessary for survival. The general strain theory by Agnew (1985 and 1992), posits that individuals experiencing strain may develop negative emotions, including anger, when they see adversity as imposed by others, resentment when they perceive unjust treatment by others, and depression or anxiety when they blame themselves for the stressful consequence. This strain is experienced by both LGBTIQ individuals and health care professionals as a result of the changes that have taken place over the years as the SOGIE community grows and demand access to services that are their right and that are protected under the constitution, while on the other hand the health care workers strive to uphold the illegality of homosexuality as stated in the Kenya penal code. The changing climate that is allowing more acceptance of homosexual rights due to civil societies and equal health rights for all irrespective of their sexual orientation guaranteed in the Kenyan constitution under the bill of rights, vis a vis the reality of the need to offer universal health care to all in equal

measure, (WHO, 2010), necessitates a study on the access of health care among sex minorities in Kenya.

### **1.3 Research Questions**

The study utilized the following research questions that acted as a guide

- i. What specific health care needs are WSWs faced with by virtue of their sexual orientation?
- ii. Are the health care services sought by WSWs available in health centers?
- iii. What is the extent of access of health care services by WSWs?
- iv. What challenges exist in seeking health care services by WSWs?
- v. What coping mechanisms do WSWs employ in seeking access to health care services?

### **1.4 Objectives of the Study**

The main objective of the study was to examine the access of health care services among Women who have sex with Women (WSWs) in Nairobi County.

#### **The Study's Specific Objectives**

- i. Find out the specific health care needs WSWs are faced with by virtue of their sexual orientation.
- ii. Establish the availability of health care services sought by WSWs.
- iii. Examine the extent of accessibility of health care services by WSWs in Nairobi County.
- iv. To investigate challenges that exists for WSWs in seeking health care services.
- v. To identify copying mechanisms employed by WSWs in their seeking health care services.

### **1.5 Significance of the Study**

This study's findings are of importance to health professional policy makers, academicians and the larger homosexual community who encounter various challenges as they seek health care services in various facilities, both public and private. Due to the illegality of homosexuality in

Kenya, little or scanty information exists hence the need to carry out this study to bring to light the WSWs struggles despite universal health care provision, and rectification of various international treaties that bar discrimination on the basis of sexual orientation.

In addition, due to the secrecy that exists among WSWs, the study is of importance to health care professionals who are faced with difficulties in upholding the law and attending to patients whose medical needs they are most likely not acquainted with. The study therefore adds into the body of knowledge on access of health care services among sexual minorities with particular emphasis on WSWs in both public and private health institutions.

The finding(s) from this study are also of use to other researchers as the society which is not static but dynamic, opens up more to the SOGIE individuals, and as the homosexual lifestyle is demystified over time.

#### **1.6 Scope and Limitations of the Study**

The study was limited to Nairobi County. The direct experiences of the WSWs in other parts of the country were not included in the study. The study also concentrated itself to urban setting and hence targeted WSWs in urban setting; WSWs experiences in rural settings were therefore not included in the study. The non-inclusion of all counties in Kenya was mainly due to time, financial and logistical constraints, and not due to non-existence of this cohort in other counties both rural and urban.

The study limited itself to reproductive health care services. It also confined itself to reproductive services required by WSWs by virtue of their sexual orientation. The focus of the study did not lean towards other health care services sought by WSWs nor toward other social services such as employment, housing, education and religion among others. Reproductive health (WHO, 2011) which includes health care services, treatment, counseling, diagnosis and prevention as it relates to: STI/HIV treatment, prevention, elimination of unsafe abortions, contraception, family planning including infertility, newborn care, antenatal and prenatal postpartum and the promotion of health sexuality.

The study included participants who were 18 years and above and therefore did not include individuals below this age group. The study concentrated on individuals between the ages of 18 and 45 years of age. Those within this age group are considered mature and able to articulate

matters surrounding their sexuality. While literature review indicates that majority of WSWs had their first same sex debut while in secondary school hence below the age of majority, the law does not allow for unsupervised studies of those considered minors. Parents of WSWs are often uninformed of their children's' sexual orientation and are therefore unlikely to give any consent.

In order to identify and analyze access of health care services among sexual minorities with specific emphasis on women who have sex with women, the research focused on quality health care, health care accessibility, availability of health care services for WSWs, the attitudes of health care personnel towards this cohort, social and cultural inhibitors of health care services

The study focused on Women who have sex with Women commonly referred to as lesbians, and hence did not include other individuals who form part of the sexual minorities such as Men who have sex with men, Bisexuals, transgender nor intersex individuals. Preliminary studies indicate that individuals who are defined as sexual minorities by virtual of their sexuality suffer diverse health related issues and challenges within the health sector.

## Chapter Two: Literature Review and Theoretical Framework

### 2.1 Introduction

In this chapter, literature on access to health care services among sexual minorities with particular emphasis on women who have sex with women was reviewed. Among the documents reviewed includes, past studies carried out on the subject, journals, reports and varying health publications.

### 2.2 Empirical Literature

#### 2.2.1 Overview of Sexual Minorities

This study sought to examine what other researchers had learnt about sexual minorities and hence bring out gaps that exist in the knowledge gap which would contribute to already existing body of knowledge. In the study, sexual minorities have been used synonymously with the LGBTIQ or SOGIE individuals.

Murray, (1998), reveals how homosexuality originated from Africa with the first recorded couple being Egyptians *Khnumhotep and Niankhkhnum*, 2400 years before Christ. In his research, he found the practice of homosexuality among communities in Ethiopia, Eritrea, Sudan, Kenya, Congo, Nigeria, Senegal, and South Africa. Indigenous African communities not only condoned, but encouraged homosexual behavior. In many of the case studies, sexual relations between men and boys was accorded an official 'marriage' status complete with dowry payment. It is explained that the custom, and not the vice, was allowable in adolescent ages as young boys were not allowed sex with girls before marriage. Relations when hunting or shepherding were an allowable relief. In other sources, South African warrior Shaka Zulu has been painted as a homosexual who had page boys at his call who were not allowed to marry until they were 'of age'; that was generally until they were no longer attractive to the chief and he had acquired younger interests. He was not alone. (ibid).

Many African leaders in the pre-colonial times took with them boy-wives who were not expected to engage in combat but would provide other services to the elder fighters. Other studies have found further proof of the indigenuity of homosexuality in Africa through local terminology that existed to describe the practice as follows, the Ethiopian Konso have two words each for penis, vagina, and sexual intercourse, but no less than four for 'effeminate man'. Among the *Mossi* in Burkina Faso, *sorones* were chosen among beautiful boys aged seven to seventeen. In coastal

Kenya, *mabasha* and *mashoga* were known to exist. As a matter of fact, pagan religions, as they would be described today encouraged homosexual practices as part and parcel of their rituals. Homosexuality is therefore an African export and not a Western import as previously envisioned.

Moving away from Africa, material rich in content exists from prehistoric Greece, that centers around issues of sexuality ranging from two way talks of Plato, such as the *Symposium*, to acts by Aristophanes, and Greek vases and artworks. (Dover, 1989). There was a regional variation of Greeks attitude towards sexuality in some areas around Ionia there were general dressing downs against same-sex *eros*, while in Elis and Boiotia (e.g., Thebes), it was happily accepted and even commemorated (Halperin, 1990). Diogenes Laeurtius, for example, wrote of Alcibiades, the Athenian general and politician of the 5<sup>th</sup> century B.C., “In his adolescence he drew away the husbands from their wives, and as a young man the wives from their husbands.” (Quoted in Greenberg, 1988, 144).

Alexander the Great who was also the founder of Stoicism, Zeno of Citium, were known for their individualized and focused interest in boys and other men. They were, interpreted as the exception and not the rule. The questions as to what gender one was attracted to was viewed as an issue of taste or preference, rather than issues circling around morals. (Berman, 1993). Greek sexual relationships were between taking either an active or insertive role, vis a vis a passive or penetrated/submissive one. The passive role was only allowed for those considered as inferior, which included such as slaves, male youths or women who were not considered citizens. The cultural ideal of a same-sex relationship was between a man older in age, probably in his 20's or 30's, known as the *erastes*, and a younger lad barely out of puberty whose beard had not yet begun to grow, the *eromenos* or *paidika*. The relationship involved courtship rituals, with activities such as gifting (for instance a rooster), and other norms. The *erastes* or pursuer had to illustrate that he had magnanimous interests in the boy or pursued, rather than a virtuously sexual concern/interest. (Roscoe, 1998). The boy/pursued was not to acquiesce overly easily, and if pursued/courted by more than one man/suitor, was to show preference and pick the nobler one. There is also evidence that genital penetration was circumvented by having the *erastes/pursued* face his lover and position his penis between the thighs of the *eromenos*, which is known as intercrural sex. The relationship was short-lived and therefore was time barred as it was required to terminate once the boy reached adulthood. (Sullivan, 2003).

Ancient Rome on the other hand had many similarities in its understanding of same-sex/homosexual attraction, and sexual issues more commonly, to primeval Greece. Under the rule of the Roman Empire, however society sluggishly developed negative views and attitudes towards sexuality, this is most likely due to economic and social tumult, even before Christianity became persuasive. (Boswell, 1980, ch.4). Researcher, John Boswell, (1980), in his book "*Christianity, Social Tolerance, and Homosexuality*", points out that many routes taken today as denunciations of homosexuality are more centered on prostitution, or where same-sex acts are described as "unnatural" the meaning is more akin to "out of the ordinary" rather than as depraved (Boswell, 1980, ch.4); see also (Boswell, 1994). Christian church fathers were horrified at any sort of sex, but in a few generations these views eased, in part due to doubt and practical concerns of recruiting converts. Consequently at the turn of the fourth and fifth centuries the conventional Christian view allowed for procreative/reproductive sex within marriage setups. (Greenberg, 1988, ch.5). All other expressions of sexuality were considered sinful, clearly forbidding homosexual acts. This aspect was reflected in Roman legal statutes. (Sullivan, 2003). In Justinian's code pronounced in 529, people who engaged/involved in homosexual acts were to be put to death. The culprits who were however remorseful were given a second chance. The Empire of the Romanians thereafter saw the upsurge in bigotry towards sexuality. (Wieringa, 2005),

The fall of the Roman Empire, replaced by other kingdoms general narrow-mindedness of homosexual acts prevailed. Few measures were contained in European secular law against homosexuality/same sex acts until the mid-thirteenth century. (Morris, 2003). Christian theologians however continued to denounce non procreative sexual activity, including same-sex acts. (Macedo, 1995) Development of homophobic writings among the clerics came about in the eleventh and twelfth centuries (Boswell, 1980, chapters 8 and 9). Towards the end of the twelfth century onto the fourteenth saw a sharp rise in intolerance towards homosexual sex alongside the persecution of Muslims, Heretics, Jews and other minorities. This is attributed to the increased class conflict alongside the Gregorian reform movement in the Catholic Church. (George, 1999a, ch.15) The appeal of a conception of 'nature' as the standard of morality was started by the Church, which drew it in such a way so as to forbid sexuality considered unnatural such as extramarital sex, homosexual sex and any form non-procreative sex within marriage not excluding masturbation. (Davis, 2012). The ecumenical council first condemned homosexual

sex, Lateran III of 1179 which stated “Whoever shall be found to have committed that incontinence which is against nature”, shall be “punished, the severity of which depended upon whether the transgressor was a cleric or layperson” (quoted in Boswell, 1980, 277). The entreaty to what was referred to as the natural law became significant in the western convention.

Laws whose enforcement was episodic against homosexuals and particularly homosexual sex were uncompromising in their punishments towards offenders during the next several centuries in Europe.

The Dutch in the 1730s escalated an anti-sodomy campaign, using inhumane means like torture to obtain forced or real confessions, where one hundred men and boys were put to death and deprived of burial (Greenberg, 1988, 313-4). The acceptance of sodomy and same-sex attraction varied by social status, the middle class taking the slenderest view, while the highest class commonly referred to as the aristocracy and nobility accepted public articulation of different sexualities. The 19<sup>th</sup> Century saw a significant diminution in legitimate penalizations for sodomy when the Napoleonic code decriminalized sodomy. Sexual roles were redefined in the 20<sup>th</sup> century. (Shilts, 1993, ch.28). Premarital intercourse became more common and eventually acceptable. The decline of prohibitions against pleasurable sex even outside marriage made it more difficult to argue against gay sex. This brought about the rise of the gay rights and freedoms brought about by the liberation movement. The American Psychiatric Association in 1973 as a result of outcomes from the liberation movement removed homosexuality from its official listing of mental disorders, in the DSM manual. Increased conspicuousness of sexual minorities mainly gays and lesbians has now become a undeviating feature of life despite a couple of critical setbacks namely the HIV/AIDs epidemic an anti-gay/homosexuality backlash (Berman, 1993). Changes in Europe have also seen the revocation of anti-sodomy laws and introduction and practice of legal equality for gays and lesbians. Some countries in Africa have also decriminalized same sex relations. WHO eradicated homosexuality from its list of diseases and ailments in 1991. According to (Kodero, Misigo, Owino and Mucherah 2011), many societies in Africa still believe that people are born heterosexual.

According to (Kodero et al. 2011), homosexuals in these societies are regarded as sexual deviants. Sexual orientation and identity in many parts of the world are viewed along a continuum ranging from heterosexuality to homosexuality. However there is a group in between

believed to be bisexual as they are attracted to both men and women. (Nathaniel M. 1987). The recognition of sexual minorities as a separate entity was first brought out in the western society.

In sociological studies, the initial attempt to carry out research on homosexuals was carried out by Plummer, with his revolutionary books *Sexual Stigma* (1975) and the making of a homosexual (1981). Foucault also carried out research on homosexuals in his book *History of Sexuality* (1979); in it, he brought out ways that society perceives sex, which then becomes organized as part of power relations such as those based on gender.

Homosexuality is proscribed in Kenya and as a result is criminalized by law (Finerty, 2012). However evidence exists to show that as at late 1990s, lesbian, gay, bisexual, transgender and intersex individuals interacted with each other socially. (Amnesty International Publication, 2013). At Independence in 1963, Kenya inherited British colonial laws including one that outlawed sex between men. Despite the harsh laws that exist against homosexuals, their numbers have been flourishing, with more closeted individuals coming out. The existence of SOGIE activist organizations strive to bring homosexuals together and to champion for their rights. (Amnesty International Publication, 2013).

### **2.2.2 The Identity of Women who have sex with Women (WSWs)**

Lesbians are positioned as invisible through “underexposure, censorship and patriarchal control” which permeates through society (Berman, 1993, p. xvii). Although women’s organizations formed over the years, focus on economic and political matters, they do not address issues of sexuality, thus providing little support for lesbians (Cock, 2003; Gevisser, 1994). Lesbians fear being “out” and face “far greater pressure to remain closeted” than their male counterparts, who can at least enjoy the privileged status of masculinity. (Gevisser 1994) notes that “there is room in society for the ‘gay bachelor’, for independent and transient men”, while women were pressured to “marry and bear children” (p22). (Lewis & Loots 1994) explain that gay men have “easier access” to the gay subculture, because men are “not confined to the domestic sphere”, in which virtue and good appearance are strongly encouraged in women (p. 146). Hence, lesbians very often lack social and political support, and are restricted within the socio-cultural confines placed upon them.

In a study carried out by (Morgan & Wieringa's 2005) titled 'narrative collection of lesbians' experiences in Africa, the authors highlight how Christianity (often combined with traditional beliefs) frequently creates difficulties for lesbians and shapes the ways that they speak about themselves. For instance, one woman in Namibia reflects on her family's beliefs saying, "Ja, it is wrong... definitely, yes, it's a sin" (p. 92). Similarly, Tanzanian women who were interviewed explained, "we are considered to be immoral and satanic" (p. 53), while a woman in Kenya describes "feeling like a sinner" (p. 39)

Researchers have attempted to carry out studies on fluidity of sexuality and have found that sexuality may not be as fixed as gay or lesbian. (Klein Sepekoff & Wolf 1985), for instance administered the Klein Sexual Orientation Grid to 384 heterosexual, bisexual and homosexual people in the USA in a bid to assess multiple variables like sexual attraction, behavior, and social preference among others; that make up a person's sexual identity. The study found that the labels of heterosexual, homosexual and bisexual are simplistic as many respondents were potentially capable of traveling over a large segment of the sexual orientation continuum (Klein et al., 1985, p. 45). The researchers also believe that the movement of peoples across sexual divides is often overlooked in sexuality studies. In a similar study targeting 80 women, carried out in the UK, (Kitzinger & Wilkinson 1995), the women reported to developing a lesbian identity after at least 10 years of heterosexual involvement. The researchers believe that claiming a lesbian identity is a process of 'self-reconstruction' (p. 102). In yet another study carried out in the USA, (Rust, 1993) implemented with 323 bisexual and/or lesbian women, only one third of the women who identified as lesbian stated that they were one hundred per cent attracted to women. The research found that some participants oscillated between heterosexual and homosexual tendencies after they faced rejection from previous relations. This shows therefore that sexuality exists on more of a continuum due to the varying attraction between the different sexes.

According to (Sophie, 1985), in a study on lesbian identity development, she examined the social, historical and political contexts that have shaped explanations of sexual identity development. Her study found that, any change in sexual orientation, must not be judged independently but in light of the surrounding context at the time of study. (Sophie, 1985), stated that the current social and political attitudes towards homosexuality, the friends and relationships the women have, and the time and place in which they live will affect the individuals' sexual

inclination. (Sophie, 1985), farther states that sexual identity is fluid and open to change by using an example of one of her respondents who was involved in exclusive lesbian relationships for thirteen years before she became heterosexual (p. 43). The respondent chose not to label her sexuality, but instead consciously chose a new path citing that ‘it is easier to be heterosexual in [mid-western American] society’ as she wanted and needed the social approval that came with being in a relationship with a man. There is therefore more power attached to being in a heterosexual relationship than in being in a homosexual relationship even in a homo-friendly society. (Sophie, 1985), therefore concludes that although her respondent was involved in an exclusively lesbian relationship she eventually become involved in a heterosexual relationship in a bid to gain acceptance within a society in which heterosexuality is the norm. Taking up a lesbian (or gay) identity does not occur in a straightforward way, but is in turn affected by socio-cultural context in which the person exists. To foster (Sophie, 1985), claim on sexual identity being pegged on the social environment, (Oswald, 2000) in a study carried out on six bisexual and lesbian women in a bid to discover how their sexual identity affected the respondent and the most important people around her. (Oswald, 2000), discovered that a woman who came out as being lesbian triggered a reaction from those around her to test their own sexuality. A few of the respondents’ family members and friends even changed their sexual orientation highlighting the interaction of one’s sexual identity with broader social relations and the fluidity of sexuality.

