ODI Report

Intersecting exclusions

Experiences of violence and displacement among LGBTQI+ communities in Kenya

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ODI   edge effect

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Cover photo: LGBTQI+ individuals living on the African continent often experience stigma and are forced to live much of their lives in secret. Credit: 2011. Travis Lupick / Flickr. CC BY-NC-SA 2.0

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Acronyms and abbreviations

CAL	Coalition of African Lesbians
CBO	community-based organisation
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSO	civil society organisation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HOYMAS	Health Options for Young Men on HIV, AIDS and STIs
INGO	international non-governmental organisation
IPV	intimate partner violence
GALCK	Gay and Lesbian Coalition of Kenya
GBV	gender-based violence
KHRC	Kenya Human Rights Commission
KNCHR	Kenya National Commission on Human Rights
KP	Key population
LBQ	lesbian, bisexual and queer
LGBT	lesbian, gay, bisexual, transgender
LGBTQI+	lesbian, gay, bisexual, transgender, queer (or questioning), intersex +
MSM	men who have sex with men
MSW	male sex worker
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NCAJ	National Council on the Administration of Justice
NGEC	National Gender and Equality Commission
NGLHRC	National Gay and Lesbian Human Rights Commission (Kenya)
NGO	non-governmental organisation
SGBV	sexual and gender-based violence
SOGIESC	sexual orientations, gender identities and expressions and sex characteristics
SOGI	sexual orientation and gender identity
STI	sexually transmitted infection
UNHCR	United Nations High Commissioner for Refugees

1   Introduction

There is growing awareness of the need to address, through policy and programming, experiences of gender-based violence (GBV)[1] among individuals and groups with diverse sexual orientations, gender identities and expressions and sex characteristics (SOGIESC) or members of the lesbian, gay, bisexual, transgender, queer (or questioning), intersex and other (LGBTQI+) community.

This study contributes to a growing body of work on these issues, focusing on Kenya as a case study to delve further into the nuance of LGBTQI+ experiences of violence. We adopt an intersectional framing to explore the various experiences that can shape the drivers and manifestations of violence – in this case, focusing on the experiences of GBV among people of diverse SOGIESC and among urban migrants or those with refugee status. Using an intersectional lens highlights the often ambivalent positions in which people of diverse SOGIESC find themselves. As we describe later in the report, not only are LGBTQI+ migrants or refugees often discriminated against, facing homophobia from other refugees and host populations, but they also experience discrimination from host members of the LGBTQI+ community who see them as benefiting where they are not.

The study is guided by three overarching questions:

1. What are the barriers to inclusive GBV prevention/protection approaches that take an intersectional view, particularly of the experiences of people with diverse SOGIESC and refugees or urban migrant populations in Kenya?
2. What approaches currently exist to address these needs in Kenya?
3. What recommendations can we derive for policy and practice?

The study consists of two components: a literature review, and consultations with key informants in Kenya. The literature review (George et al., 2021) focused on Kenya, but also brought in material from the East Africa region and globally where relevant. The literature review also served to frame the study as well as define key terms and concepts used. This report draws on the literature review and complements it with findings from the consultations. These two documents should be viewed together; while this study summarises some dimensions of the literature review to contextualise the findings from the

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1   'GBV' is a term used extensively across gender research, development and <u>UN system literature</u>. In this report, the authors would like to acknowledge current debates in the international community which question the generalising and expansive way the acronym GBV is deployed. From an intersectional perspective, ODI seeks to better engage with the range of gender-motivated (often male) violence directed towards different members of the LGBTQI+ community (who have historically been marginalised across GBV work). Although in this instance we employ the term 'GBV' to situate this report within the current literature, we will continue to interrogate the appropriateness of the term and work with our partners to develop more nuanced language.

consultations, it does not do so exhaustively. Instead, it highlights some areas to which the consultations add further depth and nuance in terms of the Kenyan context.

The framings and definitions outlined in the literature review are also relevant for this ODI report. To summarise briefly here, this study uses 'intersectionality' as a framing to highlight how multiple and overlapping forms of inequality can 'operate together and exacerbate each other' (Crenshaw, 1989, as quoted in Steinmetz, 2020, para. 2). The literature uses various terms to describe gender and sexuality, each having a history, reflecting power relations and attempts to navigate contested spaces, and speaking to particular disciplinary heritage, with translation bringing further complexity. In our study we do not endorse any particular term but rather present the findings using the categories provided in either the documents reviewed or reflecting the language respondents used during the consultations.

Where we do speak more generally, we have decided to use the terms 'LGBTQI+ community/ individuals' and 'people with diverse SOGIESC,' with either term used depending on the primary materials that are most relevant to the particular area or findings. We have also decided to primarily use the term 'GBV' instead of 'SGBV' (sexual and gender-based violence) because, while GBV can be sexual, it also takes many other forms. Too often, especially among people of diverse SOGIESC, the 'sexuality' dimension is overemphasised to the detriment of acknowledging the experience of other forms of GBV. For further details of framing and definitions, see George et al. (2021).

After a brief overview of the methodology used for the consultations, we outline and discuss the policy and programming environment in Kenya,

and the challenges related to GBV faced by people of diverse SOGIESC. We then present policy recommendations, drawing from the two core parts of the study (the literature review and the stakeholder consultations). In each section, we start with a brief synopsis of the literature review followed by findings from the consultations.

It is important to note from the onset that this report is based on a consultation, essentially, with key informants. Given the Covid-19 context, it was not possible to carry out an extensive and in-depth study by speaking to many members of different LGBTQI+ population groups. Instead, it was decided to interview representatives of their organizations who were able to take part, mostly through remote interviews.

Respondents for the consultations were identified through the desk review and through the study team's existing knowledge and experiences of working with key stakeholders, including members of the LGBTQI+ community and those involved in GBV-related service provision and policy in Kenya. A total of 19 consultations were carried out with key informants between April and May 2021, as well as two group discussions with members of the LGBTQI+ community, in this case with bisexual people and trans people. While additional discussions with other groups were attempted, including with lesbian, bisexual and queer (LBQ) women, there was a reluctance to take part in the research because of fears around confidentiality. (see Table 2, Appendix 1, for full details).

Due to the Covid-19 context, 19 of the consultations were conducted virtually through Zoom calls, one was conducted via telephone and another was conducted by the respondent self-administering the interview guide; two of these consultations were conducted with

groups while the other 19 were with individuals (key informants). The consultations were conducted by a qualified interviewer who took short notes during the process, which were expanded afterwards. Data was subsequently analysed thematically.

Preliminary findings were shared, discussed and validated with key stakeholders from non-governmental organisations (NGOs) and civil society organisations (CSOs) as well as government representatives in two separate meetings. Key findings from these validation exercises are detailed in Appendix 2; the findings are also mirrored in the recommendations (Section 4).

The findings we present here are based on views and perceptions from key informants who participated in the consultations. While the research endeavours to include voices of different LGBTQI+ community members through the interviews with representatives of their diverse organisations, this ODI Report cannot guarantee that the whole spectrum of perspectives is represented. Given the Covid-19 context and sensitivity around confidentiality, further group discussions with other groups within the LGBTQI+ community were not viable, for example with LBQ women. And while we cannot generalise the findings, they are nonetheless valid in and of themselves, and were further confirmed through the validation exercises.

2 Policy and programming environment in Kenya

2.1 Policies

The literature review provided a brief overview of the policy environment in Kenya in relation to the three overlapping areas of this study: people with diverse SOGIESC (or LGBTQI+ people), migrants and refugees, and gender-based violence. The Kenyan Penal Code continues to criminalise same-sex sexual relations between men, despite significant pressure from LGBTQI+ rights organisations in Kenya as well as international actors, which led to a petition to decriminalise homosexuality put before the Kenyan High Court in 2019 (which was rejected). Kenya's policies criminalising certain same-sex sexual acts are similar to those in many countries in Africa, although they are less severe/restrictive than policies in neighbouring Uganda.

