

**HUMAN IMMUNODEFICIENCY VIRUS AND ACQUIRED
IMMUNODEFICIENCY SYNDROME SERVICES UPTAKE AMONG
LESBIANS, GAY AND BISEXUAL YOUTHS IN NAIROBI CITY COUNTY,
KENYA**

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PUBLIC HEALTH (MONITORING AND EVALUATION) IN THE SCHOOL OF
HEALTH SCIENCES OF KENYATTA UNIVERSITY**

NOVEMBER, 2024

DECLARATION

This thesis is my original work and has not been presented for a degree in any other university.

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DEDICATION

To my late grandparents Mr. and Mrs. Brown Lanyo, and my daughter Aaliyah for being the source of my strength, commitment, and inspiration.

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Sincere gratitude to God for being with me throughout the process of conducting this research while keeping me healthy, patient, and hopeful.

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ABBREVIATIONS AND ACRONYMS

| | |
|---------------|--|
| AIDS | Acquired Immune Deficiency Syndrome |
| CDC | Centre for Disease Control and Prevention |
| GBMSM | Gay, Bisexual, Men who have sex with Men |
| HBM | Health Belief Model |
| HTC | HIV Testing and Counselling |
| HIV | Human Immuno-Deficiency Virus |
| KHRC | Kenya Human Rights Commission |
| KNBS | Kenya National Bureau of Statistics |
| LGB | Lesbian, Gay and Bisexual |
| LGBT | Lesbian, Gay, Bisexual, and Transgender |
| LGBTIQ | Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer |
| NASCOP | National AIDS and STI Control Programme |
| NGO | Non-Governmental Organization |
| MSM | Men who have sex with men. |
| SDG | Sustainable Development Goals |
| UNAIDS | Joint United Nations Programme on HIV and AIDS |

DEFINITION OF OPERATIONAL TERMS

| | |
|-------------------------|---|
| Bisexual- | Refers to sexual attraction to both men and women. |
| Gay man- | Refers to a person who is male and is sexually attracted to men. |
| Health service | This is any form of preventive, curative or promotive service offered to a person identifying as a lesbian, gay or bisexual. |
| Heterosexuality- | Refers to aromantic, sexual attraction, sexual behavior and sexual orientation between people of the different sex. |
| Homophobia - | This is discrimination, contempt, prejudice, stigma, fear, or hatred based on homosexuality towards lesbians, gays, and bisexuals. |
| Homosexuality- | This is the sexual orientation where an individual has romantic or sexual feelings towards the same sex. |
| Key population - | These are defined groups who are at increased risk of HIV due to specific higher-risk behaviors and often have legal and social issues which increase their vulnerability to HIV. |
| Lesbian- | Refers to a person whose sex is female and is sexually attracted to women. |
| MSM- | Refers to men who have sex with men, these are men who identify as gay or heterosexual but have sex with other men mainly for economic gain. |

- Sexual behavior-** Means the way in which people express their sexuality. A person's sexual practice which might be heterosexuality or homosexuality.
- Sexual orientation-** A person's sexual identity to the gender in which they are attracted; being heterosexual, homosexual, or bisexual.
- Transgender-** This is the state of a person's gender identity; it relates to the status of a person whose self-identity doesn't conform to the conventional definition of male or female.
- Youth-** This is an individual who is at the age of transition from teenage to adulthood; the African Union charter and Kenyan constitution defines the youth as person between 15 and 35 years.

ABSTRACT

The Kenyan constitution assures every Kenyan the highest attainable quality of health, without discrimination on any basis including the sexual orientation. Studies have shown a high HIV prevalence among non-heterosexuals. This study assessed the general uptake of HIV and AIDS care among the Lesbian, Gay, and Bisexual (LGB) identifying youths in Nairobi County. Studies have been conducted among the key populations particularly the MSM whereas this study focused on sexual orientation aspect particularly among the LGB community. This research sought to unpack the depth in which socio-cultural, religious, systemic, personal attitudes and perceptions base contribute to the uptake of HIV and AIDS care and interventions to be scaled up. To achieve its objectives, the study employed an analytical cross-sectional design, involving qualitative and quantitative methods of collecting data. A pretest was conducted to enhance validity and reliability of the tool and final study sample size of n=84 was recruited. Respondents were then sampled through snowballing sampling technique and beefed up using a virtual snowball sampling to reach the population. Purposive sampling was applied to determine the qualitative aspect and reached 5 key informants for interviews. The study employed self-administered questionnaires. Analytical statistical analysis was utilized using Stata15.0 and cross tabulation and spearman's rank correlation was used to compare outcome of different variables whereas qualitative analysis supplemented the results and discussion of presented data. The uptake of HIV and AIDS services was found to be 86% among the Lesbian, Gay and Bisexual youths in Nairobi. Majority identified as Gay (43%) and 15% were non-Kenyans/asylum seekers. The majority of these youths' access HIV prevention and care services from government/public health facilities followed closely by NGO led facilities. Personal attitude and perception base play a significant role in utilization; despite majority having known their status and having adequate information about transmission, 57% engaged in risky activities such as sexual activities with more than one partner. 87% of the respondents experienced injustices at home and while accessing HIV and AIDS services. This included stigmatization, violence, isolation, discrimination which affected mentally, socially, and emotionally. A majority (98%) attributed the experiences to their sexual orientation. A significant proportion of the respondents demonstrated that culture, family, and religious support influenced their uptake of HIV and AIDS services. The study recommends that health care facilities should be improved and inclusive as 71% stated that the facilities are not friendly. The health care providers should be adequately trained to provide comprehensive, non-judgmental services and policies evaluated to provide non-discriminatory services to eliminate stigmatization of the population. The results of this study intend to inform programming of HIV and AIDS for this subset of Key Population and bridge the information gap.

CHAPTER ONE: INTRODUCTION

This chapter highlights the HIV and AIDS services uptake in Kenya among the Lesbian, Gay and Bisexual youths in Nairobi City County. This includes the challenging issues, statement of the problem, rationale, objectives, limitations, and conceptual framework.

1.0 Background Information

HIV and AIDS is still one of the challenging issues in public health globally. In 2022, people living with HIV were estimated to be 39 million globally. There are an estimated 85.6 million people who have been infected, and the recent updates indicated that 630,000 million people died in the year 2022 from the epidemic (UNAIDS, 2022).

According to (UNAIDS, 2022) 20.8 million people infected are living in East and Southern Africa. The statistics of new infections has gone down by 59% since 1995 and reports indicated that efforts concentrated on the knowledge of HIV and related components among young adults who are at higher risks with 59% of new infections occurring among the 15-24 age groups.

Nairobi County is the capital of Kenya with a population of 4.3 million people and the youths aged 15-24 years' account for 18.83% (KNBS, 2019). The prevalence rate in Nairobi 6.1% is higher than the national prevalence which is 3.2% (National Syndemic Diseases Control Council (2022) World Aids Day report., 2022). Kenya National Bureau of Statistics discovered that 57% of young women and 63% young men had sufficient knowledge about the infection and its prevention (KNBS, 2022). The report also indicated that only 47% of women and 39% of men were tested for HIV and received the results of the last test hence revealing a gap in comprehensive HIV and AIDS services.

The Lesbians, Gays, and Bisexuals (LGB) belong to the umbrella group Lesbians, gays, bisexuals, transgender, intersex, and queers (LGBTIQ). This is further segregated by sexual orientation or gender identity. None of the research was found to have focused on the prevalence among this group, however a study conducted by (Kloek et al., 2022) revealed that HIV prevalence among Men who have sex with men (MSM) was estimated to be higher than 15% as compared to the rate among the general populations in Sub Saharan Africa. National Syndemic Disease Control Council concurred by finding out that the HIV prevalence among men who have sex with men was at 18.2%. (National Syndemic Diseases Control Council (2022) World Aids Day report., 2018a)

The constitution of Kenya criminalizes same sex acts but also protects the civil and human rights. Human rights activists have argued that the sodomy penal code exists to justify stereotypes and discrimination based on cultural, religious beliefs and values. However, the presence of LGB youths in Kenya is also contributed by an influx of youth from neighboring countries seeking asylum/forced migrants due to criminalization and implementation of anti-homosexuality act and laws in their countries of origin (UNHCR, 2016). Studies have shown that the proportion of gay and bisexual men who had tested for HIV in East African countries like Kenya and Tanzania increased from 64% to 73% between 2010 and 2020. The young gay men are least well served by the current configuration of adult key population services.

This study will therefore help in identification of gaps service provision, shed light on the challenges, contribute to a better understanding of the factors influencing the services, and support evidence-based policies and programming within LGB population.

1.1 Statement of the Problem

HIV and AIDS became a national disaster in Kenya a year before the 20th millennium, 22 years down the line, this menace has continually affected the people of Kenya especially the youths. This is because the youthful years are known to be most vulnerable to the pandemic.

The key population individuals possessing this kind of sexual orientation are still disadvantaged, and their behavior broadens the spectrum of sexual activities as a risk factor in society. Some of the youths engage in sex with the same gender due to some perceived reasons such as curiosity, peer pressure, life frustrations and biological predisposition. These sexual activities seem to endanger all the youths, including risking the transmission of HIV regardless of sexual orientation. The legal and social attitudes result to stigma and discrimination towards lesbians, gays, and bisexuals hence affecting the uptake of HTC services. Besides, the influx of LGB refugees and the perceived influence of the western culture it essential to assess the factors that contribute or hinder the youths from accessing HTC services.

Nairobi County being the capital city of Kenya has the most significant population in Kenya and with the highest number of youths. Studies have indicated the LGB communities are mostly found in urban centers compared to rural. Youth between the ages of 17-24 are at the highest risk of contracting HIV and this calls for a study to inform HIV care. Men who have sex with men (MSM) represent 18.2% prevalence with a HIV service coverage of 65% (National Syndemic Diseases Control Council (2022) World Aids Day report., 2018a). It is reported that some key populations such commercial sex workers, people who inject drugs, men who have sex with men (MSM)

are at high risk of contracting HIV AND AIDS yet remain marginalized in receiving the testing, counseling, and care services despite having laws that guarantee equal access to health services.

1.2 Justification

The Third Goal of the Sustainable development goals (SDGs) is about ensuring healthy lives and promoting the well-being for all. This translates to increasing access to clean water and sanitation, reducing tuberculosis, malaria, polio, and reducing the spread of HIV. HIV and AIDS was the leading cause of death among the youths in Africa. (UNAIDS, 2022)

Reports have indicated an engagement between various institutes such as ministries, NGOs, and community-based organizations to establish youth friendly clinics. (Nyasani et al., 2023) conducted a study on sexually transmitted diseases and found out that MSMs often manage to hide their sexuality but at the same time engage in unprotected sex with their wives and male partners hence increasing the risk of HIV transmission. It is therefore necessary to investigate the uptake of these services among the lesbian, gay and bisexual identifying youths.

Nairobi being the capital city of Kenya hosts the biggest number of key populations. The lesbian, gay and bisexual youths are at risk of HIV and AIDS, according to the Centre for Disease Control (CDC), gay people are at a higher risk of contracting and transmitting HIV and AIDS. Attitudes from different angles about the LGB may further be an obstacle to having an HIV test and access affordable health care to prevent and treat HIV and AIDS.

Information obtained from the study will be relevant to both national and county governments, Non-Governmental Organizations (NGOs), private sectors as well as development agencies working in the field of policy, HIV and AIDS, gender, and youth affairs as it will assist in proposing measures that bridge the knowledge gaps and efforts to improve the delivery of HIV and AIDS services among different populations.

1.3 Research Questions

1. How do personal attitudes and perception base affect the utilization of HIV and AIDS services among the LGB youths aged 18 to 35 years?
2. How do the socio-cultural and religious factors affect the uptake of HIV and AIDS services among the LGB youths aged 18 to 35 years?
3. What are the systemic factors in health care that influence the uptake of HIV and AIDS services among LGB youths aged 18 to 35 years?
4. What interventions should be scaled up to improve HIV services among the study participants?

1.4 Objectives of the Study

Main objective

To investigate the uptake of HIV and AIDS services among the LGB identifying youths aged 18 to 35 years in Nairobi City County, Kenya.

Specific Objectives:

1. To identify personal attitudes, and perception base affecting utilization of HIV and AIDS services among the LGB youths aged 18 to 35 years.
2. To determine socio-cultural and religious factors affecting uptake of HIV and AIDS services among the LGB youths aged 18 to 35 years.
3. To establish systemic factors in health care that influence the uptake of HIV and AIDS services among the LGB youths aged 18 to 35 years.
4. To determine the interventions to be scaled up to improve uptake of HIV services among the LGB youths aged 18 to 35 years.

1.5 Hypothesis

There is no association between personal attitude and perception base, socio-cultural, systemic factors, interventions to be scaled up and the uptake of HIV and AIDS services among the Lesbian, Gay and Bisexual identifying youths aged between 18 and 35 years in Nairobi City County.

1.6 Significance and expected output.

The study provided practical and theoretical implications in the current utilization of HIV and AIDS services in Nairobi. Sexual orientation practices are current issues and a topic that ought to be studied in relation to health. This contributes to the knowledge in the field and assists in eliminating the barriers to youths irrespective of their individual characteristics.

The study findings informed through recommendations, on how to improve the HIV and AIDS services and assist in mitigating the pandemic. The findings informed policy formulation for improved HIV and AIDS service delivery to LGB. Additionally, the study contributed to the rare global research evidence for referencing and further research.

1.7 Limitations of the study

Although the study was the first of its kind to be conducted among the youths in Nairobi, City County; it had its own limitations. First, the study focused on LGB youths aged between 18-35 years in Nairobi city, hence difficult to generalize to the entire country. Secondly snowballing sampling was used to identify respondents considering the hidden nature and distribution of the respondents. Thirdly, the questionnaire was self-administered, the possibility of bias can't be ruled out and there was a possibility of selection bias since the focus was on sexual orientation, those of gender identity such as transgender and intersex were not considered. The political environment in the country was not conducive for the study population due to fear of attacks. The participants were assured of confidentiality, safety, anonymity and upholding their human dignity.