Longitudinal studies carried out on the fluidity of sexuality involving 89 lesbian, bisexual and un-labelled women, by (Diamond, 2008), similarly concluded majority of the participants switched between labels – lesbians, bisexual, un-labeled or heterosexual at least once and continued to view their previous attractions and relationships as legitimate rather than as phases. (Diamond, 2008), insinuates that women who choose to be unlabeled are not confused; but instead acknowledge that their sexuality as fluid, and hence labels cannot describe them adequately. From her study, (Diamond, 2008), infers that women’s sexuality is more fluid than men’s and is more likely to be shaped by contextual factors, such as meeting the right person, regardless of her/his sex. Further (Diamond, 2008), states that when women appear to change their sexual identity, they are often judged as experiencing a ‘false consciousness’ or they were not even lesbian to start with (p. 50). On acknowledging experiences of sexual fluidity (Diamond, 2008), states that sexuality is broader than regulating who can be referred to as lesbian or gay.

In their study on homosexuality, (Murray and Roscoe 1998) discovered that thirty or so Bantu societies provide for marriage between two women, including at least a dozen Kenyan indigenous groups. Among these were the Kamba, Kikuyu, Nandi and Kisii; and to a lesser extent neighboring peoples. Approximately 5 – 10% of women in the countries where the study was carried out in these kind of marriages (Murray and Roscoe 1998). This is not considered homosexual, but is viewed as a means by which families without sons to keep their inheritance within the family (Murray and Roscoe 1998). Scholars aspect that in alternate parts of Africa this was distinguishing of women of status, such as political leaders or royals, but in East Africa however, it customarily represented a substitute female husband who supplanted a male kinsman as jural ‘father’ (Morgan & Wieringa 2005). The wife begot children for her female husband, in whose clan line they identified with. In other instances, women marry women to accomplish some level of economic independence, and a bride price was paid to the wives’ family. These independent female husbands gain acceptance as men in “male” economic roles. This dualistic female marriage was mainly pecuniary based, and exemplified the departure of sex and gender in African societies (Murray and Roscoe 1998).

Women in Lesotho according to (Murray and Roscoe 1998) engaged in socially indorsed ‘long term, erotic relations’ called *motsoalle*. (Evans Pritchard 1970) recorded that male Azande warriors in the northern Congo habitually took on youngsters who acted as male lovers and whose ages ranged between the ages of twelve and twenty. These lovers helped with household tasks and partook in intercrural sex with their older husbands/lovers. Similarly, (Boellstorff 2007) alludes to same-sex sexuality and/or desire in Africa and remarks as to how these have with time been construed by others. (Aarmo 1997), (Donham 1998), (Morgan & Wieringa 2005) and (Renaud (1997).

Kenya has a growing number of women who identify as WSWs. Their existence was formally recognized when the GALCK was registered in 2006, where their interests on a human rights platform are taken up and addressed within existing legal structures.

### **2.2.3 Health Challenges among Sexual Minorities**

SOGIE individuals as a result of their sexuality are affected by a range of social, structural and behavioral factors. According to (Lee, 2000), the LGBTIQ have unique health needs that are unlikely to be met by existing health care services. Health care professionals through no fault of

their own often lack specialized knowledge to meet their specific healthcare needs or are influenced by socialization and hence have negative attitudes towards LGBTIQ individuals. (Sanchez N.F. et al, 2006). Alternately, LGBTIQ individuals are likely to delay or all together avoid seeking health care services because of their experiences of past discrimination or perceived homophobia within the prevailing health care system. (Rabatin J. et al, 2006).

The health challenges experienced by the LGBTIQ are also affected by deeply rooted stigma, discrimination and unyielding health insurance policy (Mayer K.H. et al, 2008). Evidence from limited studies carried out on the health issues that affect sexual minorities include mental health issues or disorders and of particular concern are depression and anxiety, substance and tobacco abuse. (Mayer K.H. et al, 2008). Gay and bisexual men have a higher prevalence of eating disorders as compared to heterosexual men. WSWs are also more likely to suffer from obesity than straight/non-homosexual women that in turn increases predisposes them to risks associated with cardiovascular disease (Mayer K.H. et al, 2008).

As a population, the sexual minorities face increased risk of some cancers which often go unrecognized; for instance cervical cancer in WSWs and anogenital cancer in MSMs. In a study carried out in LA, 319 MSMs found an overall HPV prevalence of 93% as well as a 64% prevalence of high risk human papillomavirus strains. (Cranston RD et al, 2012). In another study pooled anal cancer incidence was 45.9 per 100,000 HIV positive MSMs and 5.1 per 100,000 among HIV negative MSMs, compared to two per 100,000 in men overall. (Johnson L.G, 2004). The Kenya AIDS Strategic Framework (KASF), a publication of the National AIDS Control Council (NACC, 2009), concedes that MSMs and sex workers form part of key populations for purposes of HIV programming. The HIV prevalence in the Kenyan republic among the general population between the ages of 15 and 49 is estimated at 5.6 percent, among the key populations however (NACC, 2009), the prevalence stands at 18.2 percent among men who have sex with men. The strategic framework finds that violence, discrimination and prejudice against key populations have instituted an inhibition to the reduction of new infections (NACC, 2009).

A study carried out by the [Canadian Health Survey (2003-2005)], found that there was a higher prevalence among SOGIE community to visit mental health providers as compared to the heterosexual community. LGB persons in yet another study perceived that they have less

equitable access to health care and social services and report higher unmet health needs compared to heterosexual persons (Burgess D. et al, 2007).

According to the (KHRC, 2011), homosexuals undergo varying negative reactions such as embarrassment, derogatory comments, breach of confidentiality, invasive and un-necessary questioning, rough physical handling ostracism, shock, pity, unfriendliness, condescension and fear because of their sexual orientation. This has in turn led to adjournments in seeking medical treatment among them, concealment of their sexual orientation/identity both of which immortalize the deleterious treatment cycle (KHRC, 2011). In Kenya where homosexual/same sex activities/relations are forbidden, HIV and AIDs tutelage and supplementary practices of health care considered preventative should be geared towards the LGBTIQ communities but these are often suppressed (KHRC, 2011).

LGBTIQ individuals according to (KHRC, 2011) report challenges while presenting themselves for treatment mainly in ailments associated with counselling and HIV/AIDs testing, sexually transmitted infections, and among transgender and intersex persons seeking general care. They reported of frequently being afraid of in good conscience countering to medical interrogations because being truthful may ultimately lead to condemnation, detention and/or both (KHRC, 2011). Medical practitioners have been known to contravene the confidentiality of SOGIE patients/clients by revealing them to their colleagues and/or police, in the process they attempt to preach to as they seek to redeem them or altogether repudiating them rights and access to medical care (KHRC, 2011). These individuals are supposedly extra fretful about unveiling of their sexual identity/sexuality in addition to the reaction of the health care practitioners upon learning about their sexual behavior than in getting and receiving treatment of their medical condition, as a result consequently majority of them seek medical intervention when their health condition/status has expressively deteriorated and at which time it is often too late (KHRC, 2011).

### **2.2.3.1 Factors affecting WSWs Health**

Over the years, lesbians/WSWs have been earmarked and have faced discrimination and prejudice, in both private and public, and this stigmatization of their alternate sexuality remains widespread in our society (APA, 1997; Perrin, 1996). There are many kinds of discrimination

and abuse against WSWs/lesbians that have been clearly documented, their impact on physical, social/emotional and mental health remains in need of study. Up and till 1973 the American Psychiatric Association (APA) classified homosexuality as an illness or pathological condition and this was widely accepted. Although the lifestyle is no longer classified as an aberrant condition, negative attitudes about gays and lesbians have not ceased and continue to be held by many members of the public, including professionals such as health and mental health care providers (Bradford et al., 1994b; Garnets et al., 1991; Rothblum, 1994; Wolfe, 1998).

Lesbians/WSWs are individuals who have faced prejudice and discrimination in one form or another in their lives. For example, in a multisite longitudinal study of cardiovascular risk factors in black and white adults' ages 25 to 37 years, 33% of the black women and 56% of the white women who reported to having had at least one same-sex sexual partner reported experience with discrimination on the basis of sexual orientation (Krieger and Sidney, 1997). Eighty-five percent of the black women further reported discrimination based on race. Most of the women (89%) also reported having experienced gender discrimination.

In line with the dominant focus on alternative sexualities and sexual practices among men in the public domain, LBQ organizing within the Kenya, LGBTIQ movement focusing on WSWs is much less visible (GALCK, 2016). Of the sixteen (16), LGBTIQ groups under the umbrella of GALCK, only two are actively working on LBQ women issues (GALCK, 2016). Positions of power, even within the LGBTIQ movement are rarely given to LBQ identifying women which further reduces their visibility (GALCK, 2016).

In addition in comparison to gay men, there are very few outted women engaging with the public whether in a professional or personal capacity (GALCK, 2016). The main reason for this exclusivity can be found in NGO and international donor focus on MSMs in attempts to curb the HIV/AIDS crisis (GALCK, 2016). Funds from donor agencies at the onset were therefore focused on medical and advocacy interventions targeting MSMs, sex workers and IDUs seen as high risk populations ignoring the health plight of LBQ women (GALCK, 2016).

LBQ women in Kenya face physical and structural violence from family, friends, neighbors and who form part of the larger society as a result of their sexual orientation, due to this, their physical and mental health gets a negative impact. (KHRC.2011).Whereas there are

organizations that work towards enhancing health issues among gay men, the same are few and far between for women where they exist. Lack of health service care for WSWs is derived from the fact that health care professionals do not understand the health needs of LBQ women. Cervical cancer risk among WSWs for instance may be underestimated, while this is possible due to their initial sexual debut with men. (Lee R. 2000).

In yet another study indication are that WSWs have lower rates of visiting reproductive health specialists and seeking and receiving Pap smear and clinical breast examinations as compared to heterosexual individuals (Tjepkema M, 2008).

The challenges, worries and anxiety WSWs face include mental health issues due to experiences of ostracism and discrimination, some types of cancer low perceived risk of getting sexually transmitted diseases, lack of health insurance due to no domestic partner benefits, lack of understanding of lesbians disease risks and issues that may be important to them and fear of negative reactions from their doctors if they disclose their sexual orientation, (KHRC, 2011).

#### **2.2.4 Factors affecting the Health Care System**

The Universal Declaration of Human Rights Article 1 clearly states that “All human beings are born free and equal in dignity and rights”. Consequently, Article 2 begins,” Everyone is entitled to all the rights and freedoms set forth in this declaration without distinction of any kind. Human rights belong to all of us all, regardless of our sexual orientation and gender identity” (Universal Declaration of Human Rights, UDHR, 2010). The Kenyan constitution promulgated in 2010 also provides equal health rights for all as well as the SDGs ratified by many countries around the world after the end of the 2015 MDGs. In particular SDG 4 ensures good health and well-being. Countries by signing off on the SDGs promise to ensure healthy lives and to promote well-being for all (SDGs, 2015-2016). Despite laws allowing for equal health rights for all, individuals who identify as sexual minorities face certain barriers that hinder their equal access to health care. (KHRC, 2011)

Proscription of homosexuality/same sex has activated trepidation of homosexuals (lesbians and gays) causing them to refrain from obtaining healthcare services especially from public health facilities (Mravcak S.A, 2006). Health care providers on the other hand are not clear on how to handle this group of persons once they present at the facilities because of the illegality of their

relationships; they are often torn between offering health care services to them as clients and reporting them to the authorities as violators of illegal activities as outlawed by existing laws (O'Hanlan K.A, 1999).

Stigma and discrimination is suffered by the LGBTIQ from society at large as well as the health care providers (Chandra A et al, 2006). Forms of these include isolation, denial of treatment, invasive enquiries, calling for bridges by nurses and even forced treatment based on the assumption that these people have a mental problem (Chandra A et al, 2006). This has led to SOGIE individuals to turn to over the counter, self-medication, reliance on google doctor and consultation among themselves making uninformed decisions regarding their special health needs. It results in higher than the national prevalence risk of HIV/AIDS, STIs and other health conditions. Other health issues suffered is depression, insomnia and anxiety due to dealing with discrimination, isolation, stigmatization and violence without proper treatment (Chandra A et al, 2006).

Evidence on apposite HIV and holistic health care services for sexual minorities within the health care system is lacking. Health care providers are through no fault of their own clues on means of handling their LGBTIQ clients (NACC, 2009). The medical curriculum teaches what is commonly defined as normal while the practice presents with what can only be described as abnormal. There are numerous studies which have been conducted in a bid to learn about populations' knowledge attitudes and practice; none of them have however attempted to find out a census of individuals who constitute MSMs or WSWs. We cannot definitively claim to ascertain what proportion of the population belong these sexual minority groups, and as a result are therefore excluded from HIV programming (NACC, 2009).

Due to ignorance on sexual minority health needs, the medical practitioners invent methods such as forced medical treatment. (Chandra A et al, 2006). People engaging in same sex relationships which also includes transsexuals are forced into medical diagnoses following discernments that they have a mental problems/issues and their conditions/ perceived ailments can be corrected (Chandra A et al, 2006). Intersex persons are obligated to undergo forced corrective surgical procedures to rectify their ambiguous genitalia (Chandra A et al, 2006).

Violence and mental torture is yet another impediment suffered by sexual minority individuals in health care centers. Member of the LGBTIQ community are often harassed, denied treatment and equal dignity as compared to heterosexual individuals (KHRC, 2011). There are incidences where they are handed over by medical practitioners to the police, their sexual identity exposed to community members which violates the confidentiality clause which often results in gang violence. (KHRC, 2011). Intersex persons who are denied reconstruction treatment by rigid medical systems have ended up even dropping out of school as a result of scolding and torment from fellow students and teachers which may cause them trauma (KHRC, 2011). This torture and violation affect the health of the LGBTIQ. This cohort equally suffer stress, depression and other mental ailments. This in turn results in abuse of alcohol and drugs as a coping mechanism (KHRC, 2011).

### **2.2.5 Social and Cultural factors affecting Health**

Scholar, (Dr. Basile Ndjio April 2011) a senior academic from the University of Douala, a scholar who conducts research on discriminating attitudes, provides his views about why violent disapproval of LGBTIQ/same sex individuals and communities has become rampant. The scholars' views are deeply rooted in history of colonialism in Cameroon. "From the perspective of history, just before colonialism that essentially altered the sexual practices and imagination in Africa, majority of African indigenous societies/communities were regarded by their sexual openness and tolerance. Antagonistic to ideas received, western colonialization introduced to Africa / Africans and their colonies homophobia and not primarily homosexuality; these formed part of varying social practices. The administration of colonialists drew out through anti-sodomy laws the churches moralistic view, which recognizes same-sex relationships as an expression primitivism in culture and then ultimately pushed African natives to drift towards their view of modern sexuality; that is restrictively heterosexuality.

In addition to health challenges highlighted above faced by the SOGIE community, the reaction to their sexuality is also manifested in other sectors within society. Within the family and home environment, some positive reactions are possible in equal measure with negative ones. The reactions fall on a continuum from covert, insidious forms of rejection to open verbal abuse and physical violence (Rivers, 2002, p. 34). Gay and lesbian individuals have mentioned feeling distanced and detached from their families as a result of the rejection and violence that they face

(Hetrick & Martin, 1987, p. 33). Research on violence against gays and lesbians according to (Pilkington & D'Augelli, 1995), is postulated as the most common form of bias-related violence. (p. 34). (Dean, Wu & Martin, 1992), in a separate study developed three categories of victimization that gay and lesbian individuals face: type one - verbal abuse – insults and threats of physical violence; type two – minimal physical attack – damaging of personal property, being chased, followed or spat upon, having objects thrown at one's body and type three – physical assault – being punched, hit, kicked or beaten, sexual assault or assault with a weapon. In a study on victimization, 194 gay and lesbian youth in the USA (Pilkington & D'Augelli, 1995), found a third of their respondents reported verbal assault from family members and that 10% suffered physical assault at home. Female respondents endured verbal attack (22% females vs 14% males), and physical attack (18% females vs. 8% males). The study found that females face more risk than their male counterparts, and the home poses a real threat to their physical and emotional health. The threat of violence against gay and lesbians is not unique to America but is a serious problem for this cohort in Africa. (Graziano, 2004a).

Relationships between individuals of opposite sex are fostered in the school environment (Butler, 2007; Ford, 2003; Little, 2001). Same sex partners in the same school environment experience verbal abuse, ridicule and social isolation (Rivers, 2002). These negative reactions are often perpetuated by the school institution itself and the existence of LGB students are sidelined and punished through expulsions (Markowe, 2002). (Bass & Kaufman, 1996, as cited in Little, 2001) offer the view that the negative reaction to LGB individuals in schools is a mirror of problems in larger society (p. 105). Moving away from secondary schools, to university education, relative anonymity to redefine the self away from family monitoring and interference is granted (Evans & D'Augelli, 1996) (p. 203). Despite progression in the university level, a restrictive environment for the acquisition of a lesbian, gay and bisexual identity still arises (Rhoads, 1997). Students in a study cited distress at being labeled, actual and fear experiences of harassment and rejection, the need to limit behavior to avoid unsafe situations and negative effects on performance at academic level. (Evans & Broido, 1999, p. 664). In other studies in the last two decades, (Chase, 2001), found that students' ideas and beliefs about sexual orientation will remain unchanged, “in the absence of a strong, institutionally supported public discourse” (p. 146). The negative reaction to homosexuality is thus fuelled by lessons through the media, religious teachings, or within their families. (Chase, 2001). Closer home, studies carried out in

South Africa involving 1,125 undergraduate students (Arndt & de Bruin, 2006), concluded that men had greater negative beliefs about gay men and lesbians than women, their views however towards lesbians were more positive than their views on gay men. (Arndt & de Bruin, 2006; Arndt & de Bruin, 2009) suggest male negative attitudes could be explained by the threat that homosexuality poses to masculinity, on the flip side the same males had greater acceptance of lesbians owing to the way in which lesbians have been constructed as erotically appealing to men. (Arndt & de Bruin, 2006). In the same study, students who were strongly religious presented the most negative attitudes toward gay men and lesbian women (p.21).

The community that gay and lesbian individuals live is another social environment where varying reactions are faced. (Nesmith et al., 1999). The authors in citing (Pilkington & D'Augelli, 1995) found that 29% of the respondents “did not feel at all comfortable” disclosing their sexuality to members of their community (p. 45). In the Kenyan coastal region, LGB individuals fear harm due to attacks carried out on ‘outed’ individuals by members of the community (PEMA, Kenya, 2015). Researchers (Reid, 2010) and (Graziano, 2005b) among others bring out the disparity between legal recognition granted to heterosexual couples as opposed to homosexual couples. Based on socialization, heteronormative gender roles remain entrenched (Cock, 2003; Hames, 2007; Steyn & van Zyl, 2009), where women are required to fulfill their reproductive duties (Gevisser, 1994; Horn, 2006; Potgieter, 1997) and men are equally required to take up the strong masculine stereotype (Butler, 2007, p. 79, Ratele, 2006). By and large lesbians’ sexual identities and how society treats them differs from the experiences of both gay and bisexual people. (Graziano, 2004a; Kheswa & Wieringa, 2005; Swarr, 2009).

