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Neglected or unaffected!

Investigating the Exclusions and Silences Around Lesbians Bisexuals and Queer (LBQ) Women and HIV in Kisumu, Kenya.

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List of Abbreviations

ACHPR- African Commission on Human and Peoples' Rights

CDC- Centre for Disease Control

CHMT- County Health Management Teams

DHIS- District Health Information System
FGDs- Focus Group Discussions

FSW- Female Sex Workers

GALCK- Gay and Lesbian Coalition of Kenya

GBSM- Gay Bisexual Men who have sex with men

HIV- Human Immunodeficiency Virus

HIV/AIDS- - Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

KHIS- Kenya Health Information System

LBQ- Lesbian, Bisexual and Queer

LBQ PLHIV- Lesbian, Bisexual and Queer People Living with Human Immunodeficiency Virus

LGBTIQ- Lesbian, Gay, Bisexual, Transgender, Intersex, Queer

MSM- Males who engage in Sexual acts with other Men

MSW- Men Sex Workers

MOH- Ministry of Health

NACC -National AIDS Control Council

NASCOP- National AIDS and STI Control Project

NGOs- Non-Governmental Organizations

NYAERWEK- Nyanza, Rift Valley and Western Network

NGLHRC- National Gay and Lesbian Human Rights Commission

PrEP- pre-exposure prophylaxis

RP- Research Paper

STI- Sexually Transmitted Infections

UN- United Nations

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Abstract

Several scholars contend that women who have sex with women (WSW) have been excluded from the public health, HIV and research discourse. Several studies have described LBQ women who are living with HIV as being invisible, ignored, neglected, and understudied. This exclusion has been attributed to perception that LBQ women may not easily contract HIV since they do not engage in penile sexual relations which has resulted to the epidemiological classification of LBQ women as being a low-risk group. The perception of LBQ women as a HIV low risk group is associated with their exclusion in HIV research, programming, services and the healthcare system. Since LBQ women are still at risk of HIV and some are already living with HIV, such exclusion from HIV services and programs may further aggravate the situation of LBQ women living with HIV as well as those who are at risk of HIV infection. As a result, it is imperative to unravel how the exclusion is produced in HIV programming and healthcare system so as to know how to address them. Against this background, the current study employed a feminist standpoint perspective to investigate the discourse around LBQ women's risk of contracting HIV and its implications in terms of LBQ women's exclusion in HIV programming, HIV service delivery, HIV research and the society. Specifically, the study wanted to find out: What are LBQ women's perceptions of their risk to HIV?; How is exclusion of LBQ women from HIV programming and HIV research, and HIV service provision produced?; How is exclusion of HIV positive LBQ women produced?; and What are the effects of the perception that LBQ women are at low-risk of HIV?

Through interviews and focus group discussions with LBQ women participants from Kisumu the study gathered data. The findings of the study revealed the intersecting individual, social and factors which contributed to the exclusion of LBQ women living with HIV fuelled by HIV stigma as well as sexual stigma. The intersection of societal attitudes about LBQ women and HIV with the marginalizing structures of HIV service delivery and programming is seen to generate limitations on the agency of LBQ women to navigate access to HIV services and programs. The recommendations drawn from the findings of the study to address the factors hindering LBQ women from successfully accessing HIV services and information include creation of support groups and standalone LBQ-tailored health facilities for LBQ women, inclusion of LBQ women in strategic decision-making spaces of HIV programming, creation of safe spaces for LBQ women living with HIV, knowledge based trainings and sensitizations to health care services providers on LBQ women's HIV issues and the demystification of myths and misconceptions around LBQ and HIV through awareness creation through adequate relevant research in LBQ and HIV issues.

Relevance to Development Studies

"Leave no one behind" is one of the main principles of United Nations sustainable development goals (SDGs) that aims to ensure non- discrimination and equality of all human beings. It encourages policy makers and stakeholders to identify factors that facilitate inequality and address them through policies and programs that ensures no one is left behind, especially the vulnerable groups that are often on the fringes of the society (UN, 2021). This study aims to contribute to development by identifying the exclusions that exists in the public health

discourse when it comes Lesbians Bisexuals and Queer Women (LBQ), it brings out the African context when it comes to LBQ women and HIV a subject that is often ignored in most available literature. Also, it gives visibility to the LBQ women by treating them as subjects of knowledge and the ones with the epistemic privilege. This study is undertaken in the spirit of "ubuntu" an African cosmology and Zulu term that means simply 'I am because we are'. I work collectively with LBQ women but I am also calling for collective agency with stakeholders, policy makers, researchers, academicians, activists and the society at large to play a part in ensuring that the LBQ persons are part of the public health discourse as a way of enhancing their wellness hence contributing to social change.

Keywords

LBQ, HIV, Exclusion, Kenya, Feminist

Chapter One: Introduction

1.1 Problem Statement

"... people didn't believe that LBQ people are people at any risk, because someone asked... where's the data and where is the research that was done and which LBQ women were specifically tested and proven? … Everybody was very curious in fact with that particular presentation because they wanted to see where and which data... actually carried the information about LBQ women being tested on HIV to prove that actually they are HIV positive. We didn't have any data so just told them… the same answer no one has been interested in LBQ to even basically do a research!" (FGD Participant).

Feminist theorists argue that dominant knowledge practices can disadvantage women by isolating them from inquiry (Longino, 2017). Based on the feminist argument about women being exclusion from inquiry, this study views Lesbian Bisexual and Queer (LBQ) women as being excluded from public health discourse including HIV research. Several studies have described LBQ women who are living with HIV as being invisible, ignored, neglected, and understudied (Arend, 2005; Dworkin, 2005; Marrazzo, 2005; Morrow & Allsworth, 2000). According to Logie et al. (2012), such studies have attributed the invisibility of LBQ women in HIV research to the epidemiological classification of LBQ women as being a low-risk group by previous studies.

The HIV low-risk classification has been criticized for ignoring the impact of HIV on the lives of LBQ women, and is seen to have led to the LBQ women institutionalized exclusion from HIV risk groups, HIV programs and HIV services (Montcalm & Myer, 2000). The preconception that LBQ women do not contract HIV comes from assumptions that reflect a North American bias, with its specific history and context, despite contradictory epidemiological evidence in other social and cultural contexts (Luinenburg, 1994). Even if there is evidence in some studies that show the high-risk factors of HIV that face LBQ women, it is presumed that HIV infections among this group are low because of the transfer of HIV from one woman to another is rare in North America, ignoring different patterns of sexual behaviour in the African contexts (Logie & Gibson, 2013; Logie et al., 2012 Montcalm & Myer, 2000). As result of this presumption about sexual transmission of HIV, Women who have Sex with other Women (WSW) have been labelled as an HIV "low risk" people despite the little empirical data in African contexts to back up this assumption (Logie et al., 2012: Montcalm & Myer, 2000). More crucially, as a result, LBQ women's participation in HIV-related research, treatment, education, as well as aid programs in African contexts has been limited (Montcalm & Myer, 2000).

The paucity of research and participation of LBQ women in HIV programs is evident in the Kenyan LGBTQ landscape. In Kenya, there is very little research done regarding the risk and prevalence of HIV among LBQ women and the for-HIV interventions and services by these women (Wairimu, 2013; Zaidi et al., 2016; Wilson et al., 2019). Research on HIV among members of the LGBTQ community have placed more emphasis on men who have sex with men (MSM) individuals rather than LBQ women not only in the global context but also in the Kenyan context (Montcalm & Myer, 2000: Logie, 2012: Kenya Ministry of Health, 2016: Wilson et al., 2019). For instance, "Policy for the stoppage of HIV spread Among significant communities in Kenya" reports for both 2015 and 2016 identify sub-groups of the population that are deemed to be at high risk of acquiring HIV infection include Female Sex Workers (FSW), Male Sex Workers (MSW), Men who have sex with Men (MSM) and People who Inject Drugs. These reports produced by the National AIDS Control Council (NACC) and National AIDS and STI Control Program (NASCOP) spearhead the nation's HIV agenda under Ministry of Health in Kenya (Kenya Ministry of Health, 2016). The LBQ women subgroup is secluded from the nation's fight against HIV and programs targeted at LBQ women are limited.

While there have been several HIV-related collaborations between national and international actors with MSM groups including efforts to establish stand-alone clinics for MSM, the establishment of equivalent clinics for LBQ women is limited (Mung'ala & de Jong, 2020; Wilson et al., 2019). The study by Wilson et al. (2019) identified lack of LBQ women-friendly health facilities and lesbian-friendly physicians as one of the challenges LBQ women face in accessing healthcare services. The respondents in the 2019 study found difficulties in accessing adequate health supplies that can prevent HIV infection such as dental dams and condoms. A lesbian woman who contracted HIV from 'corrective rape' explains when she visited a facility the health service provider assumed that she would not be at risk of infecting her partner and did not advise her on safe female-to-female sexual activities to prevent HIV (Wairimu, 2013). In the same report, a gay man mentions that LGBT-oriented healthcare facilities offer services to gay men but not lesbians. A program officer with the National Empowerment Network of People Living with HIV/AIDS in Kenya, a non-profit support group, in the same study, pointed out the need for additional lesbian-specific programs for lesbian women affected with HIV (Wairimu, 2013).

As part of the leadership of the Women Working with Women(3W) organization, I have also experienced difficulties to secure funding and program for LBQ women's HIV-related activities because of the lack of evidence to prove that LBQ women suffer high risk to HIV and therefore there is a need to target LBQ women in HIV services. The assumptions of HIV programming with regard to risk of WSW to HIV prevents funds being given to LBQ women organizations in comparison to MSM organizations. This is despite the fact that LBQ women organizations such as 3W have HIV infected LBQ women who need support to overcome the challenges WSW have in accessing HIV services. Working with LBQ women at 3W, I have had first-hand experience of interacting with WSW who are living with and are affected by HIV. Because of the seeming exclusion of LBQ women in HIV programming and services, LBQ women living with HIV as well as those who are at risk of HIV infection will continue facing challenges when dealing with HIV.

It has been more than a decade since LGBTIQ organizing started in Kenya with the health approach as the point of entry when championing for LGBTIQ rights, with Lesbians Bisexual and Queer women in the forefront. So where are the LBQ women in the HIV agenda? In this research paper, I investigate the reasons behind the exclusion of LBQ women in HIV programs and research discourse and how these exclusions impact LBQ women's health and lives using the case of LBQ women in Kisumu.

