

Stigma, sexual health, and human rights among women who have sex with women in Lesotho

Tonia C. Poteat,^a Carmen H. Logie,^b Darrin Adams,^c Tampose Mothopeng,^d Judith Lebona,^e Puleng Letsie,^f Stefan Baral^g

a Assistant Professor, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA.
Correspondence: tpoteat@jhu.edu

b Assistant Professor, Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, Canada

c Research Fellow, Key Populations Program, Center for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA

d Executive Director, The Matrix Support Group, Maseru, Lesotho

e Provincial Officer Northwest, National Religious Association for Social Development, Cape Town, South Africa

f Mobilisation and Networking Advisor, UNAIDS, Maseru, Lesotho

g Director of Key Populations Program, Center for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA

Abstract: *In recent years, gender and sexual minorities have become increasingly visible across sub-Saharan Africa, marking both the progression and violation of their human rights. Using data from a study with sexual minorities in Lesotho, this analysis leveraged the social ecological model to examine relationships between stigma, human rights, and sexual health among women who have sex with women in Lesotho. A community-based participatory approach was used for the mixed-method, cross-sectional study. A total of 250 women who have sex with women completed a structured questionnaire, of which 21 participated in a total of three focus group discussions. Stigma was common within and outside the health sector. Stigma and human rights abuses were associated with increased risk for HIV and STIs. Interventions to address stigma at the structural, community, and interpersonal levels are essential to ensuring sexual health and rights for women who have sex with women in Lesotho. © 2015 Reproductive Health Matters. Published by Elsevier BV. All rights reserved.*

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Introduction

Same-sex practices have existed in sub-Saharan Africa since long before European colonial powers arrived and introduced sodomy laws.^{1,2} Despite the end of colonial rule, same-sex practices remain criminalized in 38 sub-Saharan African countries; and several countries have enacted even more punitive legislation focused on homosexuality itself rather than sexual practices.^{3,4} State-led backlashes began in the 1990s during a time when the World Health Organization removed homosexuality from the International Classification of Diseases and growing numbers of people across the continent began to come out. These backlashes continue, as seen in new laws and constitutional amendments to preclude sexual

minority rights in Uganda, Nigeria, Malawi, and Burundi, amongst others.⁵ Backlash has not been limited to legislation, but has also included physical and sexual violence at the hands of the general public and even the police.^{6,7}

In their recent publication, *Born Free and Equal*,⁸ the United Nations Human Rights Commission (UNHRC) asserts that the legal obligations of States to safeguard the human rights of lesbian, gay, bisexual, transgender, and intersex (LGBTI) people are well established in international human rights law and called on States to meet five core obligations including: protection from homophobic violence; prevention of cruel and degrading treatment; decriminalization of homosexuality;

prohibition of discrimination based on sexual orientation; and respect for freedom of expression and association. This official UN document builds on earlier work by international human rights experts who drafted key principles on the application of human rights law to sexual orientation and gender identity at a meeting in Yogyakarta in 2006.⁹

Social ecological models describe how interpersonal, community, and structural (law and policy) factors impact individual health.¹⁰ Sexual stigma refers to stigma against sexual minorities,¹¹ and it operates across multiple social ecological levels. It may manifest in overt discrimination and violence (*enacted stigma*) as well as negative social attitudes and norms, and fears of rejection (*felt normative stigma*).¹² Stigma requires the exercise of power in order to be enacted,¹³ and the failure to protect LGBTI populations from enacted sexual stigma is an abuse of their human rights. Human rights have consequences for population health. There is a growing literature linking human rights abuses to increased risk for HIV and other sexually transmitted infections (STIs) among men who have sex with men (MSM).^{14,15} However, despite evidence of vulnerability to HIV and other STIs,^{16,17} women who have sex with women (WSW) have been absent from the global discourse on HIV.^{18–20} Data linking health and human rights for WSW are rare,²¹ and virtually nonexistent in the African context. Our study addressed this lack of data by examining the relationships between sexual stigma, human rights, and HIV/STIs among women who have sex with women (WSW) in Lesotho.

Methods

Study Setting

The Kingdom of Lesotho is a lower-middle-income country in southern Africa with a national HIV prevalence of 23%, and HIV is the leading cause of death.²² The law in Lesotho is silent on same sex practices between women; however, homophobic violence and discrimination occur. Official reports are uncommon due to fear of further stigmatization.²³ In 2008, a small group of friends formed Matrix Support Group, the first LGBTI organization in Lesotho. They have since grown into an officially registered, national, non-profit organization providing support, education, and human rights advocacy. A community-based participatory approach was used for this mixed method, cross-sectional research. Matrix Support Group partnered with academic

researchers in the study design, data collection, and analysis.

Study Population and Sample

Study participation required the ability to provide informed consent in either Sesotho or English. Eligibility criteria included being 18 years of age or older, assigned female sex at birth, and reporting a history of sex with a female, regardless of sexual or gender identity. Most participants were young (mean age 24.2); and 36% were unemployed. Lesbian/homosexual was the most common sexual identity (48%), followed by bisexual (29%), and heterosexual/straight (20%). Only 25% had disclosed their same-sex practices to a health worker; and 45% had disclosed to a family member. While the term WSW has been contested in Western discourse,²⁴ the diversity of sexual identities and behaviours within the study population precluded the use of a single identity label. In consultation with community members, WSW was selected as the most appropriate term to describe participants.

Ethics Statement

Ethics approval was received from the Ministry of Health and Social Welfare in Lesotho as well as the Institutional Review Board at Johns Hopkins Bloomberg School of Public Health. To maximize the confidentiality and safety of participants, no written materials describing the study were distributed nor were written consent forms used. Prior to enrolment, all recruited individuals provided verbal consent. Anonymous codes were assigned to the data for each participant; and no identifying information was collected at any point during the study.

Study Accrual

Participant accrual took place from October – November 2009 in four urban centres: Maseru, Mafeteng, Hlotse, and Maputsoe. Fifteen initial participants came from the membership of Matrix Support Group and functioned as study interviewers. They completed the study questionnaire prior to attending a two-day training that included the purpose of the research, design of the research project, human subjects protection, interviewing methods, and data integrity. Each initial participant recruited 10–15 members of their social networks, then trained those contacts how to recruit others until the desired sample size was reached. In addition to salary, an allotment of 45 Maloti (US\$ 6.50) per interview was provided for each

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