The media worldwide is a socialization agent. Most of what is known about the LGB community comes from the media. Whilst freedom of expression is guaranteed in the constitution, negative reports in the media on this cohort, often whips up hostility and fear (Isaacks & Morgan, 2005, p. 77). Publishing of identifying details about specific individuals, predictably leads to harassment, violence and in extreme cases to murder. (Baraka & Morgan, 2005, p. 25). Generalized published comments on the LGB community, puts them at risk of abuse, hostility and resentment. Media outlets/houses may inadvertently interpose an increase in the regularity of attacks on those deemed not conform to accepted heterosexual norms. (Baraka & Morgan, 2005). Attack fears whether real or imagined compels LGB persons to stay determinedly closeted.

Attitudes toward lesbian and gay individuals in Kenya are also influenced by the media. Some national media outlets/houses expressly address LGT issues objectively, others however set in recourse to scandal-mongering, gossip and sensationalist tactics. In May 2015, for instance a national newspaper “the Weekly Citizen”, a gossip tabloid, sensationally publicized an article claiming to unmask Kenya’s “Top Gays”. Despite the fact that a number of those listed being openly gay activists, others on the list were private individuals for whom the Weekly Citizen piece posed an unforgivable intrusion and violation of their right to privacy, irrespective of whether or not they are actually gay.

Religion also influences society’s attitude towards various practices and homosexuality is not an exception. This often leads homosexuals feeling excluded, harassed and victimized from the religious angle. (Horn, 2006; Reddy, 2002; Reid, 2010). “Everyone has a right to freedom of religion and conscience, including the freedom to manifest such religion, or belief in worship, observance, practice and teaching.” (Ocholla, A. 2011 p. 98). There is however a limitation of this right when it jeopardizes the fundamental freedoms and/or rights of others. Public figures which includes religious leaders often refer to Christianity and Islam as part of authentic African identity that excludes the possibility of LGB individuals. (AsHorn, 2006). Deep personal meaning and strength is found in religious faith for majority of individuals including LGB ones. In view of this, when religious leaders are seen to promote adverse attitudes, towards or the rejection of, certain populations, the rest of society see this as a stamp of approval and legitimate even mandatory part of expressing their faith. (Mohamed & Wieringa, 2005, p. 53). According to research done by (Amnesty International, 2013), in communities that are considered strongly religious, public revocation of LGB people by their religious leaders, gives them absolute approval by individuals to explicitly showcase their homophobic tendencies for all to see, which they do not hesitate to demonstrate even in violent ways. In retrospect, LGB persons many of whom are religious unlike their straight counterparts are not able to open up to their religious leaders/authorities as they are concerned that they would be ejected from the congregation they find comfort in and this is done publicly. Based on experience and drawing from reports shared by others they are likely to fear that their stories/sexual secrets will be broadcasted in newspapers, that they may also get reported to the police/enforcers of the local laws, or that they will be deprecated from religious pulpit/stands as demonic and/or evil (Amnesty International, 2013). Religion is populated with concepts of culture and tradition, that are conveniently used to

justify and to condemn same-sex sexuality. (Mohamed & Wieringa, 2005). Some selected leaders drawn from the African Anglican Church, lament as well as acknowledge that the Christian religion (church) was brought to the African continent by western missionaries who did not see African Culture as valid/legit. (AsHorn, 2006). Ironically speaking these same religious leaders however embrace, accept and foster moral prohibitions on homosexuality/same-sex sexuality that resonant the injunctions imported by colonial powers. (AsHorn, 2006.)

### **2.3 Theoretical Framework**

The case study made use of three theories to explain the access of health care services among sexual minorities in Kenya, with particular emphasis on women who have sex with women.

1. Cass's Theory of the Development of gay and lesbian identity – Cass (1979)
2. General Stain Theory by Robert Agnew (1985 and 1992)
3. Health Belief Model propagated by Rosenstock, Strecher & Becker (1994)

#### **Cass Theory (1979)**

This model is one of the fundamental theories of gay and lesbian identity development. It was developed by Vivienne Cass in 1979. (Cass 1979) proposed a six-stage model of identity formation. Cass's theory borrows heavily from interpersonal congruency theory which posits that a person's behavior is either altered or strengthened by how well facets of his/her interpersonal environment fit together (Cass, 1979). Hence, the more a person senses incongruence in his/her life, the more likely s/he is to change his/her thoughts, feelings or behavior, in order to gain consistency between his/her own and others' perceptions of him/herself (Cass, 1979)., which is a social construction modality. The theory is based on two major assumptions. The first assumption is that identity is acquired through a developmental process (Cass, 1979; Cass, 1983). The second assumption is that identity development process takes place as the individual interacts with their environment. The assumption is similar to the arguments made in symbolic interactionism theory, where it is believed that the individual develops their personality as a result of their interactions with symbols in their environment.

## **Six Stages of Development**

**Stage 1: Identity Confusion** – a person becomes aware that information regarding homosexuality may pertain to him/her. Some people might find this more significant than others, and, for some, this association cannot be overlooked. The person will endure conflict and uncertainty as s/he begins to question his/her sexuality (Cass, 1979). Some might not view homosexuality in a positive light and will try to re-establish their heterosexuality by socializing with someone of another sex. After identity foreclosure, the person would not explore a homosexual identity further, which would restore his/her sense of inner congruency. If a person does view homosexuality positively, s/he may question whether s/he is in fact lesbian or gay and would seek more information.

**Stage 2: Identity Comparison** – Cass (1979) believes that a person will acknowledge the potentiality that s/he “may be homosexual” (p. 225). By this time the individual would suffer less confusion, as the difference between his/her sense of self and his/her behavior would not be so marked. However, this state would prompt a greater concern about social isolation, where the person would feel “a sense of ‘not belonging’” both within his/her personal social circle and within a wider social context, which can cause “intense anguish” (p. 225). A person could still “pass” as heterosexual (Cass, 1979, p. 226) during this time. Cass argues that a person can use strategies to appear heterosexual, in order to minimize his/her (homo)sexual identity.

**Stage 3: Identity Tolerance** – At this stage the individual will encircle themselves with other individuals who identify as homosexuals and commences to create or join peer group(s) for purposes of support and knowledge; which, Cass (1979) explains, would allow him/her the chance to identify his/her “social, emotional, and sexual needs” (p. 229). This would produce a greater degree of separation from heterosexual society; hence, a person may try to find an LGB community. Contact with LGB people will encourage a person to adopt a more positive identity, and lead him/her to interact with only a few heterosexual people. Cass (1979) believes that if a person’s experience with the LGB subculture is negative, this could lead him/her to dissociate him/herself from the community and a homosexual identity, which would trigger identity foreclosure. If a person reaches a point where s/he can disclose his/her identity to other gay people and participate more within this sub culture, then s/he will be able to say, “I am a homosexual” (p. 231)

**Stage 4: Identity Acceptance** – A person would accept his/her identity, and have more contact with other lesbians or gay men (Cass, 1979). S/he would also consider homosexuality more positively, and prefer “homosexual social contexts” (Cass, 1979, p. 231). However, according to Cass (1979), a person could feel comfortable with him/herself, but still be fearful of what others may think. Some people may continue to pass as heterosexual, or have restricted contact with heterosexual people who threaten their sexuality. This would prevent a person from experiencing further feelings of incongruence. If this is successful, then his/her intrapersonal matrix will remain unchallenged, which will prevent any further identity growth (Cass, 1979). On the other hand, a person may decide to disclose to people s/he trusts; yet, s/he will still be aware of the incongruence between his/her own acceptance and society’s negative view towards any non-heterosexual identities (Cass, 1979). It is this incongruence which propels a person into the next stage of development.

**Stage 5: Identity Pride** – marks a time when a person starts to place less value on heterosexual people’s views of his/her identity, and grants more worth to people in the LGB community (Cass, 1979). A person will experience a strong sense of self and will commit to the LGB subculture. Cass (1979) posits that a person splits the world into “homosexuals (creditable and significant) and heterosexuals (discredited and insignificant)” (p. 233). A person will reject heterosexual ideals about lifestyles and relationships, as s/he has reached a point of not only accepting, but preferring his/her gay or lesbian identity (Cass, 1979). Often the anger that is felt over having to conform to heteronormativity will encourage a person to become politically active. An individual at this stage, digs deeper into the homosexual culture, and in the process minimizes heterosexual peers/friends; emotions intense political advocacy and of anger for gay rights/freedoms and minimal heterosexist society.

**Stage 6: Identity Synthesis** – when s/he realizes that his/her “‘them and us’ philosophy” does not always apply to his/her life (Cass, 1979, p. 234). When s/he discovers that not all heterosexual people are against homosexuality, there will be more coherence within a person’s intrapersonal matrix. Cass states that this allows a person to recognize similarities and dissimilarities with both heterosexual and gay and lesbian people and enjoy a more “synthesized” personal and public self (p. 234). Cass posits that (homo)sexual identity development is complete when a person becomes aware that his/her sexuality is not the only part of his/her identity

This theory is useful as it attempts to explain the development of lesbian identities and in a sense try to demystify homosexuality to the lay person.

### **General Strain Theory by Robert Agnew (1985 and 1992)**

General strain theory as postulated by (Agnew, 1992) maintains that stressors and strains maximize the probability of negative emotions like frustration and anger. Pressure is created for corrective action as a result of these emotions, crime being one possible response (Agnew, 1992). As a means of reducing the strain, individuals engage in illegal behavior like excessive alcohol consumption, abuse of drugs and engagement in risky sexual behavior. (Agnew, 1992). Studies on sexual minorities have brought out the incidences of higher engagement in substance abuse and engagement in risky sexual behavior as compared to heterosexual individuals.

The experience of anger arises in LGBTIQ individuals when they experience adversity as imposed by others, and resentment when they receive unjust treatment by others. Individuals experiencing anger as a result of felt injustice are less likely to feel guilty when they get involved in an anomaly, because they believe that the injustice suffered justifies their action.

There are different types of strain as classified by (Agnew, 1992); of importance to this study, objective strain will be analyzed as it refers to events or conditions that are disliked by most members of a group. Alongside individuals also experience subjective strain which refers to how each person reacts to strain they experience (Turner & Wheaton, 1995). The same strain experienced by different individuals produces varying emotional reaction. Individual and environmental factors influence the emotional reaction to strain. (Broidy & Agnew, 1997). Males and females differ in their emotional reaction to subjective strain. Although both male and female may experience anger, the anger of females is more likely to be accompanied by feelings of guilt, depression and anxiety (Broidy & Agnew, 1997). The strain therefore experienced by gay and lesbian individuals in health seeking endeavors, differs as lesbians suffer more mental strain than their male counterparts.

### **Health Belief Model (1994)**

The health belief model; a psychological model makes an attempt to predict and explain behavior surrounding health related issues, training its focus on beliefs and attitudes of individuals. The

development of the model took place in the 1950s as part of an effort by social psychologists within the US public health service to make sense of/explain the lack of public participation in health screening and prevention programs. The model has been adapted to explore a range of long and short term health related behaviors which includes sexual risk behaviors and transmission of HIV and AIDS. The key variables of the HBM are as follows (Rosenstock, Strecher and Becker, 1994)

- **Perceived threats:** these consists of dual parts; which are namely perceived susceptibility and perceived severity of a health related condition
  - **Perceived susceptibility:** this is basically an individuals' subjective perception of the risk of contracting a health related condition
  - **Perceived severity:** these are feelings concerned with the seriousness of contracting an illness/ailment or of leaving it untreated/unattended (including evaluations/examination of both medical and clinical consequences and possible social consequences)
- **Perceived benefits:** These are believed levels of effectiveness of developed strategies designed to reduce the threat of illness/ailments
- **Perceived barriers:** These include the perceived potential of negative consequences that are likely to result from taking particular and specified health actions, including financial psychological and demands
- **Cues to action:** these are events, that are either bodily (such as physical symptoms of a health related condition) and/or environmental (such as media publicity) that stimulate people to take action.
- **Other variables:** among these variables are diverse demographic, socio-psychological and structural variables that are likely to affect an individuals' perceptions and thus directly or indirectly influence health-related behavior as a result therefore

- **Self-efficacy:** This is basically the belief in being able to efficaciously achieve the behavior that is required to produce the outcomes that are desirable . (Bandura 1977)

This theory brings out the attitude and perceptions of WSW in their bid to access health care service in health care centers.

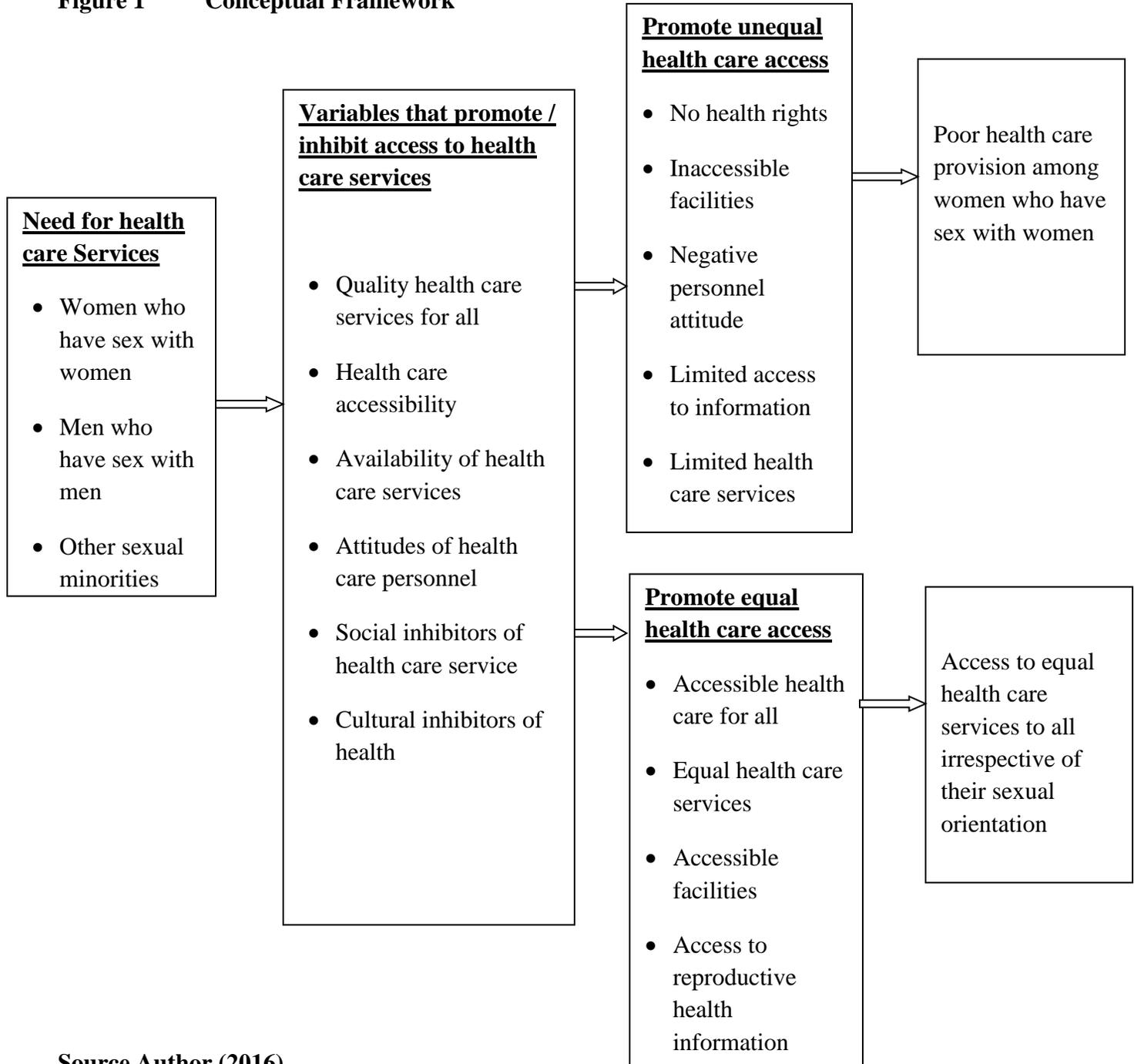
## **2.4 Conceptual Framework**

According to Miles and Huberman (1994), “a conceptual framework explains, either graphically or in narrative form, the main things to be studied; the key factors, constructs, or variables, and the presumed relationship between them” (p.18). It lays out the key factors, constructs or variables and presumes relationships among them (p. 440)

In relation to the proposed study, the conceptual framework served to highlight the relationship between access of health care services in health centers and women who have sex with women as they seek out these services and the intervening variables that lie in between.

Below is the conceptual framework:

**Figure 1 Conceptual Framework**



**Source Author (2016)**

In their attempt to seek reproductive health care services, women who have sex with women accessibility of the service was analyzed in the proposed case study through a number of intervening variables such as quality of health care services, health care accessibility, availability of health care services, attitudes of health care personnel, social and cultural inhibitors of health care service.

## **Chapter Three: Research Methodology**

### **3.1 Introduction**

This chapter describes the research methodology that was used in this study. Research methodology is of great importance as it gives a clear description of the procedures to be followed in conducting a study. This chapter therefore presents the research design, study site, study population, sampling procedure, data sources and data collection methods and analysis procedure.

### **3.2 Research Design**

The study adopted a descriptive survey design. According to Hopkins (2000) descriptive studies aim to determine the relationship between one thing (an independent variable) and another (a dependent variable or outcome variable) in a population, establishing the associations between variables and the causality. This study sought to determine access of health care services among sexual minorities with particular emphasis on women who have sex with women.

The study combined the use of both quantitative and qualitative research methods to allow deep understanding of the research problem. It also served to ensure that possible inherent bias in particular data sources, investigator and method would be neutralized by combining both research methods. Quantitative research method was used to collect and analyze hard data (numeric data), while qualitative data was used to analyze non numeric data which gave more information on the study objectives and in the process strengthened the quantitative data that was collected.

### **3.3 Site Selection**

The study was carried out in Nairobi County. According to a study carried out by the (KHRC 2011), majority of the homosexual individuals in Kenya are found in urban centers. It is noteworthy to state at this juncture, that homosexuals are also found in rural areas. They are however more visible in cities where elements of modernization make it possible for them to interact with their colleagues. Tolerance of homosexuals is higher in the cities as compared to the rural areas and hence these individuals find some mild form of acceptability in urban and suburban centers.

