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SEXUALITY AND ACCESS TO REPRODUCTIVE HEALTH CARE AMONG LESBIAN, GAY AND BISEXUALS IN ADDIS ABABA

BY

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DECLARATION

I, the undersigned, declare that this thesis is my own work and has not been presented or submitted partially or in full by any other person for a degree in any other university, and that all sources of materials used for the purpose of this thesis have been duly acknowledged.

Declared by:	**Confirmed by Advisor:**
Name:__________________________	Name:____________________
Sign:___________________________	Sign:_____________________
Date:___________________________	Date:_____________________

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Acronyms and Abbreviations

AU African Union

CSA Central Statistical Agency

HIV Human Immunodeficiency Virus

ICPD International Conference on Population Development

LGBTQIA+ Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Ally & +

LGBTs Lesbian, Gay, Bisexual and Transgender

LGBs Lesbian, Gay and Bisexuals

MDGs Millennium Development Goals

MSM Men having Sex with Men

OAU Organization of African Unity

RH Reproductive Health

SRH Sexual and Reproductive Health

SRHR Sexual and Reproductive Health Rights

STIs Sexually Transmitted Infections

UN United Nations

UDHR Universal Declaration of Human Rights

WHO World Health Organization

Abstract

Lesbian, Gay and Bisexuals (LGBs) live in Addis Ababa, Ethiopia as marginalized and criminalized individuals; resulting in the deterrence of demanding some of their basic human rights. This thesis therefore takes a closer look at the nexus between sexuality and the realization of basic human rights, particularly access to Sexual and Reproductive Health (SRH) care and services among the LGB community in Addis Ababa.

An exploratory qualitative research method with a phenomenological approach is utilized in having an in-depth look into the lived experiences of nine LGBs in relation to accessing SRH services. LGB participants were identified and interviewed using a snowball technique after the identification of index persons. An in-depth interview was also conducted among four purposively selected health care providers to explore their experience in the provision of health care services to LGBs. In addition, two purposively selected key informants participated in a key informant interview, where they reflected their opinions regarding the LGB access to SRH care and services as a community living in Addis Ababa.

The data generated from the participants were then transcribed and later translated from Amharic into English by the researcher. Subsequently, through reading, rereading and immersing-self, the researcher was familiarized with the data and tried to understand the meanings before generating initial codes, which were later thematically analyzed.

The result from the data generated indicated that, actual and perceived access to SRH care among LGBs varied inline with the differences in sexual roles as well as gender. LGBs having sexual roles with a higher probability of contracting symptoms that could expose their sexuality during a physical examination by a health care provider perceived their access to SRH care to be little to none. In comparison, LGBs whose sexual roles did not lead them to have symptoms that easily led to their sexual identity being exposed during a physical examination, perceived SRH care to be relatively more accessible. In relation to gender, all female participants perceived that their access to SRH care was not affected by their sexuality since their gender did not lead them to be questioned.

LGBs further perceive access to SRH depends on the attitude of their health care provider towards same sex relation, with full desecration to treat, mistreat or deny them treatment, if their sexuality is exposed.

On the other hand, health care provider participants reflected that, even though they did not receive any training on how to cater for the particular SRH needs of LGBs and regardless to their personal attitude towards same sex relation, they would treat them without discrimination as a result of their commitment to their work ethic standards.

The finding further indicated that, among SRH services, safe sex education and safe sex materials were deemed necessary along the lines of gender, with women having little to no awareness about safe sex materials as compared to males. The finding also reflected, among SRH care alternatives utilized by LGBs, the community is coming together to form an underground SRH care network linking friendly health care providers with LGBs seeking care in confidentiality to assure non-discriminatory care and services. This underground network was also reflected as being evermore so important in the time of the COVID- 19 pandemic, where LGBs reflected that they felt the resurfacing of marginalization as a result of heteronormative narratives that blamed same sex relation for causing the pandemic from a religious perspective.

As a result of discrimination and criminalization, LGBs living in Addis Ababa are members of the community that are marginalized from accessing basic human rights to SRH care and further at more risk of acquiring HIV and other STIs with little to no access to attain non-discriminatory treatment.

Key words: Sexuality, LGBs, heteronormativity, SRH, access.

CHAPTER ONE

INTRODUCTION

1.1. Background

Lesbian, Gay and Bisexuals (LGBs) are considered as having deviant sexual behaviors by majority of the global population. This mainly relates to these orientations being viewed as acts that are breaking societal norms, religious teachings and deviation from the biological explanations of sexuality that are related to reproduction and procreation (Block & Adriaens, 2013). The existing societal views which consider same sex relations as abnormal, serve as one of the foundations for the limited access of these sexual minorities to attain Sexual and Reproductive Health (SRH) care and services (NCBI, 2011).

The World Health Organization (WHO) defines RH as follows:

> *"Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so*" (World Health Organization, 2019).

Having the above definition in mind, the Universal Declaration of Human Rights (UDHR) further affirms that everyone is entitled to all human rights and wellbeing regardless of their sexual orientation (United Nations, 1948).

Nonetheless, the negative social attitude towards LGBs has further transcended social and religious opinion and has influenced the laws of many nations. Even though notable progress has been made globally in the decriminalization of same sex relation in the past two decades, same-sex act is still criminalized among men in 72 countries and among women in 45 countries (Daly, 2018). Despite international instruments that facilitate the reproductive health care rights of all people regardless of sexual orientation as a basis of discrimination among others, the criminalization of same-sex sexuality serves as one of the major barriers to attain access to reproductive health care among these members of the society (World Health Organization, 2015).

When we make a shift and look at the regional context, homosexual act is made illegal in 38 African countries (Amnesty International, 2020). In addition to the laws, many writings indicate that homosexuality is seen as "un-African" by the majority of the population in the region. Studies show that post-colonialism (cultural and religious), African nations predominantly reflect a common narrative regarding sexuality. This narrative mainly conveys tat homosexuality is "un-African" and a deviation from heterosexuality, which is normally regarded as natural (Matebeni, 2008). This is further reflected by the criminalization of homosexuality at a state level among many African nations, including death penalty among four nations (Amnesty International , 2018). However, the narrative that suggests sexual orientations other than heterosexuality does not exist in Africa is being contested to be otherwise (Tamale S. , 2003). Since 1989, many African nations started breaking the normative narrative of "un-Africaness" of same sex relation through legalizing a previously punishable act by law. Although decriminalization among other factors has facilitated for more tolerance of sexual minorities in some African nations, majority of the region's ordinary citizens still hold negative attitude towards same sex relation. This attitude is also reflected to serve as a barrier for the LGB community to access SRH rights fearing discrimination and stigma (Dionne & Dulani, 2020).

Ethiopia is one of the conservative, cultural and religious nations in Africa that criminalizes homosexuality even though it's one of the first nations to ratify some of the prominent regional and international human rights instruments (FDRE Criminal Code, 2005). Among the human rights instruments that Ethiopia has ratified in relation to sexual and reproductive health rights include the International Conference in Population and Development (ICPD) in 1994. The ICPD sets principles of Sexual and Reproductive Health Rights (SRHR) forward, condemning discrimination on the basis of actual or perceived sexual orientation (United Nations, 1994). Regardless to this instrument being ratified in to the law of the land, the country still maintains a nationwide criminalization of same-sex sexual conduct via the Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation No. 414/2004 on Article 629. The article that criminalizes same sex relation falls under a section for "*Sexual Deviations*", where homosexual acts, in addition to those falling under indecent acts are punishable with simple imprisonment of

not less than a year and up to ten years in cases where the crime is aggravated (FDRE Criminal Code, 2005).

This clause traces its origin from the Feteha Negest introduced in the fifteenth century adapted into Ge'ez (an ancient liturgical language of the Ethiopian church) aligning with the then newly Orthodox Christian Empire of King Zara Yacob as a spiritual guide and a basis for the nation's supreme law (Serawit, 2020, pp. 87-89)

The narratives of same-sex attraction and sexual orientation in the country has a stronghold in maintaining the illegal status of LGBs where the act is viewed as a neocolonial and Western import, hence making homosexuality to be widely viewed as "un-Ethiopian" and Western-imposed. As a result, the contenders of homosexuality as being a foreign-imposed act arise from a religious basis, which in itself is foreign serving as a basis for the current criminalization of homosexuality in the country.

The criminalization of same-sex sexual orientation is pointed out to be the main barrier for LGBs to access reproductive health care and services (Getnet & Woldekidan, 2019). This is mainly because; LGBs perceive that seeking SRH services may lead to the revelation of their sexual orientation entailing a risk of persecution and deprivation of other human rights.

All research done in relation to the LGB community in Ethiopia indicates that criminalization of same sex act to be the main challenge the community faces in relation to attaining and demanding other human rights, including access to SRH rights (Betelhem, 2010), (Balcha, 2009) (Selamawit, 2014) (Getnet & Woldekidan, 2019) (Hagos & Hailemariam, 2009) (Serawit, 2020).

