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Original Research Article

Uptake of HIV and AIDS services among lesbian, gay and bisexual identifying youths aged 18 to 35 years in Nairobi city county, Kenya

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ABSTRACT

Background: The study assessed the general uptake of HIV&AIDS care among the Lesbian, Gay, and Bisexual (LBG) identifying youths in Nairobi County. The focus was on sexual orientation and not gender identity. This research unpacked the depth in which socio-cultural, religious, systemic, personal attitudes and perceptions base contribute to the uptake of HIV&AIDS care and interventions to be scaled up.
Methods: Descriptive cross-sectional design, involving qualitative and quantitative methods. The sample size was n=84 determined through the formula n=z2(1 –α/2)(1- P)/ε2P due to unknown nature and number of the target population in Nairobi. Used snowball sampling technique and a virtual snowball sampling to reach the population. Purposive sampling was applied to reach key informants. Descriptive statistical analysis was utilized reinforced by cross tabulation.
Results: The uptake of HIV&AIDS services was 86% among the lesbian, gay and bisexual youths in Nairobi. The majority 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; 57% engaged in risky sexual activities. A majority (87%) of the respondents experienced injustices while accessing HIV&AIDS services attributed the experiences to their sexual orientation.
Conclusions: The health care providers should be adequately trained to provide comprehensive, inclusive, non-judgmental services; policies evaluated to provide non-discriminatory services to eliminate stigmatization of the population. The findings intend to inform programming of HIV&AIDS for this subset of key population and bridge the knowledge gap.

Keywords: HIV&AIDS, Gay, Kenya, LGBT, Nairobi, Stigma

INTRODUCTION

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 from the epidemic.[1]

20.8 million people infected are living in East and Southern Africa. The number of new infections has decreased by 59% since 1995 and reports indicated that efforts concentrated on the knowledge of HIV and related components among young adults (15-24 years) who are at higher risks with 59% of new infections.[1]

Nairobi County is the capital of Kenya with a population of 4.3 million people and the youths aged 15-24 years account for 29%.[2] Prevalence rate in Nairobi 6.1% is higher than the national prevalence which is 4.9%.[3] 57% of young women and 63% young men had sufficient knowledge and 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/AIDS services.[4]

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. A study 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.[5] 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. 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.

HIV and AIDS became a national disaster in Kenya a year before the 20th millennium and continually affected the people of Kenya especially the youths who are known to be most vulnerable and their broadened spectrum of sexual activities as a risk factor in society. Some 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 makes it essential to assess the factors that contribute or hinder the youths from accessing HTC services.

Nairobi County has the highest number of youths in Kenya. Studies have indicated the LGB communities are mostly found in urban centers compared to rural. The youth between the ages of 17-24 are at the highest risk of contracting HIV.[3] Men who have sex with men (MSM) account for 18.2% prevalence with a HIV service coverage of 65%. It is reported that some key populations such drug users, commercial sex workers, MSM are at high risk of contracting HIV&AIDS yet remain marginalized in receiving the HTC services despite having laws that guarantee equal access to health services.

The lesbian, gay and bisexual youths are at risk of contracting and transmitting HIV&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/or treat HIV.

The study aimed to assess personal attitudes, perception of LGB youths, socio-cultural, religious, and systemic factors influencing the uptake and determine interventions to be scaled up to improve the uptake.

METHODS

The study employed a descriptive cross-sectional design, involving qualitative and quantitative research methods. 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 researcher used purposive sampling to determine qualitative sources of data. The study employed a snowballing sampling technique to obtain the sample population due to the unknown nature of the target population. Additionally, the researcher applied virtual snowball sampling to strengthen the respondents' base. The sample size (n=84) was arrived at using the formula $n = z2(1-\alpha/2)\ (1-P)/\varepsilon 2P$.

The study was conducted from December 2021 to October 2023. The inclusion criteria specified youths who identified as LGB and gave informed written consent whereas the exclusion criteria included youths not identifying as LGB and below the consent giving age.

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.

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 general population. The format and flow of the questions was carefully organized per objectives to enhance the validity. Data reliability was enhanced whereby any questions that were offensive, ambiguous, and unclear were eliminated or revised.

The researcher visited the identified hotspots and other locations frequented by the study population. Once a 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.

The quantitative data from the study was cleaned, coded, and entered 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. Qualitative data from the key informant interviews was summarized based on major themes and particularly giving insight to the research question on interventions to be scaled up.