Kenya's policies related to refugees have mainly focused on refugee encampment alongside restrictive measures specifically targeting Somalis under securitised frameworks as a result of the country's counter-terrorism policies, which often view Somali migrants with suspicion of terrorist aims (Njogu, 2017; O'Callaghan and Sturge, 2018). Kenya's LGBTQI+ refugee and/or asylum-seeking community includes many people from Uganda; their numbers increased during 2014 around the time of heightened tensions in relation to Uganda's 'anti-homosexuality bill' (Pincock, 2020). While data on LGBTQI+ migration remains limited, between 2014 and 2015, around 400 asylum claims from Uganda were registered with the United Nations High Commissioner for Refugees (UNHCR) in Kenya, some of which include LGBTQI+ persons claiming asylum based on refugee status. While LGBTQI+ refugees fleeing to Kenya encountered similar discrimination there, including anti-sodomy laws, the presence of UNHCR in Kenya provides a particularly supportive environment by comparison. However, evidence indicates that many Ugandans fleeing to Kenya still reported 'facing a similar hostile and homophobic environment' despite the legal differences and presence of UNHCR and the protective legislation promised (ibid.).

Several pieces of legislation provide a legal framework for addressing GBV in Kenya from a rights and penal perspective. These include the Kenyan Bill of Rights (2010), the Penal Code, the 2001 Children Act, the 2006 Sexual Offences Act and the 2015 Protection Against Domestic Violence Act. Kenya has also signed key international and regional commitments related to GBV, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. There are limitations in most of these pieces of legislation (e.g. GBV is not necessarily explicitly mentioned in every document, and marital rape is not criminalised). However, what stands out in the existing documentation, and was confirmed in our stakeholder consultations, is that the needs of LGBTQI+ individuals – particularly around the lack of specialised services and training of staff on LGBTQI+ protection concerns – are not addressed in this legislation. Similarly, implementation of GBV legislation, policy and programming often focuses on women and girls, overlooking transgender people, those with

diverse sexualities, men and non-binary individuals (Chynoweth, 2019; Wilson et al., 2019; Moore and Waruiru, 2020; Right Here Right Now (RHRN), n.d.).

As key informants highlighted, like all other policies in Kenya, GBV policies are developed at the national level and are then contextualised by counties at the sub-national level, devolving implementation to the local level. Some counties like Nairobi have specific units or departments – funded by both national and county government – responsible for implementing the contextualised county GBV policies that prevent and respond to GBV among all populations (see also Section 2.2).

Despite these efforts to localise and implement national GBV policies within the county-based approach, study respondents discussed a number of challenges emerging within the policy environment. First, it was noted that the funding provided to county governments to implement GBV policies was often inadequate; this in turn led to inadequate awareness of the policies among both local policy-makers and local populations, due to lack of sensitisation efforts. Of more relevance for this study (and as also mentioned in documents analysed in the literature review), GBV policies at both national and county levels do not have a specific focus on members of the LGBTQI+ community, as they were developed to cover all populations. Respondents noted that this was a critical concern given that LGBTQI+ individuals are particularly vulnerable to violence, and thus require tailored policies to adequately support them to tackle forms of GBV which are otherwise (and often) invisibilised.

Respondents also observed a contradiction within the policy environment between Kenya's Constitution (which assures protection for all citizens against discrimination) and the Penal Code (which criminalises same-sex acts) (sections 162 and 165). The latter, therefore, violates the rights of LGBTQI+ individuals, drives inadequate protection for them, and sometimes even drives violence. Similarly, respondents noted that while Kenya is a signatory to international treaties to support equal rights (such as the Maputo Declaration, which emphasises the need to protect people whatever their sexual orientation or gender identity), LGBTQI+ individuals continue to be inadequately protected by the country's legal system. Given that the Constitution is regarded as supreme over any other regional and international laws and treaties, it takes precedence over Kenya's regional and international commitments; this means that domestic legal guarantees for the rights of LGBTQI+ people are necessary in order to render any commitments to external treaties or laws meaningful within Kenya.

Given the restrictive legal landscape, domestic NGOs and groups that support LGBTQI+ people have to work around the discriminatory Penal Code and Sexual Offences Act by drawing on guidelines from the Ministry of Health's National AIDS and STI Control Programme (NASCOP). These guidelines state that health providers are expected to provide services to all citizens, irrespective of their sexual orientation and gender identity, to prevent HIV and other negative reproductive health outcomes. Similarly, LGBTQI+ groups and CSOs successfully advocated for the recognition of intersex people in births and registration since this lack of recognition influences their access to health services. Such strategies are viewed as more pragmatic for working within existing policy frameworks rather than seeking to repeal sections 162 and 165 of the Penal Code.

Where LGBTQI+ individuals have been recognised within existing policy frameworks and specific guidelines, and where policies have been

developed to support them, this is almost exclusively through the lens of HIV. Using the term/concept of 'key populations' (KPs), which include LGBTQI+ individuals, such policies develop and advocate for HIV/AIDS-related programming in Kenya. Hence female sex workers, men who have sex with men (MSM), transgender persons, people who inject drugs, and prisoners are all covered under the category of KPs, and policies and programmes have been developed to support them in different contexts. The terminology related to HIV/AIDS advocacy and programming, and use of that arena as a vehicle for developing policies to support LGBTQI+ people in Kenya, is problematic (see George et al., 2021) as it focuses on behaviour which is reductive of the lives of sexual minorities. Nonetheless, it does provide an entry point through which to push an agenda for the protection of LGBTQI+ individuals.

Despite HIV/AIDS advocacy and programming providing an entry point, most consultation participants highlighted that inadequate policies and guidelines for protecting LGBTQI+ individuals from GBV resulted in them continuing to face such violence. It was also noted that LGBTQI+ individuals are not restricted legally from accessing GBV-related services and, similarly, service providers (both legal and health) are not restricted from providing services to those individuals as Kenyan citizens. However, accessing these services is difficult in the Kenyan context where, as highlighted in Section 3.3, members of the LGBTQI+ community continue to face stigma and discrimination. There was a general perception that policies need to take this into full consideration so that there can be deliberate efforts to specify and mainstream protection for LGBTQI+ individuals under GBV services. Respondents felt that due to discriminatory and stigmatising sociocultural values and norms in the

community, policies alone – whether specifically developed to protect the LGBTQI+ community or focusing on all populations – will not provide the protection needed unless the factors that predispose members of that community to GBV are also addressed.

2.2 Programmes

In this section, we briefly review findings from the literature review in terms of programming before turning to findings from the stakeholder consultations. The consultations provided further details on and added to the evidence base on programmes identified in the desk review. They also provided further contextualisation of the programmes, particularly within government structures and institutions. The sub-section (2.2.1) with findings from the consultations begins with an overview of the role of the Kenya National Commission on Human Rights (KNCHR), followed by an outline of the work of NASCOP and the government-run GBV units. These are among the key government institutions and programmes that address issues related to the LGBTQI+ community and GBV. We then provide some details on NGO and CSO programming focusing on programming for LGBTQI+ individuals.

The literature review provides a snapshot of existing programmes in Kenya focusing on the issues of interest to this study. To capture all programmes that deal with issues related to the diverse SOGIESC/LGBTQI+ community, refugees and migrants, as well as GBV, the following categories were used to conduct searches. These are presented as such in George et al. (2021) (see Appendix 2) along with their objectives, key components and target population, among other details.

Table 1 Snapshot of existing programmes in Kenya and target population coverage

SOGIESC or LGBTQI+	Refugee/migrant	SGBV/GBV/IPV
✓	✓	✓
✓	✓	✗
✓	✗	✓
✓	✗	✗
✗	✓	✓
✗	✗	✓

Source: authors, adapted from George et al. (2021).

There is an overlap in programmes, with some covering more than one of the areas listed above. However, it was necessary to keep these categories to highlight how these intersecting issues are dealt with by programmes. To summarise our findings from the desk review, there is limited programming for refugees and migrants in Kenya of diverse SOGIESC that focuses on GBV. Similarly, while there are a range of organisations and initiatives working on issues affecting members of the LGBTQI+ community in Kenya, these do not appear to engage refugee populations specifically. Finally, as alluded to above, programmes that focus on some members of the LGBTQI+ community often use HIV or AIDS as an entry point and thus often neglect other aspects of the lives and experiences of LGBTQI+ individuals.

