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The sexual health needs of sexual minority women in Western Kenya: An exploratory community assessment and public policy analysis

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ABSTRACT

Sexual health and rights are a core feature of human development. Yet, most work on sexual health and wellbeing in the Global South and elsewhere has historically focused on heterosexual, cisgender people, as well as sexual minority cisgender men and transgender women. This exploratory study includes an analysis of comments made during a facilitated community forum and an examination of the sociopolitical and legal environment relevant to sexual minority women's health in Kenya. Through analysis of the group discussion hosted by a sexual minority women's group, we identified multiple sexual health-related issues, including concerns related to healthcare access, healthy sexual relationships, economic instability, and freedom from violence. Based on issues identified by the forum, we conducted an analysis of law and policy in the areas of community need. The legal and policy analysis indicated that the public policy and health policy context is complicated by the presence of hostile laws regarding same-sex sexuality, an absence of economic policies to protect women, and yet some existing health policy inclusive of sexual and gender minorities that nonetheless render sexual minority women invisible. The findings indicate a need for focus on public opinion, health services, legislation, and health policy as sites of intervention.

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Introduction

Most work on sexual health and wellbeing in the Global South[1] and elsewhere has historically focused on the needs of exclusively heterosexual, cisgender men and women, as well as sexual minority men. However, our previous ethnographic work with sexual minority men in Western Kenya alerted us to the importance of making lesbian and bisexual women's sexual health needs more visible (Harper et al., 2014, 2015). When using the term 'sexual minority women' in this project, we refer to currently identified women who labelled themselves as lesbian, bisexual, or as something other than straight or heterosexual. In addition to the potential risks for sexually transmitted infections (STIs) among sexual minority women, there are multiple elements of sexual health, including access to healthcare and sexual rights, which warrant examination without the limitations of a male-focused, HIV-prevention lens. To that end, this article reviews the findings of an exploratory study,

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which included the conduct and analysis of a community forum and an analysis of the sociopolitical, legal and policy environment relevant to sexual minority women's health in Kenya.

Background

Existing leading frameworks for sexual health set forth by the World Health Organization (WHO, 2015) and other public health leaders and sexual health organisations (Robinson, 2015; Sexuality Information and Education Council in the United States [SIECUS], 2018), provide a holistic definition of sexual health that includes many dimensions, such as access to healthcare, rights to reproductive and sexual agency, opportunities for sexual pleasure and relationship satisfaction, as well as the prevention and treatment of STIs. Yet, the dominant focus of sexual health research and interventions has been narrowly restricted to STIs, especially HIV – this is also the case among the few sexual health studies focused on sexual minority women in Kenya (see, e.g. (Zaidi, Ocholla, Otieno, & Sandfort, 2016)). This limited focus on HIV and STIs is problematic for all populations as it leads the health fields to ignore the psychological, cultural, social and legal dimensions of what it means to be sexually healthy (Aggleton & Campbell, 2000; Gosine, 2005; Wade & Harper, 2017).

In addition to general population harms, the narrow envisioning of sexual health as primarily the prevention of STIs has a potentially exacerbated impact on sexual minority women, a group which rarely has access to the institutions funded by HIV-focused sources. No empirical research has been conducted specifically in Kenya to assess the institutional framework for sexual health that explains the exclusion or invisibility of sexual minority women in these health settings, however scholars conducting research in Western Kenya have linked this practice to the same myths of lesbian immunity observed in the United States (see, e.g. Zaidi et al., 2016). The known low risk of HIV transmission between those assigned female at birth has been misinterpreted to mean that women identifying as lesbian have no risk to HIV and are absent in a population of people already living with HIV in African nations (Matebeni, 2009; Reddy, Sandfort, & Rispel, 2009). This myth of 'lesbian invulnerability' (Dolan & Davis, 2003, p. 36) and a lack of attention to the ways sexual minority women, regardless of sexual identity, may be at high risk (e.g. via sex with cisgender men, risky sex with cisgender women, as sexual minority transgender women, sexual assault, or intravenous drug use) appears to have led to a general exclusion of sexual minority women from not only HIV prevention and treatment efforts, but also from sexual health research and interventions in general. As such, applying this narrow and disease-focused framework for sexual health leads to our missing the broader sexual health needs of sexual minority women, most of whom are assigned female at birth.