Using the above among others as a foundation, this research explores the nexus between heteronormative narratives of a cultural and religious patriarchal society and criminalization of homosexuality vis-à-vis the globally recognized human rights to access SRH care among LGBs living in Addis Ababa.

1.2. Statement of the problem

In Ethiopia, there are only few academic works done regarding different sexual orientations, particularly those other than the normative heterosexual orientation attached to a person at birth along with sex. The subject area other than heterosexual sexuality, and particularly the sexuality of Lesbian, Gay, and Bisexuals in general needs further study (Balcha, 2009).

The cultural and religious conceptualization of sexuality and sexual orientation has made the topic a taboo in Ethiopia and it is seldom discussed. Homosexuality besides being seen as a sin amongst the prominent religious sects in Ethiopia, Christianity, and Muslims, it is also criminalized by law of the country (FDRE Criminal Code, 2005).

Scholars and activists time and again reflect their worry that, the way sexuality is understood and conceptualized in the country could become the main source of stigma, discrimination, and even physical violence against people with any "deviant" sexual behavior to heterosexuality (Balcha, 2009) & (Selamawit, 2014). Although Ethiopia aims to exercise a democratic federal state policy, the law criminalizing homosexuality reflects that the country's democratic policy is still at its infancy (FDRE Criminal Code, 2005). The criminalization of same sex act further sheds a light on one of the possible reasons as to why LGB members of the population live in hiding and that their numbers are unaccounted for. Among the few existing literature on LGBs, all pointed out that criminalizing homosexuality prevents lesbian, gay, and bisexuals from seeking medical care and counseling, particularly related to sexual and reproductive health care in fear of prosecution as well as being ostracized by the community (Getnet & Woldekidan, 2019) & (Hagos & Hailemariam, 2009).

LGBs have special SRH needs that are yet to be addressed in addition to other related health needs including mental health (Muller, Spencer, Meer, & Daskilewicz, 2018). They also require tailor-made information on SRH, preventive SRH care needs including access to condoms, lubricants, antiretroviral therapy (ART), counseling as well as curative health care in relation to their sexuality (H.Hafeez, M.Zeshan, MA.Tahir, N.Jahan, & S.Naveed, 2017).

Studies however indicate the existence of various barriers to access the above SRH care and services among LGBs living in Addis Ababa. The barriers including fear of being

exposed leading to stigma, discrimination and criminalization; discriminatory attitudes of health care providers; lack of convenience at health facilities; and other financial impediments as hampering SRH care access among LGBs (Getnet & Woldekidan, 2019) & (Hagos & Hailemariam, 2009).

In relation to LGBs and access to SRH care, Getnet and Woldekidan's article is the first and the only. Their main findings emphasize on the heterogeneity of the health needs, access as well as sexual behavior of LGBs in a homogeneous health care system that is heteronormative (Getnet & Woldekidan, 2019). Although the study indicated heterogeneity of LGBs' health needs, risks as well as behaviors, it does not discuss further details about the basis for heterogeneity among the LGB community. This study as a result tries to fill this gap by identifying assessing two specific factors for heterogeneity; sexual roles and gender.

In addition to the above, in the era of Human Immunodeficiency Virus (HIV) and other Sexually Transmitted Infections (STIs), the wellbeing of these members of the community is directly linked to the wellbeing of the general public in its totality. The increment in the rate of STI and HIV transmission particularly in the city of Addis Ababa could also base some of its attributes on the criminalization of same-sex conduct and societal attitude hampering accessibility of SRH services to the LGB community. The misconception that exists in relation to the risk of contracting STIs such as HIV among the LGB community also owes to the inaccessibility of SRH services (Hagos & Hailemariam, 2009).

However, although there are few academic literature that explore the challenges of the LGB community in Addis Ababa from different disciplines such as legal, public health, historical as well as gender perspectives, there is paucity of information regarding LGBs' access to SRH utilizing a multidisciplinary lens with an emphasis on gender. Access to SRH care and services among LGBs living in Addis Ababa is affected by intersecting challenges not having one but multiple layers. As a result exploring access to SRH services among the community requires recognizing the intersectionality of legal, social, religious, economic, as well as gender related challenges.

Therefore, this research explores the lived experiences of LGBs in accessing their internationally recognized SRH care Rights in a heteronormative society from a gender perspective by looking at the multidimensional aspects of the issue.

1.3. Research Objective

1.3.1. General Objective

The overall objective of this study is to explore sexual and reproductive health care access among Lesbian, Gay, and Bisexuals living in Addis Ababa in light of human rights vis-à-vis the heteronormative attitudes regarding sexuality.

1.3.2. Specific objectives

1. To describe the sexual behavior and assess the sexual and reproductive health care needs of LGBs living in Addis Ababa.
2. To explore the access and challenges of the LGB community in Addis Ababa in seeking Sexual and Reproductive Health (SRH) care services.
3. To explore alternatives used to acquire Sexual Reproductive Health (SRH) care among LGBs in Addis Ababa.
4. To discuss the impact of existing heteronormative narratives in hampering the implementation of international human rights instruments ratified by Ethiopia in relation to sexuality.

1.4. Significance of the study

Ethiopian academicians from different fields of study have documented the lives of LGBs in Addis Ababa. Among the studies conducted, emphasis has been given to those exclusively done from historical, legal, public health, and gender perspectives.

These research outcomes have laid a foundation in furthering this study as a result of their proximity to the subject area. However existing studies are limited in addressing the sexual and reproductive health needs of LGBs from a gender perspective. A gender perspective is essential in order to look into how the concept of patriarchal heteronormativity plays a central role in preserving and legitimatizing gender hierarchy while subordinating women through the gendered sexual role structure (Schilt & Westbrook, 2009) Studying sexuality and access to reproductive health, as a result, will not give the full picture by only looking at the subject matter solely from a public health or that of a legal perspective. Adding a gender perspective to these components is essential to look at this topic from the very concepts and elements that were responsible for constructing "realities" and social truth such as compulsory heterosexuality that is founded upon gender-based power relations.

This research contributes to the existing literature by bringing together and exploring the multiple and interrelated factors affecting the basic human rights of LGBs in accessing SRH. These dimensions as opposed to other literature included a gender perspective in exploring societal attitudes that preserve heteronormative laws and serve as barriers for LGBs to access basic human rights particularly the right to access SRH care in Addis Ababa.

Focus is given to the common factors that are serving as barriers to access SRH among these population with sexual identities grouped under the label LGBs, which mainly relate to being sexual minorities in a heteronormative society. As a result, this study tries to explore the individual lived experiences of a number of Lesbians, Gays, and Bisexuals living in Addis Ababa in accessing SRH triangulated from the perspectives of key informants working as rights advocates discussing the experience of LGBs as a group, and the experience of health care professionals in relation to the provision SRH services.

CHAPTER TWO

LITRATURE REVIEW

This chapter sheds light on already existing literature that was used as a foundation for this study. Although few, there are trailblazing research work done in Ethiopia on this topic which this study uses as a basis. Nonetheless, vast literature is found globally related to the different sections of this study. As result, this chapter looks at state-of-the-art literature related to this topic.

This chapter has organized the materials used as a platform for this study into five categorical sections. The first section looks at the different overviews of theoretical and conceptual debates on sexuality, where concepts such as sexual orientation, gender identity, heteronormativity, and social constructionism are explored. The second section highlights the narratives regarding sexuality in Africa, by looking at the conceptualizations of sexuality, the role of patriarchy, and the criminalization of same-sex sexuality among most nations in the region in light of common narratives of "un-Africaness" of same sex relations. The third section follows by shedding a light on the nexus between the criminalization of same-sex relations and sexual and reproductive health rights in Ethiopia. The last section of this chapter discusses the theoretical framework of the study.

2.1. Overview of theoretical and conceptual debates on sexuality

The definitions of the sexualities and sexual orientations of Gay, Lesbian, and Bisexuals come from a larger definition of the "LGBTs" community and currently more incorporative with the addition of QIA+. The QIA+ in LGBTQIA+ to refer to Queer, Intersex, Ally, and Anyone else not included respectively (Gold, 2019).

"LGB" under LGBTs makes a reference to sexual orientations while the "T", short for Transgender, refers to gender non-conformity as assigned at birth (American Psychological Association, 2019). Although until recently, the term Transsexual was reserved only for individuals who had undergone some sort of medical procedure (surgeries of genital reassignment), currently it refers to anyone who has a gender identity that is in contradiction with the sex assigned at birth (American Psychological

Association, 2019). Gender identity is described as *“the person’s basic sense of being male, female, or of indeterminate sex”* (Moleiro & Pinto, 2015).