RESULTS

Demographic characteristics of the respondents

The majority, 43% (36) of the respondents were aged between 24-30 years old followed by those within 18-24 years old, 33%, and those between 30-35 years old accounted for 24%. The level of education level among the target population; 61% (56) have attained tertiary education level whereas 33% have attained secondary education.

According to the findings, majority (85%) of the respondents were Kenyans and 15% identified as Ugandans. 15% also classified themselves as either forced migrant, asylum seeker or refugees (Table 1).

According to the findings, most respondents were employed full-time or part-time 25% and 15% respectively, whereas 32% were self-employed. The majority 74% were Christians and 26% were Muslims. The findings also indicated that a majority (43%) of the respondents identified as gay, 35% identified as lesbians and 21% were bisexual (Table 2).

Table 1: Socio-demographic characteristics of the respondents (n=84).

Variable	Category	Frequency	Proportions (%)
Age (years)	18-24	49	32.5
	24-30	55	43.4
	30-35	51	24.1
	Above 35	0	0
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

Table 2: Employment, religion, and sexual orientation of youth (n=84).

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
	Lesbian	29	34.5
	Transgender	1	1.2
Religion	Christian	62	73.8
	Muslim	22	26.2
	Hindu	0	0
	Rasta	0	0

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

Access to HIV&AIDS services within the last six months

Overall, the majority (86%) respondents had access and received HIV&AIDS services within the last six months. A majority (61%) of the respondents have adequate information on HIV&AIDS prevention, transmission, and treatment. (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. Despite this, 90% are aware of their current HIV&AIDS status whereas 10% were not aware of their status (Figure 1).

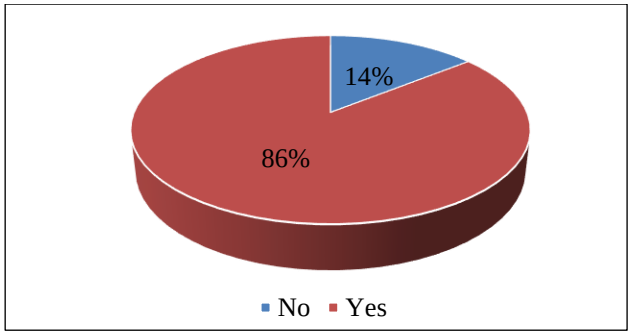

Figure 1: Access to HIV&AIDS services within the last six months

Use of protection during sex

50% of the respondents indicated that they always use protection during sex, 38% engage in unprotected sex whereas 12% use protection inconsistently. Upon further enquiry 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 (Figure 2).

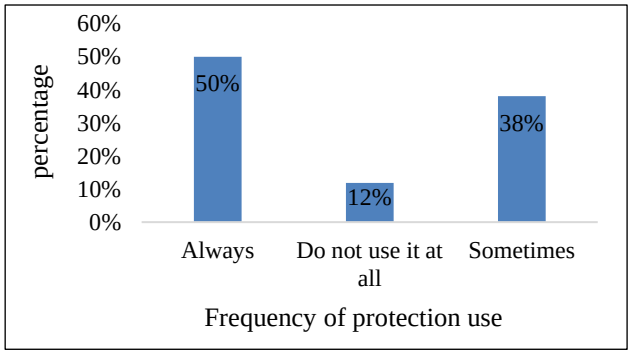

Figure 2: Use of protection during sex.

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

Experience of social injustices

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. 98% of the respondents attributed the above experiences to their sexual orientation. A majority 49% indicated that the experiences affected them socially, 28% mentally and 22% emotionally (Figure 3).

Through family support, the majority 57% agreed that the family encouraged them to seek HIV&AIDS services regardless of orientation (Figure 4).

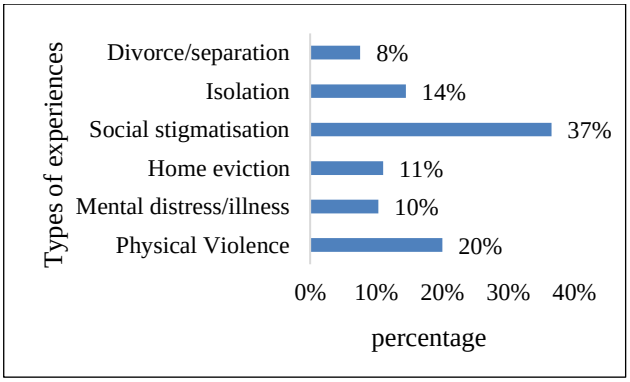

Figure 3: Experiences of social injustices.