Given the dearth of attention to sexual minority women's sexual health needs globally and in Kenya specifically, the aim of this project was to chart a research programme that was grounded in the needs identified by this population. The intention was to start small, as a foundation for future work, with an informal group of sexual minority women that currently organise and discuss sexual minority women's issues in Western Kenya. The primary research questions guiding this initial phase of our work with this community were: (1) What are the needs of sexual minority women, both related to sexual health specifically and sexual rights more generally; and (2) In what ways does the public policy and legal landscape related to the emergent community needs provide opportunities and/or threats to addressing those needs?

The project began with a community forum in a peri-urban Western Kenyan community in which participants were asked about key concerns related to sexual health and general wellbeing among LGB and other sexual minority women. Then, drawing on themes identified through the forum, the team conducted an assessment of the sociopolitical environment and public policies that may impact sexual minority women's wellbeing in order to provide a richer analysis of identified needs. We first present the methods and findings from the community forum, then an analysis of law and policies relevant to the areas of concern that emerged from the community forum.

Research team and project background

The research team is multidisciplinary and holds a long history of collaborating on research in Kenya and sexual and gender minority research in the United States. The team represents diverse training in child clinical psychology, community psychology, critical race theory, adult education, epidemiology, and international law. One of the team members and authors (Paula Abuor) is part of the community of sexual minority women in Western Kenya, a community organiser and health educator, and thus has lived experience and knowledge of the topics covered in the needs assessment. Two of the team's members (Leah Neubauer and Gary Harper), one a cisgender, heterosexual, US-born multiethnic Latina and the other a cisgender, US-born White gay man, respectively, have worked throughout Kenya for over fourteen years on primary school-based prevention efforts funded through the President's Emergency Plan for AIDS Relief (PEPFAR). The PEPFAR work informed several additional projects working with sexual and gender minority populations as well as other vulnerable communities including: youth experiencing homelessness, incarcerated men and women, and adults living in urban slum regions. Two of the team members (Bianca Wilson and Andrew Parks) worked on the project from their location in the U.S. Bianca Wilson, who identifies as a cisgender Black biracial bi-national lesbian and studies Black lesbian sexual health and health policies in the U.S., consulted on the design of the community forum questions and probes, led the thematic analysis of the notes from the forum, and assisted in the writing of the public policy analysis. Andrew Parks, who identifies as a White cisgender gay man, joined the team to add his expertise as an international LGBT law and human development scholar and activist, and led the legal and public policy analysis.

Community forum methodology and identified themes

Community forum – methodology

The project has been guided by an Interactive and Contextual Model of Collaboration (Suarez-Balcazar, Harper, & Lewis, 2005), an approach to participatory action research that makes explicit the iterative process of establishing trusting and reciprocal relationships between university and community member researchers toward developing a culturally- and community-grounded research agenda. The research described in this article was a next step after years of developing relationships with several sexual minority women leaders and community members in the area who had expressed interest in developing initiatives related to their needs. The community forum portion described in this article was driven by an effort to move from the relationship building phases of the collaboration to establishing next steps in the action research specific to sexual minority women's sexual health and wellbeing. A community forum is an open meeting designed for information sharing and/or dialogue among a connected group, a tool used in both community organising and action-oriented research (see, e.g. (Eng & Blanchard, 2006; Hills, Mullett, & Carroll, 2007; Lemkau, Ahmed, & Cauley, 2000)).

Two of the co-authors (Gary & Leah) had a history of working with gay and bisexual men and other men who have sex with men (GBMSM) in Western Kenya, primarily research focused on HIV prevention and treatment. Following the completion of a large-scale study of the socio-ecological influences on sexual risk and resilience among young GBMSM, a group of 3 LBQ women, one of who is a co-author of this article, approached the research team and asked 'what can be done of us?' In response to this request, the team first met with this small group of women to discuss how they might collaboratively undertake community-based action research together. Together this group (Paula, Leah, Gary, and two other LBQ women from the area) decided to conduct a community forum to assess the health needs of the LBQ community in Western Kenya as a first step toward developing a plan for future collaborative research and service activities.

The collaborative team spoke with several key opinion leaders from the two leading LBQ women's organisations in the city and the largest LGBT coalition in Western Kenya to structure and design the community forum, including the primary areas that would be covered in the discussion. These local

key opinion leaders led the development of the purposive sample, aiming to ensure that a broad range of LBQ women would be invited to obtain diverse perspectives. The following characteristics were considered when developing the purposive sample, although the sample was not rigidly stratified to assure equivalent numbers of members representing various combinations of identities: gender identity (gender non-binary and cisgender), gender expression/roles (butch/masculine, fem/feminine, androgynous), age, education, and career. The leaders recruited participants through a variety of methods including text/sms, face-to-face conversations, and social media (primarily Facebook). The community forum did not require institutional review board (IRB) approval according to the University of Michigan and University of California, Los Angeles IRBs because it was initially evaluative and led by non-university personnel.