Most literature indicate that there is a conceptualization of LGBs’ sexual orientations as a developed sexual identity while heterosexuality is seen as a rather normative sexual orientation one is born with. Sexual orientation refers to *“an enduring emotional, romantic, sexual or affectional attraction to another person(s) ranging from exclusive homosexuality to exclusive heterosexuality with the inclusion of various forms of bisexuality”* (Worthington & Holly Bielstein Savoy, 2002, p. 497).

Homosexuality particularly makes a reference to having sexual orientation and attraction to members of the same sex (NCBI, 2011). Academic literature defines homosexuals by dividing them into two as gay and lesbian. The term lesbian refers to women whose primary sexual orientation and relationship are with other women while the term gay refers to men whose primary sexual orientation and relationship are with other men (Moleiro & Pinto, 2015). Bisexuals on the other hand are those individuals with more sexual fluidity as opposed to both homosexuals and heterosexuals having a less static orientation with an attraction to either sex. Bisexuals are defined as individuals possessing attraction not exclusive to one particular sex (Diamond, 2016).

The literature on sexuality covers vast grounds in relation to human life from different perspectives over the various terrains of subjects of study. One of the predominant subject which is foundational for the discourse on sexuality relates to the conceptualization of sexuality from the biological model. The biological model conceptualizes sexuality and sexual behavior as *“the outcome of natural, biological drives which form the basis for a variety of social experiences”* (Mottier, 2008, p. 32).

This model is ought to be the basis for what is a normal sexual behavior and deviance in relation to assumed biological naturalness and essential human reproductive instincts. These latter gave birth to the need for social order through moral control, sex education, and legislation to keep the assumed volcanic elements of sex and sexuality in check from erupting (Mottier, 2008).

Sexuality is also defined from the perspective of essentialism. Essentialism from the perspective of sexuality states that all people have sexual orientation and these orientations are uniform across the board within time and space (Kang, 2012).

Essentialism relies on the theory of identity from biological determinism with the motto "biology is destiny" whereby genetic makeup is the only determinant that shapes social, political, and economic destiny (Kang, 2012, p. 14).

Based on these kinds of ideological perspectives, society maintained and further constructed the mainstream sexuality of the world we live in today as it did various aspects of our everyday life. The socially constructed concept of the binary system is one of which that is relevant to this study. The Binary system is generally defined as "*social constructs composed of two parts that are framed as absolute and unchanging opposites*" (Kang, 2012, p. 22). The binary system views the world as having unchanging opposites including gender. The construction of gender, male and female as two exaggerated opposites as a result of difference in sex organs, was a basis for the formation of two social groups as if these two do not have anything in common.

Judith Butler, in her book, *Gender Trouble: Feminism and the Subversion of Identity,* further argues that not only gender is a social construct but also sex, which by many feminists is referred to as natural and essential (Butler, 1990). Butler contended the binary system related to gender by further making a reference to biological and genetic findings, whereby around 10% of children born do not fully fall under the category of either (Butler, 1990).

Alfred Kinsey reported that there is a steady rate of 10% occurrence of homosexuality while 37% of males and 13% of females had at least some explicit homosexual experience (Marinucci, 2010, pp. 4-5). De-constructivist ideologies backed by scientific research such as the above contend socially constructed opinions that exist about homosexuality. For instance, opinions such as same sex orientation as being developed and not innate is contended as being less descriptive of the reality, further opening space to be more inclusive to more sexual identities besides heterosexuality.

It is reflected that gender is a social construct and so are the differentiations attached to both genders. The binary system attaches collective attributes to males called masculinity whereby a male reflects the extent of his maleness and femininity to females, an extent to which they reflect their femaleness (Zimmerman, 1987). This attachment of femininity and masculinity to sex is a construction providing society with a basis to further enhance and exaggerate differences between males and females with power relations found

shrouded within them (Mottier, 2008). As a result, cultural and religious understandings of sexuality follow on this construction of opposites, and how proper men and women should look and behave (Mottier, 2008). As a result heterosexuality or the notion of attraction to the opposite sex is deemed as normal and any deviation as abnormal, immoral, and in numerous cases, illegal. As a result, heteronormativity reflects the situation where societies around the world have become normalized to the concept of "gender" and a presupposition that sexual orientation is natural only when there is an attraction among two people from the "opposite sex" while any deviance from this norm is unnatural (Marinucci, 2010).

However, various fields of studies have defined sexual orientation differently. Among these various definitions, the American Psychological Association defines sexual orientation as follows: *"Sexual orientation refers to the sex to whom one is sexually and romantically attracted"* (Moleiro & Pinto, 2015)

This definition by disregarding normative qualifications, suggests that sexuality could be reflected by more than one type of orientation.

2.2. Highlights on narratives of sexuality in Africa

Africa is a continent with diverse societies having different cultures and religious beliefs; nonetheless, it is one of the regions that is regarded and categorized as practicing a monolithic culture particularly from the viewpoint of the Western World. This containerization and uniformization of *"multiple modernities"* (a term coined by Eisenstadt) (Eisenstadt, 2000), is further affirmed by unanimous mainstream voices coming from within the continent itself.

There is a narrative coming from majority of African countries that heterosexuality is the only "African" sexuality considering other orientation as "un-African". (Epprecht M. , 2009). Among the many things that are found veiled under the normative understanding of what is "African" or "un-African" relates to sexuality, sexual orientation, and the uniform assumptions of heterosexuality across the continent (Dlamini, 2006).

There is vast and rich literature currently found on this topic but the debate is a continuum of discussions of sexuality containerized in a region with a single denominator of "Africaness". Sylvia Tamale, in her essay with the title *"researching and theorizing*

sexualities in Africa", discusses how narratives regarding sexuality in Africa have been formed to be what it is today post-Western imperialism and colonization of the continent. She discusses how the Western explorers and missionaries used sexualities of the black race as part of their colonial motives. This was done by proposing the sexual (same-sex) acts reflected primitiveness and immorality, hence forcing Africans to abandon their way of life and adopt "civilized ways" of the West particularly by converting into their colonist's beliefs and religions (Tamale, 2011).

There is also an understanding that emanates from the people of the continent as a common voice, of certain actions being that of a representation of continent or some action as being "un-African". These kinds of "thinkings" have been reflected in many literatures to represent the sexualities of the people of the continent as if there does not exist variation among the different nations, ethnicities, and individuals. One of the claims that are regarded as un-African is a deviation from heterosexuality (Matebeni, 2008). Writers like Tamale reflect that same-sex relation, although seen as an alien and unnatural transgression of the cultures of the "North/ West", a study that was done on selected countries in Africa stretching through the Southern and Eastern parts of the region reflect the existence of sexual fluidity prior to colonization (Tamale S. , 2005)
Temale also discusses that homosexuality is shaking the grounds patriarchy is standing on by questioning heteronormativity that normalizes dominance of the male, making women disempowered recipients through penetrative sexual relations (Tamale S. , 2003).

However, this fight against patriarchy and the defiance of the patriarchal system in Africa could be backfiring. In Uganda, where Tamale herself originates from, the government has recently brought back the "Kill the gays bill" that had not been given a response by the legislative for over five years after being proposed. The earlier proposal had not become a law, as it could not get enough support in the parliament. However the bill had been resurrected and brought back to the parliament for discussion, currently still being pushed by lawmakers to make capital punishment a response for acts of homosexuality (Deutsche Welle, 2019).
This legal response in the criminalization of same-sex acts is not limited to Uganda but a response among many African countries, which further supplements sameness in the existing narratives of African countries regarding same sex relations. The Human Rights

Watch states that homosexuality is currently an act that is still criminalized in the African region by the majority of the countries (Reid, 2020).

Ethiopia is one of the countries that has been preserving this homophobic attitude as a nation legitimized by its current laws (FDRE Criminal Code, 2005). In Ethiopia, like many other countries that criminalize homosexuality, laws are used in condemning religious sins of a same-sex act described by scriptures of imported religious documents (Serawit, 2020). In fact, de-constructionist authors discuss how using the law to condemn the religious sin of the same-sex act was introduced during colonialism by British penal codes with the aim of creating a 'Sodomite- free' Africa (Misibi, 2011).

With a recent publication entitled "*Of Taming Carnal Desire: Imperial roots of legislating Sexual Practices in Contemporary Ethiopia*", Serawit B. Debele historicizes, homosexuality and narratives thereof in Ethiopia. Refraining from using Western driven naming such as homosexuality, she utilizes the term *'Zega'* which is mainly used by male homosexuals in referring to their identity that they too are citizens. She indicated that same-sex relations, in fact, pre-existed colonialism in Africa or imperialistic religions in Ethiopia, and the narratives of the act being un-Ethiopian or un- African are there as political tools in managing and governing sexuality. She indicates that this form of politicization of sexuality for governance has been used since the introduction of the Ethiopian penal code during the reign of Zara Yakob through the Fetha Negest, imported from religious documents (Serawit, 2020).