1.8 Assumptions

The youths who identify themselves as Lesbians, Gays, and Bisexuals were willing, cooperative, and provided reliable information and referral to others.

1.9 Conceptual Framework
Independent Variables

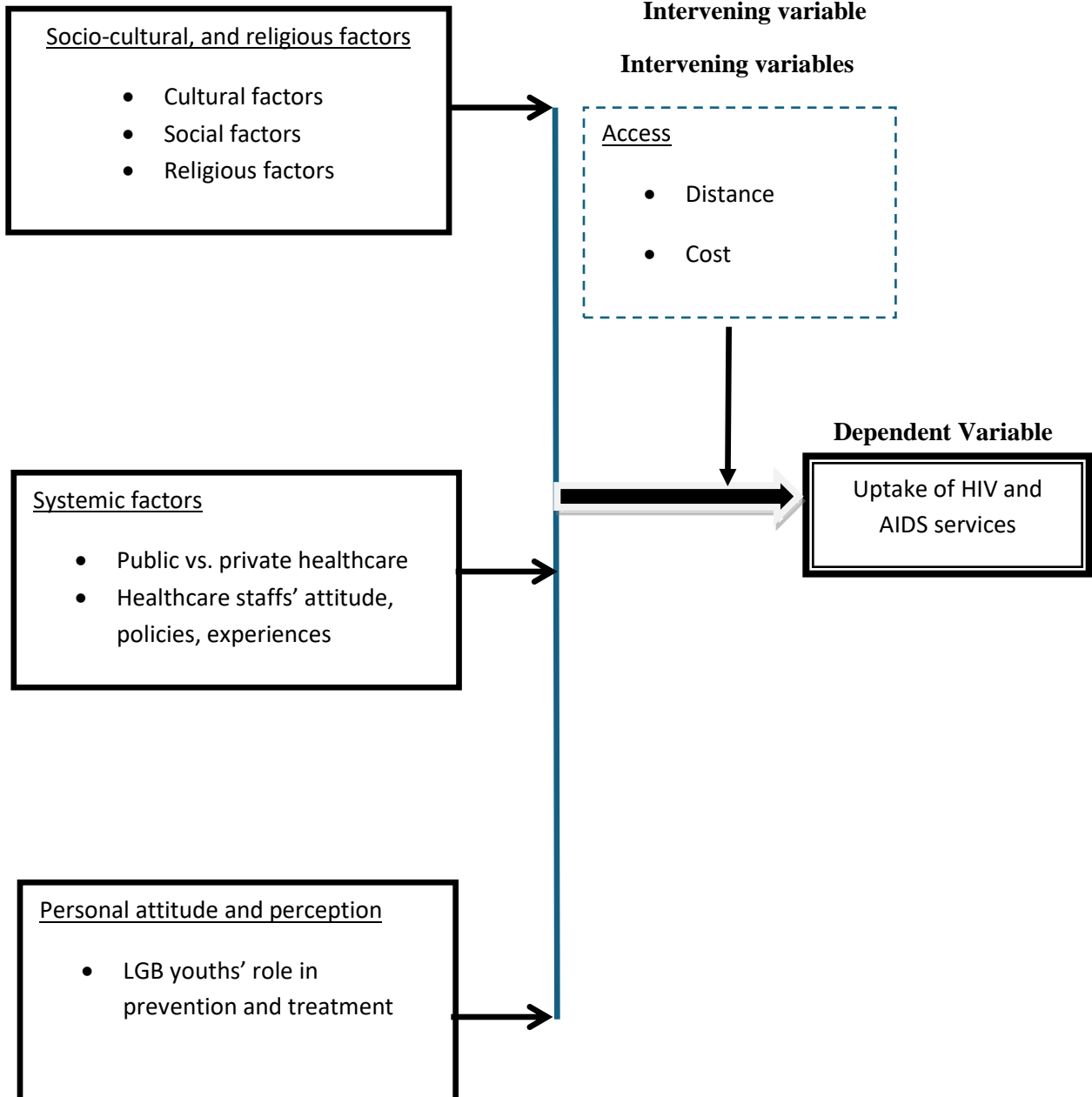


Figure 1.1 Conceptual Framework

Source: Adapted from (Sonya Arreola et al., 2012)

1.10 Theoretical framework (HBM)

The study was anchored on the Health Belief Model (HBM) which provides a robust framework for understanding the factors affecting uptake of healthcare services. By examining perceived severity, susceptibility, benefits, perceived barriers, cues to action, and self-efficacy, the study identified the key determinants of healthcare utilization among the LGB community members. This understanding informs the identification, development of targeted interventions that can be scaled up to improve access and health outcomes among the population.

Further, by delving in socio-cultural factors, the study incorporated the understanding of the interplay between the attitudes and beliefs of the LGB youths and the societal role in influencing their health seeking behaviors.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The chapter discusses literature similar to or related to uptake of HIV and AIDS services among Lesbians, Gays or Bisexual Youths aged 18-35 years. It involves reviewing documents including past studies, articles, journals, reports, and other health publications.

2.2 Lesbian, Gay, and Bisexual in African context

The LGB is an acronym for Lesbians, Gays, and Bisexuals as a matter of sexual orientation. This study sought to investigate the uptake related to these specific individuals in accessing HIV and AIDS care hence bringing out the gaps that exist in the knowledge and utilization of these services.

Homosexuality has often been declared unAfrican and some depict the practice as a way to control the population iterated by African thought and political figures. The dominant belief is that homosexuality is born out of modern civilization and not a constituent of traditional African life. According to (Chrysogonus M. Okwenna, 2021), homosexuality can be traced to African roots; such practices have been documented among Zanzibars of East Africa, Hausas of West Africa, Ovagandjeras of Central Africa, and Herero, Ovambo and Ovahimba people of Southern Africa.

Despite tracing the act of same-sex relations to ages ago, some countries in Africa have abandoned sodomy laws while others have upheld the law with stiff punishment. Kenya has shown a glimmer of hope in legalizing same sex acts but ended up criminalizing homosexuality (Adeagbo & Naidoo, 2020). The increased presence of gays, lesbians, and bisexuals has become a life feature despite the HIV and AIDS epidemic with evidence

from countries in Europe, America and Africa repealing the anti-sodomy laws and advocating for legal equality of gays, lesbians, and bisexuals. According to (Odenbring, 2022) sexual minorities have been exposed to homophobic name-calling with physical violence and threats being common.

Being gay in Africa is a complex and multifaceted topic, as attitudes, legal frameworks, and societal acceptance towards homosexuality vary significantly across the continent. Lesbians, Gays and Bisexual individuals adopt the heterosexual lifestyle to fit in. Legislations prohibiting homosexuality have acquired increasing attention in Africa and worldwide, especially within the global human rights discourse. According to (Amusan et al., 2019), anti-homosexuality laws were formed by the dynamics within the realm of national politics, damaging societal outlook, and increasing religious reaction.

Non-governmental Organizations have been at the forefront of advocacy to raise awareness about LGBT rights and issues to influence the social processes that shape these attitudes to advance socio-political and economic change (Boryczka, 2020)

In Kenya, same-sex acts/relations are criminalized by law through section 162-165 of the Penal Code. Those questioning the penal code argued that the Bill of Rights supersedes it (A. K. Anangwe, 2023). Article 21(1) and (2) of the Constitution of Kenya states, “for instance, that it is the fundamental duty of the state and every organ of the state to observe, respect, protect, promote and fulfill the rights and fundamental freedoms of every citizen”. Article 27 also states that “the government 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”.

2.3 HIV and AIDS Services among Lesbian, Gay, and Bisexual youths

Health is a state of complete physical, mental, and social well-being. Reports from different human rights groups claim that the LGB members lack comprehensive health services and simultaneously lack access to service. (Lewis et al., 2023) illustrates the severity of violence, discrimination, and stigma among the LGB members and emphasizes the necessity for legalizing same sex sexualities.

Kenyan gay and bisexual men face intimate partner violence and stigma within facilities meant to support health (Lewis et al., 2023). These experiences have shown severe implications for the health and wellbeing of these key populations including mental, physical, reproductive, and sexual health. The Kenya Health Policy 2014-2030 provides for a complete rights-based approach to health services delivery, it is, therefore, important to differentiate the rights-based approach over the specific needs of the LGB community (Ministry of Health, Kenya, 2014).

In the light of the above, the key populations are at a higher risk of contracting HIV irrespective of the local context and the LGB face societal and legal challenges that advance their vulnerability. This increases the vulnerability of LGB youths to prevention, care, and treatment of the disease. (National Syndemic Diseases Control Council (2022) World Aids Day report., 2022)

HIV prevalence among the sexual minorities is higher at 18.2% than the general population (National Syndemic Diseases Control Council (2022) World Aids Day report.,

2022). The gay members in an aim to fit in the broader community and avoiding disclosure of their sexuality or HIV status engage in the heterosexual relationships and even marriage.

The National Aids and STI Control Programme (NAS COP, 2019) conducted a mapping exercise which revealed a total of 369 hotspots in Nairobi with an estimated 10,209 MSMs. Due to structural and legal challenges, the estimated number of gay, lesbian and bisexual persons is yet to be known.

2.4 Socio-cultural and religious barriers

Social support from family, community, culture, and religion has proven to be important in promoting the health community members. Studies have often revealed that social support is facilitated by a person's disclosure of perceived ailment or stigma from a particular condition. A study conducted by (Knight & Schatz, 2022) indicated disclosure and support from family and community are influenced by age, gender, and pre-existing vulnerabilities. The study revealed that family members support amplified access to HIV care and compliance with antiretroviral therapy.

Same sex desires in Africa have often been viewed in a negative light. Political leaders have used religious-based homophobic narratives as a means of distracting their deprived natives and citizens to master popular support. According to (Adeagbo & Naidoo, 2020), toleration of homosexual intimacy is viewed as threat to the main African definition of family, marriage and patriarchal gender and power relations.

LGB individuals have faced stigma and physical harm from religious institutions, workplaces, educational and healthcare facilities. This impacts their lives including their

physical health, sexual health, mental health, socioeconomic status, and limited access to health promotion. Gay men in Kenya have experienced violence, severity, stigma, and discrimination, hence emphasizing the need to decriminalize same sex and improve interventions that support health and wellbeing (Lewis et al., 2023).

Identifying as Lesbian, Gay or Bisexual is not hazardous whether genetically, physically or biologically; the societal homophobia, fear, and hatred for people attracted to the same sex conveys risk factors for these people. An exploratory study conducted among sexual minority women of Latin and African descent revealed that the members' challenges in the uptake of health services were largely influenced by the discriminatory treatment by health care providers. They further found out that family members' encouragement was crucial in influencing their health behaviors such as delaying care (Cerezo et al., 2023).

The civil society groups in Kenya have been vocal in amplifying the issues faced by the LGB community, for instance, physical violence, mental health challenges, home eviction, social stigmatization, and isolation. A study by (Jauregui et al., 2021) suggested that there may be a relationship between violence and mental health among the sexual and gender minorities in Kenya. The study added that there is substantial human rights violations and systemic discrimination, yet not much has been done to document the mental health impact of these experiences.

Culture and religion are among the factors affecting behavior as they determine accepted behaviors, value systems, beliefs, and norms. Christianity and Islam have argued that sexuality is the crucial moral issue in Africa, hence being successful in diverting attention from real and key issues. This is a political act and must be recognized as such (Green,

2021). Religion and associated beliefs are the roots of community life in many African societies. Religious beliefs control and guide many aspects of life especially regarding sexuality. Some of the religions and denominations advocate for acceptance of LGB members while some seek to help them navigate their sexuality. According to (Stephen Mwendia Francis, 2023), a pastor has much to learn from science and psychology especially how nature influences people's sexuality in complex ways. A case study conducted by (Van Klinken, 2019) demonstrated that Kenyan traditions and Christian beliefs and practices are being nurtured and altered to allow for queer Kenyan Christian discussions hence opening avenues for rethinking the relationship between Christianity and queer activism in Kenya and Africa. According to (Martin Mutai, 2022), religion is mandated to safeguard the sanctity of marriage, and the church is averse to accepting homosexuality, but at the same time welcomes the LGBT members to worship.

2.5 Systemic Barriers

The Kenyan constitution (2010) provides for equal rights as well as SDG goals. The third SDG calls for good health and well-being. It is therefore necessary to say that the health care system is an essential factor in the utilization of HIV and AIDS services.

The Kenyan policies against homosexuality are discriminative and denies the LGBT persons from even having a freedom of expression. There appear contradictory approaches by the law between constitutional provisions and sections 162-265 of the penal code. The fourth estate has had a notable influence in enhancing the visibility of the LGBT community by giving them airtime and attention to the LGBT discourse in Kenya (Martin Mutai, 2022).

Outlawing same-sex acts/behaviors has triggered fear of the LGB individuals to access health care services from the public health facilities. A study conducted by (Fauzia Nyanje, 2020) revealed that sensitization is still minimal among the gay community in Kenya and suggested multiple ways of conducting HIV sensitization such as enhancing communication from healthcare providers and training programs about HIV infections and transmission.

There are no all-inclusive HIV health care services for the sexual minority in the Kenyan health system. Refugees in Nairobi have a challenge accessing health care due to their refugee status and risks of discrimination and breach of confidentiality in many clinics. Nevertheless, many facilities run by NGOs provide nondiscriminatory services to sexual minorities (Misedah et al., 2021). A study conducted by (Ng'ang'a Emma Wangari, 2019) also revealed that LGBT issues has not been prioritized by the law and society hence state's inability to safeguard LGBTs and selective application of the constitution.