The forum location was selected by the leaders to ensure that the space was easily accessible, safe for members of the LGBT community, and supportive to fostering open and transparent discussions. The venue was a rooftop restaurant and lounge that was closed to patrons during the forum, and was well known as an LGBT safe space, and where many members of the LGBT community ate, socialised, and danced. Participants ($N = 16$) in the community forum were welcomed by Paula who initiated this process, and then she introduced the 2 US research team members (Leah and Gary). These two members served as co-facilitators for the forum, which was held in English. The session was opened with introductions by all of the participants and the facilitators. The purpose of the community forum was explained to the participants by the co-facilitators, and comments and feedback were elicited from the participants to assure that all of the issues that they felt were most relevant were addressed during the forum.

The facilitators used a semi-structured focus group guide that was developed by the collaborative team. The team purposely included only five broad areas of inquiry so that the participants could shape additional areas of discussion based on emergent concerns. Following are the five guiding questions:

- What are the labels or terms used to describe non-heterosexual women?
- What established organisations or groups for lesbian/bisexual women currently exist in Kisumu? (What made you join? Why would someone not join? Are any health specific?)
- What are some areas of sexual health need that lesbian and bi women have that are different from gay and bisexual men who have sex with men?
- What are some barriers to lesbian/bi women's sexual health issues being taken seriously?
- What current advocacy efforts exist that already have data needs?

These served as a general framework to guide the discussion, although participants also generated additional areas of inquiry. Though the focus from the researcher standpoint was on the WHO definition of sexual health noted above (i.e. focused on access to reproductive healthcare and services, sexual rights, access to information, testing and treatment of STIs, etc), we did not limit the discussion to just these facets of sexual health.

Data were collected during the forum using multiple formats to account for a variety of comfort levels in answering questions, including: (1) Live responses from participants, for which notes were taken; and (2) Written responses from participants to collect demographic information, reflective comments & their ranking of community needs (participants generated 66 issues in total during the live discussion, they were then asked to rank the top 3). The written responses were completed at the end of the forum since these provided an avenue for offering additional information that was not shared verbally during the forum or that participants thought of when asked to reflect on the forum (reflective comments), and also gave participants the opportunity to prioritise the 66 community needs that were generated during the forum (prioritisation of community needs). Following completion of the forum and written responses, which lasted approximately 90 min, participants were thanked for their time.

Community forum – participants

Community forum participants ($N = 16$) ranged in age from 20 to 47 years, with a mean age of 27 years. With regard to gender, 15 identified as female and one as transgender.[2] Most identified as lesbian ($n = 11$) and the remaining five individuals identified as bisexual or did not identify their sexual orientation. Participants were recruited through relationships with local community-based organisations and key community leaders. This was a relatively highly educated group: 15 had some university education (they were either completing coursework or held formal degrees). In terms of ethnicity, the participants represented the dominant group of Western Kenya; most identified as Luo and one identified as Kamba. As far as religious identity, all but one identified with a Christian denomination, one identified as partially Muslim, and another participant did not identify a religion. Relationship statuses were mixed: half were in a relationship or engaged and the remainder were single or did not state their relationship status.

Community forum – analysis

Given the myriad types of data (observations, transcripts, individual surveys) for this one community forum, the data analysed for this study are essentially a set of notes from the various discussions and brief written responses between and among the participants and researchers. Though the collected data were not in depth or abundant, limiting our ability to provide rich quotes as representative data, the process of thinking through whether our interpretation of data was reflective of how participants understood the issues discussed went through a complex process, which included follow up discussions with some participants about our initial summaries. We used a basic content analysis approach to reviewing and analysing the notes and responses from the community forum. The content analysis process involved comparing, contrasting, and categorising data based on emergent themes (Schwandt, 2001). We present a categorisation of all the voiced themes instead of only those that were endorsed by most participants (Creswell, 2013; Harper et al., 2015; Moustakas, 1994).