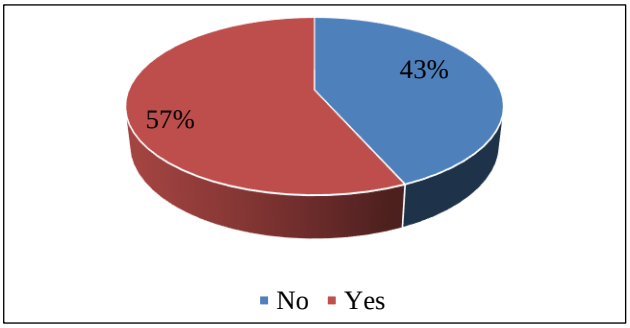

Figure 4: Family support in seeking HIV&AIDS services.

Cultural and religious perception of lesbian, gay, and bisexual youths

The majority 92% indicated that their culture is not friendly 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. The majority 65% also indicated that their respective religions were not friendly, 31% were not sure of their religions take whereas 4% agreed that their religion was friendly. Upon further enquiry, 63% agreed that their respective religion encourages access to HIV&AIDS services for the LGB identifying individuals (Figure 5).

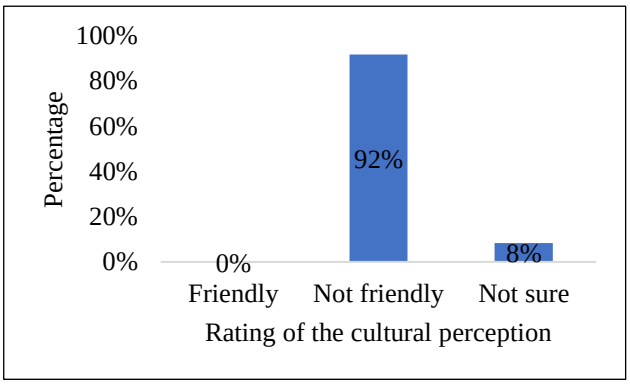

Figure 5: Cultural stand on lesbian, gay and bisexual persons.

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

Access to public or private health facilities

The majority 67% of the respondents frequent the public/government owned facilities for health services whereas 33% frequent the private owned health/non-governmental facilities (Figure 6).

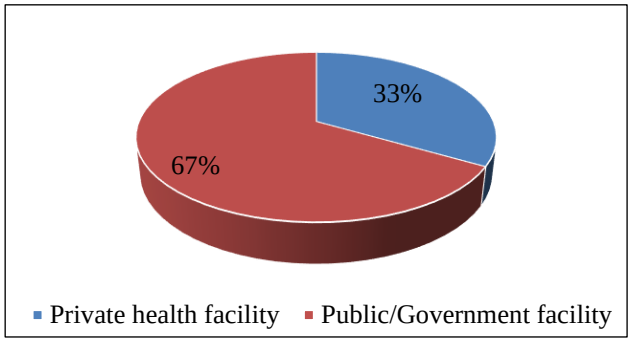

Figure 6: Where the LGB access health services.

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 (Table 3).

Table 3: Receptiveness of facilities in Nairobi city county (n=84).

	Public facilities (%)	Private facilities (%)
Friendly	5	61
Not friendly	71	21
Not sure	24	18

Experience of injustice while seeking HIV&AIDS services

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

Upon further inquiry, 89% of those who've experienced any form of injustice attributed it their sexual orientation. A majority (43%) access preventive health services such as condoms from public/government health facilities, 37% from chemists and pharmacies, 33% prefer the NGO led facilities and 19% from private health facilities (Figure 7).

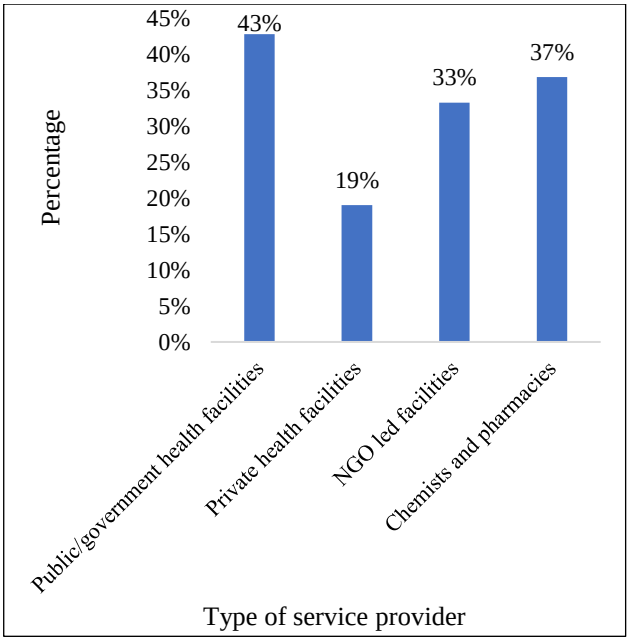

Figure 7: Access to preventive HIV&AIDS services.

