Bridging the Gaps:

Fostering Access to Health Care and Knowledge on the Sexual and Reproductive Health Rights of LBTI/WSW Persons

FARUG
FARUGANDA.ORG

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Research Report

Freedom and Roam Uganda

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ACRONYMS AND ABBREVIATIONS

AHB:	Anti-Homosexuality Bill
AJWS:	American Jewish World Services
APA:	American Psychiatric Association
DSM-II:	Diagnostic and Statistical Manual Vol. II
DSM-V:	Diagnostic and Statistical Manual Vol. V
ED:	Executive Director
FARUG:	Freedom and Roam Uganda
HIV:	Human Immunodeficiency Virus
IBU:	Ice Breakers Uganda
KAP:	Knowledge, Attitude and Perception
KULHAS:	Kuchus Living with HIV/AIDS Uganda
LBTI:	Lesbian, Bisexual, Transgender and Intersex
LGBTI:	Lesbian, Gay, Bisexual, Transgender and Intersex
MARPS:	Most at Risk Populations
PAC:	Post Abortion Care
QYU:	Queer Youth Uganda
RHU:	Reproductive Health Uganda
SMUG:	Sexual Minorities Uganda
SRHRS:	Sexual and Reproductive Health Rights
STIs:	Sexually Transmitted Infections
TASO:	The Aids Support Organization
TSIU:	Trans Support Initiative Uganda
UN:	United Nations
WHO:	World Health Organization
WSW:	Women Who Have Sex with Women

YRF: Youth on Rock Foundation

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Finally, we deeply acknowledge all those health workers who received us with a smile and a positive attitude. They welcomed us when others saw us as 'beasts' so we extend a very special **THANK YOU**.

DEDICATION

This report is dedicated to all LBTI/WSW individuals who have endured so much humiliation and pain at the hands of health workers, the very people who have sworn oaths and accepted a professional code of conduct to protect and give health care to all people without discrimination or prejudice. Keep the hope that one day all will be treated with upmost dignity and given proper treatment. **ALUTA CONTINUA**!

OVERVIEW

Government and health care providers at large almost always ignore health care issues affecting LBTI/WSW persons. To make matters worse, there is very little information available regarding the health care issues of LBTI/WSW persons. Coupled with the high levels of stigmatization and discrimination this makes it difficult for LBTI/WSW persons to access health care services, which puts them at risk of living with untreated illnesses.

Our research found that most health care practitioners lack the basic information necessary for the care and treatment of the LBTI/WSW population. For example, the majority failed in understanding the specifics associated with different sexual orientations, intersex development, gender identity, and the impact of stigma and discrimination on a marginalized individual's health. Indeed, it is quite unfortunate that most health care workers in Uganda still consider homosexuality a mental disorder, when in 1973 the Board of Trustees of the American Psychiatric Association (APA) removed homosexuality from its official diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders,* Second Edition (DSM-II). The action was taken following a review of the scientific literature and in consultation with experts in the field, who found that homosexuality does not meet the criteria to be considered a mental illness.

Ironically, health care workers in Uganda use this very manual in order to diagnose mental illness and hence must be aware of the removal of homosexuality from the list of mental disorders. Likewise, it would be beneficial for health care workers to be informed of the recent release of the DSM-V—the latest version of the manual—especially with regard to the issue of gender identity. However, rather than following up-to-date research and standards of care they follow an

edition that has been revised three times over a span of 45 years. Using obsolete criteria with knowledge of more current editions is just one example of how they simply choose to ignore vital pieces of scientific evidence and modern development.

We found that in Uganda's health care system, most policies related to health mention nondiscrimination, but none of them covers issues relating to the health of LBTI/WSW persons. Even the famous Most at risk populations Program (MARPs) is extremely vague on the issue, only mentioning men-who-have-sex-with-men (MSM) in passing. This lack of information coupled with the unfriendliness of health care personnel hinders access to quality health care for LBTI/WSW persons. In addition, most health workers use their prejudices, biases and beliefs instead of the medical code of ethics when they encounter LBTI/WSW persons. Due to the imposition of heteronormative values, onto LBTI/WSW persons who seek care, the patients are often unlikely to return for follow up or future check-ups. Others are forced to remain silent or worse, they pretend to have a boyfriend or girlfriend in order to fit into the heteronormative standard. This masquerading has harmful effects on the emotional health of the patient and could lead to the misdiagnosis of their problems. Those with too many bad experiences are afraid to return and may turn to harmful forms of self-medication.