Community forum – findings and discussion

An analysis of the community forum and the written responses revealed a few overarching categories of sexual health-related concerns and supports, as well as themes related to life as a sexual minority more broadly. The categories were: (1) healthcare services; (2) health and wellbeing; (3) family planning; and (4) economic security (see Table 1). For each category of reported issues, we describe the range of listed responses that are represented and where possible, provide quotes from written responses. Different participants used varying terms to describe the population of people they were referring to, ranging from 'lesbian' to 'LGBT' to 'LGBTI' or 'LGBI'.[3] When discussing the listed responses under each category, we use the term that we put in the community forum discussion notes that participants used. Following the list of responses to questions about main concerns and issues, we describe their responses to questions about the types of organisations they saw as resources for support and resilience.

Table 1. Distribution of reported community needs among sexual minority women in Western Kenya ($n = 16$).

Community need category	% Endorsed	% Endorsed within top 3 issues
Healthcare services	69%	69%
Health and wellbeing	81%	56%
Family planning	19%	0%
Economic security	25%	25%

Healthcare services

Some of the concerns expressed in the community forum were in the domain of healthcare. Participants noted that there was a need for lesbian, bisexual, transgender, and intersex (LBTI)-specific health centres or lesbian-friendly physicians embedded in existing health centres. The absence of, or challenges to accessing STI screening, as well as general health screening for routine physical exams, chronic disease, etc. were also noted. In addition to accessing health services, respondents listed health supplies (e.g. dental dams, gloves, and condoms to avoid STI risk, and dildos or sex toys for sexual satisfaction) as needed resources.

Health and wellbeing

Several of the needs identified by participants were in the domain of maintaining support for mental and social health. Related to mental health and wellbeing, several respondents indicated that counselling services, lesbian support groups, and substance use counselling services were needed. Regarding social health, participants indicated that there was a need for spaces in which lesbian and other GBTI people could connect. These requested spaces were both in person, such as bars, clubs, and social support groups, and virtual spaces, such as 'LGBTQI forums' on the Internet, and sexual minority women-specific print magazines. Also connected to wellbeing was the issue of safety, where a few respondents listed the specific need for domestic violence support and more generally, 'a free environment whereby all lesbians and bisexuals are treated like normal people'. As for healthy sexuality, a couple of women indicated that social and network supports (virtual and online applications) were needed for dating or finding sex partners, including the accessibility of online forums, personal security, and assurance for online dating.

Family planning

Related, yet distinct from sexual health and healthcare service needs, is the area of reproductive health and family planning. A few women highlighted the need for services that support lesbian and other women partnered with women in their efforts to be parents. This theme was represented by a few participants listing the need for sperm banks and access to sperm donor services.

Economic security

The final domain of identified needs is economic security and anti-poverty work. Several participants highlighted concerns about and interest in the economic empowerment of the LGBTI community. In addition to mentioning economic empowerment support and financial generating or money-raising opportunities specifically, resources connected to economic health included education scholarships and other subsidies for poor lesbian and bisexual women.

Opportunities for support and resilience

The main focus of the forum was to identify community needs in a context where no formal research or supported interventions were being conducted to address sexual health concerns. However, we also asked about participation in civil and community groups as a way to understand opportunities for resilience, support and community organising. We assessed community and organisational participation in order to document potential structures for social action and support. Participants noted three sexual minority women's organisations to which some of them belonged: Kisumu Lesbians & Bisexual Learners and Brainstorms (KISLEB), Women Working Women (3W), and Voice of Women in Western Kenya (VOWEK). When asked about the strength of groups like these and what lead them to join them, they listed reasons like pleasing or finding girlfriends, a need for a sports community, finding family and 'togetherness', and opportunities to 'feel normal'.

Discussion of community forum themes

Among the four community-identified categories of need, there were some issues that have been reported by other sexual minorities in the region as well. In particular, the significance of request for social support, sexual health services, and mental health services are reflected in the high rates of anxiety, depression, HIV risk behaviours, and lack of social support previously identified in a study of sexual minority men in Western Kenya (Harper et al., 2015). These types of community needs are also reflective of themes identified in other sexual and gender minority health research studies within and outside of Kenya, including economic insecurities (Muguongo et al., 2015; Spira, Chad, & Schneeweis, 2015). However, the community forum also highlighted areas that often get missed in sexual minority research that tends to centre the experiences of cisgender men. The listing of concerns related to reproductive health and lesbian-friendly healthcare providers indicate that there is a need for provider preparedness in how to address the intersections of sexual minority and women's identities in Western Kenya. Lack of comfort and experiences with discrimination when accessing services billed as lesbian-inclusive, but catering mostly to gay men, have also been reported among sexual minority women in Kenya and in other contexts (American College of Obstetricians and Gynecologists, 2012; Matebeni, Reddy, Sandfort, & Southey-Swartz, 2013; Youatt, Harris, Harper, Janz, & Bauermeister, 2017).