Nairobi County is one of the 47 counties in Kenya; as is shown in the diagram below:-

**Figure 2: Map of Kenya**



Insert Source: (www.mapsofworld.com)

Nairobi County is also the capital city of Kenya. It has a population of 3,138,369 with 1,533,139 being female and 1,605,230 being male (Population census 2009) Nairobi county extends from latitude  $1^{\circ} 16' 59''$  S and longitude  $36^{\circ} 49' 00$  E. Nairobi lies in a total area of 696 square kilometers. Nairobi County was founded in 2013 on the same boundaries as Nairobi Province. It is composed of 17 parliamentary constituencies namely; Westlands, Dagoretti North, Dagoretti South, Langata, Kibra, Roysambu, Kasarani, Ruaraka, Embakasi South, Embakasi North, Embakasi Central, Embakasi East, Embakasi West, Makadara, Kamukunji, Starehe and Mathare.

Nairobi is cosmopolitan and generates 60% of the nation's wealth.

**Figure 3: Map of Nairobi**



Source: Colorado Education Journals

### 3.4 Unit of Analysis and Unit of Observation

#### 3.4.1 Unit of analysis

A unit of analysis is the major entity that is being analyzed in a study, according to (King, Keohane and Verba 1994). In social research, it may include groups, organizations or artifacts. It is closely related to the study population. The units of analysis for the proposed study were women who have sex with women, a sub-group of sexual minorities in Nairobi County.

### **3.4.2 Unit of Observation**

The unit of observation is the entity that is described by the data collected and analyzed in the study (King et al., 1994). The unit of observation in this study was the analysis of access of health care services among WSWs in Nairobi County.

## **3.5 Target Population and Sample Population**

### **3.5.1 Target population**

The study targeted women who have sex with women commonly referred to as lesbians.

### **3.5.2 Sample population**

In regard to this study the sample population was made up of women who have sex with women in Nairobi County. The WSWs population in Nairobi County in relation to access of health care services was analyzed, looking at challenges that exist due to their sexual orientation. The sample population included that part of the population that was observed or was representative of the entire study population (Stevens, 2000).

## **3.6 Sample Size and Sampling Procedure**

### **3.6.1 Sample size**

In selecting the sample size, the researcher picked respondents who formed part of the study from organizations that cater for the needs of sexual orientation gender identity and expression individuals. Due to fear of arrest arising from the illegality of this practice, there does not exist a ledger where respondents could be picked from hence the reliance on contact individuals within these organizations.

A sample can be defined as a determinate part of an arithmetical population. This populations characteristics are subjected to further review in a bid to bring out details that are similar to the entire group (Webster, 1985). The people being dealt with are defined as a set of respondents who are chosen from a larger group and will act as representatives of that group for the purpose of the study in question.

### **3.6.2 Sampling procedure and recruitment techniques**

According to the KHRC study (2011), groups dealing with the SOGIE community exist in Kenya in spite of laws criminalizing homosexuality. Majority of these groups are registered as welfare organizations, health based NGOs, community based organizations (CBOs) or human rights organizations since it is illegal to register a group that explicitly states that it will be dealing with SOGIE. (KHRC, 2011).

Due to the illegality and stigmatization geared towards the WSW, they are known to access these organizations. These groups have established offices and hold regular meetings and seminars that bring together members of the community. The organizations in question are as follows; GALCK, OSEA, MWA, and OSEA,

The researcher interacted with these organizations and sought their help in picking out the sample population. Since there are no lists of WSW who could be picked through random sampling, prospective respondents were arrived at through non-probability sampling methods namely purposive sampling and specifically snow balling.

### **3.7 Ethical Consideration**

The group under study namely the WSWs are a sensitive lot who attract a lot of undue attention; as such it is imperative to adhere to strict ethical standards. In view of this fact, the researcher obtained the necessary approvals from the University of Nairobi and equally sought informed consent from the respondents. Confidentiality was guaranteed by using pseudo-names to protect the respondents' identity on the questionnaires as well as storing information on the researchers' personal computer and associated hardware using password protected files.

### **3.8 Methods of Data Collection**

As mentioned in the research design above, the study collected data of two types; namely quantitative and qualitative data

### **3.8.1 Qualitative Data**

Qualitative data was collected from secondary and primary sources of information. The researcher conducted literature review involving the analysis of materials touching on WSWs in Kenya and in Nairobi in particular. Interviews were conducted utilizing key questions in the questionnaire and a key informant guide, targeting two key informants.

### **3.8.2 Quantitative Data**

Quantitative data was collected using questionnaires.

### **3.9 Data Analysis**

The data collected was both qualitative and quantitative in nature. After fieldwork activities, the qualitative data was transcribed after checking for completeness and consistency as well as checking for various omissions incomplete or otherwise unusual responses. Data analysis involved editing, cleaning, transformation and tabulation of collected data. Data analysis also made use of descriptive statistics such as charts, tables, Guttman scale, measures of central tendency and cross tabulation.

### **3.10 Validity of Instruments**

According to Trochim, (1996) validity involves how much accurate the data obtained in the study represents the variable of study. The validity is compromised positively or negatively depending on the tools used to gather data, to increase validity of the tools that were used during the study; the university supervisor was consulted for expert opinion.

### **3.11 Reliability of Instruments**

To ensure reliability of the research instruments, the questionnaire was pre-tested in the organizations registered to cater for WSWs in a bid to ensure that they are easily understood by the respondents. Corrections were made where necessary.

## Chapter Four: Data Analysis, Presentation and Interpretation

### 4.1 Introduction

This chapter presents and discusses findings of data collected on assess of health care services among sexual minorities in Kenya, with specific emphasis on women who have sex with women in Nairobi County. The findings are presented in reference to the study objectives outlined in chapter one. Among the themes discussed include specific health care needs, availability of health care services, accessibility of health care services, challenges that exist for WSW in seeking health care service and coping mechanisms employed by WSW in their health care seeking endeavors. In order to illustrate the study findings, figures and tables have been used.

### 4.2 Respondents Background Information

The characteristics of the respondents studied included; age of the respondent, level of education attained, occupation of respondent, marital status of respondent, their religious affiliation and the role the respondent plays in their WSW relationship.

The total number of respondents used for this study was 60 (N=60)

#### 4.2.1 Respondents Age

The table below indicates the age distribution of the respondents

**Table 1: Age of the Respondents**

Age Group	Frequency	Percentage
18 – 24 years	15	25
25 – 29 years	26	44
30 – 34 years	11	18
34 – 39 years	5	8
40 and above	3	5
<b>Total</b>	<b>60</b>	<b>100</b>

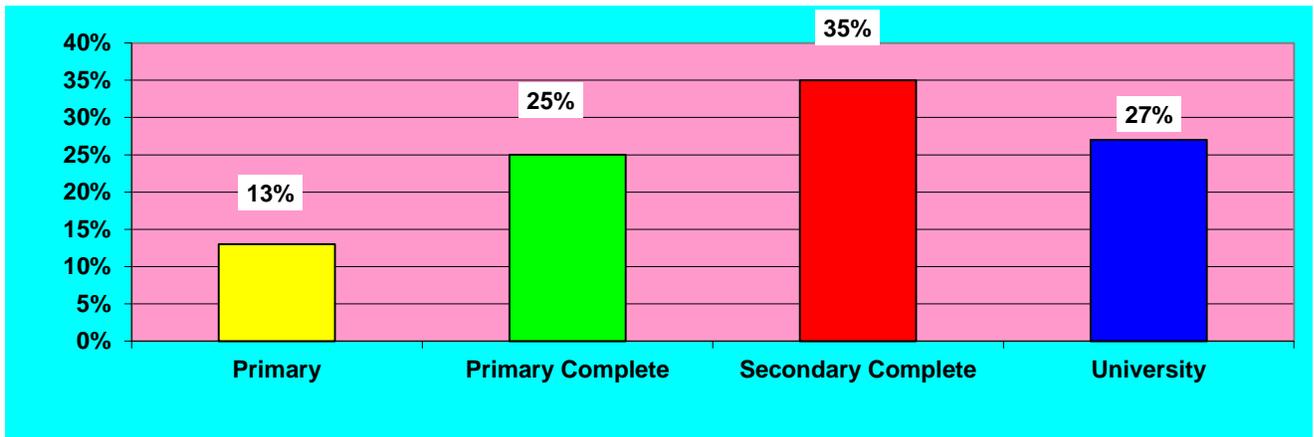
*Source: Survey Data (2016)*

As indicated in the table above, a large number of respondents (44%) were aged between 25 – 29 years. Those aged above 40 years and above were least (5%). Lesbian activities are therefore more associated with individuals who are young. Studies carried out on sexual behavior (Okal et al 2014), indicate that young people are more liberal and care free and therefore more willing to experiment without any inhibition. As they get older, majority were unwilling to participate in studies as they got married and are more concerned about their status in the community (Okal et al 2013). Lesbian activities are not restricted to the young age group. Young people lack clear identity; as people get older they get more identity as they discover themselves. Those who previously practiced lesbianism veer off and get involved in heterosexual relationships. A study on fluidity of sexuality (Sophie, 1985), found that, it was easier for lesbians to get involved in heterosexual relationships as they grew older because “it is easier to be heterosexual in [mid-western American] society to seek social approval that came with being in a relationship with a man.

#### **4.2.2 Level of Education**

The study established that majority (35%) of the respondents had the highest level of education being secondary complete. This was followed by (27%) with the highest level of education being university. A further 25 per cent were found to be primary complete while 13 per cent had their highest level of education as primary. The Figure 4 below demonstrates the distribution of the respondents along various categories of education level.

**Figure 4: Respondent's Level of Education**



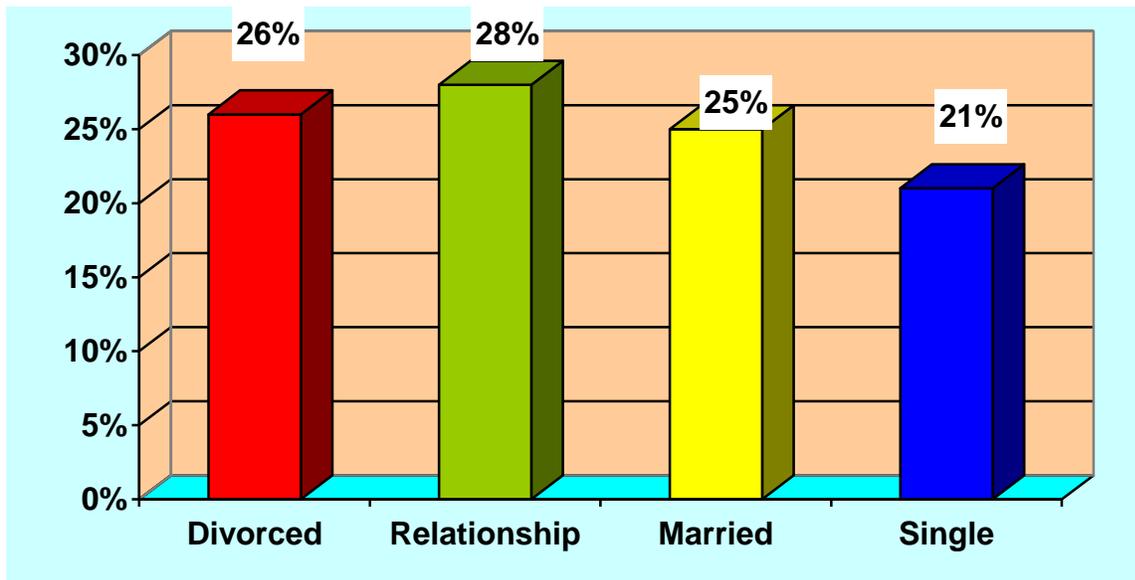
*Source: Survey Data (2016)*

This indicates that most WSW in Nairobi County are relatively well educated. Education exposes them to information regarding their health issues meaning they are more willing to participate in studies and to associate with other WSW in offering social support. High level of education also ensures that WSW are able to participate in economic activities and also allows them to get information outside what has been learnt through socialization. In addition, high level of education facilitates awareness on risk factors associated with the lesbianism lifestyle and how to mitigate and to protect against them. It also brings to fore their level of awareness and rights accorded to them through various legislature, despite homosexuality been declared illegal in Kenya. This could explain the rapid spread and growth of lesbianism.

#### **4.2.3 Marital Status of Respondents**

The marital status of the respondents was another attribute the study sought to find out. Figure 5 below shows the distribution of the respondents along the marital status.

**Figure 5: Marital Status of Respondents**



*Source: Survey Data (2016)*

In everyday language the state of being in a relationship refers to one of a heterosexual nature between a man and a woman. For purposes of this study, being in a relationship refers to woman to woman (lesbian) relationship, while those who indicated that they were married were living with a same sex partner. Those who stated that they were divorced were divided between those who were previously involved in a heterosexual relationship (18%), and those separated from their lesbian partner (8%). Those who stated that they were single were dating casually but not involved in a committed relationship.

The study established that majority of the respondents (28%) were in a relationship, about 26 per cent were divorced or separated, and 25% were married. In addition around 21 percent revealed that they were single. This goes to show that those who were in a relationship and those who were married (53%), have a level of commitment to continue with the relational status while those who were divorced have possibly learnt their lesson and opted not to continue. Those who were single are not sure whether to commit or not and could therefore sway between heterosexuality and lesbianism circumstances allowing.

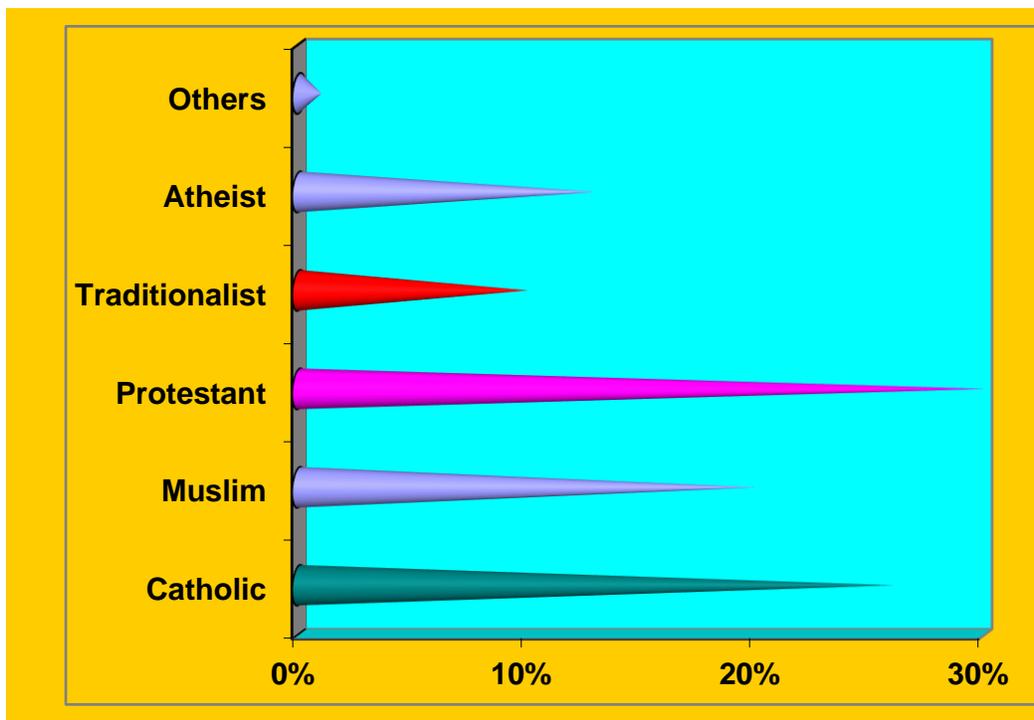
The study established that there were more respondents in a woman to woman relationship while an equally high number stated that they were married (cohabiting) with a same sex partner. This

fact draws credence to the need to assess health care services as some of the respondents stated that majority of their partners were bisexual women that made it easier to spread sexual infections.

#### 4.2.4 Religious affiliation

The religious affiliation of respondents was an attribute that the researcher sought to find out due to the outlawing of homosexuality by most religious affiliations on spiritual grounds. Figure 6 below will show the religious affiliation of the respondents sampled.

**Figure 6: Religious affiliation of Respondents**



*Source: Survey Data (2016)*

The study established that majority of respondents (30%) were Protestants, 26 per cent were Catholic, 20 per cent were Muslim, 13 per cent were atheist, 10 per cent traditionalists while 0.01 per cent professed to other faiths like SDA.

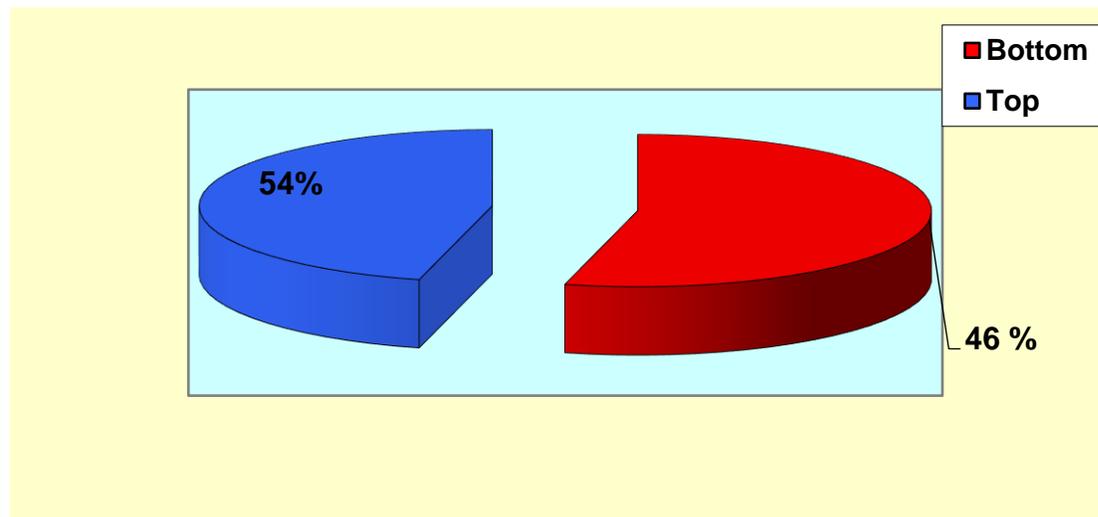
Drawing from Emille Durkheim’s study on suicide and its correlation to religion, rates of suicide among Catholics were lower as compared to protectants which he theorized was due to stronger forms of social control and cohesion among the former as compared to the latter. Using the same

principle, Protestants are more liberal in their outlook on life and their faith does not accord the same level of social control that the Catholic faith does. This could therefore explain the high number of those who professed the protestant faith and were involved in a homosexual relationship considered taboo by religion. The social control attributable to the Catholic faith appears to be waning more-so among the younger generation which would explain why respondents professing this faith followed closely at 26 per cent. The same could be said of the Muslim faith which accords its member high level of social control, and yet 20 per cent of the respondents who profess this faith were involved in a woman to woman relationship.