2.2.1 Findings from the consultation

Turning to findings from the consultations, at national level, the KNCHR and NASCOP have the mandate to carry out activities that are relevant to LGBTQI+ individuals. KNCHR is a government commission that was formed through an Act of Parliament with a mandate to protect the rights and liberties of all Kenyans. It is expected to work with national level government and non-governmental institutions. Government level includes working with the National Gender and Equality Commission (NGEC) and the National Council on the Administration of Justice (NCAJ); and non-governmental includes the the Gay and Lesbian Coalition of Kenya (GALCK) and the National Gay and Lesbian Human Rights Commission (NGLHRC). The KNCHR also works with international institutions that advocate for human rights. It is also supposed to act as a watchdog over other government institutions on matters of rights and liberties. Its ability to advocate for the rights of LGBTQI+ individuals has, however, been limited by the Penal Code (which makes same-sex acts illegal) and by the general intolerance of the police towards LGBTQI+ individuals that also results from the Penal Code. The KNCHR has, however, managed to advocate for the rights of LGBTQI+ individuals by reporting, and being witnesses in, cases of violence and abuse; it has also successfully sought constitutional interpretations of some legislation that had the potential to make LGBTQI+ individuals vulnerable (such as denial of registration of LGBTQI+ organisations by the NGO Council, and anal testing to determine sexual orientation).

NASCOP, established in 1987, operates as a unit within the Ministry of Health; it receives funding from the national government as well as from external sources including The Global Fund. NASCOP is mainly involved with technical coordination of HIV and AIDS programmes in Kenya. Its programmes focus on three broad areas: (1) HIV and STI (sexually transmitted infection) prevention; (2) HIV and STI care and treatment; and (3) strategic information, research and implementation science. One programme under the HIV and AIDS prevention unit focuses on key populations (KPs)[2] or high-risk groups, which include female sex workers, MSM, prisoners, and people who inject drugs; most recently, transgender people have also been included as a KP, with key informants noting that guidelines are being developed for the latter group. Key informants noted that they also include intersex individuals in their programme, but there is less of a focus on them than on the other five KP groups. According to NASCOP, their programming is also extended to migrant and refugee populations whom they expect to be supported to access services regardless of whether they are documented persons or not.

While the National AIDS Control Council (NACC) develops the HIV-related multisectoral policies and national HIV strategies, NASCOP develops guidelines for the implementation of HIV programmes. Programmes encompass behavioural, biomedical and structural approaches to HIV services. The guidelines for MSM service provision are within the KP guidelines, although those for transgender people are separate, as their needs were seen to be unique and not adequately covered by the wider KP guidelines. The KP programme (under NASCOP) handles GBV within its advocacy unit, with GBV being identified as an area of focus since it has significantly affected the outcomes and success of the KP programme. The unit has a violence prevention response protocol that guides KP programmes. However, NASCOP has faced challenges in engaging and developing interventions with people of diverse SOGIESC due to the fact that many remain hidden; the exception (it notes) are MSM, who are less hidden than other members of the LGBTQI+ community.

NASCOP coordinates all stakeholders engaged in HIV service provision, including those serving transgender people and MSM. NASCOP builds capacity among stakeholders who are then expected to send quarterly and/or monthly reports. It has a Committee of Experts that brings together stakeholders engaged in KP programmes on a quarterly basis to discuss and provide guidance on matters related to KPs. Committee members include members of KPs themselves, the Ministry of Gender and Social Services, the Ministry of Interior Coordination (police and administration office, e.g. chiefs), the Ministry of Education (for activities focusing on younger populations), and the Ministry of Agriculture (for nutritional support of people living with HIV). However, challenges in coordination were reported at both national and county levels, resulting in inadequate engagement of key stakeholders (especially multisectoral collaboration with other ministries) and poor coverage of services. Reasons for inadequate coordination include: inadequate funding; stigmatising attitudes of some key stakeholders who feel that KPs should not receive support through policies and programming because they

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2   Key Populations (downloads), National AIDS & STI Control Programme (NASCOP), Ministry of Health, Kenya. (See https://www.nascop.or.ke/key-populations-downloads/).

do not conform to social norms; and differences in stakeholders' goals, especially among donors, making it difficult to identify joint goals and targets.

As mentioned above, a key governmental structure that addresses GBV in Kenya is the county-led GBV units whose goal is to prevent and respond to GBV by improving access to services, defining referral pathways, and offering tracing and prosecuting of perpetrators. The Nairobi and Mombasa county GBV units are good examples; both have been operating since 2019 and are funded by the county government. They target the general population, although Nairobi county key informants reported that they have a KP programming division, which develops programmes for GBV prevention and response, focusing on KPs that include members of the LGBTQI+ community. Mombasa county GBV unit, on the other hand, does not have population-specific GBV programmes.

The county GBV units collaborate with NGOs and CSOs, taking a multisectoral and integrated approach. They have collaborated with a wide range of stakeholders, including LVCT Health, the Population Council, Health Options for Young Men on HIV, AIDS and STIs (HOYMAS),[3] the National Police Service, members of the judiciary, local leaders (such as chiefs and community leaders), and community members. Collaborations have included: identifying and tracking perpetrators and survivors of GBV; developing partnerships and referral to services for survivors; sensitisation on GBV issues; and collation of evidence for revisions of guidelines and practice. Challenges faced by the county units have included inadequate funding and difficulties in coordinating partners for service delivery (for the Nairobi unit); and for the Mombasa unit – given that it has not

yet finalised the contextualisation of GBV policies and sub-county GBV officials had just started in their roles at the time of the consultation – it had not yet carried out sensitisation activities with key stakeholders.

As also highlighted in the literature review, there is a relatively large number of programmes in Kenya run by NGOs and international NGOs (INGOs) focusing on GBV. Some focus specifically on LGBTQI+ individuals or include them as part of the vulnerable target groups. Activities run by these NGOs include the following: advocating for the rights of LGBTQI+ individuals; responding to their experiences of GBV (including through the provision of psychosocial support such as counselling and enrolment in a support group, referral to and/or support of medical services, enrolment in safe houses, tracing of perpetrators, support with reporting cases to the police, and raising legal fees for court proceedings); conducting gender diversity awareness campaigns; and empowering members through providing them with knowledge on their rights. In practice, this means distributing information on available services, enrolling individuals in support groups, and supporting them economically through provision of stipends and inputs for income-generating activities.

There are also regional and international LGBTQI+ groups that most of the NGOs operating at the community level associate with and are members of. These include the African Intersex Movement (a regional movement), Rainbow Catholics, and Rainbow Adventists (both international networks). Respondents noted that these linkages helped enhance advocacy efforts and, as discussed in the literature review, these linkages can help provide resources and shared learning for local activists and programmers, drawing on global experience. NGOs also collaborate with each other; for example,

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3   A male sex worker-run organisation (see https://aidsfonds.org/partner/hoymas).

Persons Marginalized and Aggrieved (PEMA) active in the coastal areas of Kenya partners with the KNHRC, the GALCK,[4] and Haki Africa to advocate for the rights of LGBTQI+ individuals.

NGOs (national and international) collaborate with the government of Kenya in their activities and receive funding from donors. Funders mentioned by key informants included: the United States Agency for International Development (USAID), the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund, and the Open Society Foundation. Mentioned implementers were the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) and the Church World Service (CWS), the Metropolitan Community Church's Global Justice Institute, and Other Sheep USA. While all national and international NGO programme staff consulted reported receiving funding for specific activities related to LGBTQI+ issues, this funding is often related to donors' objectives and may not necessarily always address the priorities of members of the populations they are aiming to support. Most funding is for HIV and SRH service delivery with limited funding for other programme areas. Because of the HIV focus, MSM and transgender people are more targeted than LBQ women who are often perceived to be at lower risk of HIV.

NGO staff also noted that funding amounts targeting LGBTQI+ issues are always very limited. Moreover, the programmes that do focus on LGBTQI+ issues do not necessarily offer a comprehensive approach; for instance, if responding to GBV, they may only offer psychosocial support and not legal support. As discussed in the literature review (George et al., 2021), global learning supports a holistic approach. Legal reform, support for physical and psychosocial health, improved service delivery and accessibility in multiple areas (including safe shelter), and social norm change are all fundamental components of support for LGBTQI+ people – including those that are migrants or refugees – in protecting against and preventing GBV (see, for example, Chynoweth, 2020). Some respondents suggested that integrating LGBTQI+ programmes into existing services would be one way to ensure sustainability of the programmes.