LGB individuals undergo several reactions including embarrassment, derogatory comments, breach of confidentiality, unfriendliness, intrusive questioning, and rough handling. A study by (Mkhize & Maharaj, 2020) explained that students experienced health services to be heteronormative and information presented in most health institutions didn't address issues of sexual minorities. This leads to an impact on mental and general wellbeing affecting the health seeking behaviors in the public health system and eventually physical and psychological harm.

2.6 Personal Attitudes and Perception base of the LGB individuals

Previous studies have shown that HIV and AIDS prevalence among the members of key population is on the rise despite the considerable reduction among the general population. Most of the members of the LGBT umbrella abuse alcohol and other drugs as a coping mechanism to stigma and networking among themselves. A study conducted by (Logie et al., 2020) discovered that the abuse of alcohol and other drugs in Lesotho elevated HIV vulnerabilities by reducing the uptake and use of condoms.

The LGBT community perceives themselves to be at risk of contracting HIV due to engagement in commercial/transactional sex, influence of alcohol and not using protection such as condoms. Negative attitude towards condom use, social pressures and environmental barriers are related to LGBT not engaging in safe sex. This is important to consider when developing and implementing prevention policies that address the LGB community members' perception and attitude (Mbilizi Chimwaza et al., 2022).

Migrants of sexual minorities have different needs in comparison to local minorities. A study by (Yarwood et al., 2022) indicated that there is a need to customize service access and ways to respond to their health and protection needs. The sexual minority persons sought to have non-judgmental healthcare providers and who were knowledgeable about their special needs. According to (Mwaniki et al., 2022) who conducted a qualitative study of healthcare engagement, the gay, bisexual and men who have sex with men (GBMSM) also preferred digital media in seeking telemedical consultation and health education.

2.7 Summary of knowledge gap

The risks of contracting HIV infection among the LGB youths are high as compared to heterosexual youths and this translated to increasing rates of HIV infection among the group. It is noted that there has not been increased intervention targeting this population. In Kenya, this population was not recognized in the 2019 census hence lacking the data to support any kind of intervention based on the needs. Several studies have explained the importance of access to health services without facing stigma and judgement, and access to safer sex methods as primary concerns around sexual health. The findings of this study appropriately bridge the gap and contribute to informing strategies and interventions that meet the specific needs of the LBG population.

CHAPTER THREE: MATERIALS AND METHODS

This chapter presents the study design, site description, targeted population, inclusion and exclusion criteria, sampling selection and procedures, sources of data, methods and tools of data collection, analysis, and ethical consideration.

3.1 The research design

The study employed a analytical cross-sectional design, involving qualitative and quantitative research methods to provide a snapshot of the study population. The study described the relationships between independent and dependent variables, how the socio-cultural, religious, and systemic factors, personal attitude and perception and interventions to be scaled up influence the HIV and AIDS services uptake among the LGB youths in Nairobi County.

3.2 Study area/Location

The study was conducted in Nairobi City County bordering Kiambu County both on the west and northern sides, Machakos County on the East and Kajiado County on the south. It is the smallest (696 km²) of all counties in Kenya but with the most significant population to this study. The researcher conducted the study in the Nairobi which was purposively selected due to the numerous hotspots frequented by the study population such as recreation centers and hidden enjoyment facilities.

Nairobi has a population of 4.3 million people, out of this, the youth aged 15-24 years constitute 18.83% (KNBS, 2019).

Nairobi, Kenya is perceived as a glimmer of hope among the target population due to efforts to support and uplift the LGBTQ+ community. Human rights organizations,

activists and allies are based in Nairobi advocating for more inclusive policies and non-discriminatory attitudes. However, promoting their rights and acceptance is a gradual process hence the LGB community remains hidden in Nairobi.

3.3 Study population

The study targeted the youths who confidently identified themselves as lesbians, gays, and bisexuals between the ages of 18- 35 years in Nairobi County. The study focused on the defined 18-35 age of youth according to the African youth charter to gather a more significant sample distributed by age (African Union, 2006). In addition, allied stakeholders participated in key informant interviews and provided credible insights.

3.4. Sampling techniques and Sample size

3.4.1 Sampling techniques

Lesbians, Gays and Bisexual individuals are members of groups registered as community-based organizations (CBOs), Peer Groups, Human rights organizations, and welfare organizations (Kenya Human Rights Commission, 2011). The researcher interacted with the organizations and hotspots to reach the sample population.

The researcher used purposive sampling to determine the hotspots and the key informants to be interviewed. The study employed a snowballing sampling technique to obtain the sample population due to the unknown nature of the target population. Several snowballs' chains were started through the aid of the allied organizations, at several hotspots and finally, the researcher applied virtual snowball sampling to strengthen the respondents' base.

3.4.2 Sample size

The researcher intended to reach approximately 100 respondents after careful observation of the nature of respondents, confidentiality issues and lack of verifiable data on the total number of LGB youth in Nairobi.

(Lwanga, Stephen Kaggwa & Lemeshow, Stanley, 1991) developed this formula to calculate sample size in one sample situation by approximating a population proportion (P) with specified relative precision (ϵ), with a 95% confidence level. The researcher used this formula due to lack of data indicating the number of Lesbian, Gay, and Bisexual youth in Nairobi County.

The sample size was arrived at as shown below

$$n = z^2(1 - \alpha/2) (1 - P) / \epsilon^2 P$$

n: sample size

z: z-score that correspond to an alpha level

α : alpha level: a criterion for accepting or rejecting a null hypothesis

P: projected population proportion

ϵ : relative precision

Confidence level: level at which the researcher is confident with rejecting the null hypothesis

In this study;

$$P = 95\% = 0.95$$

$$\epsilon = 5\% = 0.05$$

$$\text{Confidence level} = 95\%$$

$$z(1 - \alpha/2) = \pm 1.96$$

Thus, $n = (\pm 1.96)^2 (1 - 0.95) / (0.05)^2 = 0.95 = (3.8416) (0.05) / 0.002375 = 80.87 \approx 81$

An allowance of 10% was added to cater for attrition, hence a sample size of **89**.

The researcher issued questionnaires and 84 were correctly filled and returned; 5 key informants were interviewed.

3.5 Data Collection Tools/Instruments

All LGB identifying youths who gave free consent to participate in the study were issued with a semi-structured questionnaire for self-administration. Key informants for the study who included health service providers, Civil Society Organization officials, Community Based Organization officials, Human Right Defenders and activists were interviewed using a key informant interview guide.

3.6 Pre-test

The tools were pretested for completeness, accuracy and to determine the approximate time required to complete a questionnaire among a set of volunteers from the key population who share similar characteristics with the study population. The unclear and ambiguous questions were revised and rephrased. The pretest was conducted in Kayole Diwopa grounds attracting 10 participants through a focus group discussion, who aided in identifying potential biases, cultural sensitivities, and social desirability biases.

3.6.1 Validity

Respondents provided feedback during pretesting which aided in testing the understanding of the instrument. The format and flow of the questions was carefully

organized per objectives to enhance the validity. A mixed method approach combining in-depth and questionnaire strengthened the validity.

3.6.2 Reliability

Data reliability was enhanced by pretesting whereby any questions that were offensive to the population, ambiguous and unclear were eliminated or revised. The research protocol was reviewed by experts in the field and supervisors.

3.7 Data collection techniques

The pretested data collection tools included the questionnaire and an interview guide for the key informants. The researcher visited the identified hotspots and other locations frequented by the study population. Once consent was given, the researcher issued the self-administered questionnaires. The respondents then referred the researcher to other respondents and/or hotspots. The researcher also utilized social media for a virtual snowball which strengthened the respondents reach.

The key informant interviews were administered by the researcher to ensure efficiency and effectiveness. They were purposively selected due to their conversance with issues of Key Population particularly the LGB subset.

3.8 Data analysis

The quantitative data from the study was cleaned, coded, and entered into an excel database after which Stata15 was used to generate descriptive statistics such as frequencies, percentages and proportions of the independent variables. Cross tabulation was used to compare the outcome of different variables and Spearman's correlation

coefficients was used to assess the strength and direction of variables. Qualitative data from the key informant interviews was summarized and a thematic analysis conducted giving deeper insight to the fourth research question on identification of interventions to be scaled up. Data collected was stored in a password protected database only available to the researcher.

3.9 Inclusion and Exclusion criteria

All youths identifying as either Lesbian, Gay or Bisexual, and who gave informed written consent were included in the study.

Youths identifying as lesbian, gay or bisexual who were unwell to participate were excluded from the study.

3.10 Ethical and Community Considerations

The researcher sought clearance and approval from Kenyatta University graduate school, Kenyatta University Ethical Review Committee (KUERC) and National Commission for Science, Technology, and Innovation (NACOSTI). Voluntary and informed consent was sought from the respondents who were also assured of their confidentiality. To enhance the confidentiality, the participants were encouraged to use pseudo names while ensuring that the data was stored in password protected database only available to the researcher.

The LGB being a sensitive and hard to reach population, the community was assured of their anonymity, non-discrimination, and reinforcement of their human dignity.

CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter presents results on the uptake of HIV and AIDS services by the Lesbian, Gay and Bisexual identifying individual in Nairobi City County.

4.2 Response Rate

The study achieved a response rate of 94% despite the challenging political environment in the country and neighboring countries. A total of 84 participants were recruited.

4.3 Demographic Characteristics of the respondents

Table 4.1 Socio-demographic characteristics of the respondents

| Variable | Category | Frequency | Proportions (%) |
|-----------------------------------|---|-----------|-----------------|
| Age (Years) | 18-24 | 27 | 32% |
| | 24-30 | 36 | 43% |
| | 30-35 | 20 | 24% |
| | Above 35 | 1 | 1% |
| Gender | Male | 41 | 49% |
| | Female | 34 | 41% |
| | None of the genders | 9 | 10% |
| Level of education | Primary education | 0 | 0 |
| | Secondary education | 28 | 33.3 |
| | Tertiary education | 56 | 66.7 |
| Nationality | Kenyan | 71 | 85 |
| | Non-Kenyans | 13 | 15 |
| Migration reasons for non-Kenyans | Forced migrant/asylum seeker/refugee | 13 | 100 |
| | Willing visitor to Kenya (tourism, education) | 0 | 0 |

The majority, 43% (36) of the respondents were aged between 24 – 30 years old followed by those within 18-24 years old 32% (27), and those between 30 – 35 years old accounted for 24% (20). 49% identified as male while 10% did not identify with any gender. The level of education level among the target population; 61% (56) have attained tertiary education level whereas 33% (28) have attained secondary education. The findings, however, indicated that none of the respondents was uneducated.

According to the findings, majority (85%) of the respondents were Kenyans by nationality and 15% identified as Ugandan nationals. The 15% also classified themselves as either forced migrant, asylum seeker or refugees.

Table 4.2: Employment, religion, and sexual orientation of respondents

| Variable | Category | Frequency | Proportions (%) |
|--------------------|--------------------|-----------|-----------------|
| Employment status | Employed full time | 21 | 25 |
| | Employed part time | 13 | 15.5 |
| | Self Employed | 27 | 32.1 |
| | Unemployed | 23 | 27.4 |
| Sexual orientation | Bisexual | 18 | 21.4 |
| | Gay | 36 | 42.9 |
| Religion | Lesbian | 29 | 34.5 |
| | Transgender | 1 | 1.2 |
| | Christian | 62 | 73.8 |
| | Muslim | 22 | 26.2 |
| | Hindu | 0 | 0 |
| | Rasta | 0 | 0 |
| | | | |

According to the findings, the majority of the respondents were employed full-time/part-time (25% and 15% respectively, whereas 32% were self-employed. The majority 74% were Christians by religion and Islam 26%.

The findings indicated that majority (43%) of the respondents identified as gay, 35% identified as lesbians and the bisexual accounted for 21%.

4.4 Personal attitude and perception base affecting utilization of services among the LGB youths.

4.4.1 Information adequacy

Overall, 61% of the respondents have adequate information on HIV and AIDS prevention, transmission, and treatment.

“...yes, I understand how HIV spreads and how to prevent it. I also know about the treatments available for HIV...”

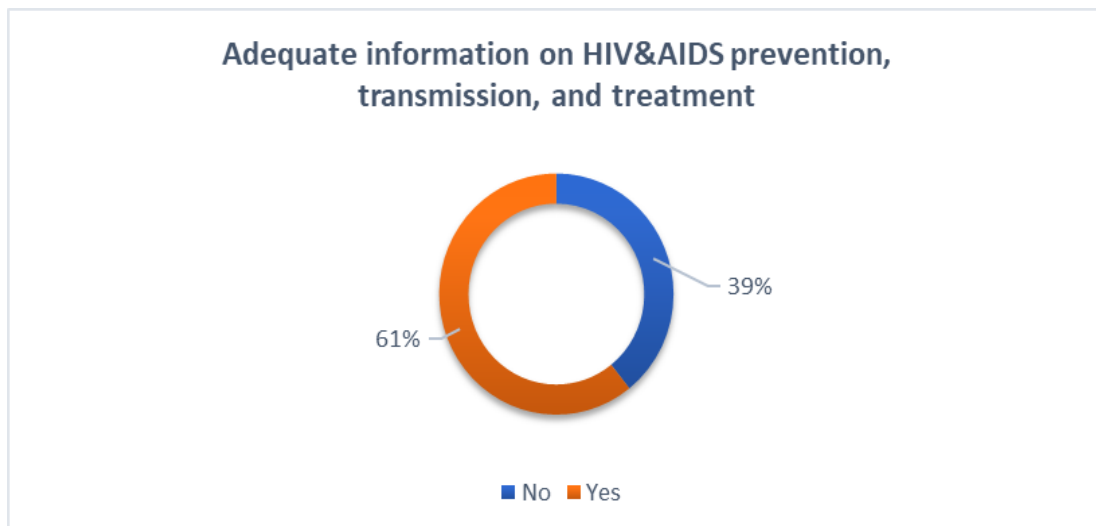


Figure 4.3: Adequacy of information on HIV and AIDS prevention, transmission, and treatment

4.4.2 Access to HIV and AIDS services within the last six months

Overall, the majority (86%) respondents had access and received HIV and AIDS services within the last six months.