Study considerations and limitations

The empirical data presented here are likely not representative of the full range of possible issues related to sexual health among sexual minority women in Western Kenya, both because of the small sample size and because it represents feedback from only one community forum recruited through convenience sampling methods. Further, the design of the project does not allow for us to make claims of what issues were more important than others, or to examine the meaning behind the stated concerns more deeply. Nonetheless, the findings highlight a set of issues that warrant attention.

The range of needs identified through the community forum and the collaborative analysis process is not only impacted by individual resources and interpersonal relationships, but also by the policies guiding Kenya's overall approaches to individual rights, health, and economic security. The next two sections provide an analysis of the social attitudes, laws, and public policies relevant to the specific set of issues identified by the community forum and feedback process.

Sociopolitical landscape analysis

The sociopolitical context of sexual minority women's sexual health is complicated by a still-recent history of European colonisation and tensions that have arisen with regard to how to view sexualities in general and same-gender sexualities in particular – either as culturally-normative aspects of African people or as artefacts of European sexual dysfunction remaining in post-colonial times (Tamale, 2011). Given these ongoing cultural debates, it is not surprising that the sociopolitical and legal environment in Kenya is generally unaccepting of sexual minority people. Levels of social stigma against these communities, as measured by public attitudes and opinion, are quite high. Eighty-eight percent of Kenyans surveyed believe that homosexuality is 'morally unacceptable' (Pew Research Center, 2014). For sexual minority women in particular, the sociopolitical context is further impacted by existing inequities between men and women. For example, Kenya ranks 146 out of 188 countries on a measure of gender inequality focused on reproductive health, empowerment, and economic status among women in each country (United Nations Development Pogramme, 2015). The intersection of cultural attitudes about sexual minorities and national norms for the treatment of women likely create compounded limitations on the agency for sexual minority women to navigate their sexual health.

Participation in religious organisations that feel negatively about LGBT people may be a significant source of these anti-LGBT views. A survey of Kenyan Christian and Muslim religious leaders revealed that 94.7% said that homosexuality was a grave sin, and 31.7% agreed that violence was called for to protect cultural values related to heterosexuality (Mbote, Sandfort, Waweru, & Zapfel, 2016). Just over 27% felt the same regarding transgender persons (Mbote et al., 2016). These sentiments may extend to the general population given that 87% of Kenyans say that religion is very important to them. Eighty percent of Christians, and 91% of Muslims attend religious service at least once a week (Pew Research Center, 2010). In educational settings, a survey of high school students in Kenya found that 95% believed homosexuality is abnormal, with little difference in results between the boys and girls. Students thought that homosexuals should be punished (66%), suspended (61%), or expelled (49%) (Mucherah, Owino, & McCoy, 2016). Regarding the causes of homosexuality, most girls felt that Western influence was the cause of homosexuality, whereas boys felt the cause was sexual starvation (Mucherah et al., 2016). As for adults in Kenya, there are no studies separating public attitudes about sexual minorities from the broader LGBT community. However, a useful indicator of attitudes about sexual minorities are studies that have examined attitudes about LGBT people in general. A study of public opinions of LGBT people globally indicates that Kenya scored in the lowest 13 of 141 countries on the Global Acceptance Index for years 2009–2013, which measured the level of social acceptance of LGBT people and rights (Flores & Park, 2018).

Law and policy analysis

Sexual orientation and the law

Sexual minority-related beliefs and healthcare practices are likely reflected in and impacted by current law and public policy. Having adopted a new Constitution less than a decade ago, the evolution of basic legal norms remains an active and heavily contested issue in Kenya. Kenya's current constitution includes progressive language which recognises the values of human rights, including international treaties, equality, freedom, and the rule of law. Though these provisions might be used to alter the sociopolitical landscape in the future, they have not yet produced significant or positive change for sexual and gender minority people in Kenya. In addition to constitution provisions, the penal code is particularly relevant to people who are marginalised because of their sexuality. The penal code continues to criminalise 'carnal knowledge of a person against the order of nature' and an 'unnatural offense'. The penal code implicates the act of men more explicitly than women through this section:

> any male person who, whether in public or private, commits any act of gross indecency with another male person, or procures another male person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male person, whether in public or in private is guilty of a felony and is liable to imprisonment for five years. (Penal Code of 1930, § 163, 15 Laws of Kenya, Cap. 63 (rev. ed. 2012)

These charges are classified as felonies and punishable by prison time up to 14 years if convicted (Finerty, 2012). In 2014, local LGBTI groups reported eight prosecutions of men under this provision (United Nations Development Programme, 2016). Prosecutions are rare and may not even become part of the public record, though one public record indicates that a student, Francis Odingi, was sentenced in 2006 to six years in prison (Oloka-Onyango, 2015).