According to respondents, another important limitation of programmes was that not all of those programmes targeting the LGBTQI+ community were led by members of that community; it was felt that some programmes had met with resistance for this reason. This was generally identified as important for programmes advocating for the rights of the LGBTQI+ community; without the key involvement of members of the community, it was felt that they were not in a position to be 'adequately' motivated to champion for their rights.

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4   The Gay and Lesbian Coalition of Kenya (GALCK) is the national SOGIE umbrella body established in 2006. The coalition consists of 16 member organisations representing LGBQ voices from across Kenya: https://www.galck.org/. GALCK has been instrumental in establishing (and re-establishing) working relationships and alliances with government institutions and civil society organizations to inspire a society that appreciates diversity which recognises that everyone has a right to equal opportunities – irrespective of their real or perceived sexual orientation, gender identity or expression.

3 Challenges faced by members of the LGBTQI+ community in Kenya

The literature review presents experiences and challenges faced by members of the LGBTQI+ community through thematic lenses (stigma, violence, access to services, privacy/visibility), followed by the experiences of different population groups. In this report we use the same thematic lenses to highlight experiences as recounted by key informants, drawing out (whenever possible) whether these experiences differ by population group. As in the literature review, we explore experiences in terms of stigma, violence and norms (Section 3.1), challenges in accessing services (Section 3.2), and issues of identity and visibility/invisibility (Section 3.3).

3.1 Stigma, violence and norms

A range of studies (e.g. Moore and Barner, 2017; Chynoweth, 2019; 2020; Plan International and Edge Effect, 2020) show how stigma against people of diverse SOGIESC can drive multiple forms and dimensions of violence (physical, emotional, sexual), discrimination, exclusion and isolation, including self-isolation. These are all particularly acute within conflict, displacement and migrant settings. Much of this stigma is shaped by harmful gendered social norms that form the basis for rigid views on masculinities, femininities and sexuality, and contribute to the normalisation of direct as well as indirect violence (in the form of discrimination) against those seen to transgress those norms. Studies show that in many settings, LGBTQI+ individuals who are considered to break or transgress established gender norms – and/or fall outside the traditional masculine/feminine binary – are stigmatised

and ostracised when their identities, practices or behaviours appear to violate these norms. All of this can serve as a driver of GBV. Conflict-affected contexts, where tensions are already heightened, can exacerbate these problems. The literature review also highlights how stigma and exclusion are experienced differently by different population groups within the LGBTQI+ community, so policy and programming (in conflict/displacement settings and other settings) need to take that into account (for further details, see George et al., 2021).

3.1.1 Stigma

> Everyone seems to stigmatise and discriminate against LGBTQI+ persons. Families reject them and even refuse to take them to school. Schools suspend and expel them based on assumed sexuality. Friends 'out' them by force and some even sexually assault them in a bid to 'normalise' through coerced sexual conversion. (Group discussion with trans people)

This quote from a discussion with trans people reflects wider sentiments of key informants interviewed as part of this consultation.

In the stakeholder consultations, respondents often raised experiences of stigma and intolerance. Stigma permeated all aspects of life, starting with family members; there were accounts of LGBTQI+ individuals being told to be silent (silenced) about their sexual identity/ orientation (at best) and being disinherited,

'excommunicated' by their families or considered a 'bad omen' (at worst). Reflecting perceptions of other key informants, in a group discussion one participant noted:

> No African family can accept one of their own being gay. It is deemed as a curse and going against nature's and God's way of sexuality. (Group discussion with bisexual men)

There were also reports of family members being physically violent towards LGBTQI+ individuals as a way of 'disciplining them to correct their behaviour' and there were some family members who would even involve the police in beating up their relative. This stigma and intolerance has also led to LGBTQI+ individuals being denied housing by landlords and community 'gatekeepers,' with some having experienced arson attacks on their property, being evicted from their homes (including from refugee camps) and being denied access to healthcare.

While most members of the LGBTQI+ community face stigma and discrimination, most respondents felt that some sub-populations faced greater levels of stigma than others – namely bisexual people (and particularly bisexual men), gay men and transgender women. Representatives of the bisexual community explained that people were often confused about a bisexual person's sexuality ('how could they feel the same for both men and women?') and it was worse for bisexual men, since society is less tolerant of men who identify with feminine gender roles or identities. Also, it was thought that trans people are more visible, which makes them more susceptible to stigmatising behaviours towards them. According to respondents, both key informants and members of the group discussion, there is a perception that lesbians experience less intolerance or stigma, because lesbianism is generally seen as engaging in limited actions of sexual behaviour, rather than as an identity per se (a 'living for the moment act'). As the literature review also found, lesbians in Kenya report difficulties in expressing and gaining recognition for their sexual orientation; limited understanding and dominant stereotypes of how diverse sexual orientation and gender identities (SOGI) are expressed mean that a woman is not believed when she says she is a lesbian (see, for example, the Coalition of African Lesbians (CAL) and GALCK, 2016).

Box 1 gives an example of the range of terms that are used in Kenya to describe members of the LGBTQI+ community. It also speaks to the issue regarding the use of country-specific terms and concepts to describe people of diverse SOGIESC. As the box shows, some terms are also specific to different regions within Kenya.

Box 1 Terms used to refer to LGBTQI+ individuals in Kenya

Many terms are used to refer to LGBTQI+ individuals in Kenya. All have derogatory connotations and some are more likely to be used in certain areas.

- *Shoga* – Used officially to describe gay men. Also used widely in Kenya to define men who have sex with men (MSM) but also to verbally abuse men who are exhibiting behaviour typically identified by society as 'female'.
- *Malaya* – National slang. It translates from Swahili to English as 'prostitute'. Used mostly by the general community to refer to gay men and transgender women, as the assumption is that they are 'behaving gay' so that they can make money through transactional sex.
- '2 in 1' – Nairobi slang for a bisexual person.
- *Msenge* – Slang mostly used in coastal areas and Nairobi. It translates to English as MSM who receive penetration. Also used as an abusive term in the same way as *shoga*.
- *Kuchu* – Coastal slang. It translates to English as weird/queer/unnatural. In official Swahili, *kuchu* describes something or someone with unnatural beauty. The term is used for LGBTQI+ individuals for not conforming to expected gender roles.
- *Lele and Lesbo* – Mostly Nairobi slang for lesbian. Also widely used in educational institutions, particularly boarding schools (secondary).
- *Wasagaji* – Swahili term, used officially to describe lesbians. Directly translates to 'grinders'.
- *Basha* – Coastal slang. It is used to describe a 'top' or 'king' MSM. It was originally used to describe philandering men.
- 'Homo' – National slang for a homosexual man.

Respondents also used language such as *jinsia tata* ('difficult to understand gender' or 'confusing gender') and *jinsia badilifu* (which translates as 'changed gender').

While some members of the LGBTQI+ community, especially MSM and male sex workers (MSWs) are comfortable with calling each other the names listed above, they find it stigmatising/discriminatory when other non-community members use those names to refer to them.

(See also: Geibel et al., 2008 for a discussion on self-reported sexual identities).

As well as experiencing stigma from others, there were reports of widespread internalisation of stigma or 'self-stigma' among LGBTQI+ individuals. This resulted from them 'feeling different,' and seeing themselves as 'not human enough' largely due to how others were depicting them. This was reported to lead to mental ill-health and psychosocial distress as well as self-imposed isolation. The literature review found that these intersecting experiences of self-stigma and experiencing stigma from others are particularly damaging for LGBTQI+ individuals in a migrant setting (see Chynoweth, 2020).

The consultations also included accounts of some members of the LGBTQI+ community stigmatising and discriminating against other members who were of a lower social class and economic status. For instance, LGBTQI+ individuals who worked as sex workers were often discriminated against by those who did not; sex work was usually a survival strategy for those who were unable to earn an income through other means.