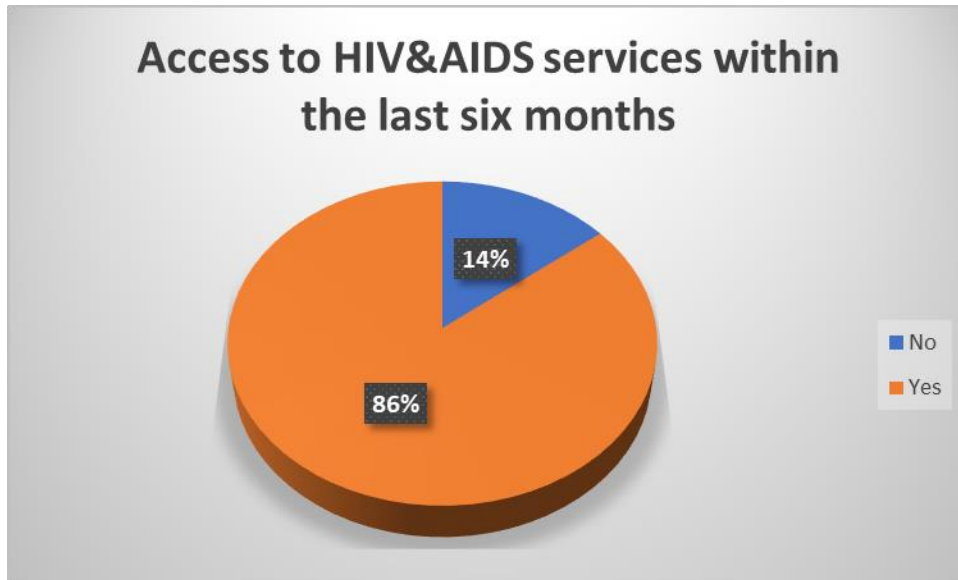


Figure 4.4: Access to HIV and AIDS services within the last six months

4.4.3 Number of sexual partners within the past six months to the study

According to the findings, the majority (57%) of the respondents have engaged in sexual activities with more than one sexual partner over the last six months. 43% have only engaged with one sexual partner.

“...I'm single, so I can have multiple sex partners...”



Figure 4.5: Engaged with more than one sexual partner over a period of the last six months.

4.4.4 Knowledge of respondents HIV and AIDS status

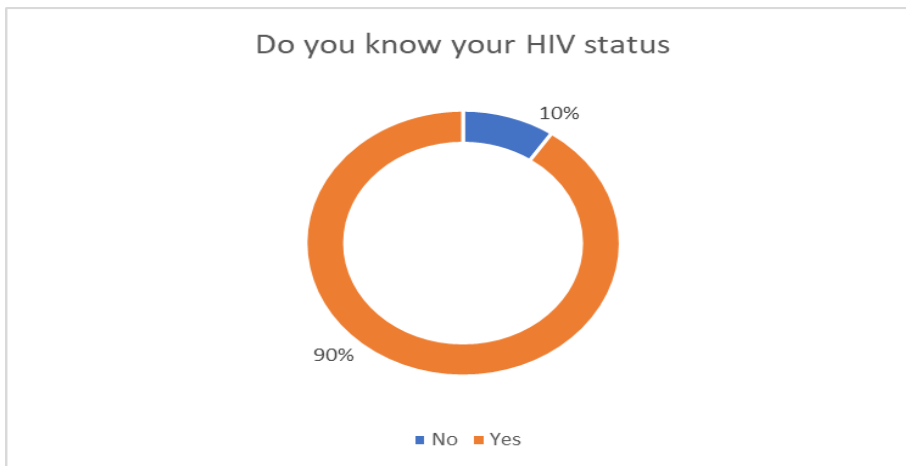


Figure 4.6: Do you know your HIV and AIDS status.

The majority, 90% (76) are aware of their current HIV and AIDS status whereas 10% (8) were not aware of their status.

4.4.5 Use of protection during sex

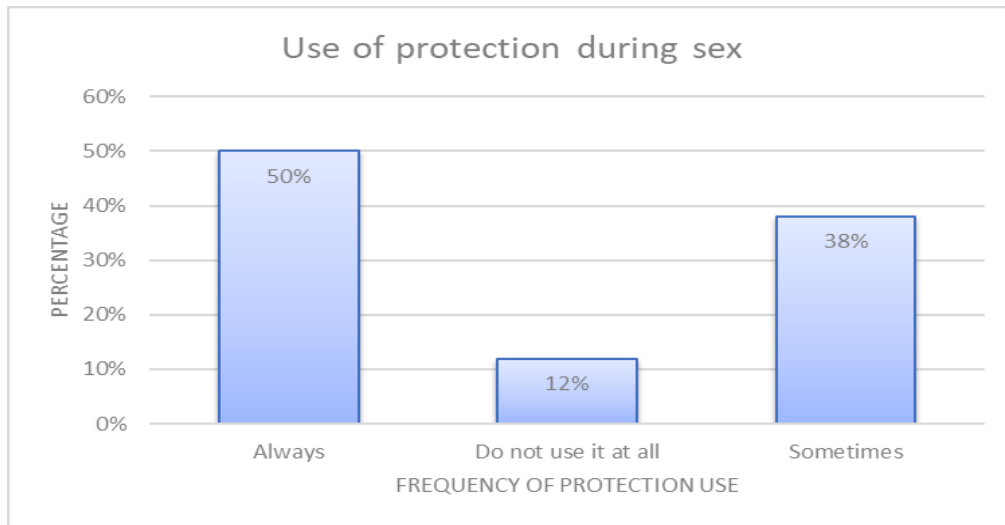


Figure 4.7: Respondents use of protection during sex

50% (42) of the respondents indicated that they always use protection during sex, 38% (32) engage in unprotected sex whereas 12% (10) use protection sometimes.

Upon enquiring the reason for not using protection, majority indicated that they have one sexual partner, 32% were under the influence of drugs and alcohol, whereas 5% argued that the condoms reduce the pleasure.

“...when I'm out partying and drinking, I sometimes have unprotected sex because I get carried away in the moment...”

4.4.6 Respondents reasons for not using protection.

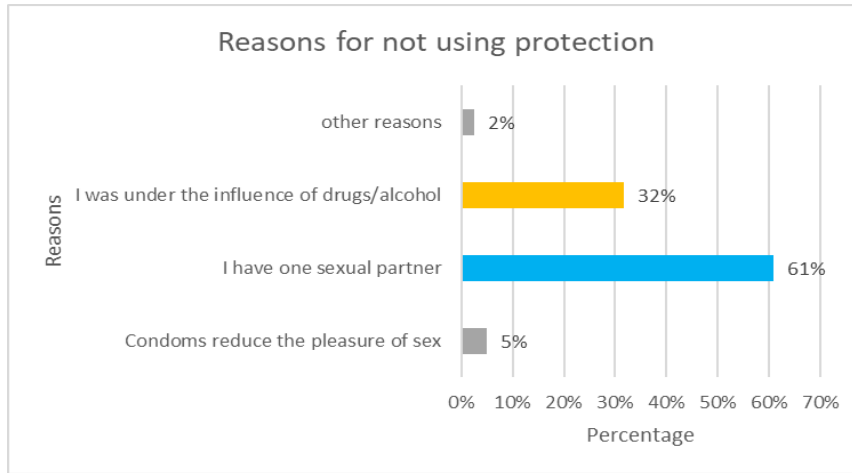


Figure 4.8: What is your reason for not always using protection.

Table 4.3: LGB perception and attitude in relation to uptake of HIV and AIDS services

| Uptake of HIV and AIDS services | Spearman's rho (ρ) | Prob > t | obs |
|--|---------------------------|-----------|-----|
| LGB knowledge of HIV and AIDS services | 0.0498 | 0.6531 | 84 |
| LGB sexual behaviour | -0.0589 | 0.5944 | 84 |
| LGB youths' awareness of HIV status | 0.4470 | 0.0001 | 84 |

Table 4.3 provides a summary of the spearman's rank correlation coefficient result for LGB perception and attitude in relation to the uptake of HIV and AIDS services. There is a very weak positive correlation between uptake and knowledge of HIV and AIDS services ($p > 0.05$, $\rho = -0.0498$), correlation was not statistically significant therefore no association. The findings showed a weak negative correlation between uptake and sexual behavior ($p > 0.05$, $\rho = -0.0589$). On the other hand, findings showed a positive correlation between the uptake of HIV services and knowledge of one's HIV status ($p > 0.05$, $\rho = 0.4470$). The findings indicated no strong evidence to support meaningful association and therefore fail to reject the null hypothesis.

4.5 Socio-cultural and religious factors affecting the uptake of HIV and AIDS services among the LGB youths.

4.5.1 Experience of social injustices

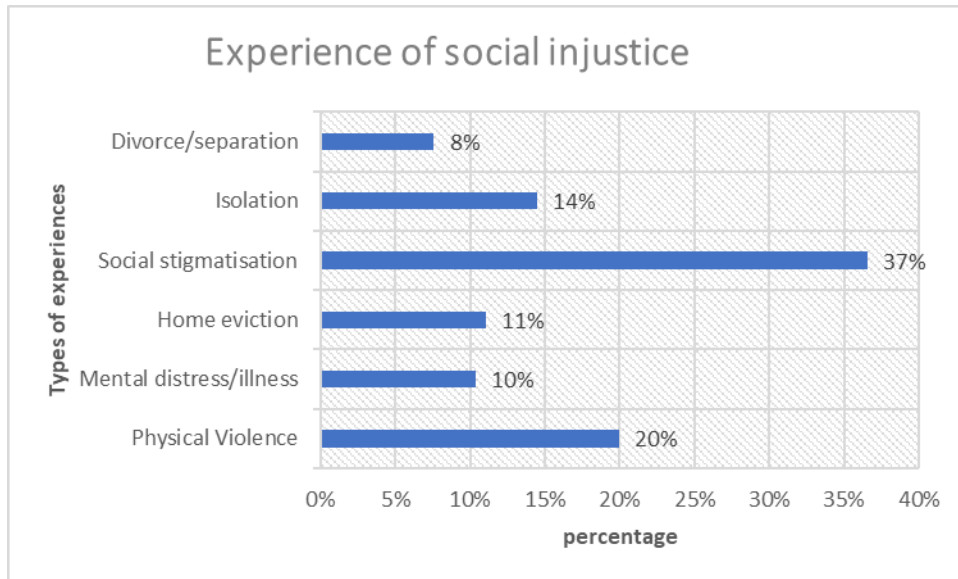


Figure 4.9: experiences of social injustices.

According to the findings, the majority 37% have experienced social stigmatization, 20% have experienced violence, 14% have experienced isolation, 11% have experienced home eviction, 10% have experienced divorce/separation. From the findings, 98% of the respondents attributed the above experiences to their sexual orientation whereas 2% did not associate it with sexual orientation.

“...my neighbors beat me up one day because they thought I was doing something with another man. It messed me up. I started keeping to myself, feeling scared and ashamed. It's hard to trust people after that...”

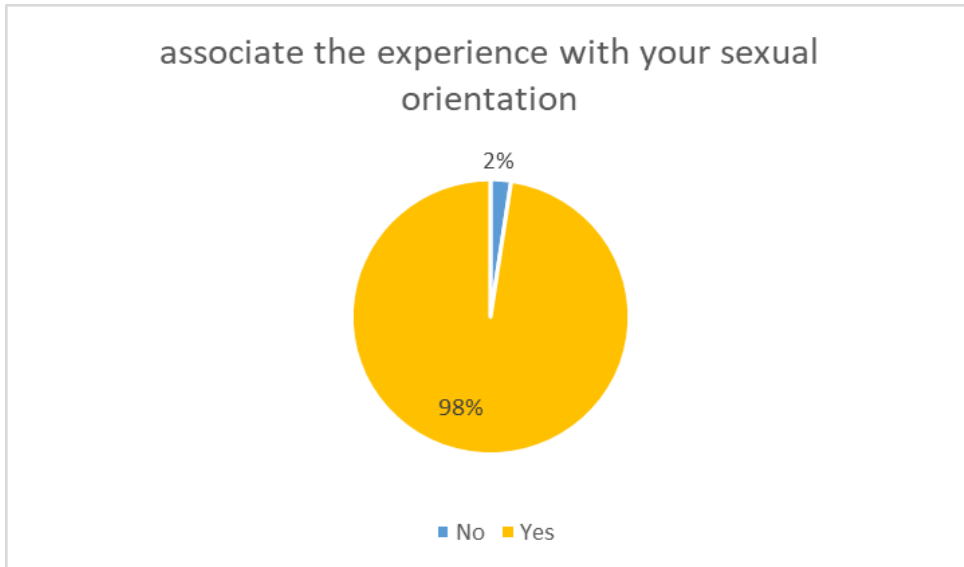


Figure 4.10: association between the experiences and sexual orientation

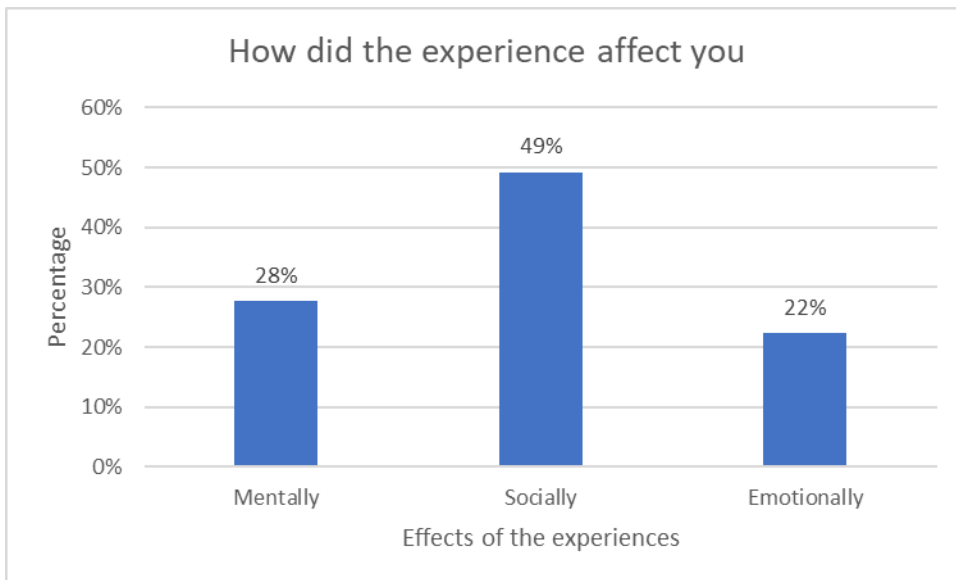


Figure 4.11: effects of the experiences

A majority 49% indicated that the experiences affected them socially, 28% agreed that it affected them mentally and 22% agreed that they were affected emotionally.