This project resulted from an interaction with one health care worker who pointed out that there was no data on the health needs of LBTI/WSW persons. He believed that LBTI health issues were not unique and that they should access the same health services as other people. To some degree he was right. However, it is important to point out that there are some needs and essential knowledge that is specific to LBTI persons. The claim that there was no collection of the knowledge

needed on the issue encouraged the Executive Director of FARUG to write a proposal with one of its objectives being the carrying out of this survey in order to better understand the current situation of LBTI/WSW peoples experiences and the levels of knowledge and experience of the health care providers.

The main aim of the survey was to find out how LBTI/WSW persons perceive the health issues affecting them: in other words, do they know their rights; particularly their sexual and reproductive health rights (SRHRs)? What are the kinds of services they require and what recommendations do they have for the improved enjoyment of their SRHRs? The survey was also intended to understand the knowledge, attitudes and perceptions (KAP) of practicing health care workers towards LBTI/WSW persons.

Given that Uganda is signatory to universal treaties and has an obligation to provide health care to its citizens without prejudice, the survey is particularly important in terms of considering the extent to which the country is compliant with its international human rights obligations. For example, Principal 8, Paragraph 8.6 of the Cairo Program of Action stipulates that, "… a commitment to promoting and attaining the goals of universal and equitable access to the highest attainable standards of physical and mental health, and access of all to primary health care making particular efforts to rectify inequalities relating to social conditions and without distinction as to race, national origin, gender, age, sexuality or disability." The government has failed to fulfill this obligation and the results of this report provide substantial data to support this claim.

METHODOLOGIES

There were a number of different activities, which preceded the execution of the survey, including the following:

Workshops

Following several meetings and the selection of the project's team, a one-day introductory workshop was held on the 12th of April 2011. This workshop was designed to introduce the project to the LBTI/WSW community in Uganda. Out of 30 invitees the workshop had an attendance of 26 people. Of the attendees there were representatives from several LGBTI/WSW organizations including FARUG, SMUG, KULHAS Uganda, IBU, QYU, TSIU, and YRF. The details of the project were discussed and endorsed by the participants. Questions were raised about the definition of SRHRs, the security of the information that would be collected, who the researchers would be, who the project partners were, and the geographical scope of the project. The research team duly answered each of these queries.

Overall, the feedback from the workshop was quite positive and most of the participants were very happy about the project to be undertaken. One member of the community summarized the views of many when they said that "…as an LBTI person I did not know that I have a right to access SRH services; this (workshop) has been an eye opener".

Formulation of research tools, and designing and printing field materials

It was quite difficult to come up with a credible tool that could help us collect measurable data. We thus formulated two questionnaires one of which was

for LBTI/WSW persons to apprehend their perceptions of the health care system and measure their knowledge about their rights. The second questionnaire was designed to assess the KAP of health care workers and the general public towards LBTI/WSW persons. Kasha, the ED and chairperson of the FARUG Board, an outside volunteer from the USA, and various community members, reviewed the questionnaires. All of the individuals who reviewed the surveys made changes and additions based on their area of expertise in order to ensure the credibility and effectiveness of the results they were intended to provide. We also consulted with one of our partners in Kenya who is an expert in the field of LBTI health. The questionnaires were open-ended with the number of questions not exceeding seven.

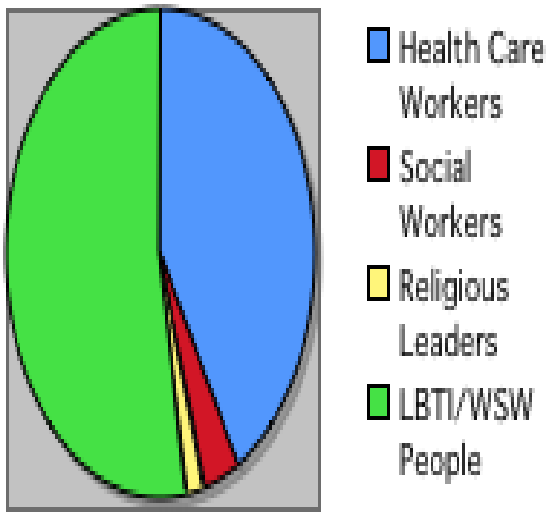
The project coordinator, with the help of the entire team, did the designing and printing of the materials. The main project poster called upon health care workers to end discrimination based on sexual orientation and included definitions of sexual orientation and heteronormativity. In addition to the posters two types of brochures were disseminated with the first talking about the health related issues for the LBTI/WSW community, and the second specifically designed to educate health care workers. We faced several challenges in producing the brochures in different languages, so we ultimately chose to only produce them in English.