In Ethiopia, the narratives about homosexuality align with the narrative of the majority of African countries that refer to the act as un-African. Ethiopian narrative regarding homosexuality mainly revolves around the act as being "un-Ethiopian" and a Western import. This concept has been discussed by Daniel Iddo Balcha, in his MA Thesis with the title "*Homosexuality in Africa*" where his findings indicate that homosexuality is not seen as an Ethiopian issue and something the West try to import. He also indicated that some also emphasized that the act does not exist in the country, which many referred to Ethiopia to be a holy land clean from such sins. He indicates that the law, which is highly influenced by religion, plays a major factor in the marginalization and stigmatization of LGBs as a result (Balcha, 2009).

2.3. The nexus between the criminalization of homosexuality and the sexual and reproductive health rights in Ethiopia

Ethiopia is an African state that has resisted and succeeded against Western colonization. This aspect owes to the country maintaining its long-lived and colorful culture. However as an ancient civilization, the country also owes some of its cultural derives from imperialism and its long relations with Western, Far East and Middle Eastern, nations among others. Christianity and Islam are the predominant religious beliefs practiced by majority of the society since the 4th and 7th century AD respectively. And in Ethiopia, as many traditional nations, culture and religion are found infused where it is difficult to tell where one ends and the other begins (Bekele & Alemayehu, 2013). Heteronormativity is preached by these religious platforms and has been for hundreds of years. The religious and cultural norm in relation to sexuality in the country as a result lays a foundation for compulsory heterosexuality. Same sex relation is preached as being a sin by the predominant religions and seen as an illness needing intervention. As the lawmakers and government leaders are born out of this society and a heteronormative culture nurtured with such narratives, it seem there are no intention arising from within the country to change this social order of homophobia (Overs, 2015).

Ethiopia is among countries that still maintain the criminalization of same-sex sexual act via its criminal code. Article 629 of the Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation No. 414/2004 states the following:

> *"Whoever performs with another person of the same sex a homosexual act, or any other indecent act, is punishable with simple imprisonment."* (FDRE Criminal Code, 2005)

Selamawit Tsegaye showcased the challenges LGBs face as a result of the criminalization of their sexual orientation in her unpublished master's thesis entitled "*The human right approach to sexual minority right: the life experience of gay, lesbian and bisexual Ethiopians living in Addis Ababa"*. Her study indicates criminalization of homosexuality has resulted in the suppression of their sexuality (LGBs) and has led to the legitimization of their marginalization. This marginalization further facilitates the social exclusion of the LGB community from several rights including from that of access to sexual and reproductive health care services. She relates the main source of challenge for LGBs to be the law that criminalizes homosexual acts. The criminalization of same sex act serves

as a barrier that prevents public programs from including this community from services such as SRH care and services (Selamawit, 2014). The study however had a holistic approach in addressing individuals who identify as LGBs as a homogenous population that experienced similar challenges regardless to factors such as gender or sexual role. As a result, this study aims to utilize this work as a platform to further address the heterogeneity that exists among the group crumbled under the term LGB by particularly exploring differences along the lines of gender and sexual roles.

An unpublished MA thesis by Betelhem Ephrem also indicated criminalization of homosexuality as one of the main challenges lesbians face in particular among LGBs. Her study focusing on lesbians further reflected that the women having same-sex relation live in hiding, marginalized from the public sphere even making the process of identification of her participants challenging. This work has contributed to describing the lived experiences of lesbians and how they define and view their sexuality in relation to what they consider a healthy sexuality. However, as majority of the participants were residing outside of Ethiopia, and sexuality was limited to lesbians, it also did not reflect the challenges of describing sexuality in a heteronormative society such as Addis Ababa. (Betelhem, 2010).

Other literatures also indicate that, criminalization of same-sex sexual orientation is the main barrier for LGBs to access SRH care services. This is because LGBs fear going to health care facilities seeking SRH services as it may lead to the revelation of their sexual orientation with a risk of persecution. Criminalization of same sex relation relates to these sexual orientations being considered as deviant behaviors breaking societal norms, religious teachings besides the biological explanations deviating from natural biological intentions of reproduction (Block & Adriaens, 2013).

Getnet and Woldekidan did an extensive study entitled: *"Health needs, health care seeking behavior and utilization of health services among lesbians, gays, and bisexuals in Addis Ababa, Ethiopia"*. The study emphasizing on the health of LGBs, identified that the heteronormative social structures and criminalization of homosexuality serve as the main barriers in accessing SRH services among LGBs (Getnet & Woldekidan, 2019, p. 11).

However, it has not been long since sexuality and SRH were given center stage and recognized as human rights as interrelated concepts. This came about through an

evolution of health services recognizing these rights as more than the healthy reproduction monitored by national and international policies to govern fertility, family planning, and population control besides safe motherhood (Griffin, 2006). Sexual health and rights have been carried as a companion to reproductive health as a form of categorization. This entanglement between sexual health and reproductive health was more or less strengthened after the surfacing of the HIV epidemic paving way for different approaches towards the incorporation of sexual health particularly towards monitoring sexually transmitted infections (STIs) (Herdt, 2010).

Sexual health and reproductive health may be entangled but problems arise when they are solely seen as being as a means and an end to reproduction. This is because among other issues, samesex relations not leading to reproduction are left unbounded under the above presumption. Definition of sexual health is mostly found attached to reproduction, however since the definition of sexual health by the WHO in 1975, the International Conference on Population Development (ICPD), and the Beijing Platform for Action have reached a consensus for a global working definition that is more incorporative:

> "*Sexual health is a state of physical, mental, and social well-being in relation to sexuality; it is not merely the absences of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled.*" (World Health Organization, 2006)

As the definition of reproductive health rights mentioned in the background of this thesis cited from the definition of the WHO indicates, this right is inclusive to all without discrimination. The ICPD also makes an emphasis on the right to access these health care services without discrimination as indicated in the definition taken from the document. The ICPD defines reproductive health care as follows:

> *"Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases"* (United Nations, 1994).

This definition regulated by the principle of non-discrimination based on sexual

orientation allows and grants all human beings to access SRH care.
Ethiopia is a signatory to all non-discriminatory international and regional human rights instruments including the UDHR and the ICPD. However, there is clear inconsistency between this international instrument ratified by Ethiopia and the local law of the land (United Nations, 1994) This inconsistency among national law and international instruments that the nation has ratified promising to uphold and abide by is a grey area to question and push the government to uphold its commitment to international human rights if non-descriminatory SRH care are to be more accessable to sexual minorities.

The Ethiopian government has adopted the current health policy in 1993, however it does not make any significant address to the issue of SRH (TGE, 1993). Further, various strategies including National Adolescent and Youth Health Strategy as well as the National SRH Strategy were developed to work towards achieving certain SRH related goals aligning with international goals like that of the Millennium Development Goals (MDGs). These documents give emphasis to SRH in relation to the reduction of HIV incidence and having adolescent-friendly SRH services aiming towards having a healthy youth. Nonetheless, this document is silent on the needs of sexualities other than heterosexual youth (FDRE Ministry of Health, 2016). In this document, attention is given to SRH in relation to the reduction of HIV and STIs transmission aligned with international goals. As a result putting into consideration the shortage in coverage with regards to access to SRH, the document forwards various proposals in increasing access among the youth particularly considering intersectional problematic to access care, like poverty and distance from health facilities and e.t.c. (FDRE Ministry of Health, 2016).
In addition to youth, the National Roadmap in the Prevention of HIV in Ethiopia specifically identifies key population groups (female sex workers and prisoners) and priority population (widowed, separated or divorced women; long-distance truck drivers; people living with HIV and their partners; people working in hotspot areas). However, this guiding document also fails to recognize LGBs as propriety or key population (FHAPCO, 2018).

However, considering the criminalization of same-sex sexuality, the country does not reflect making SRH services accessible without discrimination based on sexual orientation. This is a barrier to access care among LGBs as it makes the entire health

system neglect the needs and risks of the community further leaving health facilities and health care providers unready to cater to the needs of sexual minorities. It also creates a gap towards achieving the anticipated goal of the national commitment in the reduction of HIV and STIs in the country.

2.4. Theoretical Framework

The theoretical framework that is mainly used as a skeleton for this research is social constructionism. This theory of knowledge is concerned with the deconstruction of meanings created, changed, and reproduced through defining and categorizing groups of people in cultural context among other things throughout history (Kang, Lessard, & Heston, 2017). Social constructionism of sexuality theoretical framework further makes an emphasis on the understanding that sexuality as we know it today has been constructed by the view of society and the understanding has been transformed over time. This theoretical framework serves as an umbrella for various theories and concepts that this research utilizes in the analysis of the data generated. Significant theories and concepts such as queer theory and theory of heteronormativity are the main theories that are emphasized under the theoretical framework of social constructionism of sexuality. These theories are used in the discussion and analysis of the data. Queer theory and the theory of heteronormativity are theories used to question what is seen as truth, natural and normal. They are further used to think about the normalization process of what is seen as natural/ true or normal in relation to power. Hence, these theories together, look at the normalization of heterosexuality (Include Gender, 2016).