#### 4.2.5 Respondents role in the WSWs relationship

Just as in a heterosexual relationship, WSWs have varying roles in their relationships, the dominant and submissive partner. There are terms used such as a bottom/femme/stem to signify the submissive partner, while the top/stud/tommy boy to signify the dominant partner. The study sought to establish which role the various respondents identified with. The pie chart below signifies the varying roles. The term bottom in the diagrammatic expression below has been used to explain the submissive partner, while the term top has been used to explain the dominant partner.

**Figure 7: Role of respondents in the WSWs relationship**



*Source: Survey Data (2016)*

The study established that majority of the respondents (54%) were dominant partners commonly referred to as studs or tommy boy in the WSW jargon. While 46 per cent of the respondents identified as submissive partners commonly referred to as femmes or stems.

### 4.3 Health needs that manifest among WSWs by virtue of their sexuality

In analyzing the health needs that manifest among WSW, the respondents were asked what specific health needs they had that were as a direct result of their sexual orientation. The table 2 below shows the nature of health needs and frequency as reported by the respondents

**Table 2: Nature of Health Needs**

Nature of Health Need	Frequency	Percentage
Menstrual Disorders	15	25
Cervical Cancer	25	42
Chest problems	18	30
HIV testing	35	58
Abdominal pain	15	25
Urinary testing	25	42
Vaccination for STIs	20	33
STI testing and STI treatment	40	67
Hepatitis B	10	17
Vaginal itching	19	32
TB Testing	28	47
Tongue problems / fungal infection	16	27
Psychological issues	38	63
High blood pressure	20	33
Alcohol and drug abuse	28	47

*Source: Survey Data (2016)*

According to the tallied responses above, the top three health needs among women who have sex with women as reported are STI and STI testing at 67 per cent, Psychological issues at 63 per cent and HIV testing at 58 per cent. Treatment of these conditions is available at no cost in

public health centers but LGBTIQ individuals are likely to delay or all together avoid seeking intervention because of experiences of past discrimination or perceived homophobia within the prevailing health care system (Rabatin J. et al 2006).

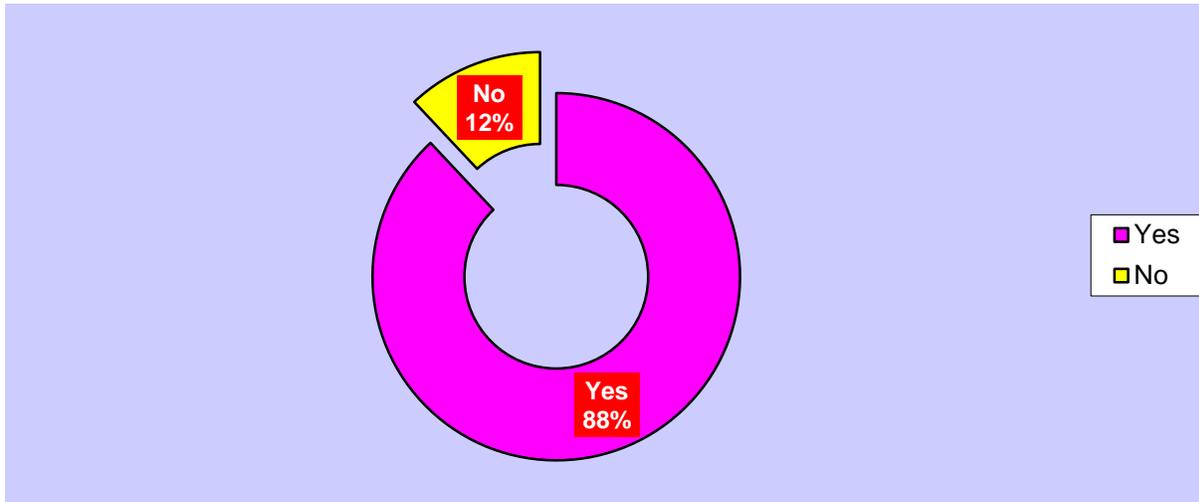
On the other hand, the health needs considered least in terms of priority include abdominal pain (25%), chest problems (30%), Tongue problems / fungal infection (27%) and Menstrual disorders (25%). These problems are considered least in importance possibly due to their direct correlation to lesbianism which attracts deep rooted stigma, discrimination and unyielding health insurance policy (Mayer K.H et al 2008).

The research established that the respondents were knowledgeable in matters health by use of the medical terms in describing their health needs such as hepatitis B, suffering from papillomavirus (HPV) and PEP testing after rape incidences which could be attributed to their level of education and by extension awareness creation arising from alternate agents of socialization outside the conventional ones.

#### **4.3.1 Treatment availability for WSWs in the health care system**

Based on the varying health needs that WSWs identified, the study sought to find out if treatment was available in the health care system. Sexual minorities including women who have sex with women face constraints inherent in human health care circles which result in less than ideal state of physiological and mental status of the patients. Medical practitioners unfortunately lack specialized training required to handle the ailments lesbians present to them according to a GALCK (2016) report. The respondents gave the following feedback as illustrated in figure 8

**Figure 8: Treatment availed to WSWs in health care centers**



*Source: Survey Data (2016)*

The research established that 88 per cent of respondents had not received treatment in health care centers when the health personnel discovered their sexual orientation while 12 per cent received treatment despite their sexual orientation. According to (O’Hanlan K.A, 1999), health care providers are often in conflict when individuals of alternative sexual orientation present themselves for treatment due to illegality of their relationships within the existing law. They are therefore often torn between offering them services as clients as prescribed by the Hippocrates code and reporting them to the authorities as violators of illegal activities.

#### **4.3.2 Reasons for negated health provision**

The study sought to find out from the respondents their opinion on the negation of health care provision in the health care center. Table 3 below shows some of the opinions shared.

**Table 3: Respondent opinion on negation of health service provision**

<b>Item No.</b>	<b>Respondents Opinion</b>	<b>Frequency</b>	<b>Percentage</b>
1	Health care personnel not specialized / trained on WSW health issues	12	20
2	Discrimination of WSW	25	42
3	Stigmatization of WSW	30	50
4	Health personnel homophobia	30	50
5	Fear of coming out among WSW	10	17
6	Expensive health care	15	25
7	Lack of machines/equipment to deal with infections	12	20
8	Punitive laws against homosexuality	35	58

*Source: Survey Data (2016)*

The study established that discrimination, stigmatization,, homophobia among health personnel and punitive laws against homosexuality are among the top reasons the respondents felt were responsible for lack of health care provision in health care centers in Kenya. This is further illustrated in the Table 4: Guttman scale below.

**Table 4: Guttman Scale: Negation of Health Service Provision**

Respondent	Punitive Laws	Stigmatization	Health Personnel Homophobia	Discrimination	Expensive Health care
1	Y	Y	Y	Y	Y
23	Y	Y	Y	Y	-
36	Y	Y	Y	Y	-
2	Y	Y	Y	-	Y
3	Y	Y	Y	-	Y
33	-	Y	Y	Y	Y
14	-	Y	Y	Y	Y
4	Y	Y	Y	-	-
5	Y	Y	Y	-	-
11	Y	Y	Y	-	-
56	Y	Y	Y	-	-
59	Y	Y	Y	-	-
6	Y	Y	-	Y	-
8	Y	Y	-	Y	-
25	Y	Y	-	Y	-
53	Y	-	Y	Y	-
40	Y	-	Y	-	Y
31	-	Y	Y	Y	-
45	-	Y	-	Y	Y
20	-	-	Y	Y	Y
17	-	-	Y	Y	Y
48	-	-	Y	Y	Y
10	Y	-	-	Y	Y
29	Y	Y	-	Y	-
43	Y	Y	-	Y	-
7	Y	Y	-	-	-
16	Y	Y	-	-	-
18	Y	Y	-	-	-
39	Y	Y	-	-	-
51	Y	Y	-	-	-
54	Y	Y	-	-	-
35	Y	-	Y	-	-
50	Y	-	Y	-	-
46	Y	-	Y	-	-
12	Y	-	-	Y	-
22	Y	-	-	Y	-

38	Y	-	-	Y	-
13	-	Y	-	Y	-
19	-	Y	-	Y	-
27	-	Y	-	Y	-
58	-	-	Y	Y	-
37	-	-	Y	-	Y
60	-	-	Y	-	Y
9	Y	-	-	-	-
30	Y	-	-	-	-
32	Y	-	-	-	-
34	Y	-	-	-	-
47	Y	-	-	-	-
49	-	Y	-	-	-
21	-	Y	-	-	-
26	-	-	Y	-	-
28	-	-	Y	-	-
42	-	-	Y	-	-
44	-	-	Y	-	-
55	-	-	Y	-	-
57	-	-	Y	-	-
41	-	-	-	Y	-
52	-	-	-	-	Y
24	-	-	-	-	Y
15	-	-	-	-	-

Source: Survey Data (2016)

### Co-efficient of reproducibility

$$C_R = 1 - \frac{\text{No. of inconsistencies}}{\text{Total number of responses}}$$

$$C_R = 1 - \frac{40}{300}$$

$$C_R = 1 - 0.133$$

$$C_R = 0.88 \text{ equals to } 88\%$$

Guttman (1950), proposes a coefficient of 0.90 as the level needed to assume uni-dimensionality. The co-efficient of reproducibility is often used as a criterion of scalability. The co-efficient measures the extent to which an observed set of response patterns agrees with that expected of a perfect scale. Using the data above, the co-efficient of reproducibility (88%) shows that the extent of observed response patterns differs from a perfect scale with 2% and hence calls within the agreeable limit of reproducibility.

As illustrated by the Guttman scale above, majority of the respondents felt that punitive laws against homosexuality are the leading cause of refusal of health care provision in health care facilities; the Kenya Penal code section 162 and 165, states that homosexuality is outlawed and defines it as “carnal knowledge against the order of nature” (Kodero et al., 2011, p 279). The outlawing carries with it a prison term of between five and seven years. These laws that lead to the criminalization of same sex instigates fear among the SOGIE community causing them not to seek out health care services. (Mravcak S.A, 2006). These laws also hinder the health care professionals from treating members of the SOGIE community for fear of losing their practicing licenses in breaking existing laws. (O’Hanlan K.A, 1999). The illegality and outlawed nature of homosexuality in Kenya creates conflict in both the individual and the health care professional when the individuals are required to openly seek services that are a right and are necessary for survival.

Societal stigmatization and discrimination of WSWs, was another factor according to the respondents that leads to refusal of health care provision. Stigma and exclusion by family and society is a challenge faced by WSW. Homosexuality is regarded as taboo and by extent invites repulsion and stigma. (KHRC, 2011). Stigma begins at family level, spreading out to the neighbors, close friends, workmates, religious institutions and finally to society at large which includes the medical personnel (David N. 2010). Societal reaction to homosexuality is linked to stigmatized service provision since many providers find it difficult to provide non-stigmatizing services to clients perceived to be practicing repulsive behavior (KACC, 2009).

Despite taking a professional oath to take care of all persons in the society, health care personnel exhibit homophobia towards homosexual individuals. WSW face negative reactions from health

care personnel if they disclose their sexual orientation (KHRC, 2011) Forms of these include isolation, denial of treatment, invasive enquiries, calling for bridges by nurses and even forced treatment based on the assumption that these people have a mental problem (Chandra A at al, 2006). This has in turn caused SOGIE individuals to self-medicate further accelerating health care crisis among this cohort.

Good health care is a critical aspect for human survival. It is however an expensive endeavor out of reach to majority individuals. The Kenyan Government through the universal health care program NHIF, has attempted to lessen the financial load on its citizens but this provision is applicable in public health care facilities, where homosexuals face the highest form of discrimination. Provision of health care services in the private sector is friendlier and less discriminative but the cost is prohibitive. The privilege of seeking health care services in the private sector is not available to all leaving majority of those who require services at the mercy of health care practitioners in the public sector.

#### **4.4 Availability of health care services for WSWs**

Health care is a universal human right. Chapter four under the bill of rights article 43 (1) states that each individual has the right (a) to the highest attainable standard of health, which includes the right to health care services including reproductive health care. The study sought to find out if there were unmet medical services respondents would like to receive, and whether health care centers were equipped to handle specific health care needs that arose as a result of their sexual orientation.

The study established that (92%) of the respondents reported to having unmet medical services that they would like to receive and that weren't available to them while (8%) of the respondents reported to having their medical services available to them.

In attempting to establish whether health care centers were equipped to handle specific health care needs that arose as a result of their sexuality, 25 per cent of the respondents reported that medical centers were equipped to handle their health needs but mainly the private health centers; while a majority 75 per cent reported that the centers were not equipped to handle their health needs.

#### 4.4.1 Services that WSWs would like to receive

The study sought to find out the health care services that WSW would like to receive. Table 5 below shows a list of preferred services as reported by the respondents.

**Table 5: List of health services WSWs would like to receive**

List of Health Care Services	Frequency	Percentage
TB Screening	10	17
Alcohol and drug abuse counseling rehabilitation	35	58
PEP treatment after rape incidences	38	63
Cancer screening	25	42
High blood pressure treatment	15	25
Provision of dental dams	32	53
Provision of finger condoms	23	38
Provision of lubricants	35	58
Cleaning of the uterus	22	37
Heart problems	25	42
Testing for HIV/AIDs	39	65
Vaccination on HPV and for STIs	36	60
Chest pains/problems treatment	37	62
Counseling – depression and marriage	37	62
Cervical cancer screening	15	25
Family planning – as a result of rape incidences	13	22
STI treatment	35	58

Cervix screening	24	40
Health training and talks	30	50
Sores in private parts	36	60
Vaginal bleeding	27	45
Clinics for WSW inclusively	38	63
Mouth sores / wounds	23	38
Abdominal pain	38	63
Itching in the genital area	12	20

*Source: Survey Data (2016)*

According to the tallied responses above, the top five health care services that WSW would like to receive include and are not limited to, testing and counseling for HIV/AIDs (65%), Clinics for WSW (63%), abdominal pain (63%), PEP treatment after rape incidences (63%), and STI treatment at 58 per cent.

While the least five health care services among WSW were listed as TB screening (17%), High blood pressure (25%), Cervical cancer screening (25%), Family planning services – after rape incidences (22%) and itching in the genital area at (20%).

**Table 6: Cross Tabulation Table (Health needs as result of sexuality & Availability of Health care service)**

Top Specific Health needs	Health Needs as result of sexuality		Services Availability	
	Frequency	Percentage	Frequency	Percentage
STI screening and treatment	40	67	15	25
Counselling and Psychological issues	38	63	21	35
HIV screening and testing	35	58	16	27

*Source: Survey Data (2016)*

According to the tallied data, 67 percent, listed STI screening and treatment as a specific health need as a direct result of their sexual orientation. Of these only 25 percent were able to access treatment for their health need. Majority of those who were able to access the health care service mentioned they lied about their sexuality for fear of discrimination and being turned away. Counseling and psychological issues were also listed as a health need sought by WSW, 63 percent expressed it as a health need. Of these 35 percent were able to access the service, this was mainly in private health care centers. Some respondents stated they preferred to seek social support from other WSW and other members of the homosexual community as they best understood challenges encountered based on shared experiences. HIV testing and screening is also another area that was raised by the respondents. The biggest challenge brought out by WSW in relation to HIV infections arose due to rape incidences they experienced in the hands of heterosexual males trying to ‘cure’ them of lesbianism. Those who sought out health care services did so in the pretense of being heterosexual to avoid being discriminated against.

#### **4.5 Accessibility of Health Care Service by WSWs in Nairobi County**

The research sought to establish the extent of accessibility of health care services by WSWs in Nairobi County. In doing so, respondents were asked if they had received discrimination or prejudice as a direct result of their sexual orientation from health care or service providers. In

this regard 95 percent, of respondents said they had received discrimination and/or prejudice from health care and service providers while 5 percent, said they had not received discrimination as a result of their sexual orientation.

As a follow up on the issue of discrimination and prejudice, the study sought to find out if this was stated by the health personnel as being due to their sexual orientation. The 90 percent of the respondents tallied stated that it was stated expressly by the health personnel as being due to their sexual orientation while 5 percent stated that it was not expressly stated. The remaining 5 percent choose not to respond.

#### **4.5.1 Health Centers offering non-discriminative health care services**

Health care seeking practice in Kenya varies across a continuum and the populace is at liberty to choose which of the available sector works for them at any particular time. The study sought to establish among the available possibilities which offers non-discriminative health care services to women who have sex with women.

**Table 7: Health Care Providers level of discrimination to WSWs by Sector**

The provision of health care services by various players in the sector varies in their level of offering discriminative services to WSW as tallied by respondents in their responses represented in the table 7 below.

<b>Health Care Options</b>	<b>Frequency</b>	<b>Percentage</b>
Public Health Care Centers	1	2
Private Health Care Centers	34	56
Herbalists	17	29
None of the above	8	13
<b>Total</b>	<b>60</b>	<b>100</b>

*Source: Survey Data (2016)*

A vast majority of respondents 56 percent reported that services offered in private health care centers offer non discriminative health care services followed by herbalists at 29 percent, and

public health care centers at 2 percent. 13 percent felt that all health care providers offered discriminative health care services to WSW.

#### 4.5.2 Reasons for unfavorable attitude towards WSWs

The study sought to find out from the respondents their thoughts on the reason for the unfavorable attitude towards WSWs. The table 8 below shows a tally of the responses given.

Asked about their thoughts on the role homophobia plays in contributing to discrimination and/or prejudice among health care personnel, the respondents gave the following responses:-

**Table 8: Reasons for unfavorable attitude towards WSWs**

Variable	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
	Freq.	Freq.	Freq.	Freq.	Freq.	
Homophobia that exists within the Kenyan society is a contributing factor to discrimination and/or prejudice among health care personnel	20	30	10	0	0	60
The Kenyan Constitution outlaws the practice of homosexuality, this directly affects the attitude of health care personnel	38	14	8	0	0	60
In addition to the Kenyan constitution there are social/cultural perception of sexual minorities that permeates the society	34	18	6	2	0	60
The health care personnel are not knowledgeable on WSW health needs	39	16	5	0	0	60
<b>Cell Representative</b>	<b>54.58%</b>	<b>32.5%</b>	<b>12.08%</b>	<b>0.83%</b>	<b>0%</b>	<b>100%</b>

Source: Survey Data (2016)

According to tallied data, 87 percent both strongly agreed and agreed that there were unfavorable attitudes towards WSW within the health care system; while 12.08 percent were not sure whether

this was true or not and could therefore be swayed to either side of the divide. A few of the respondents 0.83 percent disagreed while none strongly disagreed.

Drawing from the respondents responses, evidence from the respondents indicate that homophobia among health care personnel, the effects of the constitution on health care personnel, social and cultural perception that permeates society and health care personnel knowledge on WSW health needs leads to the unfavorable attitude towards WSW within the health care system.