4.5.2 Support of the family to seek medical services regardless of their orientation.

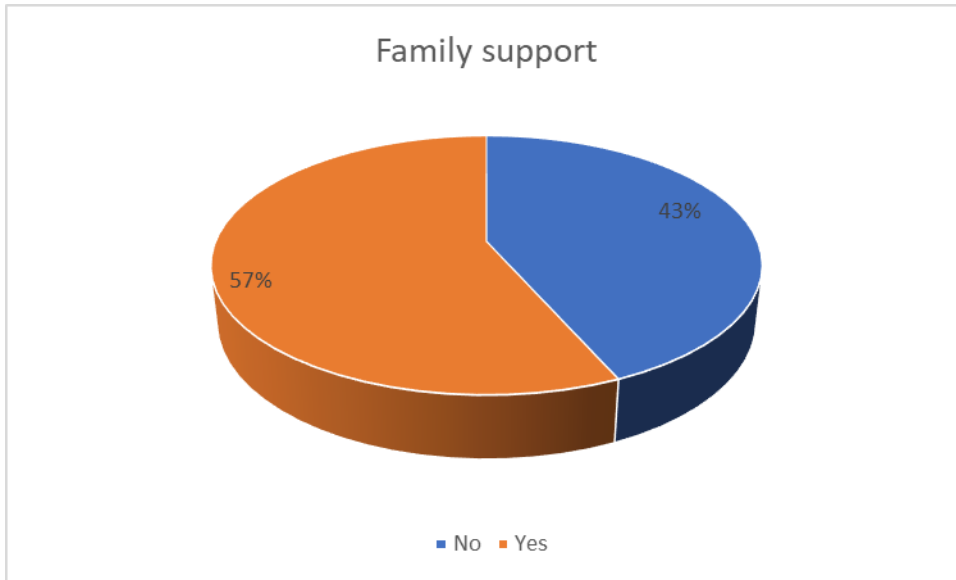


Figure 4.12: Family support in seeking HIV and AIDS services

The study sought to find out the family support available regardless of the sexual orientation. The majority 57% agreed that the family encouraged them to seek medical services regardless of the orientation. e.g these services included HIV and AIDS prevention and care services.

“...despite my sexual orientation, my family has been incredibly supportive. They've always encouraged me to be myself and have never judged me for who I am. This includes being supportive of my decision to seek out health services such as HIV and AIDS...”

4.5.3 Cultural perception of Lesbian, Gay and Bisexual persons.

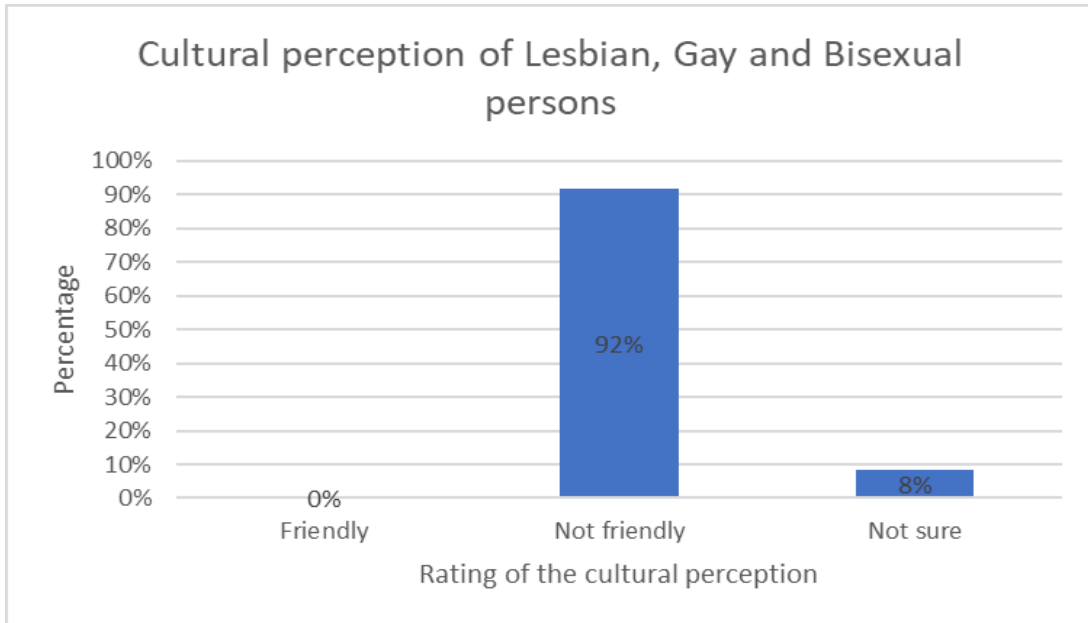


Figure 4.13: cultural stand on Lesbian, Gay and Bisexual persons

From the findings, the majority 92% (77) indicated that their culture is not friendly to the LGB individuals and 8% were not sure of their culture's receptiveness to LGB issues.

Upon further inquiry, 71% agreed that the culture discourages free access to services by an LGB identifying individual.

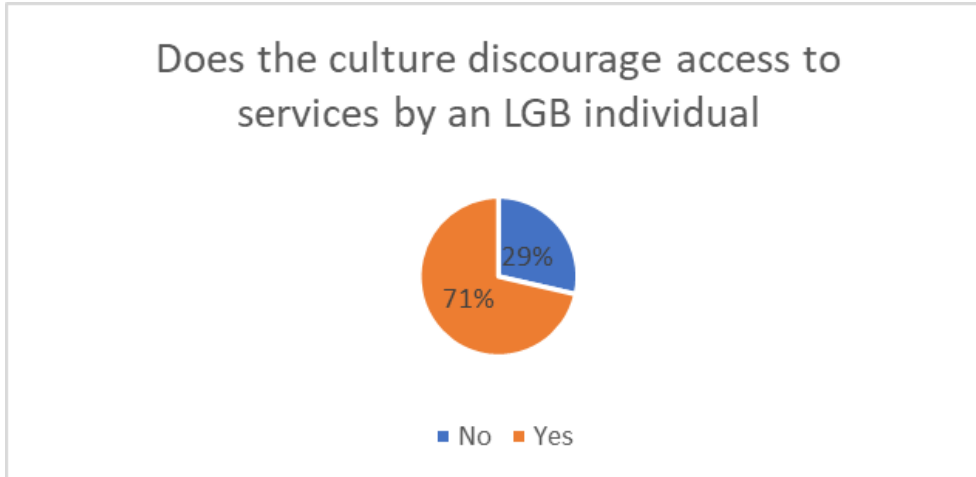


Figure 4.14: Does the culture discourage LGB individuals from accessing services.

4.5.4 Religious perception of Lesbian, Gay and Bisexual identifying persons.

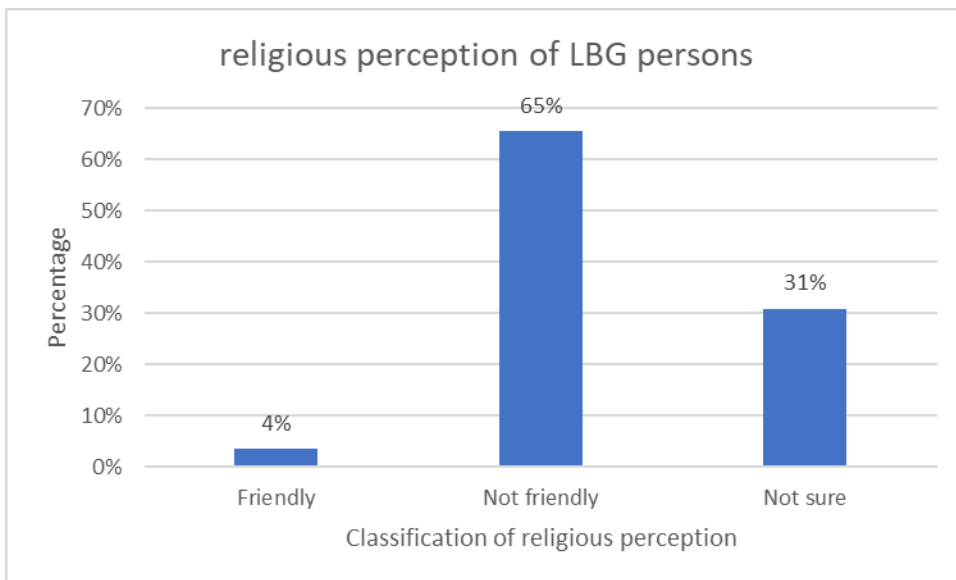


Figure 4.15: religious stand on the Lesbians, Gay and Bisexual identifying persons

According to the findings, the majority 65% (55) indicated that their respective religions were not friendly to the Lesbians, Gay, and Bisexual individuals, 31% (26) were not sure of their religions take on LGB whereas 4% agreed that their religion was friendly.

Upon further enquiry, 63% agreed that their respective religion encourages access to HIV and AIDS services for the LGB identifying individuals.

“...my priest and fellow encourage open dialogue about the issues and promote access to HIV and AIDS services for the queer community, demonstrating a commitment to love and compassion for all...”

“...I'm not quite sure where my Christianity stands on LGBT issues, and it feels like my priest and others in the congregation are always planning to pray for my 'sexual orientation'...”

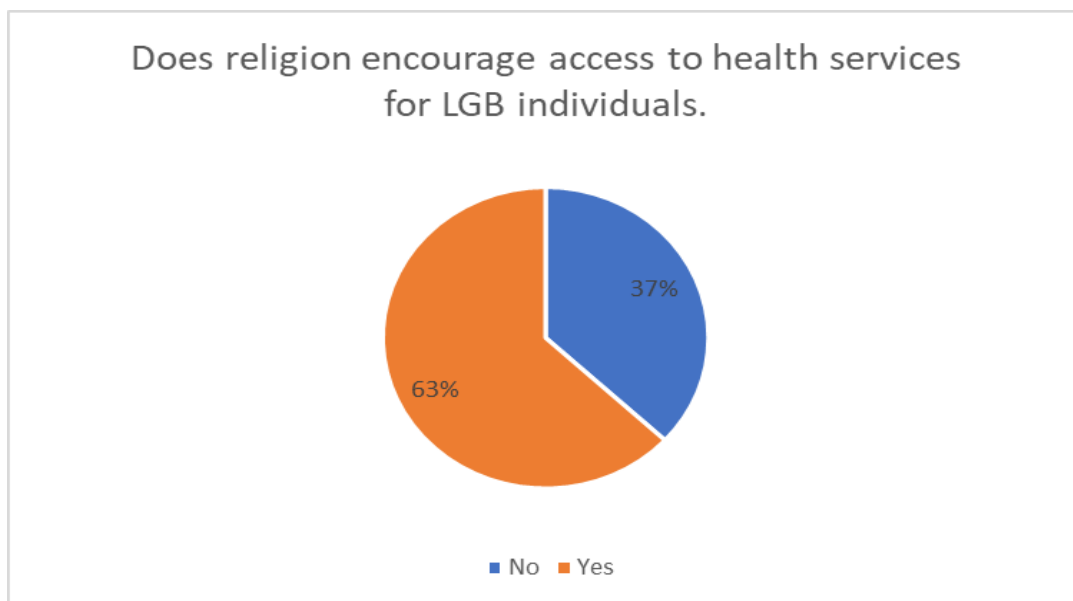


Figure 4.16: does religion encourage access to HIV and AIDS health services

Table 4.4 Social cultural factors in relation to uptake of HIV and AIDS services

| Uptake of HIV and AIDS services | Spearman's rho (ρ) | Prob > t | Obs |
|--|---|----------------------|------------|
| Family support | 0.0833 | 0.4541 | 83 |
| Cultural support | 0.1936 | 0.0776 | 84 |
| Religious support | -0.1007 | 0.3620 | 84 |
| Experience of societal stigmatization | 0.1712 | 0.1194 | 84 |

Table 4.4. summarizes the spearman's rank correlation coefficient result of socio-cultural factors in relation to uptake of HIV and AIDS services. There is weak positive correlation between uptake of HIV and AIDS services and family support ($p > 0.05$, $\rho = 0.0833$). Cultural support and uptake of HIV and AIDS were positively correlated ($p > 0.05$, $\rho = 0.1936$), uptake of HIV and AIDS services and religious support were negatively correlated ($p > 0.05$, $\rho = -0.1007$), weak positive correlation between uptake of HIV and AIDS services and societal stigmatization ($p > 0.05$, $\rho = 0.1712$). The findings indicated no strong evidence to support a meaningful association between the variables, therefore fail to reject the null hypothesis.