Field preparatory meeting

A one-day meeting was convened to prepare for the fieldwork, with a main focus on the distribution of work and providing context on the location of the research sites. The meeting also covered the issue of security of the team and of the confidentiality of the information collected. Lastly, we closed by answering the complicated question of how to introduce ourselves to people and who to

contact in case of an emergency. Following our convening two teams of researchers were sent out into the field to begin conducting the research.

The interviews were conducted in phases, with the first being in Kampala and the neighboring districts of Wakiso, Mukono and Entebbe. The second phase involved up-country visits to Mbale, Kumi, Iganga, as well as Jinja in Eastern Uganda, and Mbarara, Bushenyi, and Masaka in the Western and central parts of the country. A total of one hundred and eight (108) individuals were interviewed, with respondents being between the ages of 18 and 53. Of them there were 45 health care workers, 4 social workers, 2 religious leaders and 57 LBTI persons.



CHALLENGES

We faced several challenges while carrying out these interviews, especially from the health care workers and the general public. Most of them turned their backs on us, while a number of them did not complete the interviews. The moment they realized that we were discussing a contentious issue they refused to talk to us. Some respondents threatened to report us to the police on the claim that we were 'promoting homosexuality.'

Given the nature of the issues we were discussing, we did not have formal means of introduction like identification letters or cards and some people could not talk to us without these documents. Some of the team members were harassed, as was the case with the following encounter:

> "I met with this respondent over lunch, after we had made our orders and settled down. I pulled out my questionnaire and explained the reason for the interview. She asked me the meaning of LBTI/WSW. I explained the meaning to her and that was when the conflict began: she started shouting on top of her voice: 'White people are promoting homosexuality… they have (even) started to plant it within our society through us citizens.' I told her it was not true but she did not listen. She wanted other people to know what was going on and I told her it was okay if she did not want to answer. However, she grabbed my questionnaire and wanted to tear it. She asked me what we were looking for and asked whether she can get somewhere to report me for the 'promotion of homosexuality.' Later she told me to 'tell my bosses who 'promote homosexuality' to leave Africa alone and if they want to promote it they should stay in their own countries. This is Africa and they will not tolerate such unnatural behavior or allow strangers to teach [it to] their children.' In addition, she said she 'does not care if these people do not get medical attention. Nobody needs them in the

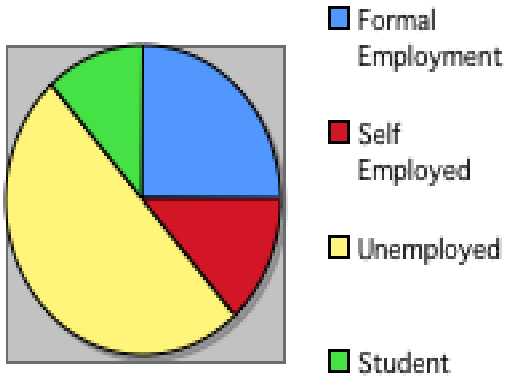
community and I wish they would start to die one by one until they are all finished.'"

Sadly, this example is one of many others like it. We encountered many health care workers with malice and contempt for LBTI people with little care or concern for their physical and emotional health and wellbeing. The next session, will further explore the findings of the research conducted.

FINDINGS OF THE RESEARCH

1.0 *Results from LBTI/WSW Persons*

The interviews were in form of individual (one on one) and focus group discussions. All 57 (100%) of the interviewees had some formal education with the lowest being S.2, while the highest had post graduate qualifications. 30 (52.63%) of the interviewees did not have any form of employment for various reasons with a major trend being forced school dropout due to being denied education by their parents. 7 (12.28%) of the respondents were still in school; 15 (26.32%) had formal employment in various fields including health, banking, education and information technology. 5 (8.77%) were self-employed.



1.1 *Defining Sexuality and SRHRS: Perceptions of Rights and Practices*

Sexuality is a broad area of study related to an individual's sex, gender identity and expression, and sexual orientation. 75% of the participants interviewed had some idea of what sexuality was about. Some defined it as the way one perceives him/herself in public. One said it was about sex combined with feelings. Yet another said sexuality was about identifying as male or female, sexual orientation, and identifying as neither male nor female.

The survey respondents defined Sexual and Reproductive Health Rights (SRHRs) as: freedom to enjoy sexual rights, the wellbeing of the reproductive

system, the ability to give birth, a study of conditions affecting the reproductive system, the mental and social wellbeing of a person and not merely the absence of reproductive system diseases, and lastly, one individual quoted a definition derived from the WHO general definition of health. Indeed, according to the WHO, SRHRs can be understood as, "the right for all persons, whether young or old, women, men or transgender, heterosexual, gay, lesbian or bisexual, HIV positive or negative, to make choices regarding their own sexuality and reproduction, provided they respect the right of others to bodily integrity."