The respondents were asked to give their thoughts on the effect that homophobia which exists within the Kenyan society acts as a contributory factor to discrimination and/or prejudice among health care personnel. Upon further probing, some of the responses received were as follows:-

*“...cannot go to a place I really know that I am not going to get treated”*

*“...Homophobia are within the public hospitals, who don't want to waste money on WSWs” “...People should stop discrimination to reduce violence against WSWs, should build clinics for just WSWs”*

*“...Once health facility personnel neglect WSWs then even members of the society will automatically discriminate them”*

*“...Homophobic professionals that make WSWs afraid of going to their clinics”*

*“...Heterosexual personnel affects members of the WSWs community” ...*

One of the key informants added that:-

*”Homophobia has really contributed to WSW which has led to many women dying because there are no clinics which can treat them”*

Homophobia is regarded as a form of prejudice or discrimination against individuals identified as members of the lesbian and gay community. Despite the hatred and injustice targeted towards this group in Kenya, their existence and growth cannot be denied, as evidenced by the social networks that exist in their support, and the groups that have been registered to fight for their rights or to cater for their health concerns. In the Kenyan republic, clerics and members of the political class do not shy away from making homophobic statements that are malevolent to sexual minorities. The second Kenyan president Daniel Moi in 1999, deprecated homosexuality terming it as an affliction against African traditions and Christian teachings.

According to the Kenya National Commission of Human Rights, the LGBTIQ community in Kenya often faces discrimination and stigma when seeking medical health care services in public hospitals. Majority of the medical personnel have been known to breach their privacy and confidentiality by exposing their sexual orientation to other colleagues. They are also not friendly and hardly understand their sexual orientation (Standard Newspaper, Nov 2016). The article found research that suggests that the LGBTIQ community in Kenya have reduced access to medical care compared to their heterosexual counterparts because majority of them have had experience of homophobic health professionals.

(<https://www.standardmedia.co.ke/ureport/article/20000224508/The-LGBT-have-a-right-to-access-health-care-services-free-from-stigma-and-discrimination>)

The lesbian and gay individuals have poor access to health care and lack provision of comprehensive services. For instance when accessing treatment for sexually transmitted infections, counseling and care for HIV/AIDs, these individuals are often afraid of honestly responding to medical interviews because honesty often leads to rebuke, and/or arrest. Medical practitioners are known to violate the privacy of lesbian and gay patients by exposing them to

other staff or police, preaching to them or denying them medical care. (Standard Newspaper, Nov 2016)

The Pew Global Attitudes Project conducted a study in 2007 that found that 96 percent of Kenyans were homophobic; this is the fifth-highest rate of homophobia among the 45 countries included in the Pew survey according to the KHRC. As evidenced in the respondents' feedback above, homophobia is also experienced in health care centers among health care personnel.

As a country determined to achieve health care for all in its vision 2030, Kenya through its health ministry should proactively make sexual minorities feel accepted and secure in public medical facilities without thinking about being discriminated and stigmatized. <https://www.standardmedia.co.ke/ureport/article/20000224508/The-LGBT-have-a-right-to-access-health-care-services-free-from-stigma-and-discrimination>

Desmond Tutu, says homophobia is to the gay community what apartheid was to the blacks; it blames and persecutes people for something that they have no control over

Majority of the respondents (50%), agreed that homophobia exists within the Kenyan society and it contributes to discrimination and/or prejudice among the health care personnel, 33 per cent strongly agreed, while 17 percent were neutral.

Below are some of the responses when the respondents were asked about what they thought about the Kenyan constitution 2010 and WSW:-

*“...They cannot treat you because the constitution is against WSWs” “...People cannot go to the health care because they know it is not right according to the constitution and may be blamed by members of society”*

*“...Yes, because the government says no sex between people of the same sex” “...The state should not discriminate, directly or indirectly”*

Based on the responses received, 64 per cent of the respondents strongly felt that the Kenyan constitution directly affected the attitude of the health care personnel; 23 percent agreed, while 13 percent were neutral.

While the promulgated constitution was supposed to give equal rights to all under article 4, it is evident that it discriminates against sexual minorities in pressing for laws that outlaw homosexuality and by also indirectly causing homophobic treatment from members of larger society.

Sections 162 and 165 of the Kenyan Penal Code criminalize actual and attempted homosexual behavior between men and between women. The act is defined as ‘carnal knowledge against the order of nature’ (Kodero et al., 2011, p 279). An individual who is convicted of this offense can be sentenced to a jail term of between 5 and 14 years. The sentence is made clear in section 162, which states that:

“Any person who has carnal knowledge of any person against the order of nature; or permits a male person to have carnal knowledge of him or her against the order of nature, is guilty of a felony and is liable to imprisonment for 14 years (Kodero et al., 2011, p 279)

On its part, Section 165 states that:

“Any male person who, whether in public or private commits any acts of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or private, is guilty of a felony and is liable to imprisonment for five years” (Kodero et al., 2011, p 279)

Article 43(1) of the Kenyan constitution states that every person has the right to the highest attainable standard of health, which includes the right to health care services including reproductive health care.

With regard to the effect of social/cultural perception that permeates throughout society and its correlation with the unfavorable attitude expressed towards WSW, one of the respondents gave the following response:

*“...The constitution doesn't want to be associated with WSWs which has led to members of the WSW community to be sent away from the society”*

Article 27 of the Kenyan constitution, states that “every person is equal before the law and should be accorded equal protection and equal benefits within that law. Equality is not limited to total and equitable gratification of all inherent rights and structural freedoms. The state and its citizenry therefore shall not discriminate overtly or covertly against anyone on the basis of marital status, pregnancy, sex, race, health status, culture, religion, belief, language or birth.

Members of the community have generally been hostile towards LGBT individuals in Kenya (Ipsos Kenya Limited, 2014). A story published by the Africa Review on February 24, 2012, captures this scenario vividly. In the story written by Nyassy (2012) it was reported that on February 23 2012 more than 100 people disrupted a meeting that was held by homosexuals in Likoni CDF Youth Empowerment and Library Centre. Following this incidence, the area police boss and provincial administration officials ordered the meeting to be closed. The mob, led by Sheikh Amir Zani of the Muzadhalfa mosque, justified their actions by saying that the meeting was illegal, ungodly and unacceptable.

Majority of the respondents (57%) strongly agreed with the statement that social and/or cultural perceptions of sexual minorities that permeates in the society affects attitudes towards WSWs, 30 percent agreed, 10% were neutral while 3 percent disagreed.

Asked to give their thoughts on the knowledge ability of WSW health needs among health care personnel, some of the respondents gave the following feedback:-

*“...Health personnel don't know of the existence of these people”*

*“....Some knows but they are just ignorance of treating WSWs”*

*“When you are sick and go to their clinic they cannot treat you because they don't know what kind of disease you are suffering from”*

*“...Yes because most of the health care professionals are heterosexual so women of WSW are left untreated”*

Health professionals deny homosexual people access to certain services, exclude them from decision making or make inappropriate comments; on the other hand the health professionals are not knowledgeable about homosexuals' lifestyle and specific health care needs. Fish J. Hunt (2008).

Due to ignorance on sexual minority health needs, the medical practitioners invent methods such as forced medical treatment. (Chandra A et al, 2006). People engaging in same sex as well as transsexuals are forced into medical diagnoses following perceptions that they have a mental problem and their conditions can be corrected (Chandra A et al, 2006). Intersex persons are forced to undergo forced surgeries in order to correct their presumed ambiguous genitalia (Chandra A et al, 2006).

Kodero et al. (2011) and KHRC (2011) report that LGBT individuals are subjected to various forms of discrimination and violation as a result of their sexual orientation. For example when the individuals need medical care, they are affected by stigma perpetuated by healthcare providers. The providers breach the privacy and confidentiality of their patients by disclosing their sexual orientation to other caregivers in the institution (KHRC, 2011) Majority of the respondents (65%) strongly agreed that health care personnel did not have knowledge on WSW health needs, 27 percent agreed, while 8% were neutral.

Another key informant gave the following response:-

*“...Forum should be held to educate health care personnel on WSWs issues”*

According to (Mravcak S.A. 2006), criminalization of same sex relationships has instigated fear of lesbians and gays causing them to hold from obtaining healthcare services especially from public health facilities. Health care providers on the other hand do not know how to handle this group of persons once they present at the facilities because of the illegality of their relationships; they are often torn between offering health care services to them as clients and reporting them to the authorities as violators of illegal activities. Health care providers are not informed on the way to handle LGBTIQ clients (NACC, 2009)

#### 4.6 Challenges that exist for WSWs in seeking health care services

LGBTIQ individuals have unique health needs that are unlikely to be met by existing health care services (Lee, 2000). These individuals are likely to delay or all together avoid seeking health care services because of their experiences of past discrimination or perceived homophobia within the prevailing health care system. The study sought to establish challenges that exist for WSW in their health seeking endeavors.

The study established that (82%) of the respondents reported experiencing challenges in their attempt to seek out health care services, while (18%) did not experience any challenges.

The study further sought to establish if the challenges experienced could be attributed to the respondents' sexual orientation. Out of the tallied responses, 78 percent of the respondents attributed the challenges to their sexual orientation, while 22 percent did not attribute the challenges to their sexual orientation.

##### 4.6.1 Factors associated with challenges experienced

The study sought to find out from the respondents their thoughts and/or explanation of the challenges they experienced in the health seeking endeavor as attributable to their sexual orientation. The table 9 below shows a tally of the responses given.

**Table 9: Challenges experienced by WSWs as a result of their sexual orientation**

Variable	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
	Freq.	Freq.	Freq.	Freq.	Freq.	
Societal socialization on sexual minorities affects service provision for WSWs	17	26	10	7	0	60
Ignorance on societies part on matters homosexual has led to misconstrued attitudes towards them	25	18	17	0	0	60
The health care personnel's fear of infringing the law that outlaws homosexuality contributes to WSWs challenges	24	28	8	0	0	60
<b>Cell Representative</b>	<b>37%</b>	<b>40%</b>	<b>19%</b>	<b>4%</b>	<b>0%</b>	<b>100%</b>

*Source: Survey Data (2016)*

Majority of the respondents tallied either strongly agreed or agreed (77%), that challenges experienced by WSW in their pursuit of health care services is as a result of their sexual orientation. Nineteen percent of those tallied were not sure if this was true while 4 percent disagreed that it was true.

The health care personnel who are part and parcel of the society suffer the effects of societal socialization and misconstrued attitudes towards homosexuals while also trying to keep within the law that outlaws homosexual behavior.

The respondents were asked to give their thoughts on the effect that societal socialization has on sexual minorities' provision of health care. Some of the respondents expressed the following thoughts:-

*“...It is due to lack of education or knowledge”*

*“...They felt untreated when they visit public health care centers”*

*“...I am human and I should not be discriminated against, I am supposed to be treated equal no matter what my sex orientation is”*

*“...This is because the society doesn't like learning anything concerning the homosexuals they only ignore it”*

*“...Everywhere people discuss sexual minorities but only in regard to gay, transgender, sex workers and bisexual but never about WSWs. “...The members of the heterosexual community hardly socialize with WSW because they say WSWs are cursed.*

*“...Depression really affects the community of WSWs”*

WSWs do not live in a vacuum but within the same society that holds negative and homophobic views towards their sexual orientation. Health care practitioners are socialized by the same socializing agents that hold divergent and negative views towards the homosexual community. Influence from the family, school, religion, political arena, peers and the media which act as socializing agents contribute to the homophobic views towards SOGIE individuals.

One of the key informants gave their view as follows:-

*“....There is no relationship between the members of WSW and the society hence no knowledge sharing exists”*

According to KHRC in a book entitled “The Outlawed Among Us (KHRC, 2011)”, majority of homosexual individuals get disowned by family and their peers upon their outing. Reports in the media bring out stories of students suspended from their schools on suspicion of practicing homosexuality often with the blessing of the larger society. The religious front has been very vocal in their rejection of alternative sexuality, while the political arena has also been openly hostile towards these individuals.

Although positive reactions to disclosure are possible, gay men and lesbians have reported negative reactions within their home environments. These reactions range from covert insidious forms of rejection to open verbal abuse and physical violence (Rivers, 2002, p. 34). In addition Hetrick and Martin (1987) argue that gay and lesbian youth have frequently reported feeling “distanced and detached from their families” as a result of rejection and violence that they face (p. 33)

Within the school environment, according to Little, (2001) LGB youth commonly experience ridicule, verbal abuse, and social isolation at school. These forms of discrimination are often perpetuated by the school institution itself, where the existence of LGB students is often denied, thus rendering them invisible (Butler, 2007; Ford, 2003). Little (2001), believes the reason for this is that “schools mirror the problems in larger society” (p. 105)

Majority of the respondents (43%), agreed that the challenges they experiences in their health seeking endeavors were attributable to their sexual orientation. 28 percent strongly agreed, 17 percent were neutral, while 12 percent disagreed.

Respondents were asked to give their thoughts on misconstrued attitudes towards homosexuals as influenced by generalized ignorance. Some of the responses given are as follows:-

*“...True coz they beat them to death or even doing stuff to them”*

*“...The ignorance in society has made WSWs suffer” “...Ignorance of treating WSWs and the community are very rude in treating WSWs”*

*“...People should stop ignoring WSW to reduce attitudes and help them when they are in need”*

*“...Suffering emotional distress because the society is fully ignorant about WSWs”*

Society in general is often ignorant in matters LGBTI and as such react with stereotyping, labelling and branding (Nkabinde & Morgan, 2005). Sadly this labeling affects many individuals who find themselves at cross roads. On one hand they recognize their sexual orientation as homosexual while on the other hand are afraid of societies judgement of them. Majority of them perceive themselves as worthless, developing a self-loathing that is reinforced by societal ignorance. SOGIE individuals hear through the media, family, church, schools and political arenas that homosexuality is bad, sinful, disgusting and is trivialized. Societal intolerance and stigma through misinformation and entrenched beliefs equally affects their health seeking endeavors for fear of being rejected and ridiculed (Reid 2010)

Majority of the respondents (42%), strongly agreed that society plays a role in influencing the misconstrued attitude towards homosexuals, 30 per cent agreed, while 28 percent were neutral.

Asked to share their opinion on the health care personnel’s fear of infringing the law that outlaws homosexuality as contributes to WSWs challenges, sampled respondents had the following to say:

*“...The fear of losing clients in their facilities”*

*“...The Government is so strict on WSWs which is not right, government not right to say that homosexuality is a crime they are also human beings should be treated equal irrespective of their sexual orientation.”*

*“...The challenges arise from certain law that sexual acts between persons of the same sex is a crime but have equal rights as human beings”*

*“...The health personnel are not ready to treat WSWs which led them to suffer from serious infections.”*

Criminalization of same sex has instigated fear in lesbians and gays causing them to hold from obtaining healthcare services especially from public health facilities (Mravcak S.A, 2006). Health care providers on the other hand are not clear on how to handle this group of persons once they present at the facilities because of the illegality of their relationships; they are often torn between offering health care services to them as clients and reporting them to the authorities as violators of illegal activities as outlawed by existing laws (O'Hanlan K.A, 1999).

Majority of the respondents (47%), agreed that the health care personnel's fear of infringing the law that outlaws homosexuality contributes to challenge among WSW, 40 per cent strongly agreed, while 13 percent were neutral.

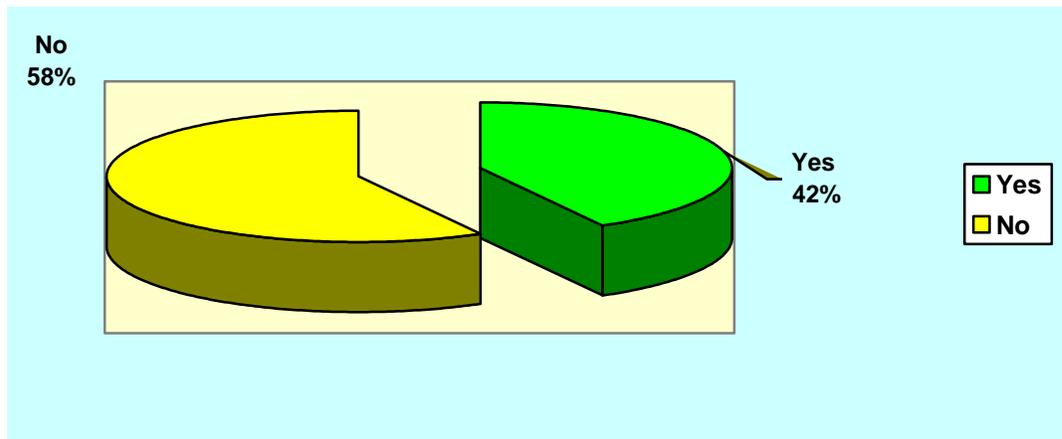
#### **4.6.2 Challenges that exist for WSWs in their bid to seek health care services**

Once the study established that there are challenges that exist among the WSWs in their bid to seek out health care services, the respondents and informants were requested to list some of the challenges they experience. Some of the recurring challenges brought out by the respondents include; misunderstanding by heterosexual doctors leading to poor attendance of health care centers, infringement of WSWs rights as a patient by health care personnel by openly discussing confidential health matters with colleagues, the provision of sub-standard and mediocre services once their sexuality is established, lack of respect and proper medical care by homophobic health care personnel, the fear of been seen and identified by sexuality in health care centers due to open discrimination, access denied in public health care centers, unaffordable and inaccessible health care and where available mainly in private health care centers, lack of education and public benefits, fear of being judged and of explaining particular health problems, limited amount of information available on health care risks and lack of personnel, equipment and clinics that are homo-friendly.

#### **4.7 Copying mechanisms employed by WSWs in seeking health care services**

As a result of challenges experienced by WSWs in their health seeking endeavors, the study sought to establish if they rally around each other for social support. The respondents tally is as illustrated in the Figure 9 below:

**Figure 9: Availability of social support for WSWs**



*Source: Survey Data (2016)*

Among the respondents' tallied, majority of them (58%), reported to not having any social support available to them, while (42%) reporting to having access to social support in health related matters.

#### **4.7.1 Copying mechanisms employed by WSWs**

The respondents who reported having social support available to them listed some of them as support offered by organizations that champion the rights of sexual minorities like GALCK, guidance and counseling offered by homosexual professionals on pro bono basis, support offered through social media platforms among sexual minorities, ideas shared by other stakeholders through networks and seminars, health forums that accord open discussions and dialogue, social support offered by peers and other sexual minorities, consumption of alcohol and drugs that offer temporary relief from real and perceived problems and compartmentalizing challenges experienced due to ones sexuality and ignoring its existence. The informants collaborated the respondents views.

The tallied respondents offered varied views on the avenues open to them in coping with health care access challenges. Majority of the respondents (53%) felt that there were no avenues open to them because there were no health professionals willing to risk losing their licenses by treating them, the other 47 percent offered varying avenues like guidance and counseling services and the assistance offered by private clinics and herbalists.