Queer theory identifies compulsory heterosexuality and heteronormativity to be an effect of historical and cultural constructs where there are normative binary categories of sex, gender, and sexual identity (Carroll, 2012). And the theory of heteronormativity refers to the normalization of heterosexual attractions and making homosexuality as its dichotomous abnormal (Warner, 1999). Although Michael warner was responsible for coining the term heteronormativity, Foucault's discussion of the concept of sexuality being a social construct based on power relations laid the foundation for the conception of the theory of heteronormativity (Warner, 1999).

Social constructionism is a lens to further look at the concept of essentialism, which

views sexuality as something innate and natural, as a socially constructed concept (DeLamater & Hyde, 1998).

> *Essentialism is the belief that various identity categories, such as female and male, feminine and masculine, homosexual and heterosexual, reflect innate characteristics that comprise the fundamental nature of the members of those categories, whereas social constructionism is the belief that such identity categories are historical and cultural developments* (Marinucci, 2010, p. 34).

Having the understanding that sexuality is a multidimensional and complex subject, the study made a reference to different concepts and theories to discuss and forward its argumentations. To showcase how various theories could be applicable we can take the Marxist theories in relation to sexuality. Marxism is a theory developed to address social equity and although equality and equity are indiscriminate of gender and it mostly does so in allowing all to participate in development and growth without discrimination. However, when we look at the underlying footing of Marxism, it subordinates multiple forms of self, and self-expression for the greater good. Marxian theory as a result subordinates sexual expression to social necessity such as reproduction and development (Srikanth, 1997).

This goes hand in hand with various cultures and religious beliefs have been known to suppress sexuality in its totality. This point could be further clarified by the following quote taken from Phill Mollen's essay entitled the inherent shame of sexuality:

> *"Sexual freedom is frequently seen as an undermining of cultural achievements. Thus, religions and ideological political groups condemn sexual liberty. Those wishing to overthrow the established culture will invoke sexual freedom. Breakdown of culture and society always leads to rape. Sexual abuse of children is rightly seen as a threat to culture and civilization"* (Mollon, 2006, p. 173)

This is only the tip of the iceberg, as sexuality plays a large role in the existence of society where most theories are inherently forced to have at least an indirect proposition on the topic.

In parallel, structural-functionalism also discusses the regulation of sexual behavior as an important component in ensuring family and social cohesion. From a functionalist Parsonian point of view, heterosexuality is seen as a necessity for a functional society. As a result, homosexuality is advised from being promoted at a large scale to avoid a

dysfunctional society that may cease to procreate (Stein, 1989).

Radical feminism provides that the social system of patriarchy privileges heterosexuality and undermines other sexual orientations. Many feminists particularly in the African context have made a direct link between patriarchal heteronormative power relations and power relations subordinating sexuality (Srikanth, 1997). McFadden with her analysis of her writing "*sexual pleasure as a feminist choice"* reflects a radical feminist theoretical framework in questioning patriarchy and its role in policing the sexuality of women and undermining sexual pleasure (McFaden, 2003).

The theoretical framework of social constructionism of sexuality derives from Marxism and Feminism to look into the investigation of the privilege of certain sexual practices and stigmatization of others like that of homosexuality (Jefson, 2008).

As a result, by making use of social constructionism of sexuality as a theoretical framework we interrogate how the notion of "African sexuality"/ “un-Africanness” of homosexuality, a shared value in the study site of this research, Addis Ababa, with narratives claiming homosexuality as “un-Ethiopian” affect LGBs’ access to SRH. Using this theoretical framework, we link how a hetronormative social construction of sexuality could be nurturing homophobic attitudes in the society and maintaining same- sex act criminalized at a state level. As a result these socially constructed heteronormative attitudes of the society and the heteronormative law could be serving as a barrier in accessing internationally recognized human rights of access to SRH among LGBs.

CHAPTER THREE

Methodology

3.1. Research design

This study used an exploratory qualitative research method. The lived experiences of LGBs were explored using a phenomenological approach. *"Phenomenology is a form of qualitative research that focuses on the study of an individual's lived experience within the world"* (Neubauer, Witkop, & Varpio, 2019). An exploratory qualitative research method with the application of a phenomenological approach facilitated for having an in-depth look into the lived experience of the study population.

3.2. Study area

The study was conducted in Addis Ababa, the capital city of Ethiopia. Addis Ababa was selected as the study site for its peculiar features offering multiple dimensions to the study, which would not have been possible to obtain from other regions of the country. Addis Ababa is the seat of the Federal Government having better infrastructure, facilities, and job opportunities making the city most preferred for settlement. As a result, there is high youth immigration from the different regions coming to secure a better professional and economic future (UN Habitat, 2017). This could be one of the reasons why the city is the most ethnically and religiously diverse among other parts of the country (World Population Review, 2020).

Addis Ababa is the largest city in Ethiopia with an estimated population of 4.8 million (Population Stat, 2020). The city is not limited to ethnic diversity as it hosts the most number of foreign citizens from around the world. As the third diplomatic city in the world and a transit hub for global and regional flights via its highly acclaimed airline located at the Addis Ababa Bole Airport, the city is a hub for global interactions. Besides, the city has been the permanent sit of the African Union Commission (AUC) headquarters since its formation as the Organization for the African Union (OAU). Addis Ababa is also the home of the United Nations Economic Commission for Africa (UNECA). It also serves as the home of many other regional and international organizations as well as embassies and their respective delegations from all over the

world. These are some of the factors that owe to the peculiar quality of the metropolitan city as compared to the rest of the regions in Ethiopia making it a node for globalization (Gameren & Tola, 2018). As a result, these attributes among many other socio-economic developments make the city an arena where different religions, cultures as well as knowledge come to be colorfully displayed; and interactions among its diverse population are inevitable.

With this study focusing on SRH, the city displays one of the highest HIV prevalence in the country at 3.4% next to Gambella placing its dwellers at a higher risk of getting HIV as well as other STIs (EDHS, 2017). The high rate of sexually transmitted illnesses requires a health care system that can tackle the problem by strategically responding to the root causes of the problem. Although the city is the home for the Federal Ministry of Health as well as more health facilities in the country as compared to other regions, with 11 public and 25 private hospitals; 98 health centers; and close to 1000 private clinics in 2017, HIV and STI prevalence remains un-tackled (Federal Ministry of Health , 2017). These special attributes were deemed relevant to better conduct the study in assessing the accessibility of SRH care among LGBs having a differentiated, religious, cultural, and economic background.

In addition to the above-mentioned attributes that Addis Ababa offers in accessing diversified population and health facilities, previous studies done on LGB population in the country confirm the existence of the LGB population in the city and that their number is not negligible. Hence this study area was selected for the ease of access it presents to identify this hidden population as compared to other parts of the country.

3.3. Study population

The study was conducted among three different population groups. We used three different groups of informants in data generation to assure the trustworthiness of the study besides gaining an all-rounded understanding of the challenges in accessing SRH services. The first group of participants was Lesbian, Gay, and Bisexuals that are over the age of 18 years (those who can personally give legal consent to participate in the study) currently residing in Addis Ababa. The second group of the population included health care providers that are trained to provide SRH and one mental health care provider that LGBs may have to identify their orientation to receive care from. And the third groups of

the population were key informants working as advocates of Ethiopian LGB community rights in regional and international platforms.

Inclusion criteria: Willing participants who identified themselves as LGBs were invited to the study and later included after giving informed consent. Physicians who are currently providing SRH and other related services and willing to discuss this topic were included. Key informants working in relation to the rights of LGB and were willing to take part in the study were included.

Exclusion criteria: Partners of LGB participants were excluded to diversify the study population. Although partners are likely to have different or even opposing experiences, the researchers wanted to avoid potential redundancy of information that may exist as a result of similar exposure leading to similar opinions.

Health care providers providing health care that does not necessitate LGBs to expose their sexual orientation for the provision of proper/ necessary care were excluded.

3.4. Sampling and Selection

This researcher used a purposive sampling method to select participants in this study. Participants were reached through a quota snowball-sampling technique, with differentiated index persons. The study selected the above-mentioned method and technique to better explore the lived experiences of these hard-to-reach/ hidden populations within the structure of their social networks (kirchherr & Charles, 2018).