1.2 Background and Justification of the Study

In 2020, in Kenya, women had the greatest prevalence of HIV, at 6.6 percent, compared to men's 3.1 percent. (The East African, 2020). Zaidi et al., (2016) stated that LBQ women in Kenya are also at risk of unfavourable sexual and reproductive healthcare results, such as HIV and STIs, making them an important target for public health interventions. The Centre for Disease Control (CDC) and Inhibition report argues that it is difficult for LBQ women to infect one another with HIV (Chan., et al 2014). Such assumptions have limited the conversation on HIV among LBQ women and have ignored other contributing factors that can lead to HIV. A research study entitled "we don't exist" conducted in Toronto, Canada shows that LBQ women are given very limited attention when it comes to HIV research as many at times all the focus is shifted to the MSM and transgender men hence leading to a feeling of exclusion among WSW (Logie., et al 2012). There has also been very little research done on WSW in Kenya when it comes to HIV apart from the study by Zaidi et al., (2016) on looking at the sexual reproductive health of LBQ women which pointed out gender inequality as a potential reason as to why LBQ women could be vulnerable to poor health. Further to a mixed method research study conducted by Voices of Women in Western Kenya (VOWWEK) (2018) on "exploring the sexual reproductive health needs of LBQ women Transgender men and WSW in Western Kenya" which also recommended need for more focus on HIV research targeting LBQT persons.

Zaidi et al., (2016) states that there are few studies in the study of LBQ women in the African and Kenyan context as opposed to studies on MSM and LGBTQ in general, creating a research gap. My research desires to contribute to filling in this research gap with a focus on Kenya. Having been an activist in the LGBTIQ and feminist movement for more than seven years, it is my observation that most of the programs do not reach the LBQ persons or rather, they give priority to the MSM, Gay men and transgender due to the fact that there are multiple studies, that justifies the health risks of these groups. My RP seeks to help close the research gap by providing evidence of the risk to HIV for LBQ women and the need for HIV services. This paper will not only contribute to fill the research gap, but in addition encourage further research on LBQ women and HIV. It will also provide evidence that can help to convince donor agencies to support WSWS research in the Kenyan context. It is anticipated that the findings of this paper will encourage debate around HIV programming for LBQ women in Kenya and hence encourage their inclusion in HIV programs. This research paper will provide an opportunity to demystify the myths and misconceptions around HIV and LBQ women.

1.3 Research objective and questions

Main research objective: To investigate the discourse around LBQ women's risk of contracting HIV and its implications in terms of LBQ women's exclusion in HIV programming, HIV service delivery, HIV research and the society.

Sub questions

1. What are LBQ women's perceptions of their risk to HIV?
2. How is exclusion of LBQ women from HIV programming and HIV research, and HIV service provision produced?
3. How is exclusion of HIV positive LBQ women produced?
4. What are the effects of the perception that LBQ women are at low-risk of HIV?

Chapter Two: Literature Review

2.1 What does it mean to be an LBQ African context?

The term LBQ is an acronym that is used to describe distinct groups of people under the general gay group. Most of the early initiatives relating to gay people across the globe focused on men. Because of this, an attempt to draw attention to issues facing gay women led to the creation of the term 'lesbian'. Moreover, Romanelli and Hudson (2017) note that people who are bisexual, transgender or queer have also been underrepresented or left out in health initiatives and research studies. However, there has been a change and it is now considered to include all these groups in matters of homosexuality. The focus of this paper is on LBQ which stands for lesbians, bisexuals and queer people. Jourian (2015) describes lesbians as women who are homosexual. On the other hand, homosexual is described as persons whose romantic and sexual feelings are towards people of the same gender. The next group, which is bisexual, refers to people whose romantic and sexual feelings are for both genders. Finally, queer is used as an umbrella term to cover for sexual and gender minorities that are not gender-binary or heterosexual. Hagen (2013) notes that the term 'queer' has many negative connotations as it was initially used as an insult and taunt to gay people. This negative usage of the term queer persists in present society and the term is considered to be more politically charged.

LBQ people unlike heterosexuals are perceived differently in most regions of the world with societal attitudes varying in these different regions. In general, there is increased acceptance of LBQ people in contemporary society (Brown-Saracino, 2015). Still, these people face numerous challenges because of their sexual orientation.

For one, homosexuality is criminalized in 73 jurisdictions across the globe (Astraea Lesbian Foundation for Justice, 2020). 45 of these nations have laws that explicitly prohibit same-sex relationships among women. Graydon (2013) notes that LBQ persons indiscriminately experience the effects of criminalization of homosexuality even if the law does not apply to them. In the case of LBQ women, they even experience criminalization not only from these laws against homosexuality but also from other laws that disproportionately affect women. Examples of such laws include regulations on sex work, abortion, adultery, and those in support of child marriage. Graydon, (2013) notes that criminalizing laws on homosexuality sanction discrimination and violence, and this combined with repressive social and cultural norms and subsequent economic inequalities make LBQ women particularly vulnerable to harassment and discrimination.

As is explained by Flanders et al. (2021), in most societies across the globe, LBQ people experience high rates of violence from their family members compared to violence perpetrated in the streets or the state. For instance, LBQ women in Ghana are commonly thrown out of their homes by their kin. They are also beaten by their family members and have their children taken away from them (Watson, 2017). Such violence is perpetrated because family members want the individuals to conform to sexual and societal expectations of heteronormative relationships where women, whatever their sexual desires, are expected to marry men and give birth and raise children. In countries with strict heteronormative societal norms, LBQ women are vulnerable to various forms of violence including blackmail and extortion through threats of being excommunicated from the society. For this reason, the women are unable or reluctant to report incidences of violence they encounter to relevant authorities. Logie and Gibson (2013) have pointed to high rates of violence against LBQ women in South Africa where gang rape is used as a way to discipline these women. Imhoff (2016) adds that this has a racial element, as black LBQ women in South Africa are specifically targeted as victims of gang rape which is seen as a form of punishment and a way to help them correct their 'wrong' sexual tendencies.

Incidences of violence against LBQ women in other regions of the world such as the Middle East and South Asia largely go unreported (Astraea Lesbian Foundation for Justice, 2020). In the Caucasus region a recent project entitled 'The Queer Women of the North Caucasus' revealed it is common for physical and psychological violence to be perpetrated by family members on lesbian, bisexual and transgender women (Astraea Lesbian Foundation for Justice, 2020). In a report by Astraea Lesbian Foundation for Justice (2020), one out of four women in the Caucasus have experienced sexual abuse and over one-third had been forced to get married to men. In highly patriarchal societies with no proper access to justice relating to gender-based violence, LBQ women, as well as activists, are effectively silenced (Hagen 2013). This reinforces the marginalization of LBQ women and their sense of inferior social status and LBQ women are made more vulnerable through the use of sexualized violence to intimidate and silence them.

LBQ women across the globe are also subjected to discrimination. Logie et al. (2011) note that women in general face discrimination in many regions of the world in terms of employment, healthcare, housing, and education and this situation is worse for LBQ women. For instance, Astraea Lesbian Foundation for Justice (2020) reports that employment discrimination that is founded on an individual's sexual orientation is a common occurrence in many regions of the world. A report to the UN Special Rapporteur on Violence against women from an Asia-Pacific report noted that there are numerous cases of forced resignations and contract termination based on gender identity or sexual orientation of women (Astraea Lesbian Foundation for Justice, 2020).

There is also discrimination in housing based on sexual orientation in many regions across the globe (O'Flaherty & Fisher 2008). There are many cases of refusal of accommodation or evictions of suspected LBQ tenants in many nations. The report by Astraea Lesbian Foundation for Justice (2020) explains that women are more likely to face this kind of discrimination compared to men in most societies. The discrimination is more serious for LBQ women who present themselves as androgynous or masculine (Gotlieb, 2015). Finally, discrimination against LBQ women is also seen in access to healthcare. For instance, LBQ women do not receive health insurance at the same level as heterosexual women due to the fact that most insurance plans offered by employers do not cover unmarried domestic partners. And since very few countries have legalized same-sex marriage, many of the LBQ women are unmarried partners. Even LBQ women who have personal insurance avoid going to healthcare facilities because of the prevalent stigmatization in most regions. For this reason, LBQ women are more likely to face health complications as their access to healthcare is limited. Logie et al. (2011) explain that a significant area of discrimination experienced by LBQ women relates to motherhood. Many developing nations such as Kenya do not have healthcare systems that can help support LBQ women in their endeavour to become parents.

2.2 What does it mean to be an LBQ woman in the Kenyan context?

Homosexuality is criminalized in 73 countries across the globe and only 26 nations recognize same-sex marriage (Flanders et al., 2021). Kenya is one of the counties that has criminalized homosexual acts. Under section 162 of the penal code of Kenya, titled 'Unnatural Offences', the Act deems carnal knowledge of any individual against the order of nature as an offence that is punished by a sentence of up to 14 years in prison (Bhatia, 2018). This law endorses discrimination against people from the LBQ community. Some of the common forms of discrimination witnessed in Kenya include suspension and even expulsion from schools, disownment, difficulty in finding and maintaining employment, and the persistent threat of violence (Mucherah et al., 2016). Such forms of discrimination prevent LBQ people from fulfilling their political, civil, economic, and social rights outlined in International Law. Moreover, another law, Chapter 63 of the Kenyan Penal Code, prohibits the sale, distribution, and public exhibitions of visual documentation that have a negative influence on the morals of people (Ndanyi, 2021). Homosexuality is considered a vice that can corrupt morals and hence its visual representation is prohibited. This prevents sharing of positive visual representations of LBQ people in health campaigns etc.

As is explained by Wieringa and Sivori (2013), discrimination of LBQ people in Kenya is influenced by various social and historical factors. Anti-homosexual laws that can be traced back to the British colonial administration in the 1920's. Religious bodies led by the British missionaries in the colonial times championed a hetero-normative agenda. This influenced public opinion and social norms on the issue of sexuality. In Kenya, in the last decades several groups have been involved in the fight against discrimination of people based on their gender identity and sexual orientation. Including filling of two petitions on decriminalisation of homosexuality, led by The National Gay and Lesbian Human Rights Commission (NGLHRC), Gay and Lesbian Coalition of Kenya (GALCK) and Nyanza, Rift Valley and Western Network (NYARWEK) (The conversation, 2019). Bhatia (2018) conducted a study in the less cosmopolitan areas of coastal Kenya and determined that even though various LBQ organizations are operating in these communities LBQ women still face many discrimination challenges. Bhatia (2018) explains that Kenya has a patriarchal society structure which favours men more than women and this is also witnessed through the discrimination of women from the LBQ community. Since the 1990s the LGBTQI community has been working together as a team to counter act patriarchal prejudice (Bhatia 2018). Even though all identities come together it is observable that gay men have benefited most in terms of accessing medical and legal services as well as media visibility (Bhatia, 2018). There are many clinics specifically for gay men operated by NGOs as it is assumed that homosexuality only involves men (Bhatia, 2018).