Facilities providing non-discriminatory services

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&AIDS services (Figure 8).

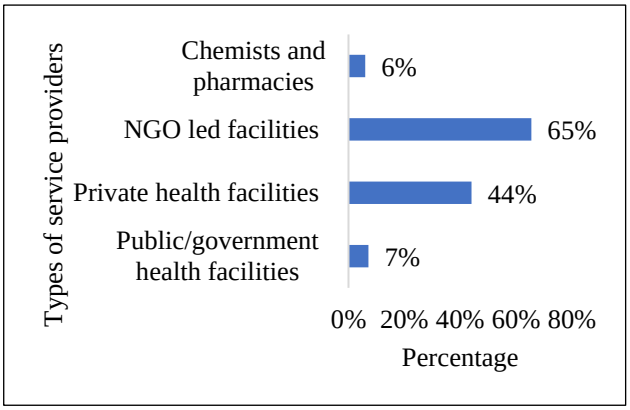

Figure 8: Facilities providing non-discriminatory services.

Health care staff equipped to handle LGB identifying individuals

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 (Figure 9).

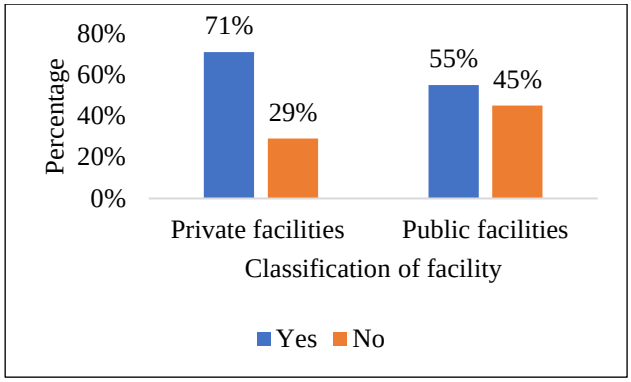

Figure 9: Health care staff equipped to handle LGB identifying youths.

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

According to the Key Informants (KI), the risks among the LGB individuals included STI contraction, mental health risks, school dropouts, hormonal imbalances, rectal cancer, drug abuse among others.

Interventions are affected by 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.

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

DISCUSSION

The respondents were conversant with HIV transmission and other prevention methods. Half of them always use protection during sex whereas 38% do not use at all and the other 12% were not consistent in the use of protection such as condoms and dental dams. Abuse of drugs and alcohol was adversely mentioned as one of the enablers of unprotected sex among the LGB community. According to a study on street connected children, HIV prevalence was directly related to provision of protective materials such as condoms.[6] Another study corroborated that an inconsistent condom use was significantly higher among the MSM participants.[7] In contrast, the findings in this study indicated that a majority (90%) of the LGB are aware of their current HIV&AIDS statuses. Many persons infected with HIV in Kenya are unaware of 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.[8]

The majority (57%) of the respondents 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&AIDS prevention, transmission, and care among the lesbian, gay and bisexual identifying youths was found to be 67%. This contrasts with another study which found that the knowledge level regarding HIV&AIDS transmission, prevention and control in Kenya was not satisfactory due to misconceptions, discriminatory attitudes observed among the participants.[9]

According to the findings, the majority have experienced injustices such as violence and discrimination where 98% attributed the experiences to their sexual orientation. Another study states that stigma and violence affects mental health, sexual health, physical health, socioeconomic status, and access to health promotion services.[10] This emphasizes the need to decriminalize same-sex orientation and interventions to support their health. Another study established that there is a higher stigma and distrust among homosexuals compared to heterosexuals.[11]