Refugee or migrant LGBTQI+ individuals were reported to face multiple layers of stigma and vulnerability. Not only do they face the psychosocial stress of being away from their homes and usually lacking viable livelihood options, but they also face stigma, discrimination and violence due to their sexuality and gender orientation. Moreover, they also face stigmatising attitudes and abuse from host country LGBTQI+ individuals. This was explained by respondents as arising from the assumption that refugees receive monthly stipends from international donors/funders and are therefore better off than LGBTQI+ individuals in the host community, with envy on the part of the latter leading to abuse and violence against the former (see sub-section 3.1.2). This, however, is common to all refugees and not all refugees get a stipend from organisations that support their stay in the country, but there is a belief that all do.

3.1.2 Violence

According to respondents, the most common forms of violence experienced by (Kenyan) members of the LGBTQI+ community were sexual violence, emotional/psychological violence and physical violence. Family members, friends, neighbours (all 'those who are well-known to the victim'), law enforcement agencies (including police and security officers) and members of the LGBTQI+ community were mentioned as the main perpetrators of this violence. There

were also reports of religious leaders being violent towards LGBTQI+ persons when trying to 'convert them back' to what is considered gender and sexual conformity.

Again according to respondents, violence from other members of the LGBTQI+ community was mostly sexual and perpetrated by intimate partners. There were also reports of violence perpetrated by fellow LGBTQI+ individuals who would blackmail an individual and extort money from them in exchange for keeping their sexual and gender orientation confidential; this also took the form of online bullying (e.g. through Facebook, Instagram and WhatsApp groups). Sexual violence was also perpetrated by the general public and family members who saw it as a forceful way to make the person conform to a particular gender identity or presentation ('correctional sex for conversion'). These forceful 'conversions' were mostly experienced by bisexual persons and transgender women. Survivors of such assaults generally do not report them since usually no action is taken and they are likely to face more ridicule and abuse from the police. Sexual assault of LGBTQI+ individuals in prison was also mentioned – something that especially affected intersex persons, who were put in jail without consideration of their gender.

Refugee or migrant LGBTQI+ individuals were reported as among those most likely to experience violence from members of the LGBTQI+ community in host countries. As discussed earlier, their peers reportedly assault and rob them since they are perceived to be better off than their host counterparts. The literature review also found that refugee LGBTQI+ individuals experience discrimination and exploitation from other members of the refugee LGBTQI+ community; in some cases, where refugees are living in urban areas, this is driven by fear that a more 'visible' member of the community will

expose the SOGI of other refugees and increase their risk of experiencing violence (see Moore and Waruiru, 2020). In camp settings, new arrivals can experience exploitation within the LGTBQI+ community due to the temporary financial support they receive (see Refuge Point, 2017). Homophobia was also reported to have led to the deaths of some refugee or migrant LGBTQI+ individuals; this was noted to have happened in Dadaab refugee camp by several respondents. Language barriers can also predispose refugee or migrant LGBTQI+ individuals to abuse since they are unable to express themselves and potentially avoid abusive situations. There were also accounts of LGBTQI+ refugees having to engage in transactional sex as a survival strategy, often resulting in sexual abuse by clients who refuse to pay them, and threaten to inform the authorities about them, which could lead to deportation.

Study respondents' reports of the drivers of violence towards LGBTQI+ persons were similar to those identified in the literature review. They included: stigma, intolerance and/ or lack of acceptance by those who come out; vulnerability due to lack of protection from the law; and lack of economic empowerment. As same-sex relations in Kenya are illegal, GBV policies offer no protection for members of the LGBTQI+ community. This makes them vulnerable to violence, whether perpetrated by the general public or law enforcement agencies (and particularly the police). Some respondents reported cases of abuse by police, who felt their actions were justified due to the illegality of same-sex relations. Some police officers reportedly arrested or threatened to arrest LGBTQI+ individuals in exchange for money, while some would disregard the person's gender while under arrest and put them in the wrong cells, where they would face abuse. Respondents generally felt that the police did not offer adequate protection to

LGBTQI+ individuals and were largely identified as perpetrators of violence – something that was strongly reflected in the secondary literature (see, for example, Goshal et al., 2018; KHRC, 2011). As a result of this situation, there is very limited reporting of violence by members of the LGBTQI+ community. The few police officers who were responsive to the needs of LGBTQI+ individuals were those who had undergone sensitisation on the rights of the LGBTQI+ community.

The consultations also show that drivers of violence are contextual. Societal tensions were seen by many as leading to an increase in protection concerns for members of the LGBTQI+ community as well as other minority groups. Examples of such tensions include election periods, when law and order is often disrupted due to violent encounters between rival political groups, and general lawlessness and 'mob-mentality.' Members of the LGBTQI+ community often bear the brunt of tensions during these periods. (Although a group discussion with members of the bisexual community noted that instabilities such as post-election violence had no correlation with violence faced by LGBTQI+ individuals since they are 'abused any time abusers get the opportunity... There is no particular time for this abuse and stigma. It can happen any time'). There were also reports of an increase in intimate partner violence (IPV) among LGBTQI+ individuals during periods of political instability/disruption; key informants explained this as resulting from likely disruption of economic activities and therefore low income leading to power imbalances between those who are earning and those who are not, which often manifests in IPV.

Key informants also identified holiday periods as a time of increased susceptibility to violence on the part of LGBTQI+ individuals, as during such periods people have more time on their hands

to identify non-conforming behaviour and to respond with intolerance towards it. Religious festivities in Kenya also led to heightened levels of intolerance and increased protection concerns for members of the LGBTQI+ community. According to some respondents, Ramadan in particular was considered to be a time when certain religious groups felt it was their obligation to make sure those around them were holy and, if not, they were thought to need 'cleaning'. This resulted in violence towards LGBTQI+ individuals, as they were seen to go against religious values that denounced same-sex relations and emphasised the need to conform to gender roles which are sex-assigned at birth.

During Covid-19, key informants reported that violence and discrimination towards members of the LGBTQI+ community had increased as part of a general increase of GBV in Kenya (and worldwide). Similarly, cases of being 'outed' and thrown out by community members increased during Covid-19 containment – this was as people became suspicious of their neighbours in the early part of the epidemic. This was due to frustrations and fear caused by Covid-19 but also due to loss of livelihoods and employment, and the disruption in services and access to service provision. This made members of the LGBTQI+ community vulnerable to violence, and disrupted programmes that had previously sought to protect marginalised groups.

There were differing perceptions around whether people living in urban or rural areas were more tolerant (or intolerant) towards LGBTQI+ individuals. On the one hand there was a view that living in urban areas, especially in precarious/informal settlements, placed members of the LGBTQI+ community at greater risk of needing protection. In areas with high population density, shared living spaces and communal services such as water points, maintaining privacy is challenging. In such areas, even if people of diverse SOGIESC may not be open about their identity or relationships, they may be discovered and, as such, may face increased discrimination and violence. There was also the sense that due to 'more joblessness and idleness in urban areas,' any minor issue can create tensions and become a trigger for violence and stigma, with LGBTQI+ individuals often facing the brunt of this.

On the other hand, one key informant noted that communities in rural areas were less tolerant of LGBTQI+ individuals, whereas people in urban areas (especially in Nairobi) tended to have more liberal and progressive views, identifying less strongly with religious and cultural norms and expected ways of behaviour compared to their rural counterparts. However, the same informant also noted that there were unexpected attitudes, citing an example that when their organisation was doing programming in coastal areas (which are heavily Islamic and where communities are strong followers of Islamic faith), community members were much more receptive to awareness raising and interventions targeting members of the LGBTQI+ community when compared to regions such as Western Kenya, which were assumed to be less religiously inclined.

3.2 Access to services and programming

As outlined in the literature review, one of the largest challenges faced by people of diverse SOGIESC is accessing services, whether for GBV, health (including mental health), legal services, housing/shelter, job opportunities or education. Services are not easily accessible by LGBTQI+ individuals, and few services involve members of the LGBTQI+ community in their design and implementation, which undermines effectiveness.

Certain sub-populations face particular difficulties accessing certain services (for example, male survivors of GBV have difficulties accessing services as they are mostly designed for women). Additionally, some HIV programming is male centred and therefore not inclusive of sexual minority women.