The focus on gay men rights in Kenya has had negative effects on other groups within the general LGBTQI community including LBQ women (Bhatia (2018). Gay men have become the main spokespeople for the wider LGBTIQ community. The fact that they do not face the same issues as LBQ women make it difficult for the men to articulate unique issues faced by the women (Logie et al., 2012). LBQ women face the brunt of nuanced discrimination and violence. LBQ women are subjected to verbal abuse, street harassment, physical attacks, and also lack access to security services. ACHPR (2017) notes that there have been cases where masculine-looking women have been placed in cells with males and have been raped by these male inmates. An act that the regional and international jurisprudence considers torture.

Another form of discrimination faced by LBQ women in Kenya relates to education. Kariuki (2017) explains that some families disown LBQ girls. Without proper access to education as families stop paying their school fees, these women grow up without formal employment with no proper shelter and income. This in turn extends the cycle of children of LBQ mothers living in deprived conditions as they in turn are not able to pay for their education and provide them with basic needs. Living in poor socio-economic and insecure conditions causes some of the women to develop mental health issues. This situation is exacerbated by the fact that LBQ women in Kenya have limited access to healthcare services. There is no specific service for LBQ women to attain counselling and other mental health services and organizations that offer health services to gay men in Kenya only a few also provide for LBQ women (Bhatia (2018). The reason for this is the assumption that LBQ women engaging in same-sex relationships have low risks of contracting STIs and HIV.

Apart from discrimination, LBQ women in Kenya also face various forms of violence. The most severe form of violence is 'corrective rape' which has been declared as torture by the African Commission on Human and Peoples' Rights (ACHPR, 2017). LBQ women are raped with the intent to 'cure' their sexual orientation, often organized or perpetrated by family members (Bhatia 2018). The LBQ women may end up pregnant and this subjects them to further discrimination and stigma as they do not receive support from their families.

2.3 History and Studies of LBQ women's risk of HIV in the African context

As is explained by Muranda et al. (2014), HIV has challenged the manner in which people in Africa conceive matters related to public health, sexuality, and law and has been one of the main challenges to economic growth and sustainable livelihoods. Worldwide, it has been clear that women are disproportionately affected by HIV because of socio-cultural and biological factors. The marginalization of women has a direct impact on their ability to access health care and other services. For this reason, feminist scholars have championed gendered approaches to public health as a way of addressing cultural, social, structural and biological factors that disproportionately affect women in the fight against HIV. Adolescent girls and young women between 10 and 24years account for the highest number of HIV infections (Kharsany & Karim, 2016). In sub-Saharan Africa, notwithstanding the fact that they only make 10% of the population, adolescent girls account for every one out of five new HIV infections (Avert, 2020). As explained above the situation is worse for women who identify as LBQ because of social marginalization and limited access to healthcare services.

In many nations in Africa, the post-colonial period has taken up discourses on human rights as well as gender and sexuality (Muranda et al., 2014). The African state mechanism has taken it upon itself to ensure the rights of women and other sexual minorities are upheld. This involves protecting them against discrimination based on sexual orientation. Nevertheless, the high levels of gender-based violence highlights that there is a deep patriarchal reaction that is holding onto traditional conceptualization of notions of womanhood and rejects varied and fluid conceptualizations of women's sexuality. This prejudice leads to little awareness of the vulnerability of LBQ women to HIV and has hindered the publication and distribution of scientific information on this matter (Karsay, 2018). Indeed, this has made LBQ women more susceptible and more vulnerable position. Efforts to address the HIV issues faced by LBQ women has to overcome the bias and prejudice towards this group held by society that leads to silence around their vulnerability. The silence of LBQ women in matters concerning sexual health represents the wider societal silences for non-conforming women and their context within the HIV pandemic (MacDonnell, 2007). Healthcare practitioners are unwilling and under-prepared to provide adequate medical health to WSW. Regrettably, these silences undermine the fact that there not an equitable access to sexual health information and services for LBQ women in Africa as the right to sexual health is linked closely to the marital status of women.

The dominant discourse about HIV and sexual health have both silenced LBQ women and spread misinformation Casteeleyn (2019). The lack of focus on LBQ women in HIV programmes has led to the misconception that LBQ women are not at risk or have a low risk of contracting sexually transmitted diseases including HIV. From the 1990s to the present time, studies have shown that the dearth of research on LBQ transmission of HIV means LBQ women have little knowledge on safe sex and HIV prevention (Muranda et al., 2014). Most studies on the spread of HIV among the LGBQTI community show that people have an extremely low level of access to sexual health (Magee et al., 2012). In an interaction with LBQ women, Muranda et al. (2014) note illustrates how LBQ women thought that issues of HIV and other STIs do not apply to them. They consider themselves as low risk and hence do not take the appropriate preventive measures. This misconception is carried on by state and other apparatus who make minimal efforts to include WSW groups in HIV programmes.

Chapter Three: Conceptual Framework

This paper uses the feminist stand point theory and intersectionality as the main concepts of the study reflected upon and understood from an African perspective.

3.1 Feminist Standpoint Theory

Feminist epistemology explains how women are disadvantaged in the production of knowledge. Feminist epistemologists argue that certain theories of knowledge discriminate against women by preventing them from being the subject of inquiry. (Anderson, 2000). Knowledge is produced through the situated knower which is determined by the knower's specific viewpoints. Feminist enquiry investigates how gender situates knowing subjects (Lang, 2011). In this study I take up feminist standpoint theory. Feminist standpoint theorists start from three assumptions. The first is that knowledge is socially constructed. The second one is that in comparison to non-marginalized groups, side-lined groupings are societally placed in a manner that permits them to be more aware of things and raise issues that are not perceived by the norm. The third is that studies on transformation need to begin with the experience of people on the margins (Bowell, 2011).

Standpoint theories point to how most knowledge is built from an epistemically privileged societally located point of view. A full viewpoint model ought to be specific (i) the societal placement of the privileged viewpoint, (ii) its sphere of operation (iii) the element of the societal position which creates epistemic privilege: for instance, societal obligation, or personal identity; (iv) the basis of its privilege: the justification of its hold on supremacy; (v) the kind of epistemic supremacy it has: for instance, higher precision, or bigger capability to stand for basic fact; (vi) the other viewpoints that are claiming a privilege, and (vii) methods of reaching that perspective: is the occupation of the societal position required or enough for acquiring admittance to the point of view? Most inadequate claims to epistemic privilege lack controversy (Anderson, 2000).

Standpoint theories normally suggest that the points of view of relegated societal groupings possess an epistemic privilege concerning governmentally disputed subjects associated to their subservience, in relation to the viewpoints of the groupings ruling over them. In a classical manner, standpoint models suggest that the viewpoint of the relegated is privileged (1) in exposing basic societal rules; (2) in the exposition of social procedures as replaceable and vulnerable to transformation via determined efforts; and (3) in the representation of the social sphere in connection to global human stakes (Anderson, 2000). Contrastingly, leading group viewpoints are representative of only superficial societal rules in connection to the interests of leading groups, and wrongly represent them as required, natural, or generally valuable.

Chandra T. Mohanty (1988) writes that mainstream American and European feminist writings about women in developing countries concentrate on the subjects of religion, family structures, the lawful system, the sexual division of work, schooling and, political struggle in order to explain status of women in the Global South. Furthermore, Borland (2009) posits that Sandra Harding stated that those at the top of social hierarchies are prone to losing sight of actual human relationships and the actual nature of social reality, causing them to overlook vital concerns about the social and natural world in their scholarly endeavours. Individuals at the bottom of social hierarchies, on the other hand, have a distinct perspective that is a better beginning place for studies. Despite the fact that such individuals are frequently overlooked, their marginalized status allows them to more easily outline key research issues and explain natural and social concerns. An implication of producing knowledge about women in developing nations without their concrete involvement in research studies and without involving their actual life experiences is that the knowledge produced does not actually reflect the true situation of the women. As a consequence, such knowledge does not lead to the creation of appropriate interventions for assisting such marginalized women.

In line with the propositions of Sandra Harding and Mohanty (1988) this study steers away from western-based studies and aims to focus on capturing and utilizing the lived-experiences of LBQ women in Kisumu in relation to HIV as primary data. This study will apply the standpoint feminist approach of epistemic privilege as proposed by Sandra Harding, putting the LBQ persons at the core of the investigation since they are the ones with the lived realities. Furthermore, the study will also include LBQ women living with HIV to provide more vivid accounts of their experience with HIV services.

Feminist Standpoint Theory from an African Perspective

According to Sylvia Tamale (2020), African culture and perspectives have been generally overlooked in feminist studies because of the colonial influence of the European countries. This bias has been transferred to literature and studies focusing on the African context which reflect a Western perspective (Bennett, 2018). Because of this, the findings of such African based studies are not considered to be part of mainstream knowledge including feminist theories. According to Datta (2004), interest in the studies focusing on gender and women, in particular, gained prominence in the 1970s. These approaches started and were popularized by Western countries and produced a dominant view of gender that was not based on African social or cultural realities and hence propagated feminist knowledge about African lives from a Western perspective rather than African perspective. Tamale (2020) notes that the organization of gender in traditional African societies was not based on patriarchal or heterosexual lines. Rather, this was learnt through colonial conceptualizations. In recent times, scholars have been trying to develop paradigms that would help in better understanding African perspectives and experiences concerning gender (Tamale, 2006). This highlights the importance of standpoint theories which are specific and strive to highlight the viewpoint of underprivileged groups.

Tamale (2020) further explains that the leading Western feminist theory disregards the African perspective and hence leads to misleading information about women in African societies. For one, Tamale (2020) explores a study on the indigenous Igbo gender arrangements in Nigeria and highlights how the Western feminist theory assumptions and understanding of sex/gender conceptions do not portray the reality of life in this society. This challenges the leading western feminist conceptualization as it introduces foreign concepts such as ‘female husbands’ and ‘male daughters’. From this, it is seen that in traditional African societies, biological sex did not always correspond to ideological gender. Furthermore, the gender system was flexible and hence in some communities, there were women playing ‘male’ roles. Again, this highlights the importance of the feminist standpoint theory considered in the current study. This theory would ensure a shift of focus in a study from western-based views to examining lived experiences of underprivileged groups in their particular contexts.

Because of the difference between the Western and African perspectives on feminism, Tamale (2006) explains that it is important for scholars to develop feminism theories that are specifically suited for the African context. She explains that there is a significant gap between the western feminism theory and practice in the African context. Tamale (2006) explains that there is a huge disconnect between feminism theories and the activist practitioners on the ground in Africa. For most African nations, women's rights and gender equality does not extend beyond the legal landscape despite the fact that the activism is founded on feminist theories that appear to work for the Western world. Tamale (2006) posits that the lack of suitable feminist theory to inform gender activism leads to half-baked and truncated feminism.