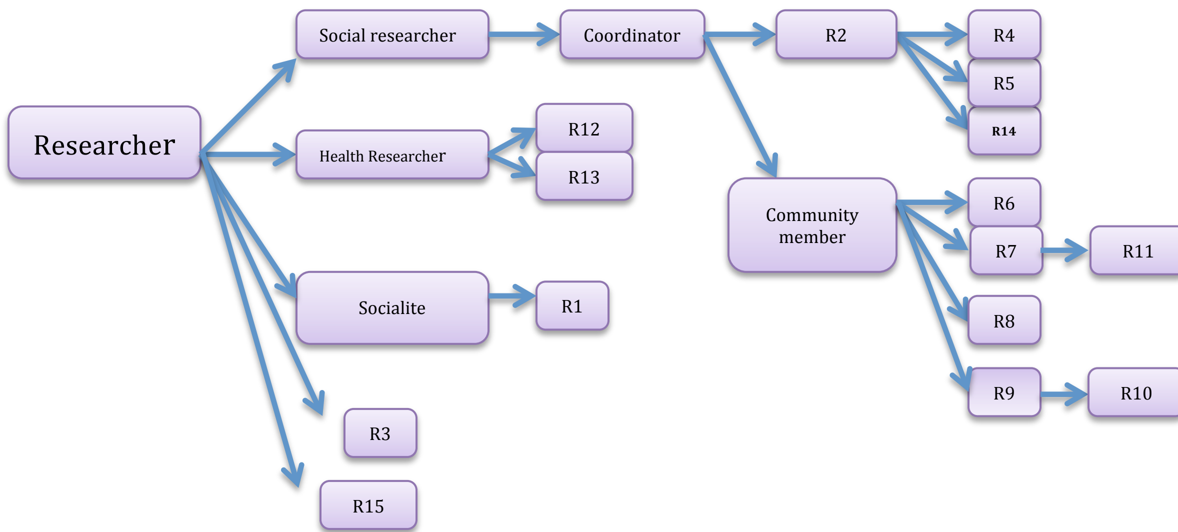
The index persons to this study were identified with the help of other researchers who conducted similar studies in the area and in the area of health as well as a socialite (a well known person in organizing social events and having multiple contact resource) living in Addis Ababa. Once the index persons were identified the researcher established trust with these persons, by taking the time to get to know them and explaining the purpose of the research, making it possible to access participants via snowball. The study participants were divided into three different population groups; LGBs, health care providers, and key informants.

Among the 9 LGB participants four identified themselves as gay, three as lesbian, and two as bisexuals. Among the second group of participants/ health care providers, the first participant was a clinical psychiatrist, the second was a gynecologist surgeon, the third a clinical nurse, and the fourth participant was a gynecologist. Among the two key

informants, one was a health rights advocate and the other is an LGBTQ+ Ethiopian rights activist living abroad.

Figure 1. **Diagram representing the recruitment network of the sample**

The researcher used three index persons, a social science researcher, a health researcher, and a socialite snowballing to the identification of all participants except for R3 and R15 whom the researcher herself purposively selected via social media and from a health facility.



After identification of the index persons for the primary group of participants, this study conducted an in-depth interview with four gay, three lesbian, and two bisexual participants. Among the proposed participants by the index person; age, socio-economic status, level of educational background, and economic status were considered with the aim of experience diversification.

In accessing health care providers, the index person was mainly a researcher on health issues. However, the researcher herself identified one health care provider. As a result, four health care providers participated in the study having different backgrounds. The researchers then interviewed four health care provider participants; a clinical psychiatrist, two gynecologists as well as a clinical nurse.

Two key informants participated after being selected purposively in relation to the knowledge and experience they have acquired regarding the LGB community living in Addis Ababa as a result of the advocacy work they are involved in.

3.5. Instruments/ tools and Data collection

In order to generate data from the selected participants, three semi-structured in-depth qualitative interview guides were prepared for the three groups of participants separately. For example, the interview guide for LGBs included questions about sexual experiences, SRH problems, challenges, health care seeking challenges, and the like. This was done to explore the lived experience of LGBs in seeking and accessing SRH care in Addis Ababa.

The semi-structured interview guide prepared for health care providers mainly focused on questions that explored the readiness of the health facilities and the care providers of Addis Ababa to provide SRH care for LGBs. It also tried to explore some of the existing attitudes of health care providers in the provision of SRH and related care for LGBs.

Interview guide for key informants had questions concerning the work that they do relating to the LGB community. These mainly including questions relating to the challenges of LGBs as a community living in Addis Ababa; whether the community has special SRH needs and the accessibility of health care facilities to respond to these needs; the social attitudes and legal implications that directly influence the care they receive. As a result, the semi-structured interview guide was used to explore the needs, challenges, and coping mechanisms of members of the community and the network that is in place concerning SRH.

Also, some emerging issues were arising repeatedly, and these were carried along to the following participants to see the commonality of the issue. One of the main emerging issues was related to the current Covid-19 pandemic and the specific challenges of LGB community particularly concerning access to health services during a pandemic as an LGB person as well as how the pandemic affected the economic, social, and overall well being of LGB leading to some health challenges.

The informed consent forms were developed for each of the three groups separately. This was done to ensure confidentiality tailored to the differentiated risks and harm that may be caused to the participants by taking part in the study as per their unique circumstances. Also, participants were informed about what the questions forwarded to them will be revolving around to confirm consent was given after participants were fully aware of what they may be expected to discuss.

The researcher then collected all the data after acquiring consent. All interviews were recorded except one where notes were taken from during the interview, as the participant did not consent to be tape-recorded. This participant also happened to be the first participant and a pretest to the interview guide, which later was included in the study.

The interviews took from as little as 20 minutes up to 105 minutes. While most interviews were done face to face by taking precautious measures such as providing masks and sanitizers, interview space was spread out by two meters distance between researcher and participant. However, we used a phone interview with four participants because of two main reasons. A phone interview was inevitable with the second key informant residing outside of Ethiopia, while the other three health providers were accessed via telephone to avoid going to hospitals to meet with them to minimize the risk of spread of the COVID 19 virus and to accommodate their busy work schedual.

3.6. Method of analysis

Once all the data was collected it was then transcribed, and translated from Amharic into English by the researcher to further maintain the confidentiality of the participants. The researcher was familiarized with the data through listening to the recordings while transcribing and by reading and rereading the transcripts to understand the content of the data generated. The data was read and reread by the researcher and finally, the data was analyzed thematically following a phenomenological approach. Themes were developed from codes and terminologies that indicated similarity as well as differentiated experiences among LGB participants. This was further triangulated with themes and codes driven from the experiences of health providers and key informants to heighten the credibility as well as the validity of the findings.

As the study utilized a phenomenological approach, in the results chapter direct quotations taken from the interviews are exhibited to highlight the lived experiences of the participants even when meanings are given to the data in the discussion section.

3.7. Ethical Considerations

Ethical clearance was sought and acquired from the College of Health Sciences, School of Public Health Ethical Review Committee to conduct this research. Informed written consent was obtained from each participant where possible harms were clearly indicated

in the form. Interviews were conducted in a place that gives optimum privacy based on the preference of the informants. Most of the participants preferred to meet in public at cafes of their preference while the rest preferred to come to an office space made ready by the researcher. The office space was quiet, convenient to direct, and located by a main roadside making participants willing and at ease. Phone interviews were conducted via secure phone application as per the preference of the participants. All data that was generated is stored in a password secured computer, which only the researcher can access. The interview and transcripts of the interview do not include any personal identifiers such as name, residence, place of work, etc. All interviews were voluntary where the right to withdraw or not to participate were communicated directly to the participants in reading before consent was acquired.

For those interviews done via telephone, informed consent was emailed to the participants, and consent was given by a confirmation email as well as affirmation of consent to participate and be recorded at the beginning of the phone conversation. Rights not to answer any question, withdrawing at any time, or postponing the interview was assured via the written consent form. Informants that have experienced some SRH and psychological issues were linked to a health care provider that volunteered to provide care by maintaining confidentiality. All identifier information is kept confidential and all data is made anonymous

CHAPTER FOUR

FINDINGS

In this chapter, the findings of the study are presented using five themes with corresponding subthemes following the general backgrounds of the study participants. The themes include: description of sexual behaviors among LGBs living in Addis Ababa; perceptions of Sexual and Reproductive Health needs among LGBs; access and barriers to SRH services among LGBs; alternatives to mainstream SRH services among LGBs. The fifth and final theme is an emerging theme which was raised by most informants later categorized as a theme with the title: COVID- 19 pandemic sheds light on existing systematic marginalization of LGBs in accessing health care facilities.

4.1. General profiles of informants

This study was conducted among three different groups of population in Addis Ababa; LGBs, key informants, and health care providers. The data was generated using a semi-structured in-depth interview among LGBs and health care providers while a key informant interview was conducted with key informant participants. Themes and subthemes were developed using codes generated from the interviews among LGBs, health care providers, and selected key informants. The detail of the demographic background of the participants is presented in the table below.