#### 4.7.2 Mechanisms to ensure equal access to health services for WSWs

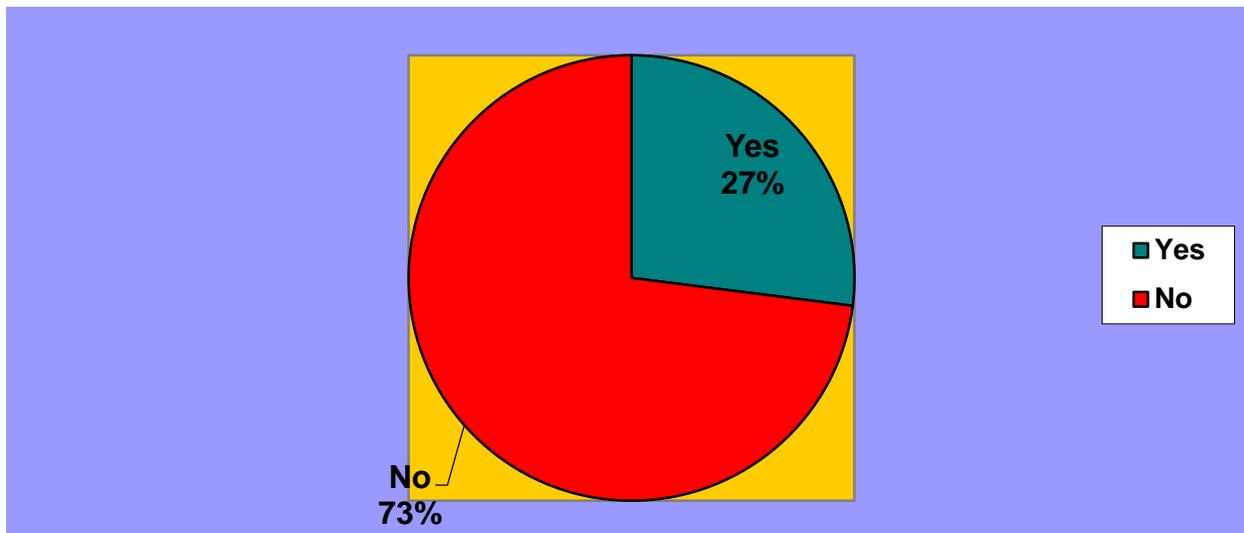
The study also sought the respondents opinion on what they thought should be done to ensure equal access of health care services for WSWs. A variety of responses were received and recurred around; establishing clinics for homosexuals exclusively manned by homo-friendly health personnel, attempts by health care personnel through changes in their syllabi to better understand LBQ women and their health needs, decriminalize homosexuality by repealing laws that outlaw the practice, county governments provision of health care services to WSWs by making provisions in their annual health budgets, increased peer education and creation of awareness around WSW issues, equality and equity in health care access for all irrespective of their sexual orientation, and provision of health care insurance to WSW and their partners.

#### 4.7.3 Kenya health care system in dealing with WSWs health needs

The Kenya health care system is divided into various sectors, mainly divided into the formal and informal sectors. These include the public health care system, the private, which also includes herbalists or traditional health attendants, faith healers, witchdoctors among others. The study sought to establish if the Kenya health system is equipped to deal with health needs of sexual minorities and specifically WSWs.

Among the respondents tallied, 73 percent felt that the system was not equipped, while 27% felt that the system was equipped. Figure 10, below shows that illustration

**Figure 10: Kenya health system ability to deal with WSWs health needs**



*Source: Survey Data (2016)*

The key informants and respondents who felt that the Kenyan health care system was not equipped to handle WSW health care issues gave varying reasons for their belief. Among those given were lack of diagnostic equipment specifically for WSW health needs, lesbians dying from diseases either due to stigma and no specialized clinics to handle their health issues, the existing laws that criminalize homosexuality, the generalization with heterosexual women yet the two have varying health needs, society in denial and burying their collective head in the proverbial sand on the existence of WSW, health care system and donors only concerned about GBQ men and heterosexual individuals at the expense of WSW and health personnel ignorance of WSW health needs.

## **Chapter Five: Summary, Conclusions and Recommendations**

### **5.1 Introduction**

This study sought to establish the access of health care services among sexual minorities in Kenya with emphasis on women who have sex with women in Nairobi County. The specific objectives of this study were (i) to find out the specific health care needs WSWs are faced with by virtue of their sexual orientation, (ii) establish the availability of health care services sought by WSWs, (iii) examine the extent of accessibility of health care services by WSWs in Nairobi County, (iv) to investigate challenges that exists for WSW in seeking health care services and (v) to identify coping mechanisms employed by WSW in their health care seeking endeavors. This chapter gives a synopsis of the main study findings and draws conclusions and recommendations based on the research findings.

### **5.2 Summary of the Findings**

The study found out that a large number of the respondents were aged between 25 – 29 years at 44 percent, though their existence was found to range from between 18 – 45 years. This is against a backdrop of their existence and visibility as stated by Berman (1993), where he states that Lesbians are positioned as invisible through “underexposure, censorship and patriarchal control” which permeates through society. On marital status of the respondents, a majority of those tallied were either in a relationship or married a finding that demonstrates the activeness of homosexual relationships in Kenya despite laws criminalizing them.

#### **5.2.1 Specific WSWs health needs by virtue of their sexual orientation**

The study established that WSWs have varying health needs with majority of respondents listing; STIs, psychological and mental health issues and HIV testing and treatment as the top priority needs while chest pains, tongue/fungal infection and menstrual disorders were listed as low priority.

The research established that the respondents were highly knowledgeable on their health needs as well as mitigating mechanisms in dealing with those needs. Majority of the respondents visit clinics set aside for heterosexual sex workers and pose as such to allow them get medical services because they get turned away when they identify as lesbians.

It is important to note at this juncture that some of the WSWs were reluctant in sharing out information on their health needs mainly for academic purposes because they felt that it would not result in any assistance on their part.

### **5.2.2 Availability of health care services by WSWs**

On the establishment of availability of health care services, the study sought to find out if there were unmet health needs respondents would like to receive and if the health care system was equipped to handle this specific health needs. 92 percent of the respondents reported to having unmet medical services that they would like to receive and that weren't available to them while (8%) of the respondents reported to having their medical services available to them. Some of the respondents tallied mentioned that on ailments there were not directly specific to their sexual orientation, they posed as heterosexual patients as past experience had subjected them to discrimination and prejudice on the part of health care personnel.

In attempting to establish whether health care centers were equipped to handle specific health care needs that arose as a result of their sexuality, 25 per cent of the respondents reported that medical centers were equipped to handle their health needs but mainly the private health centers; while a majority 75 per cent reported that the centers were not equipped to handle their health needs.

### **5.2.3 Extent of accessibility of health care services**

On the extent of accessibility of health care services, respondents were asked if they had received discrimination or prejudice as a direct result of their sexual orientation from health care or service providers. In this regard (95%), of respondents said they had received discrimination and/or prejudice from health care and service providers while (5%), said they had not received discrimination as a result of their sexual orientation.

As a follow up on the issue of discrimination and prejudice, the study sought to find out if this was stated by the health personnel as being due to their sexual orientation. The 90 percent of the respondents tallied stated that it was stated expressly by the health personnel as being due to their sexual orientation while 5 percent stated that it was not expressly stated.

#### **5.2.4 Health Challenges that exist for WSWs**

In regard to challenges that exist for WSWs in seeking health care services, 82% of the respondents reported experiencing challenges in their attempt to seek out health care services, while (18%) did not experience any challenges.

The study further sought to establish if the challenges experienced could be attributed to the respondents' sexual orientation. Out of the tallied responses, 78 percent of the respondents attributed the challenges to their sexual orientation, while 22 percent did not attribute the challenges to their sexual orientation.

According to Meyer et al (2008), the health challenges experienced by the LGBTIQ are affected by deeply rooted stigma, discrimination and unyielding health insurance policy. The respondents in the study were asked to list some of the challenges experienced which they gave as (i) Misunderstanding by heterosexual doctors leading to poor attendance, (ii) Doctors infringing on WSW rights as a patient, discuss their health matters openly with colleagues (iii) Offer of mediocre service once their sexuality is established (iv) Lack of respect and proper medical care by homophobic health personnel, (v) Fear of been seen and identified by sexuality in health care centers due to open discrimination (vi) Access denied in public health centers (vii) Unaffordable health care where available mainly in private health centers (viii) Lack of health care access, education and public benefits (ix) Fear of been judged and of explaining particular health problems (x) Limited amount of information available on health care risks and (xi) Lack of personnel, equipment and clinics that are homo-friendly.

#### **5.2.5 Copying mechanisms employed by WSWs**

Due to inherent challenges that exist among WSW in their bid to seek health care services, among the respondents' tallied, majority of them (58%), reported to not having any social support available to them, while (42%) reporting to having access to social support in health related matters.

The respondents who reported to having social support availed to them listed some of these avenues as (i) Support offered by organization – GALCK, (ii) Guidance and counselling, (iii) Social media support (iv) Sharing ideas through networks and forums, (v) Open forums and dialogue through health forums, (vi) Seeking support from peers and other WSW, (vii) Alcohol

and drug abuse as a means of escape and (vii) compartmentalizing the problem and ignoring its existence.

The tallied respondents offered varied views on the avenues open to them in coping with health care access challenges. Majority of the respondents (53%) felt that there were no avenues open to them because there were no health professionals willing to risk losing their licenses by treating them, the other 47 percent offered varying avenues like guidance and counseling services and the assistance offered by private clinics and herbalists.

### **5.3 Conclusion**

A number of conclusions can be drawn from the findings of this study. First, despite laws criminalizing homosexuality in Kenya, the existence of this cohort within our society cannot be denied. Secondly WSWs have specific health needs that they suffer as a result of their sexual orientation. Thirdly, despite the constitution outlaying equal health rights for all, WSWs by virtue of their sexuality do not have these services availed to them and also have problems accessing these services. Fourthly, there are challenges that exist as established by the study of WSWs in their health seeking endeavors and lastly some WSWs employ varying coping mechanisms to help them in mitigating these challenges while others get involved in alcohol and drug abuse as a means of escape.

### **5.4 Recommendations**

The findings of the study have important implications for health professional policy makers, academicians and the larger homosexual community as they seek to mitigate health challenges faced in Nairobi County and in Kenya in general. They also provide directions for further research.

#### **5.4.1 Recommendations for Policy**

- (i) While acknowledging that homosexuality has been criminalized in Kenya, the existence of WSW cannot be ignored and the health plight they suffer as a result of their sexual orientation offers wide spread consequences to the general health sector, in that regard advocacy on their health needs would go a long way in stemming the rise in HIV/AIDs cases been reported in this cohort that is a strain in the general health budget

- (ii) The study further recommends the establishment of homo-friendly desks in both public and private health centers which would allow easy access to health care services as majority of WSW are reportedly dying from treatable ailments for fear of violence and discrimination.
- (iii) Finally there should be a repeal of laws criminalizing homosexuality as a means of stemming rise in deaths and stigma targeted towards these individuals in society.

#### **5.4.2 Recommendations for Further Research**

This research examined the access of health care services among sexual minorities with specific emphasis on women who have sex with women. However the research did not examine the key themes across sectors. In a bid to deepen the knowledge in this area, need for additional research is necessary owing to the fact that this cohort is growing, in addition to emerging gaps that were outside the scope and agenda of this study. An example of this would be:

- (i) A further study on other sexual minorities like transgender and intersex individuals would broaden the level of knowledge and bring out insights on these varying groups which would be compared to those already in existence
- (ii) The study would also recommend studies on other aspects of daily living among WSW such as employment, education, religion ,housing and families in a bid to get an all rounded sense of obstacles that exist in these sectors and possible means of mitigating against them

## References

- Aarmo. M., (1997), "How homosexuality became 'un-african'; the case of Zimbabwe'. In Blackwood, ed., *Female Desires: Same-sex Relations and Transgender Practices across Cultures*, SE Wierringa, New York: Columbia Univ. Press P 255-80
- Agnew, Robert, "Foundation for a General Strain Theory of Crime and Delinquency." (1992) *Criminology* 30:47-87
- Amnesty International (2011): *Making love a crime* publication
- Amnesty International (2013): *Rising Levels of Homophobia in sub-Saharan Africa*
- Arthur Kleinman (1980), *Patients and Healers in the context of culture: An Exploration of borderland between Anthropology, Medicine and Psychiatry*. Berkeley
- Arndt & de Bruin (2006), *Attitudes Towards Lesbians and Gay Men: Relations with Gender, Race and Religion Among University Students*: Thermo Fisher Scientific Journal
- Bandura, A. (1989). Perceived self-efficacy in the exercise of control over AIDS infection. In V.M. Mayes, G.W. Alebee and S.F Schneider (Eds.), *Primary Prevention of AIDS: Psychological Approaches* (pp. 128-141) London: Sage Publications
- Baraka & Morgan (2005), *The Cultural Politics of Female Sexuality in South Africa*
- Bangemihl B (1999) *Biological Exuberance*, St. Martin's Press
- Basile Ndjio Dr. (2011), University of Doula Cameroon, 27<sup>th</sup> April 2011. Interview with Amnesty International for *Making Love a Crime Publication* [Amnesty International Publications]
- Berman, Paul, 1993, "Democracy and Homosexuality" in *The New Republic*, 209(25): 17-35.
- Beyrere, C., et al., (2011) *The Global HIV Epidemics among Men who have Sex with Men*, Washington, World Bank.
- Boehmer U: Twenty years of public health research: Inclusion of Lesbian, Gay, Bisexual and Transgender populations. *American Journal of Public Health* 2002, 92(7):1125-1130
- Boellstorff, T., (2007), *Queer Studies in the House of Anthropology*, Department of Anthropology, University of California, Irvine, California

Boswell, John, 1980, *Christianity, Social Tolerance, and Homosexuality: Gay People in Western Europe from the Beginning of the Christian Era to the Fourteenth Century*, Chicago: The University of Chicago Press.

Burgess D et al (2007), Effects of perceived discrimination on mental health among Homosexuals. Arizona State University

Bradford J, Ryan C, Rothblum E D. National Lesbian Health Care Survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology*. 1994b;62(2):228–242.

Bass & Kaufman (1996), *Psychological Perspectives on Lesbian, Gay and Bisexual Experiences: Journal*

Broidy, Lisa & Agnew “Gender and Crime: A General Strain Theory Perspective” (1997) *A Journal of Research in Crime and Delinquency*: 34: 275-306

Bryld, M., (2001), “The Infertility Clinic and the Birth of the Lesbian: The Political Debate on Assisted Reproduction in Denmark’, *European Journal of Women’s Studies*, Special Issue, *Lesbian Studies, Lesbian lives, Lesbian Voices*, ed., Nina Lykke, 299-313. London Sage

Butler, J., (1990), *Gender Trouble: Feminism and the Subversion of Identity*, London: Routledge

Butler, J., (1997), “Against proper objects’, Elizabeth Weed and Naomi Schor, eds., *Feminism meets Queer Theory*, Bloomington: Indiana University Press pp. 1-31

Campbell, K, (2000). *Relationship characteristics, social support, masculine ideologies and psychological functioning of gay men in couples*. PhD Dissertation. The California School of Professional Psychology, Alameda.

Cass, V. (1979), Homosexual identity formation: A theoretical model. *Journal of Homosexuality*, 4,219-235

Chaiklin H. Attitudes, Behaviour, and Social Practice. *Journal of Sociology and Social Welfare* 2011; 38(1): 31-54

Chandra A, Mosher WD, Copen C, Sionean C. (2008) Sexual Behavior, sexual attraction and sexual identity (*National Health Statistic Report*: PubMed)

Chase (2001), Adolescents’ and Young Adults’ Perception of Homosexuality and Related Factors in Three Asian Cities

Cloete, A., L. C Simbati, et al, (2008) “Stigma and Discrimination experience of HIV-positive men who have sex with men in Cape Town, South Africa.” AIDS CARE 20(9): 1105-1110

Creswell, J., & Miller, D. (2000). Determining Validity in Qualitative Inquiry. *Theory into Practice*, 39 (3), 124-130

Croucher (2002), Minority Stress and Mental Health in Homosexuals, *Journal of Health and Social Behavior*

Cock (2003), *Women Voicing Resistance: Discursive and Narrative Explorations*

Constitution of Kenya, 2010 Chapter 4 Article 43 (1a), Government Printers, Nairobi, 2010. Also available at [http://www.kenyalaw.orf/kenyalaw/klr\\_app/frames.php](http://www.kenyalaw.orf/kenyalaw/klr_app/frames.php)

Cranston R et al (2012), Enigmatic Liaisons: A Review of Same-Sex Courtship and Relationships

David K. (2010) The Need to decriminalize Homosexuality, KHRC Conference Nairobi

David N. (2010) Homosexuality and Religion in Kenya, KHRC Conference Nairobi

Dean, Wu & Martin (1992), Midlife and Older LGBT Adults: Knowledge and Affirmative Practice

Diamond (2008), *Sexual Fluidity: Understanding Womens Love and Desire*

Donham, D.L., (1998) “Freeing South Africa: The ‘Modernization’ of Male-Male Sexuality in Soweto’, *Cultural Anthropology*, 13(1), 3-21

Dover, K.J., 1978, 1989, *Greek Homosexuality*, Cambridge, MA: Harvard University Press.

Edwards J. The healthcare needs of gay and lesbian patients. In: Kuhlman E, Annandale E (eds). *The Palgrave Handbook of Gender and Healthcare*. Palgrave Macmillian; 2012. P. 290-305

Evans & Broido (1999), Understanding Gay Identity: Development within the Multiple Identities LGBTIQ: *Journal*

- Evans-Pritchard, E. E. (1970), "Sexual Inversion among the Azande," *American Anthropologist* 72: 1428-1434
- Finerty, C. (2012), Being Gay in Kenya: The implications of Kenya's New Constitution for its anti-sodomy laws. *Cornell International Law Journal*, 45, 431-459
- Fisher, T., Davis, C., Yarber, W., & Davis, S. (2012). *Handbook of sexuality-related measures* (3<sup>rd</sup> ed.). London: Routledge
- Fish J, Hunt R. Prescription for change. Lesbian and bisexual women's health check. London: Stonewall; 2008
- Foucault M., (1978) *The History of Sexuality 1: The Will to Knowledge*, Trans. Robert Hurley, New York: Penguin Books (Original Publication 1976 as *Histoire de la Sexualite 1. La volonte de savior* (Paris)
- Foucault, Michel, 1980, *The History of Sexuality. Volume One: An Introduction*, Robert Hurley (trans.), New York: Vintage Books.
- Johnson CA (2007), Off the Map: how HIV programming is failing same-sex practicing people in Africa, IGLHRC, p. 39, [www.ighrc.org](http://www.ighrc.org)
- Gevisser (1994), *Homosexuality: A History from Ancient Greece to Gay Liberation*
- Graziano (2004), *Stigma, Discrimination and Living with HIV/AIDs*
- Jablonski (2004), *Sexual and Reproductive Health Risks among key populations vulnerable to HIV*
- Johnson L. G (2004), *The Story of Sexual Identity: Narrative Perspectives on the Gay, Lesbian and Bisexuals*
- Jones KM, Pynor RA, Sullivan G, Weerakoon P.A "Study of Attitudes towards sexuality issues among health care students in Australia. *Journal of Lesbian Studies* 2001; 6 (3-4): 73-86
- GALCK (2016) Publication: *Research on Lived Experiences of Lesbian, Bisexual and Queer Women in Kenya* [www.icop.or.ke/uploads/2016](http://www.icop.or.ke/uploads/2016)

Garnets L, Hancock K A, Cochran S D, Goodchilds J, Peplau L A. Issues in psychotherapy with lesbians and gay men. A survey of psychologists. *American Psychologist*. 1991;46(9):964–972

George, Robert P., 1999a, *In Defense of Natural Law*, New York: Oxford University Press

Greenberg, David F., 1988, *The Construction of Homosexuality*, Chicago: The University of Chicago Press.