The majority 49% indicated that the experiences affected them socially, 28% mentally and 22% emotionally. From the socio-capital lens, a majority 57% agreed that they have a supportive family which encouraged them to seek HIV&AIDS prevention and care services regardless of their orientation. A study on psychology of sexual orientation and gender identity corroborates that family support was a significant predictor of depression level.[12] The findings suggested that the contribution of biological and chosen families support is significant to mental health. Another concluded that trusted health providers and supportive families eased many men with selective disclosure of sexual orientation, self-acceptance, and social identity.[13]

Cultural beliefs influence people's thoughts and feelings about their health, seeking help and responding to the recommendations. The majority 92% agreed that their culture is not friendly to the LGB youths and 8% were not sure of their culture's receptiveness. 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 on myths and stereotypes against homosexuality corroborates that the African culture rival's homosexuality and is often used to perpetrate discriminatory attitudes towards LGBTQs.[14]

Religion and spirituality such as sharing thoughts, praying for each other is considered as a source of social support. A majority 65% of the respondent's religion were not friendly to the LGB identifying youths, 31%

were not sure of their religions take while only 4% agreed that their religion was friendly. 63% agreed their religion encouraged access to HIV&AIDS services by the LGB identifying individuals.

According to a study on law, religion, and politicization of sexual citizenship in Kenya, sexual orientation has been fueled by religious clergy and by politicians who wanted to align themselves with religious organizations for respectability seeking to influence the nation's legal norms around sexuality. The same clergy seek to frame homosexuality as un-African, unacceptable and a threat to African moral and family values.[15]

Majority 67% of the respondents' access HIV&AIDS services from the public health facilities whereas 33% access the services in private health facilities. A majority accessed preventive HIV&AIDS services from public facilities, over the counter, NGO led clinics and private health facilities. This corroborates with findings from a study on homosexuality risks in Kilifi which who found out that health services were somewhat gay friends and a majority (80%) access the services from government facilities.[16] A majority (71%) however indicated that the public facilities were not friendly to the LBG youths whereas 24% were not sure. Conversely, 61% indicated that the private facilities were friendly to the LGB youths. Despite this, a majority (87%) have suffered from a form of injustice while seeking HIV&AIDS services such as stigma and discrimination attributed to their sexual orientation. This corroborated with another study which found out that homosexuals reported higher stigma and distrust of healthcare providers.[11] This study established that a majority (65%) agreed that the NGO led facilities provided non-discriminatory HIV&AIDS services to LGB identifying youths followed by private health facilities (44%) and government facilities (7%).

Health providers were not knowledgeable to handle the gay needs. This is in contrast with the findings of this study where 71% of the respondents agreed that providers in private health facilities and 55% in public facilities are well equipped to handle LGB identifying individuals.[11]

The risk of acquiring HIV is 25 times higher among gay men and MSM. 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.[17] 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&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 and high cost of care. Another study corroborates with these finds and concludes that there is a need to increase support from providers and peers for those living with HIV infection.[13] Another study that sufficient coverage of KP with quality HIV program is critical to achieving the ambitious global HIV targets.[18] This study established 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.

The uptake of HIV&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 Policy for Prevention of HIV infections among Key Populations in Kenya by NASCOP (2019) will enhance the service delivery for the diverse groups. A study on socio-economic and legal environment of the gay community in Kenya corroborates with the findings of this study and states that there is a failure by the state to protect the LGB and fails to apply the human rights for all as per the 2010 constitution.[19] The study established that interventions can be upscaled through evaluating policy reforms to complement the current constitutional articles on the bill of rights.

Although the study was the first of its kind to be conducted among the study population in Nairobi, City County; it had its own limitations. The study focused on LGB youths aged between 18-35years in Nairobi city recruited through non-probability methods hence not an equal chance for every population member to be included. Snowballing sampling was used to identify respondents considering the hidden nature and distribution of the respondents. 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 queer, transgender and intersex were not considered. The political environment in the country was not conducive for the study population due to fear of violence and targeted attacks.

CONCLUSION

The lesbian, gay and bisexual identifying youths in Nairobi City County are knowledgeable on HIV&AIDS transmission and prevention methods. The majority know their HIV&AIDS status despite half of them engaging in risky sexual activities with multiple partners and using protection. Family, religious, and cultural support is essential in the uptake of HIV&AIDS service since there exists social stigma, violence, divorce, isolation, and home eviction which affects the LBG youths mentally, socially, and emotionally. The majority of the LGB identifying youths access HIV&AIDS preventive and

care services through the public health facilities despite the facilities being rated as unfriendly occasioned by stigma and discrimination. 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.

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