LGTBQI+ individuals often lack appropriate information and knowledge about services and, even if they do know where to access support, they prefer to consult traditional healers, religious leaders and elders because of issues of confidentiality and trust. Service providers often have negative and stigmatising attitudes towards LGBTQI+ individuals, including racism and xenophobia (particularly towards refugees), which further limits access. With respect to housing or shelter, accounts of eviction and blackmail by landlords are common in the literature. Finally, services are not effective, and providers are not trained in how to deal with the intersectional experiences that this study focuses on, and which represent the lived experiences of members of the LGBTQI+ community, whether they are migrants/refugees or members of the host LGBTQI+ community.

Findings from the consultations pick up on many of the issues raised in the literature review. Respondents reported that they usually sought assistance from programmes run by community-based organisations (CBOs) or NGOs, as those programmes are easier to access than government programmes. However, even these CBO and NGO programmes are not widely available. In relation to GBV services, it was noted that there were few across the country and those that do exist are 'blind to the plight of LGBTQI+ individuals who face double vulnerabilities.' Similarly, it was noted that in general, there are few facilities that provide non-discriminatory services.

While NASCOP has developed guidelines and has built the capacity of organisations to provide services to all, irrespective of a person's SOGIESC, some members of the LGBTQI+ community have been denied services (even upon referral) or have been stigmatised by health providers, as one person explained:

> Being gay is enough for one to be denied services in health facilities. Health providers don't want to offer services to gay men and ask homophobic questions like how gay men have sex, how one decides to have his anus penetrated... (Group discussion with bisexual people)

This has resulted in inadequate uptake of services by LGBTQI+ individuals (including poor adherence to treatment for those with HIV), who tend to rely instead on reaching out to informal providers and talking to their peers about their struggles and experiences. There have also been cases of health providers denying family planning services to bisexual and transgender persons and of male health providers demanding sex from lesbians and intersex persons in exchange for service provision. This kind of blackmail is made possible by the legal context, as discussed earlier; it is one of the most critical ramifications of continuing to criminalise same-sex relations.

> Some healthcare providers even sexually abuse them in order to give them services. There have been cases of lesbians and intersex persons being sexually assaulted by male healthcare providers who demand sex before offering any service. (Group discussion with trans people)

Among migrant and refugee LGBTQI+ individuals, language barriers were also identified as restricting both access to and uptake of available services.

There were concerns that although some health programmes had provisions to include LGBTQI+ individuals, they only focused on engaging men who have sex with men, male sex workers and transgender women, and left out other sub-populations. This is especially the case for PEPFAR programmes which focus on populations at highest risk of HIV. As discussed earlier, this gap has been recognised, and there is an ongoing collaboration between NASCOP and LGBTQI+ network organisations to develop its eighth strategic framework that will include integration of all LGBTQI+ individuals in HIV programming.

Respondents had divergent views on the merits of targeted services as opposed to better integration into mainstream service provision. While most organisations focusing on members of the LGBTQI+ community felt the need to provide them with targeted or exclusive services, most respondents from NGOs and government/policy-makers reported that lack of integration of LGBTQI+ individuals into existing services had further contributed to the stigmatisation of and discrimination against this group. There would also need to be similar consideration of whether LGBTQI+ refugees or migrants should be integrated into mainstream services for refugees (making those services sensitive to the needs of LGBTQI+ people) or whether they should have separate, targeted services. Given that the literature reviewed lacked consensus on this issue of mainstreaming or separating services, raising pros and cons to both approaches, the consultations suggest some support for the former (mainstreamed/

integrated programming) in the Kenyan context, though with the proviso to have separate, targeted services if an individual requested or needed them (see recommendations).

More generally, as also noted in the secondary literature, there is a fear that service providers in public health facilities may report LGBTQI+ individuals to the police if they seek services, resulting in reluctance to use formal services. Relatedly, given that same-sex sex relations are illegal in Kenya, members of the LGBTQI+ community lack legal protection and there are few lawyers and advocates who agree to provide legal representation for LGBTQI+ individuals, as a participant in a group discussion with bisexual people noted, 'No advocate can easily take up cases of abuses towards LGBTQI+ individuals as some of them are homophobic and transphobic'. Difficulty in obtaining legal representation also makes it difficult for LGBTQI+ individuals to report any criminal acts they are subject to. One respondent gave an example of inadequate protection, in that there are instances of government agencies conducting forced anal tests to confirm same-sex relations despite a court ruling that such tests are unconstitutional. As discussed earlier, the lack of legal protection also makes it easy for members of the LGBTQI+ community to be abused by police officers; fear of extortion and abuse also makes LGBTQI+ individuals less willing to report experiencing GBV to police or legal services.

While NASCOP has been engaged in advocacy activities that support LGBTQI+ individuals in accessing health services, its efforts are limited to those activities or issues that act as direct barriers to uptake of health services – for example, a health service provider is expected to provide health

services to LGBTQI+ individuals irrespective of whether the law interprets their sexuality as illegal. While there is evidence that fear of the authorities might influence LGBTQI+ individuals' access to health services, NASCOP does not engage in advocacy efforts around amending or reviewing laws that instil fear and prevent service access. There are, however, efforts by NASCOP to encourage legal stakeholders to be supportive of LGBTQI+ individuals, especially in their response to reports of GBV, by building their capacity in reporting for healthcare purposes and being sensitive to the needs of LGBTQI+ individuals.

In terms of access to other services, respondents noted that LGBTQI+ individuals are denied job and other business opportunities. This has led them to engage in informal and/or illegal income-generating activities for which formal status/papers are not needed – including petty trading and transactional sex.

> People are denied jobs because they are gay. People even use dressing (the clothes they wear) to deny LGBTQI persons jobs. (Group discussion with bisexual people)

Gaining access to jobs and employment opportunities is even more challenging for refugee or migrant LGBTQI+ individuals since, as also identified in the literature review, they often lack identification or other paperwork needed to work. Being denied training opportunities as well as being withdrawn from, suspended or expelled from school was also reported to be a frequent occurrence for (Kenyan) LGBTQI+ individuals. Sometimes family members also stopped supporting a young person's education or training if they disclosed their sexual orientation, which also resulted in people tending to hide or not disclose their identity (see Section 3.3).

Respondents reported that LGBTQI+ individuals are denied access to a range of other services, including: insurance companies reportedly denying medical cover to non-heterosexual partners; LGBTQI+ individuals being prevented from adopting a child; and LGBTQI+ individuals being denied the freedom to practise their faith.

3.3 Identity, privacy, visibility and being 'out'

Largely driven by harmful social norms, people with diverse SOGIESC are often invisible and can become 'hidden populations'. This invisibility is often reflected in policies and services that are not appropriately targeted, but it can also be self-imposed for safety and survival. The need to remain invisible is often greater in conflict settings or contexts of displacement, especially where people are living in camps and in close proximity. In such contexts, people with diverse SOGIESC face multiple layers of risk, including from the host community, other refugees or migrants, as well as their own families. This need to conceal one's SOGI can also put significant strain on an individual's mental health and well-being. Similarly, when LGBTQI+ individuals become more visible or 'outed,' this can put them at greater risk of stigma, discrimination and violence. Mislabelling of individuals with terms that do not align with their own identity and preferences was also highlighted as a risk affecting people of diverse SOGIESC – leading also to services being inappropriate for them. There have also been reports of labels and terminology in host countries being different from those in a person's home environment, leading to confusion and lack of a shared understanding among refugees with diverse SOGIESC (see, for example, Millo, 2013).

Before discussing the findings from the consultations, it is important to highlight a few

points from the literature around the distinct experiences of different LGBTQI+ population groups. While LGBTQI+ individuals share some common experiences and protection concerns, certain sub-populations under the LGBTQI+ umbrella have distinct experiences, and those groups may be rendered invisible by lumping them all together. This is important because failing to disaggregate the experiences of different groups will make it difficult for policy and programming to offer appropriate protection for them. Some key sources do disaggregate the experiences of sub-populations; however, most of the literature continues to conflate discussion of lesbian, gay, transgender (men and women), non-binary, intersex and queer experiences, and therefore make some groups invisible.