Halperin, David M., 1990, *One Hundred Years of Homosexuality: and other essays on Greek love*, New York: Routledge

Hetrick E. S & Martin A. D (1987), Developmental Issues and their resolution for gay and lesbian adolescents

Horn P. (2006), Heterosexism and homophobia, Textbook of homosexuality and mental health. Washington DC: American Psychiatric Press

Kenya Health Policy 2014 – 2030, Government Printers, Nairobi (2014). Also available at [https://www.afidep.org/?wpfb\\_dl=80](https://www.afidep.org/?wpfb_dl=80)

Kenya Human Rights Commission, The (2011), *The Outlawed Among us: A study of the LGBTI community's search for equality and non-discrimination in Kenya*. *KHRC Publication*

Kenya National Aids Strategic plan 2009/10 – 2012/13 Nairobi available at [http://www.nacc.or.ke/images/stories/knasp\\_iii\\_document.pdf](http://www.nacc.or.ke/images/stories/knasp_iii_document.pdf)

King G., Keohane R., Verba S., *Designing Social Inquiry* (1994) Princeton

Kitzinger C. & Wilkinson S (1995), *The Social Construction of Lesbianism: A Reappraisal*

Klein et al (1985), *The Klein Sexual Orientation Grid – Bisexual.org*

Kleinmann A (1985) *Illness Meanings and Illness Behaviour* in S. McHugh & M. Vallis (Eds) *Illness Behavior: A Multidisciplinary Model* (pp. 149 – 160) New York: Pleum

Krieger N, Sidney S. Blood pressure: The CARDIA study of young black and white adults. *American Journal of Public Health*. 1996;86(10):1370–1378.

Krieger N, Sidney S. Prevalence and health implications of anti-gay discrimination: A study of black and white women and men in the CARDIA cohort. *International Journal of Health Services*. 1997;27(1):157–176.

- Kodero, H., Misigo, B., Owino, E., & Mucherah, W. (2011). Perception of students on homosexuality in secondary schools in Kenya. *International Journal of Current Research*, 3(7), 279-284
- Lee S. (2000), Social attitudes toward homosexuality: The Relationship of Authoritarianism and Related constructs
- Lewis, J. & Loots (1994), Homosexuality and the City: A Historical Overview
- Lykke, N., (2010) *Feminist Studies, A Guide to Intersectional Theory, Methodology and Writing*, Routledge Taylor & Francis Group, New York & London, pp. 31-45; 51-69
- Macedo, Stephen, 1995, "Homosexuality and the Conservative Mind," *Georgetown Law Journal*, 84: 261-300.
- Markowe (2002), Lesbian and gay Identity: European Perspective: Journal
- Marks, D.F., Murray, M., Evans B., Willing, C., Woodall, C., and Sykes, C., (2005) *Health Psychology: Theory, Research and Practice* (2<sup>nd</sup> Ed.) Thousand Oaks CA: Sage
- Mayer K. H et al (2008), *Sexual and Gender Minority Health: What We Know and What Needs to Be Done*
- Morgan, R., & Wieringa, S., (2005), *Tommy Boys, Lesbian Men and Ancestral Wives: Female Same-Sex Practices in Africa*, Johannesburg: Jacana Media
- Morris, B. (2003) At the Michigan Womyn's Music Festival', *The Gay and Lesbian Review Worldwide* 10(5)
- McConaghy, Nathaniel. "Heterosexuality/homosexuality: Dichotomy or continuum." *Archives of sexual behavior* 16.5 (1987): 411-424.
- Muchoki Samuel, Galavu Lydia, Isaiah Muchoki and Akinyi Ocholla (2010), 'Uncomfortable territories. A study on same sex practices in traditional Kenyan communities and mapping homophobia in a cultural context

Murray, S. O (1998) “Homosexuality in Traditional Sub-Saharan Africa and Contemporary South Africa: an overview,” in *Boy-Wives and Female Husbands. Studies on African Homosexualities*, ed, S.O. Murray and W. Roscoe, New York St. Martin’s Press. pp. 1-18

Nathaniel M (1987), *The Evolution of Human Homosexuality*. New York: Sanhedrin Press

National Aids Control Council Strategic Plan 2010-2013  
[http://www.nacc.or.ke/2010/images/downloads/knasp\\_iii.pdf](http://www.nacc.or.ke/2010/images/downloads/knasp_iii.pdf)

O’Hanlan K A. Lesbian health and homophobia: Perspectives for the treating obstetrician / gynecologist. *Current Problems in Obstetrics, Gynecology and Fertility*. 1995;18(4):93–136.

O’Hanlan et al (1996) “Lesbian Health – Current Assessment and Directions for the Future”

O’Hanlan K A, Crum C P. Human papillomavirus-associated cervical intraepithelial neoplasia following lesbian sex. *Obstetrics and Gynecology*. 1996;4(Part 2):702–703

Oswald (2000), *Inclusion and Belonging in the Family Rituals of gay and lesbian people*

Perrin E. C (1997), *Sexual Orientation in Child and Adolescent Health Care*

Pilkington & D’Augelli (1995), *Lesbian, gay and bisexual identities over the lifespan: Psychological perspectives*: New York: Oxford University Press

Plato, *The Symposium*, Walter Hamilton (trans.), New York: Penguin Books, 1981.

Plummer K. (1975) *Sexual Stigma: An Interactionist Account* (London: Routledge)

Plummer K. (1981) *The Making of the Modern Homosexual* (London: Hutchinson)

Plummer K. (1992) *Modern Homosexualities: Fragments of Lesbian and Gay Experience* (London: Routledge)

Plummer K. (1995) *Telling Sexual Stories: Power Change and Social Worlds* (London: Routledge)

Population Control Council (2009) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987482/>

Ratele et al (2006) *A Reflexive Inquiry into Gender Research: Towards a New Paradigm*

Reddy A. (2002) *Gay Rights, the devil and the end times: public religion and the enchantment of the homosexuality debate in Zambia*

Reid M., (2010) *Women at the Crossroads: A Prostitute Community's Response to AIDS in Urban Senegal*, Amsterdam: Gordon & Breach

Rivers (2002), *Youth, Education, and Sexualities: An International Encyclopedia*

Roscoe M., (1987) "The Mamlukes," in *Cultural Diversity and Homosexualities*. Ed. S.O. Murray, New York: Invington pp. 213-219

Rosenstock I., Strecher, V., and Becker, M, (1994). The Health Belief Model and HIV risk behavior change. In R.J. DiClemente and J.L. Peterson (Eds), *Preventing AIDs: Theories and Methods of behavioral interventions* (pp. 5-24). New York: Plenum Press

Rothblum E D. "I only read about myself on bathroom walls": The need for research on the mental health of lesbians and gay men. *Journal of Consulting and Clinical Psychology*. 1994;62(2):213–220.

Rust (1993), *Sexual Identity Development among Gay, Lesbian and Bisexual Youths*

Shilts, Randy, 1993, *Conduct Unbecoming: Gays and Lesbians in the U.S. Military*, New York: St. Martin's Press.

Sophie, J (1985). A critical examination of stage theories of lesbian identity development *Journal of Homosexuality* 12, 39-51

Sullivan, Andrew, 2003, *Virtually Normal: An Argument about Homosexuality*, New York: Knopf.

Tjepkema M (2008), *Health Care use among Gay, Lesbian and Bisexual Canadians*

Thorne, S.E., & Robinson, C.A (1988) Shifting Images of Chronic Illness Image 30(2) 173 – 179 *Journal of advanced nursing*

Turner, R, Jay, Blair Wheaton and Donald A. Lloyd "The Epidemiology of Social Stress." (1995) *American Sociological Review* 60:25-140

UNAIDS, "Guidance Note 2012: Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses

[http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/key\\_human\\_rights\\_programmes\\_en\\_May2012.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/key_human_rights_programmes_en_May2012.pdf)

UNAIDS, “The Gap Report 2014: Gay men and other men who have sex with men”  
[http://www.unaids.org/sites/default/files/media\\_asset/07\\_gaymenandothermenwhohavesexwithmen.pdf](http://www.unaids.org/sites/default/files/media_asset/07_gaymenandothermenwhohavesexwithmen.pdf)

UNAIDS, “The Gay Report 2014: Transgender people,”  
[http://www.unaids.org/sites/default/files/media\\_asset/08\\_Transgenderpeople.pdf](http://www.unaids.org/sites/default/files/media_asset/08_Transgenderpeople.pdf)

Universal Declaration of Human Rights article 1 available at  
[http://www.un.org/en/documents/udh\\_2010](http://www.un.org/en/documents/udh_2010)

Weaver T. & Wilson U (1984) Towards an understanding of the cultural roots of homophobia in order to provide better midwifery service for lesbian clients.

Wolfe A. New York: Viking Press; 1998. One Nation, After All: What Americans Really Think About God, Country, Family, Racism, Welfare, Immigration, Homosexuality, Work, the Right, the Left and Each Other.

Yogyakarta principles (2006), [www.http://yogyakartaprinciples.org/principles.html](http://www.yogyakartaprinciples.org/principles.html)

## APPENDICE

### Appendix I: Interview Schedule Questionnaire

My name is Catherine W. Kariuki, a post-graduate student at the University of Nairobi. I am carrying out a study on access of health care services among sexual minorities in Kenya: a case study of women who have sex with women in Nairobi County. The information collected will be used for research purposes only and will be treated as confidential. I will highly appreciate your participation.

Questionnaire Serial Number: \_\_\_\_\_ Date of Interview: \_\_\_\_\_

Name of the Administrative Location: \_\_\_\_\_

#### PART A: Respondent's Background Information

1. Age of the respondent (in complete years) \_\_\_\_\_

2. What is the respondent's highest level of education?

a. Primary

b. Primary Complete

d. Secondary complete

e. University complete

3. Main occupation of the respondent

a. Unemployed  b. Salaried Part Time  c. Salaried Full Time

d. Self employed

4. Marital Status of respondent

a. Single  b. Married  c. Divorced/Separated

d. In a relationship

5. What religious affiliation does the respondent ascribe to?

a. Muslim  b. Hindu  c. Catholic  d. Protestant

e. Traditionalist  f. Atheist  g. Others (Specify)

6. What role does the respondent play in the WSWs relationship?

a. Bottom

b. Top

**PART B: Health needs that manifest among WSWs by virtue of their sexual orientation**

7. Do you have specific health needs as a direct result of your sexual orientation?

a. Yes

b. No.

8. If Yes (Question 7), please name and describe them

---

---

---

---

---

9. If Yes (question 7), has treatment been availed to you in the health care system?

a. Yes

b. No

10. If No (question 9), what in your opinion negated the provision of the health care service?

---

---

---

---

---

---

---

**PART C: Availability of health care services for WSWs**

11. Are there unmet medical services you would like to receive that are not available to you?

a. Yes       b. No

12. If Yes (question 11), are health care centers equipped to handle specific health care needs that arise as a result of your sexual orientation?

a. Yes       b. No

13. If, yes, (question 11) please list the services you would like to have

---

---

---

---

---

---

---

---

14. If No, (question 12), what options are available for WSWs outside the formal health care in service provision?

---

---

---

---

---

---

---

---

**PART D: Accessibility of health care service by WSWs in Nairobi County**

15. Have you received any discrimination or prejudice as a direct result of your sexual orientation from health care or service providers?

a. Yes                       b. No

16. If yes, (question 15), was it expressly stated by the health personnel as being due to your sexual orientation?

a. Yes                       b. No

17. Among the various available avenues for health care provision, which of the ones listed below offer non-discriminative services to open WSWs

a. Public health care centers       b. Private health care centers   
 c. Herbalists                       d. Others (specify) \_\_\_\_\_

18. If Yes, (question 16) what do you think the unfavorable attitude expressed towards WSWs was based on?

<b>Your thoughts</b>	<b>Explanation (Basis of your thoughts)</b>
<p>a. I think the homophobia that exists within the Kenyan society is contributing factor to discrimination and/or prejudice among health care personnel</p> <p>b. Agree <input type="checkbox"/></p> <p>c. Strongly agree <input type="checkbox"/></p> <p>d. Neutral <input type="checkbox"/></p> <p>e. Disagree <input type="checkbox"/></p>	

<p>f. Strongly disagree <input type="checkbox"/></p>	
<p>1. The Kenyan constitution outlaws the practice of homosexuality, this directly affects the attitude of health care personnel</p> <p>a. Agree <input type="checkbox"/></p> <p>b. Strongly agree <input type="checkbox"/></p> <p>c. Neutral <input type="checkbox"/></p> <p>d. Disagree <input type="checkbox"/></p> <p>e. Strongly disagree <input type="checkbox"/></p>	
<p>2. In addition to the Kenyan constitution, there are social/cultural perception of sexual minorities that permeates the society</p> <p>a. Agree <input type="checkbox"/></p> <p>b. Strongly agree <input type="checkbox"/></p> <p>c. Neutral <input type="checkbox"/></p> <p>d. Disagree <input type="checkbox"/></p> <p>e. Strongly disagree <input type="checkbox"/></p>	
<p>4. The health care personnel are not knowledgeable on WSWs health needs</p> <p>a. Agree <input type="checkbox"/></p> <p>b. Strongly agree <input type="checkbox"/></p>	

c. Neutral	<input type="checkbox"/>	
d. Disagree	<input type="checkbox"/>	
e. Strongly disagree	<input type="checkbox"/>	
5.Others (Specify)		

**PART E: Challenges that exist for WSWs in seeking health care services**

19. Do challenges exist for WSWs in their health seeking endeavors?

a. Yes                       b. No

20. If Yes, (question 19), would you attribute it to your sexual orientation?

a. Yes                       b. No

21. What would you associate your affirmative answer to the question 20 above to?

<b>Your thoughts</b>	<b>Explanation (basis of your thoughts)</b>
<p>1. I suspect that societal socialization on sexual minorities affects service provision for WSWs</p> <p>a. Agree <input type="checkbox"/></p> <p>b. Strongly agree <input type="checkbox"/></p> <p>c. Neutral <input type="checkbox"/></p> <p>d. Disagree <input type="checkbox"/></p> <p>e. Strongly disagree <input type="checkbox"/></p>	

<p>2. Ignorance on societies part on matters homosexual has led to misconstrued attitudes towards them</p> <p>a. Agree <input type="checkbox"/></p> <p>b. Strongly agree <input type="checkbox"/></p> <p>c. Neutral <input type="checkbox"/></p> <p>d. Disagree <input type="checkbox"/></p> <p>e. Strongly disagree <input type="checkbox"/></p>	
<p>3. The health care personnel's fear of infringing the law that outlaws homosexuality contributes to WSWs challenges</p> <p>a. Agree <input type="checkbox"/></p> <p>b. Strongly agree <input type="checkbox"/></p> <p>c. Neutral <input type="checkbox"/></p> <p>d. Disagree <input type="checkbox"/></p> <p>e. Strongly disagree <input type="checkbox"/></p>	
<p>4. Other (specify)</p>	

22. Briefly describe/list challenges that exist for WSWs in their bid to seek health care services

---

---

---

PART F: Coping mechanisms employed by WSWs in seeking health care services

23. Do WSWs rally around each other for social support specifically in health matters?

a. Yes

b. No

24. If Yes, (question 23), which coping mechanisms are mostly employed?

---

---

---

---

---

---

---

25. If No, (question 23), what avenues are open to WSWs in coping with health care access challenges

---

---

---

---

26. In your view, what should be done to ensure equal access to health care services for WSWs?

---

---

---

---

27. Do you feel the Kenya Health care system is equipped to deal with health care needs of sexual minorities especially WSWs?

a. Yes       b. No

28. If No, (question 27), please expound

---

---

---

## **Appendix II: Interview Guide for Key Informants**

My name is Catherine Kariuki, a post-graduate student at the University of Nairobi. I am carrying out a study on access of health care services among sexual minorities in Kenya: a case study of women who have sex with women in Nairobi County. The information collected will be used for research purposes only and will be treated as confidential. I will highly appreciate your participation.

### **This Interview Guide is for the Following Key Informants (Target Population)**

- a. The representative from Minority Women in Action
- b. The representative from Rainbow Women in Kenya

### **Background Information**

1. Date of Interview
2. Administrative Location
3. Name of Organization
4. Name of the Respondent, Designation, Age, Sex

### **General Issues about Access of Health Care Services among WSWs in Nairobi County**

5. Are there specific health needs WSWs faced with by virtue of their sexual orientation?
6. If so, which needs are they?
7. Has treatment for those specific health needs been availed to you in the health care system?
8. If not, what in your opinion is the reason for lack of service provision?
9. Do you have unmet medical services you would like to receive that are not available to you?
10. If so, are health care centers equipped to handle specific health care needs that arise as a result of your sexual orientation?
11. Kindly itemize the list of services that you would like to receive
12. Are there options outside the formal health care system available for WSWs
13. Have you been able to access health care services as a WSW individual?
14. Have you received any discrimination or prejudice as a direct result of your sexual orientation from health care or service providers?
15. Where discrimination has been experienced, was it stated expressly by the health personnel as being due to your sexual orientation?

16. Among the health services options available to WSWs, which ones offer non-discriminative services?
17. Does the outlawing of homosexuality as stated in the Kenyan constitution affect provision of health care services for WSWs?
18. Does the social/cultural perception of sexual minorities have a bearing on health care personnel attitude towards WSWs?
19. In your opinion, are health care personnel knowledgeable on WSWs health needs?
20. Are there challenges WSWs face in their health seeking endeavors?
21. Based on the challenges highlighted above, what coping mechanisms are available to WSWs?

**THE END**

**THANK YOU SO MUCH FOR YOUR COOPERATION!**