Tamale (2006) suggests that we should consider the political structures, institutions, and systems in order to develop a proper feminist theory that considers the African perspective. This would also involve theorizing the work on the home-grown feminist theory that would reconceptualise the crucial connection between theory and practice. Nkekana (2015) notes that gender transformation is one of the main challenges to African futures. Following feminist methods of enquiry, it is important to include people from marginalized groups in studies about them, therefore to knowledge about the African context needs to include African women's views for transformation to be possible. Feminist standpoint theory privileges the viewpoint of those who are normally relegated to the margins of the dominant discourse (Borland,2009). In this RP the privileged, viewpoint is of LBQ women in Kenyan society.

This study uses a standpoint feminist theory philosophy in structuring the study and analysing data gathered. According to Rolin (2009) the feminist viewpoint philosophy counsels a social researcher to double the procedure of creating proof using a tactic of empowering individuals. Standpoint theory suggests that the relegated are the originator of 'truth' concerning suppression, that is quietened by archaic objectivist study techniques because they create knowledge from the viewpoint of people in influential positions (Harding, 2004). Considering LBQ women as a marginalized group when it comes to accessing

HIV services, this study has employed the standpoint theory as a methodology in exploring their lived experiences in relation to their knowledge, perceptions and access to HIV services.

Tandon (2018) points to one of the criticisms of the standpoint feminist research being female researchers from outside the categories claiming to "speak for" those within these categories or they can allow themselves within the politics of these categories. In order to address such a risk of appropriating the voices of the LBQ women, this study led by a queer woman from Kisumu chose to directly work with LBQ women in Kisumu who are members of social movements and pay less attention to outside parties who are not LBQ women themselves. Another critique of the feminist standpoint literature according to Rege, (1998) is that such research risks generating a narrow frame identity politics and this research addressed this possible limitation by paying more attention to the lived experience of the LBQ women participating in the study.

3.2 Intersectionality

Another conceptual tool the research paper uses in order to explore the experiences of LBQ women is intersectionality. Intersectionality refers to the interdependent and mutually constitutive relationship between social identities and structural inequities (Logie et al., 2011). The concept of intersectionality views the intersection of identities as synergistic, producing different and distinct experiences of oppression and opportunity (Purdie-Vaughns & Elibach, 2008). Multiple social categories such as socioeconomic status, race, ethnicity, gender, sexual orientation, and socioeconomic status intersect at the micro-level of individual experience to mirror various interlocking systems of subjugation and privilege at the macro, social-structural level, such as heterosexism, sexism, and racism, according to intersectionality theory (Hankivsky, 2012). Additionally, intersectionality denies the supposed additivity of disparities and challenges current research methodologies that highlight any one axis of inequality, such as gender, class, or race. Intersectional-based research looks at the repercussions of various intersecting forms of oppression at the interpersonal level. Such research aims to explore, taking into account economic and socio-political histories, the underlying causes of those interpersonal experiences, as well as other types of and systemic structural aggression.

Public health research aims to improve people's health and well-being. Such an improvement necessarily entails addressing health inequities that might arise from historical, economic, political and social discrimination (Rapid Response Service, 2013). As Bowleg (2012) contends, intersectionality immensely benefits public health research. A person living with or at risk of HIV and a person at the intersection of multiple identities and experiences faces different challenges and obstacles (Rapid Response Service, 2013). Taking into account the complexity of peoples' lives it is important to not exclude one group of people from HIV research and advocacy simply because they do not fit in any of the categories considered high-risk. Rapid Response Service, (2013) suggests that applying the concept of intersectionality to HIV research could reveal previously invisible social injustices and more completely address the social and structural drivers of the continuing exclusions and discrimination of some vulnerable groups in HIV research and programming.

Intersectionality may be particularly relevant in the context of stigma associated with HIV. This is because HIV-associated stigma originates from and may be made worse by intersecting subjugated identities in the case of marginalized groups. Furthermore, HIV-associated stigma exacerbates social and structural inequities based on sexual orientation, gender, class and race. According to Logie et al. (2011) HIV-related stigma analyses are not only complicated by the intersection with other forms of stigma, but also by the multiple levels of stigma. From an intersectional perspective, HIV-associated stigma encompasses intertwining levels of stigma from individual, social and structural purviews. Individual-level factors would originate from individual beliefs and attitudes. Society-level factors would emanate from social norms and community norms. Structural-level factors would come from health and social systems, policies and laws of the land as well as political and organizational power. At the individual-level, factors that influence stigma include intrapersonal elements such as personal attitudes, beliefs and knowledge (Logie et al., 2011). At the society-level, factors that influence stigma include relations with family and friends.

Some researchers have employed an intersectional theoretical approach to explore overlapping stigmas experienced by HIV-positive women. According to several studies conducted by such researchers, HIV prevention barriers among Black women in Canada include HIV-related stigma, sexism, racism, and homophobia highlighting the salience of an intersectional approach in investigating HIV-related stigma (Williams et al., 2009; Newman et al., 2008; Tharao & Massaquoi, 2001). For instance, policy, economic, social, and institutional factors enhanced the vulnerability of North American Black women to HIV infection, according to an examination of low-socioeconomic status Black women's and community service providers' opinions on HIV risk and prevention by Newman et al. (2008). The study by Williams et al. (2009) also found that significant risks linked with HIV prevention among black women, including individual, familial, community and institutional factors are not divergent, but rather connected. Collins et al. (2008) conducted a qualitative study in New York City to better understand the many identities that interact to influence HIV risk among Latina women with severe mental illness. Based on the findings of the study, the consequences of those numerous identities which included immigrant status, poverty, race and gender, could not be implicitly disconnected and were not always additive, but the intertwining impacts can promote greater HIV risks.

In the case of LBQ women and HIV, Logie et al. (2011) asserts that there is not much information about the connections between the intersecting stigma and experiences LBQ women who are living with HIV in accessing HIV-related services. An enhanced understanding of the experiences of HIV-positive LBQ women who face intersecting stigmas can inform HIV-related exclusion reduction interventions among LBQ women, health promotion initiatives for LBQ women, and enrich comprehension of stigmatizing processes among LBQ women living with HIV. This study applied the concept of intersectionality as an axis of discrimination to examine the manifold types of exclusions that face LBQ women with regard to HIV services, research and programming. Specifically, the study employs intersectionality to interrogate how the assumption that LBQ women are a low-risk group compared to other groups, particularly those in LGBTQI community, seemingly produces exclusions of LGBT women in HIV programming and the society at large.

Chapter Four: Research Methodology

4.1 Research Area

The research was conducted in one of the major cities of Kenya, Kisumu. The choice of this city was because of the heavy presence of LBQ women, the LBQ Social movements and organizations in the county. The county also has more LBQ visibility in the country as compared to other areas and actively engage with the Ministry of Health (MOH) and other mainstream NGO's in carrying out activities. It mostly targeted LBQ membership organizations; these are LBQ led organizations with programs targeting LBQ Women and have the LBQ women that are involved in their activities.

4.2 Position in the LGBTIQ community

Having worked in the LGBTIQ and the feminist movement for more than seven years now and also being a leader of the oldest and one of the first LBQ Organization in Kisumu, I am deeply embedded in the discourses around the topic. I have engaged with a lot of networks and advocacy, including technical working groups representations. I am part of and I identify with the LBQ community hence reaching out to particular people and organizations to be part of this research proposal was not a challenge. I was aware that my leadership position could make the participants feel obligated to take part in the research to please me or for fear of losing out of programs that my organization runs, as the organisation has involved many LBQ women in different interventions. I aimed to prevent this by disclosing that the participants were fully aware of the intentions of the research as an individual academic research and that by participating they will help to fill a research gap when it comes to HIV and LBQ women. It is in the spirit of "ubuntu" that the research has been undertaken. I could do this research because I am part of this community. One of their own, who suffers the same exclusions and in the same spirit the LBQ women contributed to the research so there is a collective ownership and the future benefits of this research belongs to all the community.

4.3 Research Design

In this study the qualitative case study design is used to explore the workings of HIV programs in relation to LBQ women taking a feminist standpoint approach. In quantitative research, if the initial responses appear vague to the researcher, qualitative data can be used to provide context and possibly explain something that numbers alone cannot disclose (Almeida et al., 2017). This research design was chosen because it was hoped that through it the perceptions of LBQ women and HIV and the implications of these perceptions would be comprehensively unpacked.

The qualitative approach was also appropriate due to its high level of flexibility. According to Almeida et al., (2017) through qualitative research it becomes possible to generate authentic detailed data and emotional responses. By this, it became possible for the researcher to evaluate the emotional variations of participants and follow-up on some answers that extra more information.

4.4 Sampling and Participants of the study

The research employed critical case sampling technique in selecting participants. According to Patton (2007) critical case sampling is when a researcher collects samples that are most likely to provide him or her with the information he or she needs. This sampling technique is important for this study because allowed the selection of a sample of participants who were likely to offer a wealth of information regarding matters of LBQ women and HIV as opposed to the general population. In the application of these technique, only individuals with who are LBQ women or with close proximity to issues of LBQ women and HIV were selected to participate in the study. Applying the critical case sampling technique, the research sampled 40 LBQ women (20 of whom are HIV positive) and four LBQ leaders from LBQ social movements in Kisumu. The four leaders are LBQ women themselves. The choice of all participants being LBQ women was done with the belief that the LBQ women are the ones with the lived reality and hence their voice on the subject of LBQ women and HIV would be heard.

Profile of the participants selected for the study was as follows:

Age	Number of LBQ women participants
18-30 years	20
Above 30 years	24

HIV Status	Number of LBQ women participants
Positive	20
Negative	24
Chose not to disclose	0

Highest level of education	Number of LBQ women participants
University/college	11
Vocational training	17
High school	15
Primary school	1
No formal education	0

4.5 Data collection process

The study was based on qualitative data and did not attempt to collect data on socio-economic aspects of the participants. Instead, the focus was on the emotions and concerns and understanding of the community. The questions were therefore semi-structured and that allowed for more deeper discussions which captured even more information. Semi- structured interviews and focus group discussions (FGDs) were the chosen tools for collecting data in the study. FGDs were chosen because they can stimulate new ideas, offer flexibility in the questions asked and also enhance the understanding of participants' opinions. The nature of FGDs allows respondents to discuss their pre-existing ideas as well as provide feedback on new information mentioned by fellow group mates

(Hennink, 2013). The interviews where used to gather data from key informants while focus group discussions were employed in gathering data from LBQ social movement members.

In conducting the FGDs, the 40 respondents were split into four groups of 10 each so that each FGD consisted of 10 respondents. The first step in carrying out the FGDs was selecting questions and discussion prompts and organizing them on a focus group questionnaire guide. Before the focus group discussions were started, the participants were reminded about the purpose of the study and were given consent forms to design. The consent forms reiterated the goal of the study, outlined the participants' rights, identified the compensation and required participants to sign to show their voluntary acceptance to participate in the study. To break the ice and get the participants talking, the researcher started the discussion off by introducing herself and inviting the participants to do the same. During the FGDs, the researcher sought equal representation from the participants by prompting those who were quite to also render their input to the discussion. For LBQ leaders, four key informant interviews were conducted.