All 57 (100%) of the LBTI interviewees perceived SRHRS as rights because they are inherent and human rights are rights regardless of ones sexual orientation or gender identity, which is coherent with the WHO definition of SRHRS. However, when asked what exactly these rights were, 30 (52.63%) did not know their individual SRHRs. We can surmise that this result was partly due to the lack of access to information about their health rights. Notably, only 27 of those interviewed (47.37%) mentioned the right to information, treatment and access to health services.

When asked whether they enjoy these rights, 40 (70. 28%) agreed that they did enjoy the rights but to a limited extent because they are careful to not identify themselves as LBTI/WSW when accessing services. 17 (29.82%%) said that they do not fully enjoy these rights because of discrimination, stigma, harassment, confidentiality issues, and restrictive laws that do not allow same sex relationships. While most of them felt the need to go to health facilities with their partners, it was something that they dared not do. In the words of one participant, *"...as a Transgender person, it's very difficult for me to go to the health centers and seek help without being noticed because I am very visible."*

While LBTI/WSM persons have unique sexual practices, compared to heterosexuals, they are still susceptible to transmission of STIs. This risk of transmission is greatly increased because health care practitioners refuse to take into consideration the range of sexual activities of LBTI/WSW because of social, religious, and cultural stigma. Ignorance and lack of education of health care workers, in addition to lack of safe and accessible health care in general, results in a drastic increase in the risk of transmission for LBTI/WSW persons.

Indeed, when asking health care workers about the specific sexual practices, history, and complications of LBTI/WSW individuals, the responses were uninformed and influenced by negative cultural perceptions. Respondents believed that LBTI people were those who: had multiple partners, had high occurrences of unprotected sex, had accessed abortion services, were in bisexual relationships including some who were in heterosexual relationships as a cover up to fit in society, and who had used some form of contraceptives. Many of those interviewed had heard of the occurrences and risk of HIV/AIDs, cancers, and STIs but very few had preformed screening tests on their patients to ascertain their status and overall, many were not knowledgeable about the recommended safety techniques specific to LBTI/WSW person's individual practices.

1.2 *Critical SRHRS Concerns among LBTI Individuals*

All 57 (100%) of the LBTI/WSW interviewees wanted increased access to services such as:

- Counseling to help cope with the daily stresses of life because LBTI/WSW persons (especially Tran's persons) face psychological torture in their daily lives from family, friends and the general public.

- Access to medical care without discrimination.
- Safe sex information that is specific to LBTI/WSW persons.
- Post abortion care (PAC).
- Posttraumatic counseling following rape or any other form of violence.
- Information on HIV, STIs and cancers that is well researched and specific to their needs and practices.
- Provision of safe sex materials like condoms, dental dams and lubricants.
- Access to counseling and hormones for Trans persons.
- Information on fertility issues.
- Inclusive Safer-Sex education.
- Vaccinations against Hepatitis B virus.
- Access to PEP following rape.

All interviewees saw the need to be given an opportunity to participate in the formation and implementation in the general national programmes and services. That way, the concerns and health issues that are specific to them would be included alongside the work to help properly educate and end stigma among medical health care professionals.

Most of the health concerns of LBTI persons are no different from those of anyone else, however some concerns are specific. For example, many LBTI persons are subjected to discrimination and outright violence, which increases stress and takes a toll on an individual's mental health. In addition, not only are LBTI persons at risk for HIV, there is also mounting evidence that they are more likely to smoke and use alcohol than their heterosexual counterparts, which could increase the risks of lung cancer, emphysema and heart disease. This peak in substance use and abuse is likely correlated with coping with the stresses of daily

life that result from the fears and disadvantages of holding a socially marginalized status.

When asked if they have access to HIV, mental health, STI, and cancer screenings as well as necessary treatment services, 70% of the interviewees said they do have access to these services but that to access them they do not reveal their sexuality. They are often guarded about discussing their sexual behavior with health care providers, fearing that "coming out" will lead to discrimination.

However, some interviewees—especially Trans persons—do not have access to HIV, mental health, STI, and cancer screenings and treatment services because of their appearance. At a high cost some interviewed admit that they go to private health care providers to get the care they need. The problem is, however, that the majority of LBTI persons cannot afford these services given the fact that most LBTI persons are economically disempowered due to their sexual or gender identities. Most of the LBTI persons (80%) thus feel that they receive less health care than the population as a whole. If they are able to access services, many interviewed believes the quality of their care suffers. Additional barriers, including negative experiences in the past and mistrust of the medical profession, made those interviewed apprehensive about seeking care in the future. Some of them refuse to visit health care providers at all.