Though there has not been a known prosecution of a woman under the above-referenced carnal knowledge provision, it has been argued that they are included through the neutral use of 'persons' in sections describing carnal knowledge and unnatural acts. Though the law has not been the basis for a formal prosecution of women in Kenya, the existence of the law serves as grounds for state-sponsored acts of intimidation and harassment against all sexual minorities, including lesbians and other women partnering with women. Human rights researchers have found that the legal prohibition leads to a number of negative consequences for sexual minorities: harassment by state officials,

cases of torture, denial of child custody to lesbian mothers, inhumane and degrading treatment by police, stigma and exclusion from the family, blackmail and extortion by security agencies, workplace discrimination, eviction from housing, restricted access to healthcare, and exclusion from educational institutions (Karugu & Mbaru, 2011).

The impact of the Kenyan law as a direct source of fear and intimidation also became apparent during the period that the anti-homosexuality law in Uganda received attention in Kenya and internationally. The Ugandan Anti-Homosexuality Act, introduced in 2010, added prohibitions of 'promotion of homosexuality' to the already existing sodomy law and provided a death penalty as a possible punishment. In early 2014, the news of the passage of the law in Uganda appeared in many news outlets in Kenya. In response to its passage a member of the Kenyan Parliament called for full prosecution of all homosexuals under Kenya's sodomy law. Aden Duale, Leader of the Majority in the Kenyan National Assembly, said that homosexuality was as 'serious as terrorism. It's as serious as any other social evil' (The Hansard, 2014). The leader of the Republican Liberty Party in Kenya proposed legislation calling for life imprisonment or public stoning (Oloka-Onyango, 2015).

During that same period, according to a report filed with the United Nations Human Rights Council by a coalition of Kenyan non-governmental organizations (NGOs), two lesbians were publicly beaten and stripped by a mob in Nairobi, and four health clinics providing reproductive health services to gay men were forced to temporarily close for security reasons (Gay and Lesbian Coalition of Kenya (GALCK), National Gay and Lesbian Human Rights Commission (NGLHRC), Coalition of African Lesbians (CAL), & S. R. I. (SRI), 2015). The same report also included claims that between 2012 and 2014, 12 lesbians reported being raped because of their sexual and gender non-conformity, 10 lesbians and gay men reported being beaten within their houses, and 21 students reported being expelled from school due to their suspected homosexuality. The coalition's report also included the results of a survey conducted by the NGOs in which 'seventy percent of LGB people interviewed alluded to being coerced into heterosexual relationships and marriages' (Gay and Lesbian Coalition of Kenya [GALCK] et al., 2015).

Amidst this negative tide, there has been some legal progress for sexual minority communities. In 2014, the Kenyan High Court ordered the Kenyan Non-Governmental Organization Coordination Board to approve the registration of Transgender Education and Advocacy (TEA), which paves the way for it and similar organisations to begin operations (Godfrey Dalitso Kangaude, 2017). Kenya's sexual and gender minority movement has assumed a much more visible, public presence, even gaining acceptance from local authorities in some locations, indicating the potential of future opportunities to build infrastructure and capacity (Muguongo et al., 2015). Nevertheless, given the restrictive sociopolitical and legal environment specific to sexual and gender minority status, it is not surprising that there would be limitations on the availability of healthcare and other support services specifically geared to sexual and gender minority communities.

Sexual health policies and institutional practice

Community forum participants expressed need for an increase in health services that demonstrate knowledge about and sensitivity to the concerns of sexual minority women. This finding can also be understood in the context of current sexual health and general health policies in Kenya. There are health services in Kenya, and Western Kenya in particular, that provide services for sexual and gender minorities. The increase in healthcare services to members of the LGBT community in Kenya, and elsewhere in Sub-Saharan Africa, has been linked to the increased health policy focus on disproportionately high HIV infection rates among gay, bisexual, and other men who have sex with men (GBMSM). In Kenya the HIV epidemic is primarily focused on the general population in certain regions of the country, but there are very high prevalence rates among certain groups that are identified as Key Populations – men who have sex with men, people who inject drugs, and sex workers. These populations are highlighted in the latest Kenya AIDS Strategic Framework 2014/2015–2018/2019 by the Ministry of Health, and this document recognises that legal,

cultural and social barriers are related to these populations' increased vulnerability to HIV. Given this, there has been an increase in healthcare facilities focused on providing HIV prevention services (including the relatively recent distribution of pre-exposure prophylaxis to GBMSM), HIV testing, and HIV treatment – all with a primary focus on GBMSM.