The data collection process was accompanied by adherence to the World Health Organization and Kenyan Government’s standards of COVID-19 prevention. Such standards including, COVID-19 screening and testing, keeping 1.5 meters’ space between participants, continuously washing of hands with clean water and soap, use of alcohol-based sanitisers, covering the nose and mouth while coughing and sneezing and proper wearing of face masks at all times during the research engagements.

4.6 Data Analysis

Data gathered from the study was analysed using thematic analysis. According to Evans & Lewis (2018), researchers working in the social sciences that utilize realism or constructionist perspectives can benefit from thematic analysis. While constructionist paradigm allows for the world to be known any way that individuals view it, realism upholds that individuals are bounded by a real social and physical world (Madill et al., 2000). The current research study can be positioned in both constructionist and realist paradigms as it will allow for the dynamics of HIV among LBQ women to be known in the way that the women themselves perceive them and also show how the LBQ women are influenced by the real social and physical world. The initial step for conducting the analysis was to get familiar with the data that was in form of audio files and transcribing the data. I read through the transcripts and actively observed patterns and connotations that appeared across the responses. In the next step, I developed a set of preliminary codes that represented the patterns and meanings that I had observed in the data. I created a codebook to keep track of the data and read through the data again to identify any interesting excerpts and apply suitable codes to them. In the third step of data analysis, I grouped together all the excerpts connected to a certain code (Nowell et al., 2017) I then sorted the codes into prospective themes and determined how different codes could be combined and determined is there are themes that could be made into sub-themes. In the fifth step, I reviewed and revised the themes I had developed and ensured that each theme had adequate data to support it and that each of theme was distinct. For some themes that were similar, I merged them and eliminated themes that did not have adequate data to back them up. After the fifth step, I began formulating how the themes could come together as a narrative and began the culminating stage of writing the final RP report to tell the story of the collected data. I ensured that the narrative and discussion of the findings tell a coherent story about the collected data. The discussion includes my own interpretive analysis and makes arguments for the claims that I present.

4.7 Research Ethics

The Research paper adhered to the human rights principle of "Do no harm" throughout the data collection process as it targeted members of the LBQ community who are considered to be amongst the most marginalised in the society. It also observed several research ethical considerations including informed consent, voluntary participation, confidentiality and anonymity of participants. The participants were provided with snacks and refreshments and were also compensated for their time by providing them with transport reimbursement to cover for the cost they incurred coming to the research venue.

4.8 Limitations

The study focused on LBQ women of Kisumu County with whom I was in contact and there did not have the same representation of rural participants. This could have led to biases in the study. The FGD was conducted under strict COVID-19 restrictions and hence the participants could not mingle freely as they were further divided to even smaller groups to avoid overcrowding as a measure to prevent the spread of COVID-19. This meant I could not go into more unstructured discussions.

Using qualitative research gives an avenue for deeper discussion and can at times results to difference in opinion and arguments among participants. I found myself in an awkward position when participants sought clarification from me on areas they did not seem to agree on as they looked at me as an expert at the moment. I solved this by reemphasizing to the participants that it is the difference in opinion and perception that the study is informed and they shouldn't be worried about being right or wrong. There were also instances when participants got very emotional and broke down during the discussion, I handled this by pausing the discussion for some time and engaging the participants in ice breakers. I ensured that the participants were aware of the available free counselling session and referred them to a counsellor who could offer them support. I had a personal bias when I started my research with the belief that the LBQ persons are excluded from HIV matters but in the process of data collection I realized that there were more exclusions from within the LBQ community.

Therefore, being a leader who has been in the community for a long time and residing abroad at the time of data collection, I was very conscious of the privilege and power dynamics that I might have presented at the time. The participants must have felt obligated to participate in the research for the fear of being left out in future programs of my organization. Being the researcher, I might have influenced the discussion to go my way as I had a formed opinion of what I was looking for with my study. My level of education and place of study might have intimated some of the participants as they looked at me as an expert. To ensure a power balance, I explained to them that they were the ones with epistemic privilege and hence the most important people and aspect of the study. I also replayed some moments and activities that we participated in together a few years ago so that they could look at me as an equal and as part of them. I allowed everyone to give their own perspective to my questions including storytelling to avoid my personal bias in the research, and explained that my study abroad is meant to be implemented in our context and therefore they should be free to discuss in the context that we are in without feeling the need to compare.

Chapter Five: Findings and Discussions

5.1 Introduction

The current study set out to investigate the perceptions of LBQ women's risk and its implications in terms of exclusion of LBQ women from HIV programming, services delivery and research. The data collected from the interviews and FGDs was analysed using thematic analysis and the findings were organized into themes (see appendices for interview guide and FGD guide. The findings chapter is segmented based on the study's sub-questions and the findings are presented in form of themes emergent form the data that made meaningful contributions to answering the research sub-questions.

5.2 Perceptions of LBQ Women's Risk to HIV

Disagreement with the perception that LBQ women are a HIV "low risk group

All the participants from the interviewed groups vehemently disagreed with the assumption that LBQ women are a HIV low-risk group. They cited the presence of a substantial number of LBQ women who are HIV positive and various ways through which LBQ women could get HIV.

One of the respondents, a leader from one of the LBQ women organization mentioned that;

> "I would say that perception is misleading because we are looking at data, we are looking different aspects on HIV because we find that we have LBQ who are bisexuals, how safe are they how true is it that they have safe sex, forget about that even lesbians, how is their sex life safe because people are using toys and all that how are they taking care of that?"

Another key informant, also a leader at mentioned that;

> "Personally, I believe that it is not true cause we are at high risk of HIV considering we are out here you know there are cases where by you get a partner has not come clean with their HIV status and someone is negative and the other is positive you know, when you meet you have a sexual engagement, see… the person is at risk so there is nothing like we are not at risk".

A respondent from the LBQ women FGD group mentioned that

> "I think it is an assumption. Because we have LBQ women who are HIV+ and I think the government or a few researches I have done by myself, the government wasn't willing to support the fact that LBQ people can be at a high risk of infection. For me and the experiences, I have had... the government doesn't believe that LBQ women are at risk of transmitting HIV".

While all the participants perceived the assumption that LBQ women are a HIV low risk group as being wrong, there were some indications of the belief that assumption is true by some members of the LBQ women's community. Acknowledging this belief, a HIV positive LBQ participant said that;

> "the kind of sex we have as same sex relationship you find that we do the scissoring we do the licking you know it is still risky but most of us tend to believe that it is only penetrative sex that gives us HIV which is a myth, so I believe LBQ women even in heterosexual marriage people are at risk of contracting HIV at the same level so it is just a myth and misconception that most LBQ women believe in and I think it is time we opened up and stopped putting ourselves in this act".

Adequate Knowledge of HIV risk and transmission pathways among LBQ women participants

While criticizing the claim that LBQ women have a low-risk of acquiring HIV, the participants mentioned several pathways through which HIV is transmitted in LBQ women. Such pathways included scissoring, licking, sex with men, sex work, injection drug use, sexual violence/corrective rape.

One of the key informants mentioned that;

> "LBQ women who do sex work and do not come open about it and end up involving themselves with so many partners and as a result are at a high risk of contracting HIV".

A participant who is HIV positive said that;

> “some of us were born with HIV, yes some of us were previously married and I think the other part of it is we are at high risk of contracting HIV we tend to think we are safe and that is why I have said it is a myth and misconception number one the kind of sex we have as same sex relationship you know it is still risky”.

Discussion

LBQ women are perceived to be at a low risk of contracting HIV than other groups in the LGBTQI community (Marrazzo, 2005; Arend, 2005; Logie et al., 2012; Zaidi, 2016). When asked about their opinion of this perception, all the respondents disputed this assumption and went ahead to explain the various ways through which LBQ women can contract HIV. From the responses provided, there is an indication of widespread knowledge and experience of the proposition that LBQ women are a HIV- low risk group in the LGBTQI community by the LBQ women who participated in the study. It is also important to note that one of the respondents highlighted the presence of some LBQ women who still believe that they cannot contract HIV since they do not engage in penile-vaginal intercourse. This may indicate a lack of awareness of the ways through which HIV is spread among some LBQ women and may warrant for the need for creating further consciousness of the risk to HIV that all LBQ women face and the ways through which they can get affected.

In standpoint feminist theory, Harding (2004) proposes that it is common for those at the top of social hierarchies to be unaware of actual human relationships and the true nature of social reality, and as a result, they overlook key concerns about the natural and social spheres in their academic studies. Individuals at the bottom of social hierarchies, on the other hand, have a distinct perspective that is a better beginning place for studies (Harding, 2004). Considering the LBQ women as one of the groups in the bottom social hierarchies because of their discrimination, their knowledge regarding HIV risk among LBQ women should be considered as valuable in the context of the convention assumption from previous studies of marginalized groups. Furthermore, by some of the LBQ women living with HIV narrated how they acquired HIV further revealing the actual nature of their reality which was lacking in previous studies on LBQ women, particularly those in Kenya. From their responses, some of the LBQ women who participated in the study hardly have sexual relations with other women exclusively since some of them have sexual relations with men and this exposes them to risks linked to heterosexual sex such as HIV. As such these LBQ women are still at much risk of contracting HIV as heterosexual women making them a significant population for HIV public health efforts. Marrazo and Gorgos (2012) note that even though LBQ women are usually perceived as low risk for HIV transmission, evidence shows that there is the transmission of other STIs including herpes simplex virus, human papillomavirus, trichomoniasis, and hepatitis B. Logie et al. (2014) research has also revealed that LBQ women have comparable STI incidence to heterosexual women and that there are similar knowledge gaps on safe sex practices for both LBQ and heterosexual women.

5.3 Invisibility of LBQ women in HIV research discourse and programs in Kenya

Exclusion of LBQ women in HIV research and data collection in Kenya

The focus group participants and key informants highlighted the exclusion LBQ women from HIV research and the need for the few existing studies about LBQ women and HIV in Kenya to be translated into action. The findings of the study revealed that having conversations on HIV and LBQ women or including LBQ women in HIV research is always met with a lot of opposition and request for evidence or proof of data that LBQ persons are affected which is hardly there hence leading to their exclusion in HIV matters.

An FGD member explained that;

> "... people didn't believe that LBQ people are people at any risk, because someone asked... where's the data and where is the research that was done and by who with LBQ women in specifically tested and proven. … Everybody was very curious in fact with that particular presentation because they wanted to see where? which data... actually carried the information about LBQ women being tested on HIV to prove that actually they are HIV+. And we didn't have any... just told them… the same answer no one has been interested to basically do research!"