4.6 Systemic factors in health care that influence the uptake of HIV and AIDS services among the LGB youths.

4.6.1 Access to public or private health facilities

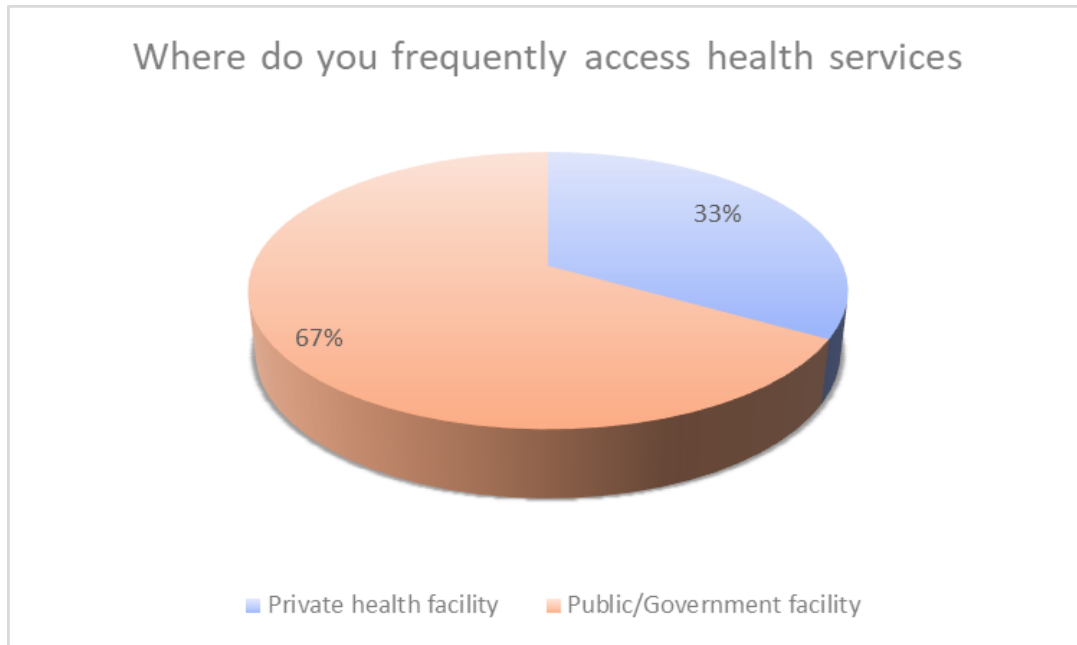


Figure 4.17: where the LGB access health services

The majority 67% (56) of the respondents frequent the public/government owned facilities for health services whereas 33% (28) frequent the private owned health/non-governmental facilities.

4.6.2 Receptiveness of facilities in Nairobi

Table 4.5: Receptiveness of facilities in Nairobi city county

| | Public facilities | Private facilities |
|--------------|-------------------|--------------------|
| Friendly | 5% | 61% |
| Not friendly | 71% | 21% |
| Not sure | 24% | 18% |

According to the findings, the majority 71% of respondents who frequently seek services from public facilities indicated that the facilities were not friendly to the LBG identifying youths whereas 24% were not sure. On the other hand, 61% of those who frequently sought services from private health facilities indicated that they were friendly to the LBG identifying youths.

4.6.3 Experience of injustice while seeking HIV and AIDS services

The majority 87% (73) of respondents agreed that they have suffered from a form of injustice when seeking HIV and AIDS services such as stigma and discrimination. 13% have not experienced any form of injustice while seeking HIV and AIDS services.

Upon further inquiry, 89% of those who've experienced any form of injustice attributed it their sexual orientation.

“...When I went to the public clinic for HIV/AIDS testing, the nurses treated me differently because I'm gay. They seemed judgmental, whispered among themselves, and even refused to make eye contact...”

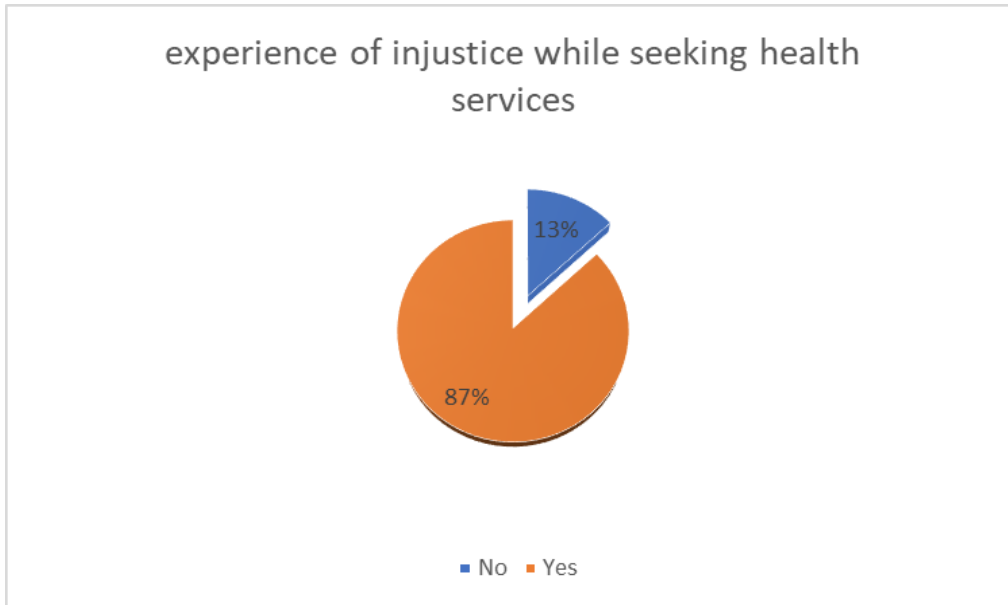


Figure 4.18: experiences of injustice while seeking health services

4.6.4 Access to preventive HIV and AIDS services.

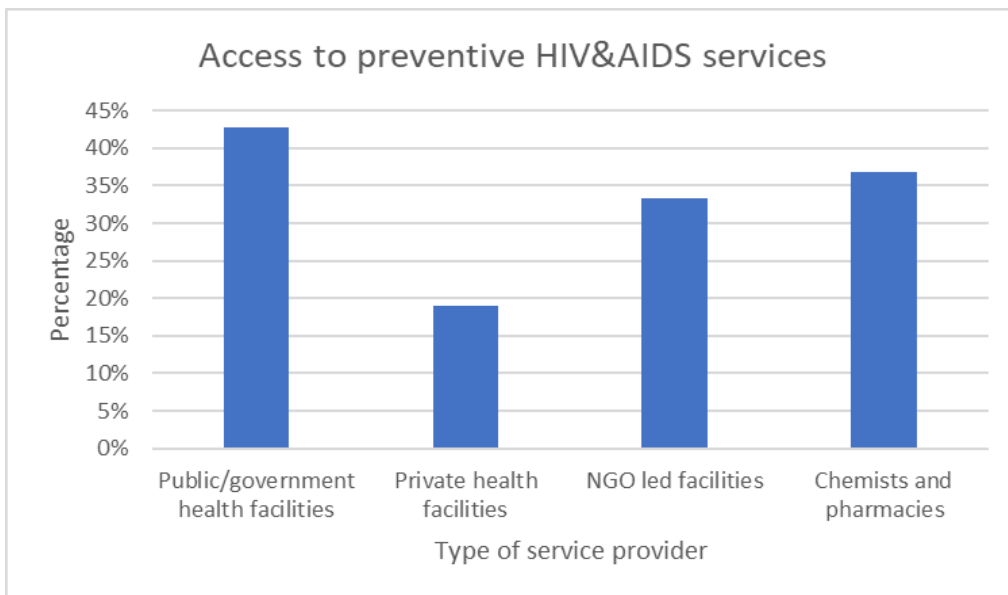


Figure 4.19: Access to preventive HIV and AIDS services

According to the findings, majority 43% access preventive health services such as free condoms from public/government health facilities, 37% access the products from chemists and pharmacies, 33% prefer the NGO led facilities and 19% from private health facilities.

4.6.5 Facilities providing non-discriminatory services.

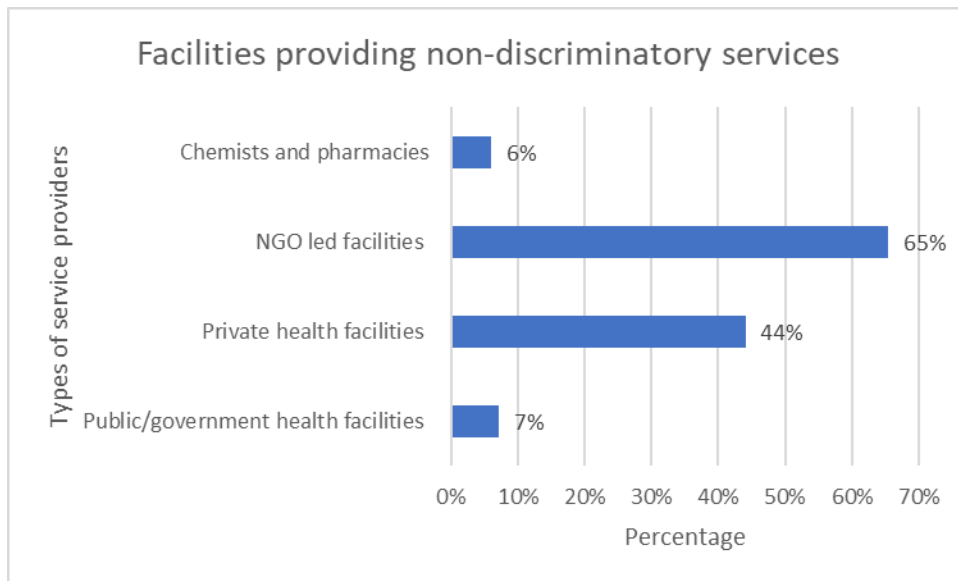


Figure 4.20: Facilities providing non-discriminatory services

According to the findings, the majority 65% agreed that NGO led facilities provide non-discriminatory services to the LGB identifying youths, 44% agreed that private health facilities, and only 7% agreed that the government facilities provide non-discriminatory HIV and AIDS services.

4.6.6 Health Care staff equipped to handle LGB identifying individuals.

According to the findings, 71% of the respondents agreed that providers in private health facilities are well equipped to handle LGB identifying individuals whereas 55% agreed that those in public facilities are equipped to handle the population.

“...doctors in private hospitals show a higher level of understanding and respect for queer individuals like me. They seem better prepared to address our unique needs. Unfortunately, the same cannot be said for public hospitals, where I've encountered discomfort and judgment from some providers...”

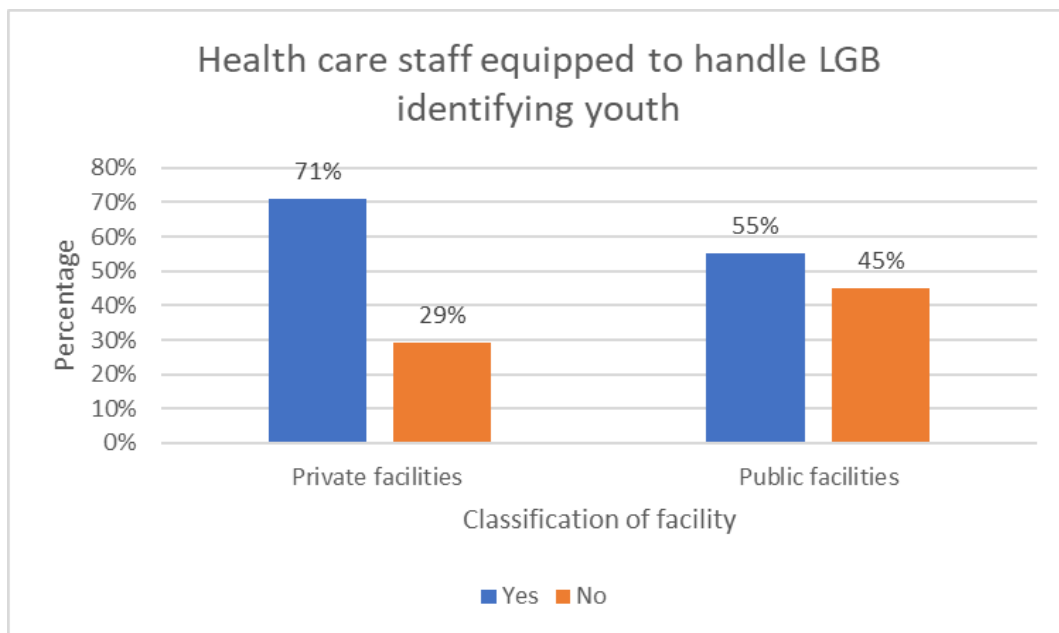


Figure 4.21: Health care staff equipped to handle LGB identifying youths

Table 4.6 Systemic factors in relation to uptake of HIV and AIDS services

| Uptake of HIV and AIDS services | Spearman's rho(ρ) | Prob > t | obs |
|---|--------------------------|-----------|-----|
| LGB experiences of systemic injustice | 0.0576 | 0.6026 | 84 |
| Healthcare staff being equipped to handle LGB | 0.1891 | 0.0850 | 84 |
| LGB services from public health facilities | 0.1132 | 0.3051 | 84 |
| LGB services from private health facilities | -0.0489 | 0.6584 | 84 |
| LGB services from Non-Governmental Institutions | -0.0102 | 0.9265 | 84 |

Table 4.6 summarizes the spearman's rank correlation coefficient results of systemic factors in relation to uptake of HIV and AIDS services by the LBG population. The findings indicated a weak positive correlation between the LGB experiences of systemic injustice and uptake of HIV and AIDS services ($p > 0.05$, $\rho = 0.0576$). Healthcare staff being equipped to handle LGB youths indicated a weak positive correlation with uptake of HIV and AIDS services ($p > 0.05$, $\rho = 0.1819$). LGB services at public health facilities indicated a weak positive correlation with uptake of HIV and AIDS services ($p > 0.05$, $\rho = 0.1132$), LGB services at private facilities indicate a weak negative correlation with uptake of HIV and AIDS services ($p > 0.05$, $\rho = -0.0489$), LGB services at Nongovernmental institutions indicated a weak negative correlation ($p > 0.05$, $\rho = -0.0102$). The findings indicated lack of strong evidence to support meaningful association and therefore fail to reject the null hypothesis.