1.3 *Barriers, Risks and Vulnerability*

The interviewees said that they have many issues that prevented them from accessing quality SRHRS services. These barriers include: lack of information about available services, fear of being discriminated against, fear of discussing their sexuality, fear of being isolated and diagnosed as mentally ill, the ignorance

of health care providers, facing public humiliation, the cost of the health care, long distances to health care facilities, non approachable health workers, and differences in language just to name a few. The barriers presented contribute to the reality that the community is vulnerable and at risk of living a poor quality of life due to poor health care seeking behaviors. In addition to the listed barriers some LBTI/WSW's reported experiences of being violated either through physical harm or psychological torture at the hands of unsympathetic or hostile health care providers. Indeed, the interviews indicated lesbians in Uganda face the risk of being raped and sexually harassed, especially by those who feel that they should teach them a lesson or teach them how it feels to be penetrated by a man. Some of these rapes are perpetuated by family members and encouraged by religious leaders in the name of finding a 'cure.'

When asked who was responsible for these challenges, 90% said it was the responsibility of the government because it is supposed to protect all its citizens, the policy makers for making discriminatory policies, society for being so homophobic and transphobic (making LBTI persons to live in fear), and lastly, medical professionals who are ignorant about LBTI health care issues or hostile to LBTI persons. Interviewees also noted numerous times that religion has been used as the justification of homophobia and trans-phobia due to the tendency of western religious leaders importation of conservative religious views from abroad to garner fear and hate towards LBTI people. For conservative religious leaders, inciting a religious war against sexual freedom and reproductive health is a lucrative business venture at the expense of the local range of diverse sexual expressions and gender identities that have always existed in Uganda.

1.4 *Lived Experiences*

Most of the interviewees had never identified themselves as LBTI when presenting to the health care provider except, for a few of the Trans persons who are very visible and their gender can be questioned. The reason for nondisclosure of their sexuality was mainly the fear of being rejected. One interviewee lamented that *"however much I would prefer to disclose my sexuality because then I would get proper diagnosis and hence the right intervention, I dare not because I fear being humiliated and rejected."* Some have had experiences so negative with health care providers that they would rather remain with the medical problem than face the care provider.

One person interviewed shared that on a visit to a local hospital the nurse became so hostile they left without getting the treatment. Feeling a threat to their physical safety they ran out because the Nurse was throwing insults and shouting on top of her voice saying "Banange Mujje mulabe omusiyazi" (come and see the homosexual). The patient said, *"I was so humiliated that I never wish to go back to any health care provider"*. Another person was denied treatment because of the dress code they exclaimed, *"I wonder what health has got to do with a dress code!"* Again an additional patient, who recalled being sedated by the doctor and examined against his consent, said *"it was a very bad encounter and humiliating, the doctor had told me that I was to be examined and I was not comfortable with it so I said no. He then tricked me that he was going to give me medicine and I go home; instead he sedated me and examined me without my consent."* Such actions are unethical and wrong because a patient has the right to refuse any procedure being performed if they do not want it. Another interviewee had gone to the hospital very early and was the first person in the queue, but the nurse kept on

skipping her just because she looked different and she was the last person to be attended to with a lot of questions like "are you a man or woman?" Such comments make LBTI persons afraid of seeking health care services and are very humiliating, degrading and painful.

Some people have had their rights directly violated. One interviewee said, *"I had been involved in an accident and was semiconscious. By the time I gained full consciousness I found myself in a male ward undressed yet there were male patients around, I felt so small and embarrassed, I kept on wondering why they had done this to me? It became clear to me that they used this as a form of punishment."* Every human being has a right to privacy and to be treated with dignity. The health care workers have ethical and moral principles that guide their practice, for example, the principle of *non-malfeasance*, which is the duty to prevent or avoid doing harm whether intentional or unintentional. In nursing, intentional harm is never acceptable. In this case a nurse must not knowingly act in a manner that would intentionally harm the patient but the health care providers harmed this person by psychologically torturing her when they breached her right to privacy and treatment with dignity.

1.5 *Recommendations*

The LBTI interviewees were asked what they think should be done in order for them to enjoy their health rights. Their recommendations included the following:

- Train medical personnel about the needs of the LBTI community.
- Sensitize health care workers around LBTI identities.