When asked about the assumption that LBQ women are a HIV low-risk group, the participants criticized existing studies whose findings seem to support this assumption. One of the key informants claimed that such studies are incorrect especially for the case of Kenya. She further explained that LBQ women who are HIV positive hardly disclose their sexual orientation when they go for HIV testing because of the stigma associated with homophobia.

Another participant from the FGD responded that;

> "I have done a few program research studies myself even for MSM, and anytime you could ask about the LBQ women, they would always say... that LBQ people are not always at risk of contracting HIV. Then when you ask them the fact that LBQ women are already infected with and suffering from HIV the only thing that they would say is show us the data".

A key informant explained that;

> "I would discredit such studies or books because the fact is HIV is there and as LBQ women who are sexually active we are exposed to it the fact that the studies are saying that we are not at risk that is a big lie that can be discredited if more LBQ women who are HIV positive come out as being positive and being LBQ women".

Identifying the need for challenging the studies that have concluded that LBQ women are at low-risk of HIV, one of the participants of the FGD said that;

> "but still the people who are conducting that research need also to be like challenged, we start from where it started, we get the limitation of that research and how many people did they interview to make a part of that informs that key population do not include LBQ women".

The findings also revealed the absence of provision for capturing LBQ HIV positive women data in the Kenya Health Information System (KHIS) previously known as District Health Information System (DHIS) and most LBQ women's data are mostly captured under sex workers' data.

One of the women in the FGD group explained that;

> "If you look at that definition of what key populations in organizations that deal with HIV vulnerable groups, it's either sex workers and

> nowadays they say including trans, then they say MSM, people who inject drugs, and even the marginalized, migrants…but LBQ women cut across all these spectra and our data is left out".

Another participant explained that while acting as a counselor during a HIV test drive. They had a case of a trans who came for HIV test and they wanted to be described as He but, we couldn't write he as they were not conforming to what the forms that we were given to fill in for the registration of participants. The only boxes available to fill in for sex and gender dictated male or female only.

Exclusion of LBQ women from participation and decision making in HIV programming

The FGD participants and key informants also pointed out the limited engagement of LBQ women in HIV programming. For instance, when asked about the exclusion of LBQ women in HIV programming, a participant from one of the FGDs mentioned that;

> "I think they are excluded, there is no day I have heard that they have brought programs for LBQ who have HIV. Even teaching about HIV, the positive LBQ women who have HIV have been left out".

One of the key informants mentioned that;

> "HIV programming is much more on bisexual men than women. and yet they are both proportionately affected by HIV. So, you will find that it is easy to go to a drop-in centre, that bisexual men are being offered services but you will never get services that are specific to bisexual women and that amounts to bi-erasure in HIV programming".

Another key informant explained that;

> "I have done HIV programming at the Key populations, I have done also with the general community, children, and women as well, it's never specifically LBQ, and... there's no place you will hear the name LBQ. All the HIV programming is strictly for the key populations and the general public".

Regarding involvement in decision making processes in HIV programming, one of the key informants explained that

> “even within feminist and LGBT spaces that advocate for women rights, LBQ women’s voices are not quite there or are not quite hard most of the times LBQ people we are just in the forefront when it comes to protesting jointly with other feminist but when it comes to serious involvement, they don’t even engage us… we are nowhere, not in regional, national or international when it comes to HIV in fact, we are invisible”.

An FGD participant explained that;

> “I don't think in terms of the level of leadership in HIV programs there's inclusion in terms of LBQ women... and that's the reason why there's this gap I believe if women were involved at that higher level, I believe there will be something to talk about now”.

Self-isolation of LBQ women from HIV programs due to their exclusion from the programs

From the findings of the study, it is evident that the manner in which programs have been designed are not LBQ friendly and also do not call for the participation of LBQ women, hence LBQ persons tend to stay away from them as they do not respond to their specific needs.

A respondent in one of the FGD’s explained that;

> “Because there are no programs that target LBQ women in that case, there is no space for women to feel they are free because the world has already given these women like zero risk on HIV matters since they believe that infection sexual penetration is the only major method of infection”.

Another FGD participant mentioned that;

> “LBQ women have been isolated from all the other programming because most of the HIV programs focus on matters of MSM and believe that HIV is transmitted through the penis and all that. So, they focus on everything men but the focus is not directed in any way towards LBQ women”.

Exclusion in accessing HIV donor funding

Some of the responses in this study indicated that priority for funding to groups which submit comprehensive data and evidence of HIV infection rates and effects. As a result of this prioritization, Gay Bisexual and Men who have Sex with Men (GBMSM) projects on HIV take the largest portions of donor funding with LBQ women's movements left with a very small pool of donors to fundraise from.

One of the respondents explained that when securing funds for LBQ social movements they face difficulties due to lack of data on LBQ women and HIV. The participant explained that;

> "When it comes to HIV money when you go through the GBMSM angle and write a bit about LBQ women you will find, but even if the allocation comes for LBQ the GBMSM does not give the LBQ women what is due, and they skew that data by clamping it all up by even taking up LBQ data and clamping it as GBSM data. So, our data gets lost and we also don't get the money".

In correspondence, one of the key informants explained that;

> "even the funding patterns and how we know the funders, they don't even prioritize HIV or SRHR for LBQ women because of the perception that has been there so we have not been able to like develop a program that is geared towards LBQ and HIV".

Discussion

The invisibility of LBQ women in public health research in Kenya is identified by the study of Zaidi et al (2016) affirms that the general lack of study on LBQ women compared to MSM and heterosexual men and women can be ascribed to LBQ women's perceived lower risk of HIV contraction of LBQ women. The findings of this study add to the discussion by identifying ways through which this invisibility is embedded in the research discourse due to the perception that LBQ women are a HIV-low risk group. These findings confirm feminist standpoint theory that women and other marginalized groups are excluded from the institutions that develop and classify knowledge about social life (Naples, 2017). Viewing LBQ women as the marginalized group in this study, the respondents narrated several incidences which demonstrated how they are excluded in HIV research institutions as well as governmental bodies involved in public health data collection such as the Kenya Health Information System previously known as the District Health Information System. As explained by Logie et al. (2014) the exclusion stems from the fact that HIV programmes and interventions assume that LGBTQI people are mainly males and hence disregard the plight of LBQ women and their specific concerns.

The effects of the exclusion from research has led to the self-isolation of LBQ women from HIV programs and difficulty for LBQ women social movements to access donor funding. The LGBT women avoid going to HIV programs and projects because they say the programs do not offer packages that are specific to the needs of the LBQ women. Because of the perceived low risk of LBQ women contracting HIV, there is less urgency and concern in getting involved in HIV relevant programmes and research. Indeed, there is extremely low utilization of sexual health programmes among this group (Logie et al., 2014). This is despite the fact that there are comparable rates of infection between heterosexual and LBQ women.

The difficulty in getting donor funding stems from the fact that there is little to no evidence and data that LBQ women are at as much risk of HIV infection as other marginalized groups in the LGBTQI community, there are many LBQ women living with HIV already and that there is need for HIV services among LBQ women in Kisumu. Because many donors require showing such evidence as a prerequisite for giving grants and donations to social movements, this inhibits the efforts of LBQ social movements.

5.4 Exclusion of LBQ women's needs in HIV healthcare structure

Insufficient LBQ-tailored care and treatment HIV services

When asked about accessibility to HIV services by LBQ women, one of the key informants mentioned that;

> "To be honest I feel they are not very readily available unless someone has a particular doctor or nurse in mind that you know knows your sexual orientation and you can visit but they are not easily accessible so

> I think, if I would walk into one, I will not maybe disclose my sexual orientation and in most cases, people don't disclose their orientation at that particular time so they are not very accessible because by identifying you differently they have already stigmatized you".

A HIV positive LBQ woman from the FGD mentioned that;

> "I think some services are there but it becomes difficult to access them while being honest about our sexual orientation. For instance, when it comes to mental health issues like disclosing to somebody who is not an LBQ woman and does not understand your issues. Also, there are those counsellors who have their own values that are against homosexuality so it becomes difficult to know exactly where to get suitable counselling services and that is why I think mental health issues are on the rise among LBQ women because they don't know who to open up to".

Insufficient LBQ-tailored HIV prevention information and tools

From the responses gathered from the FGD's and key informants, it was deduced that there is lack of LBQ tailored information on how LBQ women can prevent themselves from being infected. This leaves LBQ women with only information on how to prevent infection in heterosexual relationships and not knowing of any other choices that are appropriate for LBQ women.

One of the key informants mentioned that;

> "Lack of information that is specific to LBQ persons is very limited for instance when we go for a HIV test with my partner either I will find a service provider that has no information about generally how I need to I protect myself as an LBQ person or together as an LBQ couple that is discordant, how do we even protect ourselves? such kind of information is lacking and I think those are some of the things that we need as a community".

Furthermore, a lack of LBQ sexual protective commodities was expressed in all discussions as compared to the availability of sexual protective tools accessible to GBMSM. A respondent from the FGD group consisting of HIV negative LBQ women explained that;

> "There are no commodities for HIV prevention in all nearby clinics. Like if we say we want dental dams… which are supposed to be given by the government... it's a commodity that cuts across all…".

Another respondent from an FGD consisting of HIV positive- LBQ women mentioned that;

> "Getting dental dams is an issue and a problem so we have to improvise by either tearing the female condom and using it as one or even the male condom since the female condoms are equally expensive and hard to come by. Getting the finger condoms is now just hectic and for that reason the transmission of HIV in LBQ women continues".

Exclusion of LBQ women from accessing HIV prevention medication was also identified form the study's findings. A respondent from the FGD said that;

> "regarding PrEP- pre-exposure prophylaxis, HIV programs focus on sex workers so we go as sex workers, because the programs are structured in a manner that it is either you're gay or a sex worker, so most of the time we pretend to be sex workers to access this service".

Judgmental and discriminatory HIV service delivery

The responses from the participants indicated various incidences where there were treated differently and discriminated against by healthcare providers when they made attempts to get HIV services such as HIV tests.

One of the respondents in the FGDs explained that;

> "I think it will be very important if the LBQ women had HIV services on their own because even the health care workers discriminate LBQ people, once you go to the facility and introduce yourself as an LBQ woman who would want maybe services on HIV. The first question a health worker who is not sensitized well would ask is why you want HIV services and you are a woman having sex with a fellow woman?"

Recounting her experience of going for HIV test together with her partner, one of the key informants explained that;

> "last time when I went for HIV testing with my partner, the service provider who was there, almost refused to attend to us... like he was asking how do I test you two together? Like why must I do that and I was like

> she is my girlfriend, I want to know her results, and the girl is also saying, yeah just test us. Then he became serious, the provider became too serious and I was like she is my sister, we want to know the results all of us. So, we just got tested, though the provider was left in some kind of shock?”