Table 1. **Demographic background of participants and a key to figure 1**

LGBs									
No	**Sex**	**Age**	**Sexual orientation**	**Marital Status**	**Education Level**	**Occupation**	**Current Employment Status**	**Religion**	**Place of Birth**
R1	F	31	Lesbian	Never Married	Completed High school	Sport professional	National Sports team professional	Orthodox Christian	Addis Ababa
R4	M	33	Gay	Never Married	University Degree in Computer Science	Computer scientist	Freelancer in computer science	Atheist	
R5	M	32	Gay	Never Married	University degree in IT	IT professional	IT consultant in NGO	Orthodox Christian	Addis Ababa
R6	M	23	Gay	Never Married	High school dropout	Waiter/ sex work	Un-employed	Protestant Christian	Addis Ababa
R7	M	20	Gay	Never Married	Secondary school (technic)	Electronic technician	Un-employed		Adama
R8	M	32	Bisexual	Married	High school drop out	Sex work	Un-employed	Orthodox Christian	Addis Ababa
R9	F	33	Lesbian	Divorced	Elementary school dropout	Labor and domestic work	Un-employed	Orthodox Christian	Woldiya
R10	F	27	Lesbian	Never Married	Elementary school dropout	Bartending/ sex work	Un-employed	Monotheis t	Addis Ababa
R11	M	38	Bisexual	Divorced	Preparatory / technique school graduate	Technical works	Building works	Orthodox Christian	Addis Ababa

KIIs								
No	**Sex**	**Age**	**Educational background**	**Field of work**	**Experience**	**Marital status**	**Religion**	**Place of Birth**
R2	M	32	BSc degree	Health advocacy	6 years	Never married	Orthodox Christian	Addis Ababa
R3	M	36	BSc in Computer Sciences	HR advocacy	8 years	Never married	Protestant Christian	Addis Ababa

Health Care Providers								
No	**Sex**	**Age**	**Educational background**	**Specialization**	**Experience**	**Marital status**	**Religion**	**Place of Birth**
R12	M	45	MD	Consultant Asst. Prof. of Psychiatrist	15 years	Married	Orthodox Christian	Wollo, Dessie
R13	F	46	MD	OBGYN/ SRH professor	14 years	Married	Orthodox Christian	Addis Ababa
R14	M	34	Nursing	Clinical Nurse	4.5 years	Never married	Orthodox Christian	Addis Ababa
R15	M	42	MD	OBGYN	10 years	Married	Orthodox Christian	Addis Ababa

4.2. Description of sexual behaviors among LGBs in heteronormative society is multifaceted

This theme is organized in four sub-themes, which focus on discussing the various elements that are linked to the description of varying sexual behavior among LGBs living in Addis Ababa. These subthemes include: *sexual identity development and self-labeling describe sexual behavior; varying sexual roles among LGBs describe varying sexual risk behavior; living as an LGB in heteronormative place such as Addis Ababa entails having a double life; short-lived relationships are customary among LGBs leading to multiple sexual partner lifestyle.* These subthemes were formed based on the codes derived from the data.

They are used as a springboard to link the sexual behaviors among LGBs and their peculiar sexual and reproductive health care needs and access.

4.2.1. SEXUAL IDENTITY DEVELOPMENT AND SELF -LABELING DESCRIBES SEXUAL BEHAVIOR

The participants who identified themselves as gay, lesbian, and bisexual did so based on two differentiated grounds. Those who have actualized their sexual identity from an early age and those who utilize a marker in time-related of a particular sexual experience in labeling their sexual orientation.

Some stated that they had the sexual orientation they currently have as long as they can remember. On the contrary, the rest of the participants stated that they started developing same-sex and bisexual orientation after a particular same-sex sexual conduct in their lives. Majority of the participants who link their same sex sexuality to a particular same sex conduct indicated that they have tried to reverse their sexuality in their lifetime as a result of societal pressure and wanting to fit in as normal.

This feeling of being pressured in to reversing same-sex sexuality to feel normal within a heteronormative society is a commonality among many LGBs. A clinical psychiatrist further affirmed the above by sharing his experience as a practitioner with the following quote:

> *"During my practice, I have had some cases where people who had same-sex orientation come to the clinic with different mental health problems including depression and anxiety. And some of them come with distress and wanting to change their sexual orientation. And this is*

because they live underground with the constant worry that their affair can expose them to punishment for breaking the law and that they will end up in jail. And more importantly, the societal norm constantly shows them that they are not welcome in this country and the practice is not acceptable socially"

Some relate a sexual experience that was entered after consuming alcohol, for financial gain or fear of losing financial benefits for their current sexual orientation. In addition, majority of the participants who refer to their first same-sex experience as a defining moment for their current sexual orientation also reflected that they view their sexuality as an abnormality that they would like to alter if they could to fit within the community.

A statement by a 23 years old gay sex worker reflects the above by pinpointing a defining moment in time he believes was responsible for his current gay sexual identity that he wishes to reverse.

" *I was about 16 when I got into the life after my mother got sick. When she got bedridden, I felt helpless and started going out with rich men for money, and then I got comfortable and I started enjoying the life … but I wish I led a normal and acceptable life, I even tried to reverse my sexuality by being with women, but it's hard because this is who I am …"*

A 38-year-old bisexual discussed his sexual identity development owes to having a sexual experience with a male friend and then going back and forth between both sexes:

"My first same-sex intercourse encounter is responsible for my sexuality today, I don't know what my life would be like today if I had not spent a night with my best friend who came from country X for vacation. We went to drink and party …when he approached me sexually I was surprised at first and the next day when the alcohol wore off I got more scared but after he calmed me down our affair turned in to love…I started going out with other men after our relationship ended, but since there was a lot of pressure from my family to get married, I married my first girlfriend, had a baby and lived with her for two years before getting a divorce. I enjoy being with men more because they understand me but I also enjoy being with women because it's easy since it's accepted socially and I try to be with women as much as I can even though I prefer men…"

A 27-year-old lesbian indicated her first sexual experience was responsible for her sexual identity as narrated in the following quote:

"I had 16 siblings and we had a difficult life. A rich woman in our neighborhood used to support me whom I started living with. When I was 16, she made me do sexual things with her. This went on for years owing to my sexuality today. And now I work as a bartender and I have sexual

relations only with women, and I am also involved in sex work to earn a living. So that's how I got into this life but I wish I could live a normal life like others, I don't know why I keep doing this…I even tried to kill my self several times because I know I am not accepted"

A 32-year-old lesbian who has two children from a previous marriage stated the following in describing the development of her current sexual identity:

" I am a lesbian because the woman I worked for as a part-time domestic worker was approaching me sexually repeatedly and I let her, because at first I did not know how to respond, but I kept having sexual relations with her because she was supporting me and my children financially. So this is my life… (Crying) ... and even after I left the woman, I only have relations with women, I prefer them, and men already disgusted me ever since my ex-husband raped my seven-year-old younger sister…but I wish I could just be normal so I don't have to live in fear, except I have tried and I couldn't"

Although a single sexual experience was pointed out as a marker in time defining current sexuality among most participants, not all reflected they wanted to reverse their sexuality. A 20 years old gay participant who has sex with men for financial gain indicated the following:

"I got into this life by accident when I met someone on Facebook who used to live outside of Ethiopia. He came to City-X, where I used to live, and started approaching me sexually. I told him I would only be willing to sleep with him if he does me some financial favors in return … that is how I got into this life. But when we spent more time together I started liking the life and I fell in love with him, I had a girlfriend at the time but I started avoiding her to live this life, I prefer it and even though it's hard I would prefer to live this way in hiding…"

A married bisexual also reflected how his first same-sex sexual experience is responsible for his bisexual sexuality development. Similarly to the above participant, he did not want to reverse his sexuality although he believes it is considered wrong:

"My high-school sweetheart got pregnant when we were in the 10th grade, so we got married and she had the baby. As life became very hard trying to raise a little girl, my wife left to the Middle East to make a better living as a domestic worker. After that one day, my friend who helps me a lot to get a job and in raising my daughter came to my house carrying a bottle of wine and eventually we had sex... and this was the day I became a bisexual… I am still married and I have sexual relations with my wife when she comes to visit but I still maintain my relationships with other men and I earn my living as a sex worker too… I don't want to leave my wife but I enjoy being with men far more"

On the contrary to the above only two gays and one lesbian participant stated that they always had a sexual attraction to the same sex and knew that they were gay/ lesbian from an early age even before ever having their first sexual experience.