4.7 Interventions to be scaled up to improve uptake of HIV services among the study participants.

According to the key informants, sexual minorities include persons with diverse sexual desires other than the norm. They comprise of a small group of people with sexual practices and preferences perceived to be far from normal. The Key informants also

identified the risks among the LGB individuals which included Co-STI contraction, mental health risks after diagnosis with HIV, school dropouts, hormonal imbalances, rectal cancer, drug abuse among others.

“...Unplanned pregnancies especially for bisexual women and STI contraction are just an example of the risks...”

From the qualitative data, some of the barriers that hinder access and utilization of these services include non-disclosure of sexual preferences, poor comprehensive and specific health care information for different identities, discrimination, and stigmatization of LGB, lack of specialists in targeted sexual reproductive health in public facilities and a high cost.

The data indicates that there are many factors that affect the upscaling of interventions. These include socio-cultural issues that condemn the practices and experiences of LGBs, legal and structural factors that criminalize same-sex acts through section 162 of the penal code, demonization of the minorities by politicians and leaders, medical insurance to cover all couples irrespective of sex, and education/skills of the health care providers.

According to the Key Informants, improving the uptake of HIV and AIDS services will involve training/refresher training of providers in both urban and peri urban areas, secondly, implementing the Key Population Policy Framework KP as provided by NASCOP which gives a clear picture of how sexually diverse groups should be treated, thirdly, developing a comprehensive curriculum that tackles all identities. Fourth, policy reforms to complement the current constitutional articles on the bill of rights fifth, evaluating the existing policies and lastly integrating some of HIV and AIDS services with sexual and reproductive health.

The qualitative analysis revealed the importance of community-based interventions, including peer education and support groups, in addressing stigma and providing accurate information. Additionally, the need for confidential and non-judgmental healthcare services was emphasized. Participants also called for increased advocacy efforts to decriminalize same-sex relationships and ensure legal protection for LGB individuals. The findings emphasized the critical role of community-led initiatives, healthcare provider training, and policy reforms in improving the health outcomes of the LGB community in Nairobi City County.

CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter contains the discussion of the research findings analyzed in chapter four, the conclusions drawn from the summary of the findings, and the recommendations proposed arising from the conclusions. Recommendations on the implications of the research on theory, management practice and policy, and suggestions for further research are discussed.

5.1 Discussion

The study investigated the uptake of HIV and AIDS services among the Lesbian, Gay and Bisexual youths aged 18 to 35 years in Nairobi City County. After the analytic analysis of data, the following conclusions were made:

5.1.1 Personal attitude and perception base among the lesbian, gay and bisexual identifying youths aged 18 to 35 years.

According to the findings, the respondents were conversant with HIV transmission and other prevention methods. Half of the respondents mentioned that they always use protection during sex whereas 38% do not use at all and the other 12% were not consistent in the use of protection. The Lesbian, Gay and Bisexual community members use items such as condoms and dental dams for protection. Influence of drugs and alcohol was adversely mentioned as one of the enablers of unprotected sex among the LGB community. *“Unplanned pregnancies especially for bisexual women and STI contraction are just an example of the risks”*, Said one of the key informants.

According to (Nyumayo et al., 2022) study on street connected children, HIV prevalence was directly related to provision of protective materials such as condoms. A study by (Lai et al., 2020) corroborated that an inconsistent condom use was significantly higher among the MSM participants. In the contrary, this study indicated that a huge majority (90%) of the Lesbians, Gay and Bisexual individuals in Nairobi City County are aware of their current HIV and AIDS status. In the contrary, according to (Okal et al., 2020), many persons infected with HIV in Kenya don't know their status due to barrier to testing such as attitude of the provider, HIV knowledge being limited, awareness of partner status, high risk perception among others.

The majority (57%) of the study participants have engaged in sexual activities with more than one sexual partner and only 43% have been consistent with one partner. The adequacy of information on HIV and AIDS prevention, transmission, and care among the Lesbian, Gay and Bisexual identifying youths was found to be at 61%. The remaining 33% did not have adequate information. This contrasts with a study by (Caminada et al., 2023) who found that the knowledge level regarding HIV and AIDS transmission, prevention and control was unsatisfactory due to misconceptions, discriminatory attitudes observed among the participants in Kenya.

5.1.2 Socio-cultural and religious factors among the lesbian, gay and bisexual identifying youths aged 18 to 35 years.

According to the findings, the majority 37% have experienced social stigmatization, 20% have experienced violence, 14% have experienced isolation, 11% have experienced home eviction, 10% have experienced divorce/separation. From the findings, 98% of the respondents attributed the above experiences to their sexual orientation whereas 2% did

not associate it with sexual orientation. According to (Lewis et al., 2023) stigma and physical harm affects sexual, mental, and physical health, socioeconomic status, and access to health promotion opportunities. This emphasizes the need to decriminalize same-sex orientation and interventions to support their health. Another study by (Shangani et al., 2018) established that there is a higher stigma and distrust among homosexuals compared to heterosexuals.

According to the findings, a majority 49% indicated that the experiences affected them socially, 28% agreed that it affected them mentally and 22% agreed that they were affected emotionally. The research also sought to investigate the socio-capital position of Lesbian, Gay and Bisexual identifying youths; The majority 57% agreed that they have a supportive family who encouraged them to seek HIV and AIDS prevention and care services regardless of their orientation. (Milton & Knutson, 2023) corroborates that family support was a significant predictor of depression level. The findings suggested that the role of biological and chosen families support is significant to mental wellbeing. A study by (Graham et al., 2018) concluded that trusted health providers and supportive families eased many men with selective disclosure of sexual orientation, self-acceptance, and social identity.

Cultural beliefs influence people's thoughts and feelings about their health, when and from whom they seek help and respond to the recommendations. The study sought to find out the influence of culture on HIV and AIDS services among the LGB youths. The majority 92% agreed that their culture is not friendly to the LGB youths and 8% were not sure of their culture's receptiveness. Upon further investigation, 71% agreed that their

culture discourages free access to services by an LGB identifying individual hence contributing to the stigma associated with seeking care.

A study conducted by (Malesela Edward Montle, 2021), corroborates that the African culture as well as the rivals of homosexuality is often used to perpetrate discriminatory attitudes towards LGBTQs.

Religion and spirituality such as sharing thoughts, praying for each other is considered as a source of social support. This study established that a majority 65% of respondent's religion were not friendly to Lesbian, Gay and Bisexual identifying youths, 31% were not sure of their religions take while only 4% agreed that their religion was friendly. Upon further investigations, the study established that 63% of the religion encouraged access to HIV and AIDS services by the LGB identifying individuals.

“All struggling LGB and other identities usually seek answers form religion to understand their evolving identities, however this is usually a difficult stage in one's life as the messages usually criminalize such groups and in so doing member cause significant mental distress to persons of diverse sexual groups. This also makes it difficult to access comprehensive sexual health services”, said one of the key informants.

According to (Parsitau, 2021), debates about sexual orientation in Kenya have been amplified by religious clergy and by politicians who wanted to associate themselves with religious organizations for respectability seeking to influence the nation's legal norms around sexuality. The same clergy attempt to portray homosexuality as un-African, unacceptable and a danger to African moral and family values.

5.1.3 Systemic factors in health care among the lesbian, gay and bisexual identifying youths aged 18 to 35 years.

According to the findings, Majority 67% of the respondents' access HIV and AIDS services from the public health facilities whereas 33% access the services in private health facilities. To further break it down, the majority accessed preventive HIV and AIDS services such as condoms from public facilities, followed by over the counter, NGO led clinics and private health facilities. This corroborates with findings from (Evah Maina, 2017) who found out that health services were somewhat gay friendly and a majority 80% access the services from government facilities.

Contrary to (Evah Maina, 2017) who found out that 55.6% of the facility were friendly, this study established that the majority 71% of respondents who frequently seek services from public facilities indicated that the facilities were not friendly to the LBG identifying youths whereas 24% were not sure. On the other hand, 61% of those who frequently sought services from private health facilities indicated that they were friendly to the LGB identifying youths.

Despite the friendliness of the health facilities, a majority 87% of the respondents have suffered from a form of injustice while seeking HIV and AIDS services such as stigma and discrimination. This was attributed to their sexual orientation. This corroborates with findings from (Shangani et al., 2018) who found out that homosexuals reported higher stigma and distrust of healthcare providers. This study established that a majority 65% agreed that the NGO led facilities provided non-discriminatory HIV and AIDS services to LGB identifying youths followed by private health facilities (44%) and government facilities (7%).

(Shangani et al., 2018) found that health providers were not knowledgeable to handle the gay needs. This is in contrast with this study where 71% of participants agreed that providers in private health facilities are well equipped to handle LGB identifying individuals whereas 55% agreed that those in public facilities are equipped to handle the population.

5.1.4 Interventions to be scaled up to improve uptake among the lesbian, gay and bisexual identifying youths aged 18 to 35 years.

A report by UNAIDS on reaching key population groups with sexual and reproductive health states that the risk of acquiring HIV is 25 times higher among gay men and MSM (UNAIDS, 2022). Key populations also face challenges due to prohibitive legislation and high levels of discrimination especially the lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) communities. According to the findings of this study, the risks among LGB include Co-STI contraction, mental health risks after diagnosis with HIV, hormonal imbalance, drug abuse among others.

The study also found that some of the barriers hindering utilization of HIV and AIDS services among the LGB include non-disclosure of sexual preferences, poor comprehensive and specific health care information for different identities, discrimination and stigmatization and lack of specialists in targeted sexual reproductive health in public facilities and high cost of care. *“Insurance including employment- given insurance should cover persons of diverse sexual orientations”*, said a key informant. (Graham et al., 2018) corroborates with these findings and concludes that is a need to enhance support from healthcare providers and peers for those living with HIV infection.

(Musyoki et al., 2021) argues that impactful coverage of key populations with quality HIV interventions is vital to achieving the ambitious global HIV targets since the KP are underserved in the HIV response. The study corroborates with (Musyoki et al., 2021) by establishing that factors affecting the upscaling of interventions include socio-cultural issues that condemn the LGB, legal and structural factors that criminalize same sex acts through the penal code, demonization of the minorities by religious and political leaders, medical insurance for coverage of the couples irrespective of sexual orientation and the skills and knowledge of health care providers.

From the qualitative data, the uptake of HIV and AIDS services by the LGB identifying youths in Nairobi will be enhanced by development of a comprehensive curriculum and training of service providers in the urban and peri-urban areas of the metropolitan. Secondly, the implementation of Prevention of HIV infections among Key Populations Policy in Kenya by NASCOP (2016) will enhance the service delivery for the diverse groups. *“The Key Populations Policy Framework 2016 (KP) as provided by NASCOP gives a clear picture on how sexually diverse groups should be treated in relation to access”*, said one of the key informants. The qualitative data from this study established that interventions can be upscaled through evaluating policy reforms to compliment the current constitutional articles on the bill of rights.

5.2. Summary of Findings

The uptake of HIV and AIDS services by the Lesbian, Gay and Bisexual identifying individuals in Nairobi City County was found to be 86%. The majority of them 67% accessing services through the government owned/public health facilities compared to 33% utilizing the services through private facilities. A majority (43%) of the LGB

community members accessed HIV prevention services such as Condoms and Prep (preexposure prophylaxis) from the public health facilities followed by 37% who used over the counter method such as chemists and pharmacies, and 33% who accessed through the NGO led health facilities. Interestingly, a majority, 65% of the respondents classified the NGO led health facilities as being more friendly and offering nondiscriminatory services.

According to the factors influencing the uptake of HIV and AIDS services, personal attitude and perception played a role in determining the utilization. A majority 67% of the respondents reported to have adequate information about transmission, 57% have had more than one sexual partner and 90% know their current HIV and AIDS status. The majority of LGB youths have often complained about mistreatment in different avenues and situations. The study found out that 98% of the LGB have experienced social injustices attributed to their sexual orientation hence affecting them socially, mentally, and emotionally. The study also found that there is gap between services offered in public facilities compared to the private ones. The reception by staff in both facilities contributed to the perception of friendliness of the facility by the LGB identifying youths. This is because 87% have experienced injustice when accessing the HIV and AIDS services. The study also made recommendations on the interventions and strategies that ought to be scaled up to improve the service delivery and uptake by the group.

Given the challenges of accessing the LGB population who are often marginalized, a snowball sampling technique was used to recruit participants. While this method presents limitations in terms of generalizability, it allowed for the collection of in-depth data from a relatively homogenous group. To address the small sample size and non-normal

distribution of data, non-parametric statistical tests were utilized which indicated that there was no strong evidence of relationships hence a need for bigger samples. The study adhered to ethical principles, ensuring participant confidentiality and informed consent.