- Lobby the Government to support the human right of equal access to quality health care services for LBTI persons.
- Set up health care services within LBTI organizations.
- Establish health facilities run by the LBTI community.
- Identify LBTI friendly health care centers.
- Advocate for the removal of all discriminatory laws.
- Push the Government to create user-friendly services.

2.0 *Results from health care workers and other stakeholders*

In this section we approached close to 120 persons in the sectors of health care or religion as well as members of the general public at random. 51 accepted to do the interviews, 30 persons did not complete the interview and 39 persons refused to do the interview at all

The interviews with this group were quite challenging, in some cases the moment the meaning of LBTI/WSW was explained, the interview abruptly ended. We did have some positive receptions from people but many refused to talk to us. Most of the homophobic statements justifying their refusal to participate in the research were attached to religion, culture and societal values.

This survey showed that there is a general lack of knowledge about LBTI issues. When we talked about sexuality within the context of sexual orientation, the first thing that came to the minds of many was sexual practices. For example, one Muslim leader said *"I know it is not good to judge people but I will, because what these people are doing is not correct and that's what the Quran says about it, as a Muslim leader, I would encourage all people who engage into this kind of behavior to pray to Allah to help them. Maybe their parents cursed them or others*

but I know they can change. There for I will not answer any of your questions and I am sorry if I have offended you".

2.1 *Defining a Sexual Minority*

Many of the respondents had some idea of who a sexual minority was; however most of the definitions were negative. Some of the definitions included:

- A person or people, who have sexual preference which is not heterosexual;
- People who are not sexually satisfied, and are confused about what they want when it comes to sex. These are persons who are few as the word "minority" says and have deviated from the normal way of sexual practice by being in same sex relationships.
- Sex among the smallest group of people with a mental disorder or problem.
- People who have failed to know the value of their reproductive system and hence misusing them.
- People who indulge in prohibited sex.
- People who have high libido for same sex organ and low libido for opposite sex.
- Mad people because most of them are drug addicts and some of them are introduced and manufactured into homosexuality by the western culture.
- People who are diverted into their own kingdom because Allah did not create a woman for a woman.
- Something that is usually not important.

Most of the definitions were explicitly homophobia, based in ignorance, or assumed as religiously or culturally 'prohibited'. Of those interviewed very few had positive views of sexual difference.

2.2 *Encounter with a Sexual Minority*

70% of the respondents that said they had an encounter with a sexual minority reported that their reaction was negative while those who had not encountered someone said they would not react positively. Only a small percentage of the respondents who had met someone that identified as a sexual minority found their reaction was positive.

A sample of respondent reactions ranged from one which said that if she had come across "gays and people who masturbate [she] would perceive them as if they had habits which go on growing and get addictive just like those of smokers and alcoholics." She later confessed that she believes, "we [society] just need to stop them [LBTI] people from the habit of masturbating." On the other side of the spectrum we interviewed a counselor of over 3-years of experience who said he had never met a sexual minority. He said, *"if I ever met such a 'character' I would consider it okay because I don't know how it begins or how it enters some one's mind although, there are dangers because they are having 'un-natural sex.'"* It is important to point out, as these two samples from the larger pool of those interviewed reflects consistently with the whole, in that the reactions of those who have met a sexual minority as well as those who have not hold a bias that sexual minorities are "choosing or addicted" to behaviors which are unnatural and dangerous. These statistics exemplify just how deeply homophobia and intolerance of sexual difference is rooted. Below are some of the other things that many of the respondents said they had or would do if they met a sexual minority:

- Report them to the police.
- Encourage them to get help for their behavior and discuss the advantages of healthy, 'normal and legalized sexual orientation or gender identity consistent with heteronormative social expectations.

- Feel pity for them because they are cursed, sick, or addicted.
- Feel embarrassed for them and not want to be associated with them.
- Run away from them for fear of being infected by their sickness or curse.
- Ask them why he/she has 'decided' to live such a disgusting life.

The responses above suggest a lot about the pervasive negative and often uninformed perceptions of sexual minorities in Uganda. The next section will expand upon these perceptions and present the statistical insights provided by the research conducted.

2.3 *Perception of Sexual Minorities*

Out of the 51 respondents interviewed, only 8 (15.7%) perceived sexual minorities as normal human beings just like any other person deserving to live their lives without interference of any sort. The rest 43 (84.3%) had varied negative perceptions of sexual minorities, including that they are: abnormal, disgusting, ungodly, people who don't know that their organs are identical, people who lack parental guidance, people who have something lacking in their brains, people who are mentally unstable, people who are very lonely and have failed to get partners from the opposite sex, and lastly, people who practice dangerous sex and have problems like prolapsed anus or infertility.