In Kisumu there are at least four non-governmental organisations that provide healthcare services to GBMSM (primarily HIV related), and these organisations are focused on GBMSM (MAAYGO [Men Against AIDS Youth Group]), Key Populations (KASH [Keeping Alive Societies Hope]), HIV (LVCT Health [Liverpool Voluntary Counseling and Testing]), or general public health (Impact-RDO [Impact Research and Development Organization]), as well as specific research studies that provide HIV-related services (Anza Mapema Study through the Nyanza Reproductive Health Society). Due to an increased focus on providing a holistic approach to HIV prevention and eventual eradication among GBMSM (Graham & Harper, 2017), these facilities often provide other health-related services, such as substance use care. Given this male-centered health and service focus, these facilities may not be fully inclusive or accepting of LBQ or other sexual minority women, and are not likely equipped to deal with their sexual health-related needs. Even though some organisations aim to provide LGBTI-friendly services, they are typically primarily focused on those assigned male at birth, with limited services for others in the sexual and gender minority umbrella.

We note that in the absence of protective anti-discrimination laws that enumerate sexual orientation and gender identity and in the presence of anti-homosexuality laws, bias reduction interventions within healthcare settings will likely remain challenging. Though men who have sex with men are listed explicitly as part of the nation's HIV strategic planning, the health needs of sexual minorities are less present in general health planning. Perhaps, the lack of inclusion of the needs of sexual and gender minority people in health development and planning is reflective of the country's current health policy plan, titled 'Health Policies In Kenya And The New Constitution For Vision 2030', in which no mentions are made about these populations (Kibui et al., 2015). These populations and specific health concerns are also not listed as part of the section on vulnerable populations or core health rights under the Kenya Health Act, 2017.

Finally, one area in which sexual and reproductive health policies could directly impact the types of needs identified by the respondents which are uniquely relevant to sexual minority women is the regulation and availability of sperm banks and services for assisted reproductive technologies. Provision of assisted reproductive technologies for women who are partnered with women may include alternative insemination procedures (either intracervical or intrauterine insemination, or in-vitro-fertilisation), administration of fertility drugs, and assistance in storing or acquiring sperm from known or anonymous donors. In 2014, the Reproductive Health Care Bill was introduced to set parameters around ethical and social concerns related to conceiving children with the help of assisted reproductive technologies (Kenya Gazette Supplement No. 57 (Senate Bill No. 17), 2014). If this bill had been passed, it would have been a major step in public policy acknowledging the needs and rights of people wanting help with conceiving children, particularly regarding the use of surrogacy. However, the language of the bill likely reflects the institutional frameworks of many reproductive health care facilities in that it explicitly defines a 'partner' of a woman as an opposite sex partner. There have been calls to create more guidelines around reproductive technologies by professionals at the Kenya Medical Research Institute (the national centre for epidemiology for Kenya) (Mkoji, 2015). A related bill covering a broader array of assisted reproductive technologies than the 2014 bill, including intrauterine insemination and sperm banking services, was introduced in 2016; yet, it similarly defined a couple as a 'male and a female' (Parliament of Kenya, 2016). However, at this point, neither bill has passed into law and the rights of sexual minority women to access the few existing fertility clinics with anonymous sperm in Kenya seems to be theoretically possible. Yet, these bills appear to signal the likelihood that future health policies and laws on the subject will not be inclusive of sexual minority women seeking to become pregnant. Further, sexual minority women's access to reproductive assistance services are not only limited by the level of inclusion in

health law and policies, but are also impacted by the economic policy landscape as using these services requires a high level of financial means.

Economic policies and gender

The concerns about economic sustainability expressed by the sexual minority women participants must be understood intersectionally- meaning not only in the context of laws specific to sexual and gender minority people, but also laws specific to the rights and protections for women generally, and then how the combination of these laws may affect opportunities and health for Kenyan sexual minority women. The Kenyan economy remains among the poorest 25% of countries in the world. Roughly 40% of Kenyans live in poverty (Bogoev et al., 2016). Women face high levels of inequality and with a score of 0.565 on the 2015 Gender Inequality Index, Kenya ranks 135 out of 159 countries (United Nations Development Programme, 2016). This score indicates that the status of women's health, education, access to civic institutions, and labour market opportunities are not equitable to that of men. The connections between poverty and sexuality have been established by development theorists (Jolly, 2006). Poverty and inequality are experienced not just in economic terms but also as exclusion. Sexual minority women living in poverty are restricted in their economic, social, and health freedoms and opportunities. Their lack of financial resources likely creates limits in their autonomy and self-efficacy in determining the trajectories of their lives.