5.3 Conclusion

From the study findings, the following conclusions can be made:

1. The Lesbian, Gay and Bisexual identifying youths in Nairobi City County are knowledgeable on HIV and AIDS transmission and prevention methods. The majority know their HIV and AIDS status despite half of them engaging in risky sexual activities with multiple partners and using protection.
2. Family, religious, and cultural support is essential in the uptake of HIV and AIDS service since there exists social stigma, violence, divorce, isolation, and home eviction which affects the LBG youths mentally, socially, and emotionally.
3. The majority of the LGB identifying youths access HIV and AIDS preventive and care services through the public health facilities despite the facilities being rated as unfriendly occasioned by stigma and discrimination.
4. Scaling up of key interventions such as refresher trainings, evaluation of KP policy framework, comprehensive curriculum for health providers, implementation, and evaluation of the existing policies to conform with human rights and constitution will eventually increase the coverage of LGB with quality HIV programs.

5.4 Recommendations for policy action.

Based on the conclusions above, the study recommends the national and county governments, non-governmental organizations, development partners, and health care stakeholders to:

1. Improve strategies that will target the LGB youths with HIV and AIDS information and increase HIV and AIDS awareness. These might include use of peer educators, targeted outreaches, seminars and publish IEC materials in their social groups.
2. Promote strategies that advocate family support, demystify cultural misconceptions and advocate for a religious voice that's inclined to improving HIV and AIDS among the LGB identifying youths. The availability and visibility of such networks can positively influence the uptake of services by creating safe and inclusive environments.
3. Enact policies that promote LGB friendly facilities hence destigmatizing HIV and AIDS services delivery and respond to the needs of Lesbian, Gay and Bisexual youths.
4. Implement and evaluate the existing policies and strategies to include the Lesbian, Gay, and Bisexual components. These barriers can result in a lack of trust in the healthcare system, making LGBT youths reluctant to seek HIV/AIDS services.
5. Provide comprehensive training to the public health providers to adequately respond to the needs of the Lesbian, Gay and Bisexual identifying youths. Lack of

cultural competency can create barriers to accessing appropriate and non-discriminatory healthcare services.

5.4 Suggestions for further research

The study makes the following recommendation for further studies:

1. The uptake of HIV and AIDS services among other gender identities such as transgender and intersex.
2. The effects of anti-homosexuality laws in Kenya and neighboring countries in accessing health services among the migrants and those affected internally.
3. Census/survey of lesbian, gay and bisexual populations in Kenya.

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APPENDICES

APPENDIX I: INFORMED CONSENT

My name is John Lanyo, I am a Master student from Kenyatta University. I am conducting a study titled “uptake of HIV and AIDS services among lesbians, gay and bisexual identifying youths in Nairobi City County, Kenya”. The information will be used to investigate the uptake of HIV and AIDS services and bridge the knowledge gaps and efforts to improve the delivery of HIV and AIDS services among this population.

Procedures to be followed.

Participation in this study will require that I ask you some questions and record the information you provide in a questionnaire.

Voluntarism

You have the right to refuse participation in this study. Please remember the participation in this study is voluntarily. You may ask questions related to the study at any time.

You may refuse to respond to any questions, and you may stop an interview at any time. You may also stop being in the study at any time without any consequences.

Discomforts and Risks

Some of the questions you will be asked are on intimate subjects and may be embarrassing or make you uncomfortable. If this happens, you may refuse to answer these questions if you choose. You may also stop the interview at any time.

Benefits

If you participate in this study, you will help us to learn how to institute measures and better interventions in providing HIV and AIDS services among the Lesbian, Gay and Bisexual individuals. You will also aid in providing insights into the knowledge gap among this group.

Reward

There are no rewards or any payment to you if you participate.

Confidentiality

The interview/data provided will be treated with utmost confidentiality. Your name will not be recorded on the questionnaire. The questionnaires will be kept in a locked

cabinet/password protected database for safe keeping. Everything will be kept private and only shared with the study team.

Contact Information

If you have questions about the study, call the Prof. Alloys Orago 0722483*** or Dr. Judy Mugo 0720671*** or John Lanyo/Investigator 0718500***

However, if you have questions about your rights as a study participant: You may contact Kenyatta University Ethical Review Committee Secretariat on chairman.kuerc@ku.ac.ke,

Participant's statement

The above information regarding my participation in the study is clear to me. The study has been explained to me and I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time. I understand that I will still get the same care and medical treatment whether I decide to leave the study or not and my decision will not change the care that I will receive from the clinic today or that I will get from any other clinic at any other time.

Name of Participant(pseudo)_____

Date_____

Signature or Thumbprint_____

Investigators statement

I, the undersigned, have explained to the volunteer in a language s/he understands, the procedures to be followed in the study and the risks and benefits involved.

Name of Interviewer_____

Date_____

Signature _____

APPENDIX II: RESEARCH INSTRUMENTS**A. SEMI-STRUCTURED QUESTIONNAIRE****a. Background information**

1. Name:(Optional/pseudo):.....
2. Location:
3. Age of the Respondent:
4. Highest Level of Education:
 - a) Primary
 - b) Secondary
 - c) Tertiary
 - d) No education
5. Nationality:
6. If the respondent is not Kenyan, then further probe the status
 - a) Forced migrant/refugee
 - b) Willing visitor to Kenya
7. Main Occupation of respondent:
- a) Unemployed
 - b) Employed part time
 - c) Employed full time
 - d) Self Employed
8. Religious Affiliation
 - a) Christian
 - b) Muslim
 - c) Hindu
 - d) Traditionalist
 - e) Rastafarian
 - f) Atheist
9. Sexual Orientation
 - a) Lesbian
 - b) Gay

- c) Bisexual
- d) Other:(specify)

b. Socio-cultural and religious barriers

1. Have you personally experienced any of the following?

- a) physical violence
- b) mental illness or distress,
- c) home eviction,
- d) social stigmatization,
- e) isolation
- f) Divorce/separation
- g) Other,(Specify)

2. If yes, would you associate the experience with your sexual orientation?

- a) Yes
- b) No

3. How would you say the above treatment affected you?

- a) Mentally
- b) Socially
- c) Emotionally
- d) Other

4. Has anyone from your family encouraged you to seek medical services (HIV and AIDS?)

- a) Yes
- b) No

5. What is your cultures' perception on LGB issues?

- a) Friendly
- b) Not friendly
- c) Not Sure

6. Is there any part of your culture that discourages access to HIV and AIDS for an LGB individual?

- a) Yes
- b) No

7. Expound

8. What is your religions' take on LGB issues

- a) Friendly
- b) Not friendly
- c) Not Sure

9. Does your religion encourage access to HIV and AIDS services for an LGB individual or couple?

- a) Yes
- b) No

c. Systemic Barriers

1. Where do you frequently access health services?

- a) Public/Government facility
- b) Private health facility
- c) Other

2. How would you classify services at the facility?

- a) Friendly
- b) Not friendly
- c) Not sure

3. Have you suffered any form of injustice or prejudice while accessing HIV &AIDS services? (e.g. stigma, discrimination)

- a) Yes
- b) No

4. If yes, can this be attributed to your sexual orientation?

- a) Yes
- b) No

5. Where do you access HIV and AIDS prevention services? E.g. condoms and lubricants

- a) Public health facility
- b) Private health facility
- c) NGO led facilities
- d) Chemists and Pharmacies
- e) Other

6. According to your own judgement which among the above options offers non-discriminatory services to LGB individuals?.....
7. From your opinion and observation, are the health service providers equipped to handle LGB identifying individuals?
- a) Yes
 - b) No
8. If yes/no please explain

d. Personal Attitude and Perception

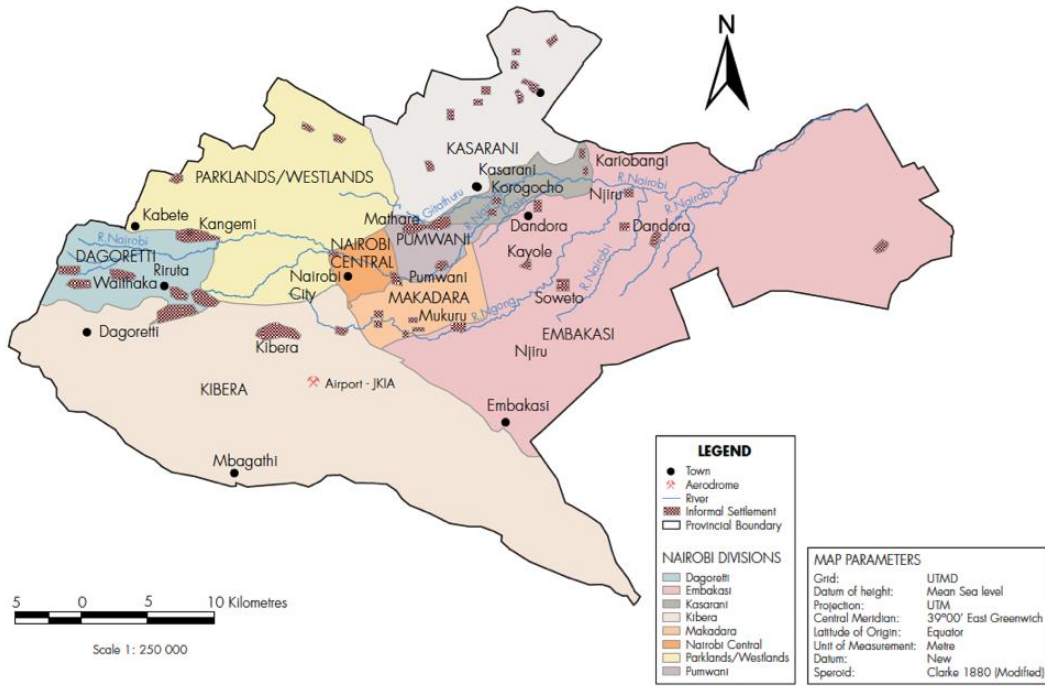
1. Have you accessed HIV and AIDS services within the last six months?
- a) Yes
 - b) No
2. Do you have adequate information on HIV and AIDS prevention, transmission, and treatment?
- a) Yes
 - b) No
3. Have you engaged with more than one sexual partner over a period of the last six months?
- a) Yes
 - b) No
4. Do you know your HIV status?
- a) Yes
 - b) No
5. How would you rate your use of protection during sex? (Includes condoms and dental dams)
- a) Sometimes
 - b) Always
 - c) Do not use it at all
6. If the answer is (a) or (c) above, what is the reason behind not always using it?
- a) I have one sexual partner
 - b) Condoms reduce the pleasure of sex
 - c) I was under the influence of alcohol/drugs

d) Other specify

B. Key Informant Interview Guide– (LGBTI focused NGO, Health provider, Activist)

1. What is your understanding of sexual minorities?
2. What are some of the HIV and AIDS risks among the LGB youths?
3. What is your understanding of the Kenyan health system in relation to the LGB?
4. What are some of the barriers that the LGB identifying individuals experience in trying to access HIV and AIDS services?
5. Would you say there are LGB friendly facilities? Name them?
6. In your opinion, is there a link between socio-cultural, religion and being LGB in relation to accessing HIV and AIDS services?
7. Are there some structural challenges e.g. policies that instigate lack of access to HIV services among the LGB?
8. What is your opinion on insurance cover for LGB couples?
9. Are the health service providers trained in handling LGB identifying individuals?
10. Where do the LGB access HIV and AIDS prevention materials from? (E.g. health education, condoms, and lubricants)
11. What are the existing strategies that ensure equality in accessing HIV and AIDS services
12. What do you think should be done to provide inclusive services to the LGB individuals?

APPENDIX III: MAP OF NAIROBI CITY COUNTY



Map production: RCMRD

APPENDIX V: APPROVAL FROM THE KUERC

**KENYATTA UNIVERSITY
CENTRE FOR RESEARCH ETHICS AND SAFETY**

Fax: 8711242/8711575
 Email: chairman.kuerc@ku.ac.ke
 Nairobi, 00100

P. O. Box 43844,

Tel: 8710901/12

Website: www.ku.ac.ke
 Our Ref: **KU/ERC/APPROVAL/VOL.1**

Date: 18th /10/2022

John Lanyo
 P.O Box 43844, 00100
 Nairobi.

Dear Mr. Lanyo,

APPLICATION NUMBER: PKU/2567/I1693- UPTAKE OF HIV/AIDS SERVICES AMONG LESBIANS, GAY AND BISEXUAL IDENTIFYING YOUTHS IN NAIROBI CITY COUNTY, KENYA

This is to inform you that **KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE** has reviewed and approved your above research proposal. Your application approval number is **PKU/2567/I1693**. The approval period is **18th /10/2022 to 18th /10/2023**

This approval is subject to compliance with the following requirements;

- i. Only approved documents including (informed consents, study instruments, MTA) will be used
- ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by **KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE**
- iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to **KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE** within 72 hours of notification
- iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to **KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE** within 72 hours
- v. Clearance for export of biological specimens must be obtained from relevant institutions.

- vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
- vii. Submission of an executive summary report within 90 days upon completion of the study to **KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE**

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) <https://research-portal.nacosti.go.ke> and also obtain other clearances needed.

To serve you better, researchers are kindly requested to access and complete a customer feedback form and sent it back online as you continue with research and upon completion of data collection found on the following website link;
;https://docs.google.com/forms/d/1ytWefDwvyyz5h1oz_VIn0xbxg3uGdlDzMXFWNDsMrRPQ/edit?usp=sharing

Yours sincerely



Prof. Judith Kimiywe

Director: Centre for Research Ethics and Safety

APPENDIX VI: APPROVAL FROM NACOSTI


REPUBLIC OF KENYA


**NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY & INNOVATION**

Ref No: **579683** Date of Issue: **21/November/2022**

RESEARCH LICENSE




This is to Certify that Mr., John Lanyo of Kenyatta University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nairobi on the topic: UPTAKE OF HIV AND AIDS SERVICES AMONG LESBIANS, GAY AND BISEXUAL IDENTIFYING YOUTHS IN NAIROBI CITY COUNTY, KENYA for the period ending : 21/November/2023.

License No: **NACOSTI/P/22/21518**

579683
Applicant Identification Number


Director General
**NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY &
INNOVATION**

Verification QR Code



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