Discussion

The Kenyan State has a constitutional mandate to ensure the highest attainable standard of health care services for all citizens including reproductive and HIV healthcare services. As indicated by the findings of this study, such services are however unavailable, insufficient or discriminatory in the case of LBQ women. The themes discussed above indicate the exclusion of LBQ women in the HIV healthcare structure based on the responses from the interviews and FGDs. Furthermore, themes designate several structural factors that influence the exclusion of LBQ women in the healthcare HIV healthcare structure in Kenya. These factors include LBQ-disapproving healthcare practitioners, lack of planning and budgeting for HIV protection commodities for LBQ women as well as the lack of healthcare practitioners who have been trained on HIV in LBQ women. These factors are similar to what was discovered by the study of Wilson et al. (2019) on the sexual health needs of minority women in Western Kenya. the authors concluded that the practice of health policy is not inclusive of LBQ women it does not have LBQ-specific health facilities, LBQ-friendly health physicians and does not offer LBQ-friendly health supplies. The implications of the presence of these factors in the healthcare system is that of LBQ women self-isolate themselves from going to seek HIV services.

A history of marginalization of sexual minority women from health services has been a major contributor to the low levels of engagement of LBQ women in HIV prevention programmes. In fact, there are few services that are tailored to satisfy the health requirements of LBQ women and the care provided is not usually enough (Anderson et al., 2001). Pinto et al. (2005) explains that LBQ women do not regularly visit gynaecologists and even get tested for STIs including HIV. Logie et al. (2014) explain that lesbians report significantly lower rates of Pap testing compared to other groups in the LGBTQI spectrum. Moreover, Yi et al., (2010) notes that lesbians have higher chances of not having a regular doctor compared to heterosexual women whereas bisexual women have higher rates of unmet healthcare needs.

Another implication is that LBQ women choose to register as heterosexual women when going to receive HIV services in order to avoid discrimination or judgmental treatment from health practitioners. Such registrations by LBQ women further compromises statistics of LBQ women in terms of their HIV infection rates and numbers. According to Anderson et al. (2001) the issue for most individuals is not being comfortable enough to disclose their sexual orientation to people including healthcare practitioners. LBQ women usually decide not to reveal their sexual orientation because of concerns regarding low standards of care, confidentiality, and fear of negative or inappropriate responses.

5.5 How exclusion of HIV positive LBQ Women is produced in health system and society

Exclusion of LBQ women living with HIV by the other LBQ women

Stigma and discrimination within the LBQ community towards LBQ persons who are HIV positive is just as bad as the one from the general community as it can be deduced from the respondents in the FGD with HIV positive LBQ women. For instance, the participants explained that it was difficult for HIV negative LBQ women to date or have an intimate relationship with HIV positive LBQ women.

One of the participants explained how some LBQ women have been isolated because they were dating someone who was HIV positive;

> "The journey is not easy, like for example let me say I'm dating this person whose HIV positive... then people get to know everybody will be like, my girlfriend has HIV maybe even I have it, so your friends will abandon you because you're dating someone with HIV. The journey is very difficult."

In correspondence, a key informant explained that;

> "We have had sessions in the past with 3W where some members, their own perception, they said they wouldn't date a HIV person. They got asked even if they come and disclose? They said NO! you can imagine?"

Dating LBQ women living with HIV has been seen as a favor done to them by their negative partners exposing them to all forms of violence from their intimate partners and for the fear of their status being outed, they stay in these toxic relationships.

One of the FGD respondent living with HIV explained that;

> "...when one of my friends who is positive told her partner about her HIV status, the partner then took her captive and told her you have to stay in a relationship with me, or I am going to tell the whole community that you are HIV positive. It was violence, blackmail and became a big issue"

Family and community rejection and exclusion based on HIV status and sexual orientation

For the LBQ women living with HIV in this study they experienced HIV stigma in different ways.

One of the FGD respondents explained that;

> "So, you see when you are positive and your family and community get to know about your status, they want to disband you from their community because you are LBQ and you are also positive".

Another respondent narrated how she was excommunicated from the church after revealing her HIV status and sexual orientation;

> "Even in churches my pastor discovered that I was HIV positive and also dating a fellow woman cause coincidentally social media and the next thing I was told was you make the holly church go to hell what we need you to do is to stay away for a while we pray as pastors and decide whether we can come back but again. I am a human being what do you do? you leave the church and wait until it took a year before I went back to church."

Citing rejection from family members, a respondent living with HIV explained that;

> "It got to a time when I had to disclose to my siblings about my HIV status and at the same time, I disclosed my sexual orientation, for me it was the rejection that hurt me the most and some have rejected me to date. Some don't allow me to sit next to their children because I will not only infect them with HIV but also recruit them in to lesbianism."

Discussion

Persons who belong to the subordinated-groups and identities face a cumulative disadvantage, according to intersectionality (Purdie-Vaughns & Eibach, 2008). According to proponents of the additive model of intersectionality, an individual with more than one intersecting identities suffers from various types of discrimination linked with each of his or her subjugated identities when they are added together (Almquist, 1975). Therefore, the more undervalued identities an individual has, the more prejudice he or she would encounter in the long run. Taking the sexual orientation and HIV status of LBQ women as subordinate identities, the findings of this study reveals that the participants living with HIV face more cumulative discrimination because of these intersecting identities.

The data from the FGD involving the LBQ women living with HIV revealed the intersection of HIV-related stigma and sexual stigma emanating from the sexual orientation identity and their HIV status. These stigmas interacted to produce different types of discrimination among LBQ women investigated in this study. According to Herek (2007), sexual stigma which refers to the devaluing of sexual minorities and the negative attitudes and lower levels of power afforded to non-heterosexual behaviours, identities, relationships and communities. Instances of rejection of LBQ women who are living with HIV as narrated by families and the community at large as the beneficiaries exposed demonstrated the presence of sexual stigma emanating from heteronormative assumption that homosexuality is not morally acceptable.

HIV stigma refers to negative attitudes and beliefs about people with HIV. It is the prejudice that comes with labelling an individual as part of a group that is believed to be socially unacceptable (Stangl & Grossman, 2013). For the LBQ women participants in this study, they experienced HIV stigma through three major ways. The first form of HIV-related stigma stemmed from the belief that only a certain group of individuals (in this case heterosexuals) can get HIV and LBQ women cannot get HIV. The second source of HIV-related stigma was other people making moral judgements about HIV women who attempted to take steps to prevent HIV transmission. The third source of HIV-related stigma originated from the feeling by others that LBQ women deserve to get HIV because of their sexual orientation, which was termed as "immoral". All these forms of HIV-related stigma overlapped with sexual stigma that the LBQ women living with HIV faced contributing to their discrimination in the family, society and healthcare system as suggested in the additive model of intersection.

Chapter Six: Conclusion and Recommendations

Conclusions

This study sought to employ a standpoint feminist perspective to investigate the perceptions of LBQ women's HIV risk and its implications in terms of LBQ women's exclusion in HIV programming, HIV service delivery, HIV research and the society in Kisumu, Kenya. The research privileged women from Kisumu as knowing subjects in order to understand how they perceived their risk and the reasons for their exclusion from the healthcare system, the society as well as in HIV research, service delivery and programming. In accordance with the feminist standpoint theory, the research paper gathered data learning from the lived experiences of LBQ women in Kisumu county listening to how they perceived their interaction with HIV programming and service delivery. The study included LBQ women living with HIV to further understand how they face exclusions in various spheres of their lives as a result of their exclusion from HIV education and health services based on the assumption that they are not highly prone to HIV infection.

As the discussion shows, participants vehemently criticized the prevalent perception that LBQ women are a HIV low-risk group, and further challenged the dominant narratives of research and institutions that support this perception. Countering that dominant narrative, the women described the various ways it was possible for LBQ women to be infected with HIV including through sex with other women, heterosexual sex (since they do not exclusively have sex with women), blood transfusion, being born with it, sharing of sex toys, rape and sex work. With regard to exclusion of LBQ women in HIV research, healthcare system, service delivery and programming, the research paper found multiple levels of exclusion including the marginalization of LBQ women in HIV research and data collection in Kenya, marginalization of LBQ women from participation and decision making in HIV programming, insufficient LBQ-tailored care and treatment HIV services, insufficient LBQ-tailored care and treatment HIV services and judgmental and discriminatory HIV service delivery.

An unexpected finding of this study is the intersecting individual, social and factors which contributed to the exclusion of LBQ women living with HIV fuelled by HIV stigma as well as sexual stigma. The individual factors included facing homophobia, HIV stigma and reduced self-esteem due the women's self-perception of failing to adhere to familial, cultural and religious dictates have led to self-isolation. Social factors that have impacted their lives due to stigma include exclusion by families, religious denominations and community members. The women also point to their sense of diminished social status where they are seen as less culturally and religiously observant in the community. As well as social exclusion the women poor material institutional exclusion describing rejection and biased treatment by health practitioners. Poor self-worth, combined with stigma due to negative societal attitudes about LBQ women and the material lack of HIV service delivery and programming structures has limited the agency of LBQ women to navigate access to HIV services and programs.

The study was able to harness the trust that the LBQ women of Kisumu had with one of their own so they were willing to share their intimate and embodied lived realities and unique perspectives in the context they live. As a researcher coming from that community, I was able to use strong objectivity in engaging from a position of knowing myself the experiences that HIV and LBQ women were voicing as the privileged subjects of knowledge in this study. My position of a privileged queer woman with considerable educational background, networks and position of influence in the society I could speak with them about their situation as one who shares the same oppression of exclusion. The level of trust and knowing I could build about the injustice that the LBQ persons suffer indicates how critical such research is to point the way forward for future policy. It is in exercising "strong objectivity" as an academic and a researcher that I have been able to use my privileged position as a conduit of their voiced needs. I conclude the RP then with the following recommendations for improving the wellbeing of respondents which I plan to carry out on my return to the community. In the spirit of "ubuntu" the research was conducted together with the women in order to give visibility to the LBQ women as part of our collective struggle to change public health policy and to take into account the experiences and voices of women that have informed this research.

- **The exclusion of the LBQ women in the healthcare system and community warrants the need for support groups and standalone LBQ-tailored health facilities for LBQ women both infected and**

affected with HIV: LBQ women with HIV seem to be getting support from their fellow positive LBQ women where together they form a support system, it is therefore advisable for the HIV positive persons to have a space where they can share their experience, support one another and champion for HIV positive persons. (issues of disclosure can be discussed and handling rejection). Furthermore, the LBQ-tailored health facilities should have the HIV preventive commodities available for LBQ women which has been reported to be a major challenge in this study.