To give an example, some of the literature highlights the invisibility of lesbian, bisexual or queer women in Kenya, both within LGBTQI+ communities and in wider society. Studies have noted that public discourse around diverse sexual orientations is generally dominated by discussions of gay men and expressions of 'anti-gay' homophobia among politicians, with limited acknowledgement or understanding of women with diverse sexual orientations (e.g. CAL and GALCK, 2016; Goshal et al., 2018; Wilson et al., 2019). Discussions and literature around experiences of gay men and MSM in Kenya is relatively widespread; both groups face homophobic attitudes, GBV and discrimination by health service providers, employers, landlords and neighbours. MSM are also closely linked into debates around HIV and AIDS. However, discussion of the distinct experiences of bisexual men is limited, and the literature indicates that biphobia, within both the LGBTQI+ community and wider society, contributes to a reluctance among bisexual men to self-identify (Refuge Point 2017).

Similarly, transgender men as a sub-population appear to be invisible, in both Kenya and the East Africa region, and there is also relatively limited discussion of the distinct experiences of LGBTQI+ children and adolescents. The latter could be explained by a fear of working with and/or identifying LGBTQI+ children and adolescents, as organisations could risk legal repercussions if their engagement is interpreted under the law as 'recruitment' into homosexuality or 'perversion' of minors (Refuge Point, 2017; Arcus Foundation, 2019).

Some of these issues were picked up in discussions with key informants, though it is important to note that these themes of visibility and identity are cross-cutting; both affect and are affected by the contexts and situations described in the previous sections. While respondents noted that there are some benefits to LGBTQI+ individuals in Kenya self-identifying – including getting access to programmes that target LGBTQI+ people and being able to connect with their peers for psychosocial support – the risks of self-identifying and 'coming out' currently outweigh the benefits. Lack of legal protection, discrimination by service providers as well as family members and friends, and fear of rejection and assault have led many (especially those who are dependent on others) to keep their identity hidden. It was also noted that for younger members of the LGBTQI+ community, 'coming out' may result in being pulled out of or suspended/expelled from school.

According to one key informant, people in urban areas were more likely to 'come out' because they would feel more anonymous and/ or were able to associate more with their peers. However, as already mentioned, in peri-urban and/ or precarious settlement dwellings with more poverty, LGBTQI+ individuals are likely to face

more abuse compared to those living in wealthier areas. Relatedly, attaining some degree of independence – especially financial independence – was also felt to facilitate someone self-identifying, or coming out, since independence meant they did not have to worry about being expelled from school or from the family home.

As discussed earlier, there were reports from both the literature and from respondents in the consultation, of LGBTQI+ individuals who had revealed their sexual orientation and/or gender identity (at least to some people) being blackmailed or extorted in exchange for keeping it a secret, often by peers or other fellow members of the LGBTQI+ community. It was also noted that refugee LGBTQI+ individuals who self-identify not only risk blackmail and extortion but also arrest, detention and deportation. The literature review found that in many cases, refugee and migrant LGBTQI+ individuals did not report crimes and abuse to police for fear of deportation (see, for example, Chynoweth, 2020). There were also reports in the literature review of some members of the LGBTQI+ community who had self-identified being denied registration in national identity (ID) documents – this has been the case for transgender individuals in particular, due to denial of their existence and/or procedural bottlenecks that make the process cumbersome. This has led to arbitrary arrests on the basis of 'impersonation' of transgender individuals where the gender marker on their ID does not align with their gender expression (Goshal et al., 2018). This has, in turn, resulted in poor documentation and/ or low reporting of the needs of transgender individuals for service provision, which also makes it difficult to monitor their experiences with and uptake of programmes.

It is also important to note that in some cases the decision to be 'outed' is not up to the individual – that is, they may not have the power to conceal (or reveal) their sexual orientation and/ or gender identity. Some people are considered more readily identifiable as a member of a specific group, or at least as somehow non-conforming or non-normative. The concept of 'passing' has been used to speak to the privilege (or lack thereof) of being able to go undetected by others (see IOM, 2020: 6).

Generally, the current environment in Kenya makes people with diverse SOGIESC reluctant to self-identify and thus they prefer to remain hidden. This has not only inhibited their access to health and other services, but has also made it difficult for programmes to engage with them. This lack of access to services has led some individuals to rely heavily on informal coping strategies. On the more positive side, respondents in our consultations mentioned spending time reading, writing and pursuing activities such as bodybuilding, swimming and gymnastics, which takes their mind off their situation. However, most noted turning to negative coping strategies, including: isolating themselves and not going out of the house; dressing as straight or cisgender to hide their true identity and thus not drawing attention to themselves; resolving to (or at least trying to) conform to prevailing sexual and gender norms; and resorting to drugs and alcohol. All of these negative coping strategies further increase depression, mental ill-health and psychosocial distress, reflected in frequent accounts of suicidal thoughts and suicide attempts.

4 Recommendations

Both aspects of our study – the extensive literature review and consultations with key informants in Kenya – have shown that people with diverse SOGIESC continue to experience a range of intersecting vulnerabilities that are heightened in contexts of displacement and when considering issues related to GBV. Not only do LGBTQI+ individuals face discrimination and abuse according to their particular identity and whether they belong to a specific sub-population under the LGBTQI+ umbrella, but they also face stigma, discrimination and even violence linked to their status as migrants or refugees, and if they are living in poverty or living with a disability. These intersecting vulnerabilities can be largely traced back to gendered social norms and beliefs about expected behaviours, and the sanctions meted out for not complying with those norms and behaviours.

With ongoing advocacy campaigns and programmes by various organisations in Kenya, the stigma and violence directed towards members of the LGBTQI+ community is (according to respondents) on the decline (though it was also noted that lack of disaggregated data, due to limited reporting of stigma and violence, makes it difficult to ascertain the real extent of any decline). However, much more needs to be done. All respondents in our consultations agreed that in the absence of appropriate and supportive laws and policies, and with service providers continuing to hold discriminatory attitudes towards people who do not conform to expected behaviours, people with diverse SOGIESC will continue to be vulnerable to stigma, discrimination and violence.

Here, we propose recommendations to ensure that programming and policy are inclusive of the needs and priorities of people with diverse SOGIESC, including taking into account their intersecting experiences and vulnerabilities. We propose separate recommendations for legislators and policy-makers, and for service providers and programme implementers. The recommendations reflect findings from both components of the study – the literature review and the consultations. (Recommendations arising from the consultations are noted as such; where not indicated, the recommendation pertains to findings from the literature review).

4.1 Recommendations for legislators and policy-makers

- Develop laws that adequately protect all citizens in Kenya and identify vulnerable and marginalised populations and sub-populations that need extra protection, including members of the LGBTQI+ community. (This was stressed by key informants).
- Develop GBV policies to enable members of the LGBTQI+ community to easily access GBV-related services.
- Repeal or abolish hostile laws that negatively impact people of diverse SOGIESC, and which often end up criminalising them. (This was identified in both the literature review and by key informants).
- Enact stronger non-discrimination and rights-based legal frameworks by developing more specific protections against discrimination based on sex, sexuality and gender in all areas of the law.

- Improve resourcing for and awareness of existing national laws, which will also allow them to be strengthened and better enforced.
- Improve awareness and enforcement of international agreements and commitments that protect people who have experienced GBV, such as the Universal Periodic Reviews (UN Human Rights Council, 2020) and the 2010 Maputo Protocol. (This was identified by key informants).
- Strengthen and improve enforcement of existing regional and international child protection laws to protect the rights of LGBTQI+ children and youth, also mandating legal consequences for those who abuse those rights.
- Enact and implement stronger non-discrimination laws to protect NGOs working with people of diverse SOGIESC.
- Key informants also noted the need to ensure that members of the LGBTQI+ community are genuinely and actively involved in the development of legal and policy reforms and guidelines.

4.2 Recommendations for service providers and programme implementers

4.2.1 Improve health and GBV-related programming

- Health and GBV services should be age-appropriate and tailored to the needs of people with diverse SOGIESC, including sub-populations, also taking into account other intersections such as LGBTQI+ individuals with disabilities and those who are refugees or migrants.