One way to ensure that all women, including sexual minority women, have equal access to economic security is to enumerate sex and/or gender in anti-discrimination laws. In Kenya, the Constitution does not exclude women from the population of people that have basic civil rights. However, gender and sex are excluded from the list of social statuses considered within the anti-discrimination provision of the Constitution (Mucai-Kattambo, Kabeberi-Macharia, & Kameri-Mbote, 1995). Mucai-Kattambo et al. (1995) argue that the lack of inclusion of gender and sex as protected classes (whereas race, religion and other statuses are included) leaves women vulnerable and reduces access to legal interventions when they are discriminated against. Anti-discrimination laws specific to employment settings (e.g. hiring and inter-employee behaviours) are also relevant to the socioeconomic wellbeing of sexual minority women. In this context, too, there is a lack of protections specific to women (Mucai-Kattambo et al., 1995). Related to protections along gender status, it also important to note that there are no enumerated protections for gender expression or sexual orientation. As such, sexual minority women who express themselves in more masculine ways, and therefore are more likely to be assumed to be a sexual minority in the workplace, are at particular risk for discrimination at the intersection of sexuality, gender and gender expression given the lack of legal protections along all of these axes (*Amici Curiae Brief of the National Women's Law Center in support of Plaintiffs-Appellees, DeBoer v. Snyder*, 2014).

Conclusions

The deeply nuanced history and present-day happenings for sexual minority women in Kenya demands mixed-method, interdisciplinary, and indigenous research frameworks that address the complex interplay of historical, post-colonial, sociocultural, economic, political, and physical factors (Currier & Migraine-George, 2017). Indigenous frameworks call attention to research and knowledge-generating processes that centralise principles of reflexivity, reciprocity and value one's locality and the contextual individual experiences accumulated in one's land of origin (Mpofu, Otulaja, & Mushayikwa, 2014; Simpson, 2000). To that end, we engaged in a process of assessing the sexual health and wellbeing needs of sexual minority women in Western Kenya, discussed our understanding of those stated needs, and provided an analysis of the social, legal, and public policy context that would ultimately impact actions to address those needs. We identified multiple sexual health-related issues that participants attending a community forum discussion on sexual minority women's issues felt needed to be addressed, spanning domains of healthcare access, healthy sexual relationships,

economic instability, and freedom from violence. The public and health policy context is complicated by the presence of hostile and unsupportive laws regarding same-sex and same-gender sexuality, and an absence of economic policies to protect women and health policies inclusive of sexual and gender minorities. As such, efforts to improve the sexual health lives of sexual minority women in Western Kenya, or Kenya generally, may want to focus on shifting public opinions on same-sex sexuality and broadening support for economic equity among women, as well as increasing focus on sexual health services beyond HIV related activities. As an analysis of empirical data and public policy, this study served as a first step in a long-term project designed to make visible and to address the needs of sexual minority women in Western Kenya and to identify pathways to community and political action.

Notes

1. The term 'Global South' refers to countries previously described as 'developing countries', which are located primarily in the Southern Hemisphere. An alternative, but a less-used term to refer to the complex concept that categorises a set of countries with various indicators of political, economic, and cultural subjugation as a function of colonialism and Western Imperialism is 'LAACAP' referring to Latin America, Caribbean, Asia, and the Pacific. Either 'Global South' or 'LAACAP' are preferred to terms such as 'developing', 'underdeveloped', or 'third world' (Chant & McIlwaine, 2009).
2. The community discussions were conducted in the context of an effort to bring attention to sexual minority women and gender minority people who partner with women-identified people. One person at the forum who listed transgender as their identity did not state their sexual orientation, but there were no findings unique or specific to transgender people to report. As such, we have included this participant's perspectives in the project as an informed and connected informant on the topic who is clearly also identified with the sexual minority women's community given their presence at the forum.
3. One of the co-authors, Abuor, notes that intersex-identified women do not commonly disclose their conditions or identities, yet many sexual minority women in Western Kenya add the 'I' in the labels as a way to be inclusive.

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