- **The exclusion of LBQ women in decision making processes of HIV programming eventually leading to the lack of programs that are tailored to address the HIV-related needs of LBQ women. As such there is need for inclusion of LBQ women in strategic decision-making spaces:** spaces like technical working groups (TWG), NASCOP, and County Health Management Teams should purpose to include LBQ person who can influence programs, policies and strategies on HIV. Furthermore, **there is need to have LBQ women trained on policy issues:** with LBQ women being experts, they can apply to those competitive positions in NASCOP and get in to those spaces where the LBQ agenda can be presented making LBQ women part of all programs.
- **Visibility to the LBQ women in HIV programming was low and the respondents associated the low visibility with less research, data and statistics on LBQ women and HIV:** there is need for LBQ women to bring their voices to spaces through resistance by demanding to be present in spaces where strategic matters on HIV are being discussed.
- **The exclusion of LBQ women living with HIV in the society and HIV programming necessitates the creation of safe spaces for LBQ women living with HIV:** the hostile environment in the LGBTIQ community and the society at large when it comes to LBQ women living with HIV has facilitated more harm than good when it comes to HIV prevention and management and uptake of Health care services, there is therefore need for awareness creation on HIV matters to the community to prevent the silent existing stigma and discrimination towards LBQ.
- **The discrimination of LBQ women in the healthcare system indicates there is a need for knowledge-based trainings and sensitizations to**

health care service providers on LBQ issues: health care service providers have been reported to be offering discriminatory services to the LBQ women with very little knowledge on LBQ issues. In order to increase uptake of HIV services by the LBQ women in health care facilities the service providers need trainings on offering friendly and dignified services from a human rights-based approach. **This includes the** recognition that there is a diverse LBQ community; immigrants, sex workers, women living with disability and in rural require specific support.

- **The absence of data on LBQ women and HIV contributes to the perception that LBQ women are at low risk of HIV infection and this endorses the need to update the Kenya Health Information System (KHIS) to capture LBQ data on HIV:** it is hard to find LBQ data on HIV because the KHIS does not have a provision to capture HIV data related to HIV hence hard to tell the number of LBQ women with HIV since the data is never captured hence making it hard to program for HIV in LBQ. There is need for researchers to conduct new research in Kenya and stop basing their interventions on past research that was not conducted in the Kenyan context. Such research by academicians, programmers and researchers need to be done with the objective to document the gaps that exists in LBQ and HIV and provide strong recommendations to facilitate HIV programing towards the LBQ women.
- **Donor funding needs to target LBQ HIV programs:** donors should fund LBQ HIV programs, provide services including preventive commodities and keep careful record of the results in order include the education and policy provision of LBQ women on HIV.
- **There is a need to demystify myths and misconceptions around LBQ and HIV through awareness creation:** there are a lot of myths and misconceptions around HIV when it comes to HIV and LBQ which puts LBQ women at more risk of HIV. The community seems to be very ignorant when it comes to matters HIV and there is also poor uptake of services amongst the LBQ women hence need for Sexual Reproductive Health and Rights (SRHR) education to the communities and the LBQ community.

- **Need for local and international advocacy on LBQ inclusion in HIV programs:** holding the Kenyan government accountable on matters of inclusion of LBQ women in the healthcare system and HIV programming.

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APPENDIX

FGD GUIDE

1) **Negative Participants**

Section One: Bio Data LBQ persons

a) Age Range: 18 to 30 or 30 to 50

b) Number of Children

c) Sexual orientation/identity:

Section Two: Perceptions of LBQ women's HIV Risk and need/availability for HIV-related services

a) As an LBQ woman what is your opinion about the general perception that LBQ women are at a low risk of contracting HIV?

b) What are some of the ways through which LBQ women can contract HIV?

c) What are some of the HIV services that LBQ women need?

d) How can you describe the availability of such HIV services for LBQ women? (do they access these services? How are they treated at medical facilities, access to information, access to counselling services)?

Section Three: How LBQ women are affected by HIV

a) How are you and other LBQ women affected by HIV? (effects on health, social life, family relations, sexual relationships, economic status)

b) How do you perceive LBQ women living with HIV (modes of transmission?)

c) With the perception that LBQ women are a HIV low-risk group, how easy/difficult is it for an LBQ woman living with HIV to disclose publicly that they are infected? (experiences around disclosure)

d) How would you describe the journey of an LBQ person living with HIV those you are familiar with if any (their coming out, partners and family reactions any evidence of stigma/discrimination/isolation and so on)?
e) Could you reflect and narrate on occasions/events that you have felt that LBQ women have been excluded in HIV programs/programming (could be your own story or someone's experience/activity)

Section Four: Effects of perceptions of LBQ women's HIV Risk in HIV programming

a) How has your involvement in HIV programs been, if any? at organizational, regional or national level (role, frequency, benefits,)
b) How has your perception of HIV risk among LBQ women influenced your involvement in HIV programs and HIV services? (self-isolation, self-stigmatization)
c) How has the general perception that LBQ women are a low-risk HIV group affected their involvement in HIV programs? (involvement in policies, invisibility/visibility, lack of access to information)
d) How do you find the available HIV programs in terms of their inclusion of LBQ women?
e) How do you feel about the involvement, representation and influence of LBQ women in HIV programming spaces? (tokenism, decision making, leadership)
f) Give me a small description on why you would say that the LBQ persons have self-isolated themselves from HIV programs/programing or have been excluded from HIV programs/programming? (participants are allowed to agree/disagree or both giving an explanation)
g) As we wrap up our discussion, what are some of the things you would love to see, or done differently that would enhance LBQ involvement, recognition and visibility? (this could include recommendations in programing, involvement, service provision, information, policy development, partners and donors or research)

2) FGD guide members (HIV positive)

Section One: Bio Data

a) Age Range: 18 to 50
b) Number of Children:
c) Sexual orientation/identity:

Section Two: Perceptions of LBQ women's HIV Risk and need/availability for HIV-related services

a) As an LBQ woman living with HIV what is your opinion about the general perception that LBQ women are at a low risk of contracting HIV?
b) What are some of the ways through which LBQ women can contract HIV?
c) How has access to HIV services been for you as an LBQ woman living with HIV? (treatment at medical facilities, reactions to disclosure of HIV status, access to information, couple counselling)

Section Three: How LBQ women are affected by HIV

a) How can you describe your experience living with HIV as an LBQ woman? (effects on health, social life, family relations, sexual relationships, economic status)
b) Looking at the lives of other LBQ women, how do you think they are affected by HIV?
c) With the perception that LBQ women are at low risk, how easy/difficult is it for an LBQ person living with HIV to disclose publicly that they are infected? (experiences around disclosure, hiding ARV'S treatment medication, not disclosing)
d) Kindly reflect on your disclosure process if at all you disclosed your HIV status to your partner, family, or community and how the experience was for you. (challenges faced such as being abandoned, discrimination, stigmatization, being outed to the public)
e) If you reflect back, are there occasions where you have felt discriminated or stigmatized because you are an LBQ person living

with HIV. (denial of a service, partner treating you differently or leaving, the wider LGBT community)

Section Four: Effects of perceptions of LBQ women's HIV Risk in HIV programming

a) How has your involvement in HIV programs been, if any? at organizational, regional or national level (role)

b) How has your perception of HIV risk among LBQ women influenced your involvement in HIV programs and HIV services? (self-isolation, self-stigmatization)

c) How has the general perception that LBQ women are a low-risk HIV group affected their involvement in HIV programs? (involvement in policies, invisibility/visibility, lack of access to information, biasness)

d) How do you find the available HIV programs in terms of their inclusion of LBQ women?

e) How do you feel about the involvement, representation and influence of LBQ women in HIV programming spaces? (tokenism, decision making, leadership)

f) Give me a small description on why you would say that the LBQ persons have self-isolated themselves from HIV programs/programing or have been excluded from HIV programs/programming? (participants are allowed to agree/disagree or both giving an explanation)

g) As we wrap up our discussion, what are some of the things you would love to see, or done differently that would enhance LBQ involvement, recognition and visibility when it comes to HIV? (this could include recommendations in programing, involvement, service provision, information, policy development, partners and donors or research)

3) KII guide for social movement leaders (LBQ Leaders)

Section One: Bio Data

Age Range:

Period of leadership and movement involvement:

Sexual orientation/identity:

Section Two: perceptions of LBQ women's HIV Risk and need/availability for HIV-related services

a) What do you have to say about the general assumption that LBQ women are at low-risk of HIV?
b) What are some of the HIV services that LBQ women need?
c) How can you describe the availability of such HIV services for LBQ women? (do they access these services? How are they treated at medical facilities, access to information, access to counselling services)?

Section Three: How LBQ women are affected by HIV

a) How many LBQ women living with HIV are in your social movements if any?
b) With the low-risk assumption, could explain how easy/difficult it is for LBQ women who are living with HIV to disclose their positive status?
c) What is the reception like for LBQ women living with HIV in LGBTQ organizations and the larger LBQ community? (LBQ women's stigmatization for being positive and assumptions surrounding their positive status)
d) Do you have instances where LBQ persons living with HIV have felt discriminated, stigmatized or isolated simply because they are LBQ and having HIV at the same time? (could have been reports from a partner, family, service provider organizations or even the wider LBQ movement)

Section Four: Effects of pperceptions of LBQ women's HIV Risk in HIV programming

a) Are you aware of and can you name any HIV regional and national technical working groups? (Such groups are under NASCOP, G10, HPN, KP Consortium, KP Gender Technical Working Group (Kisumu))

b) Are you part of any HIV regional and national technical working group? Please name the ones you are involved and explain how you are involved in them and your experience/ of the involvement? (how inclusive are these groups, what could LBQ women be missing by not being part of them)

c) What are some of the HIV related projects you have conducted/ing? Please describe the turn out, involvement and engagement of the LBQ women. (self-stigma, discrimination, reserved or openness, reactions from those who are HIV negative towards those who are positive)

d) How does the perception of LBQ women about their 'low risk to HIV' affect them? (both positively and negatively) (having multiple partners, relationships, access to HIV-related information, uptake of HIV services, disclosure of their HIV status)

e) How has your experience been regarding designing of HIV programs for LBQ women (availability of evidence/data, working with partners, visibility of the LBQ women, perceptions of partners)

f) How has the general perception that LBQ women are at low risk of HIV affected funding, networking, representation, involvement, access to information and access to prevention and HIV management for LBQ women?

g) How/what's you're feeling about the involvement, representation and influence of LBQ women in HIV programming spaces? (tokenism, decision making, leadership)

h) Give me a small description on why you would say that the LBQ persons have self-isolated themselves from HIV programs/programing or have been excluded from HIV programs/programming? (participants are allowed to agree/disagree or both giving an explanation)

i) Lastly, as an LBQ leader would you have some particular things you would love to see change when it comes to LBQ and HIV and what can be done to enhance LBQ involvement, recognition and visibility when it comes to HIV? (this could include recommendations in programing, involvement, service provision, information, policy development, partners and donors or research).

Image of two women scissoring (*source: Women Working with Women*)

Online booklet on the Myths and misconceptions on HIV by 3W: https://3wkenya.org/wp-content/uploads/2020/01/3W-Booklet-3.pdf