- Ensure that members of the LGBTQI+ community are genuinely consulted and involved in developing and implementing services and programming.
- Recognise that LGBTQI+ community organisations are often GBV service providers and ensure that these organisations are included in coordination and consultation, and are adequately funded.
- Recognising that LGBTQI+ community members often face discrimination that leads to poverty, ensure that GBV services are affordable.
- Develop and deliver rights-based training to promote inclusion of people with diverse SOGIESC and inclusive service provision, ensuring that the LGBTQI+ community is involved in service design and delivery.
- Adopt a dual strategy of improving inclusion of people with diverse SOGIESC in mainstream GBV services, while also providing specific and exclusive services for those community members who are unlikely to use mainstream services for reasons of privacy, legality or trust.
- Carry out targeted outreach and engagement activities, particularly for groups that are often invisible and excluded from services (such as lesbian, bisexual and queer women and LGBTQI+ children and adolescents).
- Ensure that governmental GBV units are sufficiently resourced and trained on the unique needs of people with diverse SOGIESC, including appropriate infrastructure and staff with relevant skillsets, including paralegals.

4.2.2 Improve and link services and programming to other sectoral approaches

- Ensure that programming is integrated and includes (for instance) education, psychosocial support and safe spaces for all members of the LGBTQI+ community.
- Fund and support access to safe shelter and safe spaces for LGBTQI+ individuals, particularly for certain groups such as refugees, transgender persons and unaccompanied minors. Ensure that LGBTQI+ community members participate in the management of these services.
- Develop or link LGBTQI+ individuals to livelihood programming that can reduce poverty and the need to engage in survival sex work, thereby also reducing exposure to sexual exploitation and violence. (Key informants mentioned the need to incorporate economic empowerment approaches as part of GBV prevention efforts, including through the provision of seed-funding to LGBTQI+ individuals or groups).
- Provide cash assistance to LGBTQI+ refugees who have severely limited access to livelihood opportunities, while also mitigating the risks of GBV faced by those who receive such support.

4.2.3 Improve coordination

- Improve coordination and referral between service providers, including linking existing LGBTQI+ support services with LGBTQI+ refugees and migrants who may not be aware of those services.
- Improve coordination more generally between CSOs, NGOs and CBOs to prevent

disharmony in terms of programmatic and intervention approaches – which includes involving LGBTQI+ individuals themselves in the development and implementation of programmes and interventions.

4.2.4 Improve and expand ongoing sensitisation and advocacy work

- Continue training, sensitisation and capacity-building activities with actors in the public and justice sectors whose work involves dealing with people who experience GBV, including police, prosecutors, lawyers, and judges. (This was emphasised by key informants).
- Develop programmes to reduce stigma and discrimination towards members of the LGBTQI+ community, including community-based campaigns that engage community and religious leaders.
- Integrate learning on the rights and dignity of LGBTQI+ persons into school curricula and curricula used by NGOs.
- Key informants noted the need to identify and work with champions of LGTBQI+ issues to strengthen advocacy efforts and support prevention of and response to LGBTQI+ experiences of GBV. However, members of the gender-conforming community must also be included so that advocacy is not just about LGBTQI+ rights, but is about fundamental human rights and liberties.

More generally, as identified in both the literature review and the consultations, policies, programmes and services must be adequately resourced, accessible, tailored and affordable to different sub-populations within the wider

umbrella of people with diverse SOGIESC. This is particularly the case in humanitarian contexts, where, as identified in the literature, 'diverse SOGIESC inclusion has fallen behind other inclusion domains' (Dwyer, 2021). These policies and programmes need to be based on learning and best practices and must take into account country-specific norms and sociocultural factors that drive discrimination and abuse based on SOGI. Also, as key informants highlighted, there is a need to strengthen multisectoral approaches to advocating for the rights of members of the LGBTQI+ community. These approaches need to involve relevant government ministries, including judicial and legislative actors, human rights advocates, healthcare service providers and community members. There was also a call for stakeholders to improve coordination, identify shared goals, and develop and implement joint work plans.

Finally, there is a need to engage with – and to co-create and co-produce with – people of diverse SOGIESC when designing and implementing programmes. This applies across humanitarian, development and community services, in health, education and other key sectors. The aim must be to ensure that programmes and services are appropriate for different population groups and are sensitive to context.

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Appendix 1   Respondents in the consultations

Table 2 Breakdown of respondents who took part in the consultations

Type of organisation (e.g. LGBTQI+ network, NGO, policy-makers/ government bodies)	Number of respondents	Vulnerable group represented
Policy-makers/ government bodies		
• National AIDS and STIs Control Programme (NASCOP) • Nairobi Metropolitan Services County Health Management • Mombasa County Health Management • Kenya National Commission on Human Rights	5	LGBTQI+
LGBTQI+ network representatives		
• Gay and Lesbian Coalition of Kenya (GALCK) • Ishtar MSM • Persons Marginalized and Aggrieved (PEMA) Kenya • Other Sheep Africa • KP (Key Populations) Consortium • Health Options for Young Men on HIV/AIDS/STI (HOYMAS) • Trans Alliance • Jinsiangu	8	LGBTQI+ and refugees/ migrants
NGO		
• National Gay and Lesbian Human Rights Commission (NGLHRC) • HIAS Kenya • United Nations Population Fund (UNFPA) • Office of the High Commissioner for Human Rights (OHCHR) • LVCT Health • Coalition of Violence Against Women (COVAW)	6	LGBTQI+, refugees/ migrants
Group consultations with representatives from the LGBTQI+ community		
• Bisexuals • Transgender	2* 3*	Bisexual and transgender

* Respondents per group

Appendix 2   Validation exercises

We validated our preliminary findings through two separate workshops that brought together 24 stakeholders from CSOs and 6 from government. During the plenary sessions, we received the following feedback when discussing these two topics (many of the issues raised are also reflected in the recommendations section).

How can we use this evidence from intersectional analysis in our advocacy work?

- There is a need to be more deliberate in utilising the 'onion strategy' in conducting research around key populations (KPs) and sexual minority groups. Most research focuses on LGBTQI+ individuals as one population, whereas sexual minorities have different and unique experiences of marginalisation and vulnerability.
- Each specific sub-population also needs unique policy objectives to address their needs. These policies also need to be scaled up to reach the most marginalised communities.
- We can use this evidence to advocate for more detailed, comprehensive and compelling data on each of these groups. Data can be on population estimates, service needs, etc.
- NGOs and relevant stakeholders should provide safe spaces for LGBTQI+ individuals who have experienced (or been threatened with) violence. It is possible that these considerations have not been made due to lack of targeted funding. We can use these findings to advocate for such interventions.
- Sensitise communities about the existence of LGBTQI+ populations among them to begin to curb stigma.
- There is a need to review the entire legal framework to challenge some conflicting sections of laws that exacerbate discrimination against LGBTQI+ populations while they are seeking legal, health and other public services.

How can we practically apply intersectionality in our advocacy work?

- Engage policy-makers to enact laws that protect the rights of minority populations.
- Address the needs of sexual minority persons that are living with disability, as they face unique challenges.
- LBQ women have not been able to benefit from programming around HIV and AIDS and have not been included in KP HIV programming.
- Despite a robust legal system and Kenya's Constitution, there is a lack of sensitisation among duty-bearers about the content of existing laws and policies that protect people from violence. For example, many duty-bearers (policy-makers and service providers) do not fully understand the Sexual Offences Act.

- Include indicators for LGBTQI+ populations in SGBV prevention and response policies to reduce systemic discrimination.
- Having worked closely with other interagency bodies, this would be a great avenue to explore how this information could be disseminated to them, as their contribution would be invaluable, as well as capturing wider perspectives.
- It is important to contextualise the issues that affect various KPs in various counties so as to establish the main issues emerging from particular locations, and how to address the same.
- There is a need for inclusive policies linked to the human rights-based approach where principles such as equality, non-discrimination and equal participation are upheld. This would widen the scope, making sure that no one is left behind when formulating policies and looking at what initial steps could be taken by state and non-state actors so that all are on board.
- Introduce intersectionality at the core of all policies to understand what is limiting them in achieving their goals. Interventions would then be based on the gaps identified due to intersectionality failures.
- Apply human rights perspectives and give minority populations a platform to have a voice and contribute to the design of services and formulation of policies that affect them.

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