When asked if the issue of homosexuality is ever mentioned in any course unit during the years of study, the majority said yes but it is always termed as social deviation or behavioral disorder. Most of them were not aware that homosexuality was removed from the DSM II. Although they agree that they have a moral and ethical obligation to treat people without any form of discrimination, most of them implicated cultural and religious beliefs to justify their statements of

hate and take precedent over their ethics and oath as medical practitioners. One respondent captured the sentiments of many when they said, *"categorically, I will not allow ethics to interfere with my culture and religion, this subject is totally disgusting and unacceptable and all those who promote it should be hanged!"*

2.4 *Should Sexual Minorities Have the Same SRHRS as Everybody Else?*

The same 8 (15.7%) of the interviewees who perceived sexual minorities as normal human beings agreed that sexual minorities should have the right to access quality health care. They believed that health care, including sexual and reproductive health, is a basic human right. Of those who felt this way many agreed that health issues affect everyone and care should not discriminate based on color, race, location or sexuality. The minority of respondents who felt this way likewise, agreed that identity should not be a reason to deny people their inherent rights because all humans deserve equal access, care, and treatment.

A majority of 43 interviewees (84.3%) had this to say: *"Sexual minorities do not deserve equal access to sexual and reproductive rights because what they are doing is illegal in the eyes of the law and the only care they need is treatment to change their habits so that they can fit in society."* Many of these same people feel that the government should pass the Anti-homosexuality Bill (AHB) so that these people are "stopped through the punishment of their immoral and unnatural actions". One respondent went as far as asking *"why should they be given rights when what they are doing is illegal and a sin against God?"* This individual went on to say that *"they should be left to die or be killed… [Because] God was not stupid to create man and woman."* Another respondent was recorded saying, *"Sexual minorities do not deserve rights because their behavior is not acceptable*

and they should be punished severely so that they can reform." When asked how she believed 'reform' might be achieved she answered saying "*...because they are controlled by something and are not themselves if you can give them the services, talk to them through counseling, they can stop this habit"*.

When taken to a personal level one well educated medical professional lamented, *"how can you wake up one day and find that your son or daughter is homosexual? This is an issue which should not be discussed because it's an abomination and no rights are deserved."* The interviewer followed up and asked what he would do if he found out that his daughter or son was homosexual, and he responded by saying he would *"take him or her to prison and make sure that he/she is thoroughly punished, thereafter I [would] take them to church for polishing."*

Some research participants justified responses against equal access to health care using medical reasons. One medical professional thought that LBTI/WSW persons do not deserve SRHRs rights because of a belief that their "reproductive systems are not active so they cannot reproduce." A very rare counter point from a health care worker from Western Uganda provided a sense of jaded hope that straddled a line rarely crossed when she suggested that even though she believes it is not biblically 'correct' that it should not be a barrier for health care saying that, "of course, we know who created sex and the Bible says it's supposed to be between a man and woman, but if a woman decides to sleep with a woman then they should still get the services just like any other person".

The various responses recorded exemplify the complexity of social, religious, cultural, and often false medical beliefs that maintain both individual and

institutional positions of opposition, oppression, and intolerance towards sexual and reproductive health for sexual minorities. To combat these interlocking systems of exclusion we recommend the human rights perspective relating to sexual and reproductive health outlined below. It has been ratified in many basic human rights treaties. The research we conducted suggests that many health care workers are unaware of existing human rights treaties and thus education on the following issues among health care providers in Uganda is a crucial first step. Items of importance to be highlighted should include:

1. The right to the highest attainable standard of physical and mental health care including sexual and reproductive health for all.
2. The human right of equal access to adequate health care related services regardless of sex, race or other status.
3. The human right to education and access to information relating to health, including reproductive health, family planning to enable couples to conceive if and when they desire, and the freedom for "individuals" to decide freely and responsibly to all matters of reproduction and sexuality.

All these rights do not discriminate against any one and since Uganda is a signatory to these human rights treaties, they have a legally binding mandate to educate health workers to stop discriminating against people when it comes to sexual and reproductive health. It is a matter of human rights and alleviating human suffering. Personal and religious beliefs and prejudices should not factor into the realization of any ones basic human rights.

2.5 *Learning About Health Issues Affecting Sexual Minorities*

We asked the respondents if they would be willing to learn more about the health issues affecting sexual minorities. 60% of the respondents said yes but only to try and change the sexual minorities' way of behavior and not to accept them or provide them with better care and treatment. 75% of the respondents believed that these people are recruited and go into the vice because of monetary benefits due to situations of poverty and can change with spiritual guidance and counseling.

Only one doctor who was willing to learn more had a desire to do so based on the fact that, *"…since I have Trans-friends, I need to learn more about their health needs and how to help them access health care in this hostile system in Uganda."* On the other hand, a respondent from Western Uganda was not interested in learning more about them but hoped to protect the community and the children from them. He said that he has been involved in outreach activities at schools to teach students against this shameful vice. Others just wanted to know how sexual minorities have sex, why they behave the way they do, and wish to carry out scientific tests on them to find what causes them to behave the way they do. A small minority were mostly interested in knowing about trans and lesbian health issues only. For example, one respondent from Western Uganda said "I would like to meet some if they are there and ask them what is good and why they are interested in such sex". He also said that, "I cannot imagine having sex with a man but I would tolerate sex between women." Lastly, those who said that they were 'not interested in learning' gave the reason that if they got interested they would be 'promoting homosexuality'. For the majority of those responding in this way their reasoning was because homosexuality is not accepted and thus they fear social and legal repercussions from such support.

2.6 *Their Recommendations*

We asked the respondents what should be done in order to promote the SRHRs of sexual minorities from their own perspectives. The answers were mixed with both positive and negative responses. Samples of the recommendations from medical professionals starting with the positives followed by the negative include:

- Awareness and sensitizing of health care workers and the public at large is needed.
- The media should be taught on how to report SRHRS issues of sexual minorities.
- The Government should remove laws that discriminate against sexual minorities.
- There should be education about the challenges facing sexual minorities and the price of discriminating against them since people are misinformed.
- It needs to be spread that LBTI/WSW persons should be treated as human beings and not sex objects.
- Activists should try as much as possible to uncover the myth about homosexuality.
- A lot of advocacy must be targeted towards legislators, policy makers, and religious leaders.
- Health facilities that are educated on and support LBTI/WSW needs should be identified and supported.
- The Government should give services to this group especially HIV related services because they are so much in need of them as they have increased

the percentage of HIV infection. "They are dyeing slowly by slowly and I don't blame them but why are you asking me questions that target only gays?"

- "They should be killed so that the society is saved of these bad people because they are very bad and they do not deserve any rights whatsoever."
- Laws to punish those who practice homosexuality should be implemented.
- They should be imprisoned.
- "Why should we promote their rights? They should be stopped; I don't see any reason why as far as I am concerned these people should be promoted but be killed or migrate."

BRIEF OVERVIEW OF THE FINDINGS

Most of the LGBTI persons are willing to access health care services but have barriers that hinder them. One stark finding was that most of the LGBTQI people interviewed were unaware of their basic SRHRs.

The majority of the health workers interviewed are very negative when it comes to sexual minorities and most of them are not willing to learn about the health issues affecting such minorities despite the fact that they lack knowledge in this area. Most of the health care workers we interviewed also attach their personal & religious beliefs as well as their cultural norms to their profession and thus feel they have an obligation or at least the right to impose them onto their clients.

CONCLUSION

It is apparent that most LGBTI persons have the zeal to take care of their health but face a great deal of obstacles in their way which include harassment, lack of knowledge about their health, and fear among the many others outlined in this report.

Most health workers have deeply rooted homophobia and they use religion and personal beliefs to justify their homophobia, although they are aware that they have an obligation to treat all their clients without any form of discrimination. It is also apparent that religion and culture plays a big role in fueling homophobia within the general public. This study also shows that most health workers still refer to homosexuality as a mental illness that needs correction. Existing policies do not address the health issues affecting LBTI persons.

RECOMMENDATIONS

Given some of the main findings of this survey, it is clear that there is a need to educate and equip sexual minorities with information regarding their right to health. Health workers, likewise, need to be educated on the existence of sexual minorities. It would be helpful to remind them that since Uganda is a signatory to human rights treaties they have a mandate to stop discriminating against people for any reason when it comes to health care. They must know that each and every individual deserves equal access and treatment irrespective of their sexuality or sexual choices. It would also be extremely beneficial for both the business of the health care workers and accessibility to services for LBTI folks if a database was established to identify LBTI friendly service providers and health care centers.

Finally, it is extremely crucial that advocacy and lobbying of the Government to include sexual minorities in the national health programs be stepped up. Health care professionals, Government officials, and Advocates for SRHRs must revisit the health policies and develop a strategic advocacy plan to include health issues affecting LBTI persons. The idea that Trans and intersex identities are a myth to the medical personnel must be reversed and challenged. And lastly, there needs to be much more awareness and education about the complexities of SRHRs for LBTI people and those who are responsible for providing comprehensive and quality health care services.

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