A 32 years old gay participant reflects actualization of sexual identity from an early age where he had a sexual attraction to people of the same sex regardless of religious and cultural pressure as follows:

> "*I was raised both by my family and by my community in a way that is deemed to be decent culturally, especially growing up in the 80s, all neighbors were responsible for shaping me. So I lived in a way that fulfilled the expected standard of being well behaved, religious and a good student, abiding by the norms and culture of my environment. However, growing up, I have always had an attraction for men, and of course, I had struggles with self-doubt because I did not understand my feelings. I felt like I was the only one until I went to university because I did not have the exposure. You see I came from a family that many may call very poor; we did not have a television or anything like that where I had the means to understand why I was like that"*

A 33-year-old gay participant contesting being introduced to a certain sexual orientation as not the reality in his case shared a similar reflection as the previous participant:

> *" By the way, as many may say, I was not introduced to this life. I was this person as long as I can remember and I have endured so much harassment not only by others but also by my own self because it was hard for me to accept my self, considering the social and religious attitudes around me about gay people"*

A 32-year-old lesbian similarly indicated that actualizing her sexual orientation was not an easy process in a heteronormative society where same-sex sexuality is condemned. She discusses her sexual orientation in relation to her overall personality, which did not conform to the expected gender roles from an early age as follows:

> *" I knew my self from an early age, I grew up playing with my brothers even though I was supposed to be like a girl according to my family and the community, I never really felt feminine, I just wanted to play outside all the time. People even referred to me as a male and when I got a bit older I told a girl that I was attracted to her ... But it's hard living a life where you are different from everyone else, and there is so much harassment towards a woman like me who does not conform to the rules of the community, but this is who I am."*

Sexual identity development, which is reflected to be divided into two among LGBs, is a variable that has direct relations in the description of the sexual behavior of individuals in the community. This differentiation of actualization of sexuality in a heteronormative society dictates different sexual behaviors including fluctuation in sexual orientation to seem normal entailing risky sexual behavior.

4.2.2. VARYING SEXUAL ROLE AMONG LGBS DESCRIBE VARYING SEXUAL RISK BEHAVIOR

It was indicated by most participants that sexual roles among LGBs dictate sexual behaviors. Gay and male bisexual participants indicated that their sexual roles vary depending on their sexual intercourse roles. It was indicated that there are three types of sexual intercourse roles among gay and bisexual males. They are referred to as top, which is referred to as '***awchi'*** in Amharic**,** bottom, referred to as '***wochi'*** in Amharic and versatile, referred to as ***'verse'*** in short. Top/ ***awchi*** which will be referred to as top from here onwards refers to the male in a gay or bisexual relation that exclusively prefers to perform a penile-anal penetration. The bottom/ ***wochi***, referred, as bottom from here onwards is a male in a bisexual or gay relationship that exclusively prefers to receive an anal-penile penetration. On the other handversatile/ ***verse***, referred to as verse from here onwards is a male preferring to play both roles giving and receiving anal-penile penetration during intercourse. On the contrary, among female participants, it was not indicated that there is a clear dissection of sexual roles but rather sexual relations attached to power relations.

The sexual role is an important component in describing sexual behavior. And among male participants in gay and bisexual relationships, their sexual roles differed with differing effects in health needs and access, which is discussed under the following themes.

Concerning the above, a 23-year-old gay sex worker mentioned that he has sexual roles in his relationships mostly entailing him to play a bottom role. He discusses that his sexual role has led him to contract hemorrhoids even though it is a role of his preference:

> *"I have been working as a prostitute since a young age and mostly I play a role as a bottom or wochi, that is what I prefer to be honest but it has caused me some illnesses like hemorrhoids…"*

Similarly in the same-sex relationship he has with men, a 32-year-old bisexual sex worker expressed his sex roles as verse having both top and bottom roles in his relations exposes him to hemorrhoids:

> *“I was in a relationship with a man for almost two years and sexually we both were verse, which means there was not any distinct role that was left for one of us, we compromised to please each other as top and bottom. But working as a sex-worker I am mostly bottom, it depends on the demand of the client and sometimes this may cause hemorrhoids if safe materials are not used ”*

A 38 years old male bisexual expressed how he would only stick to his top/ awchi sexual role with male sexual partners.

> *“... After my first lover went back to his boyfriend in county X, I tried to date other men by meeting them through people I know in the Zega community. And there were times I met men who proposed I play a bottom sexual role. I have never played that role and I refuse that, it's not for me, I have never tried it and I never plan to.”*

Among the gay and bisexual male participants, some did not agree with the term sexual role at all. The following statement by A 33-year-old gay participant explained how he views sexual roles:

> *"I do not believe in roles, sexual or gender, that is very patriarchal, I do not get into a relationship because I lack something, and I know that gays are seen in a very sexualized way but it's more for the company and common interest that I get into a relationship and not so that I or my partner has a long term role to fulfill."*

Another 32-year-old gay participant similarly mentioned that relationships are not always related to sexual needs and are not about performance via roles even though that is how the gay community is usually depicted by the community by stating the following:

> *"I started my sexual and romantic life late, I was only in a relationship because I met someone who is like me and you know we stayed together for almost two years but our relationship was not very sexual, I am not limited to one role but I do not want to label my sexual role and I do not want to pressure my partner so we did not have penetrative sex”*

Lesbian participants reflected that their sexual roles had hierarchy and power relations in expressing, demanding, and receiving sexual pleasure. They also mentioned that in relation to the power relation they have experienced discomfort and pain.

A 32-year-old day-time housekeeper discusses the following about the hierarchy in the different sexual relation she had:

> *"Since the first woman I had same-sex relation with was my employer I did whatever she told me and sometimes, it would even be painful… After that, I was going out with other women I met, and I did to them what my former employer used to do to me by dominating and never caring about the need or the wellbeing of the other woman…but when I met my last girlfriend, my sexual role changed and I compromised with my partner since I loved her…"*

A similar experience was reflected by a 23-year-old lesbian sex worker:

> *"I was 16 when the woman that was supporting me and I was living with had sexual relations with me. Starting the first time she told me what to do and I did what she told me…the first time I had the freedom to express what I liked was with my girlfriend of choice…. But now since I earn my income from sex-work, there is no freedom, I do what they ask and sometimes clients may have long fingernails and since they are paying, they don't care if they hurt me…"*

The above reflects sexual roles among LGBs varied not only along the lines of sexual orientation but also related to power relations and preference among each sexual orientation. These differentiated roles entail differentiated effects on health.

4.2.3. LIVING AS AN LGB IN ADDIS ABABA ENTAILS LIVING A DOUBLE LIFE

All LGB participants indicated that living in Addis Ababa as a homosexual/ bisexual person is very hard. They indicated that even though Addis Ababa is a more cosmopolitan city, it is still inhabited mostly by a religious and cultural heteronormative population having normalized only to heterosexual relations and viewing homosexuality as a deviant sexual orientation. Although the participants had different sexual orientations, as gay lesbian, and bisexual, they all described their life as being one of hiding and fearing legal and social consequences if identified to be having a sexual relationship with a partner of the same sex. Besides, most participants indicated they fear societal punishments that bases its assumptions on false narratives about homosexuality depicting the LGB community particularly males as rapists, sinners, and practicing western driven deviant behavior. The participants as a result indicated that they waste a lot of energy in trying to keep up with two personalities as a single person. The following

quotations from different LGBs describe how difficult life in Addis Ababa is for their community:

> *"Life in Addis Ababa as a gay person, and the country, in general, is very hard. Except for a few people that are open-minded friends and members of the LGB community, I hide my gay identity. You cannot have two lives at the same time but that is what I have to do every day, I live two different lives as two different people in the same body. I have to act in one life and hide who I am in the other. I am the same person but I am forced to project two different personalities, which is exhausting."* (33 years old gay person who is a professional)

Another 32-year-old gay participant also stated the vast parity in the two lives he has to live every day as a religious member of the community while being gay:

> *"I have been going to church since my childhood and my spirituality is not something I can separate myself from, as I am not able to separate myself from my gay sexuality, both are a part of me. I live by trying to make a sort of balance even though it's tough, because the religious community considers the act a sin and the society sees us as abnormal. And there are false narratives about how someone owes to their homosexual identity such as being raped and becoming rapists… these false narrative are only there to maintain patriarchal heterosexuality "*

Male Bisexual participants also reported that they are afraid of being identified in their relationships with other men. As a result, they have to live one life in disguise and the other in the open, as the prior (homosexuality) is not accepted. The following quote gives a glimpse of the situation:

> *"I am a married man and my wife lives in Beirut... I was in a relationship with a man and I was living with him pretending that we were only roommates. Sometimes when we have disagreements the people who rented us the house and other neighbors ask us why we quarrel like husband and wife, so we had to be careful not to be exposed and face consequences. It's a sin and its against our culture, so we have to act as heterosexual as much possible" (a 32 years old male bisexual male)*

Lesbians also reported that having same-sex relationships is challenging because it is condemned and these relations are also something are is done in hiding:

> *"… I had to leave the rental house I lived in for years with my children when my employer, the woman I had my first same-sex relation kept coming over while intoxicated and crossing the line in front of my children. There were also times when she would be too loud and the neighbors can hear her say unacceptable things. I had to leave the house because I did not want my children and neighbors to witness my life of*

sin that I was hiding, it made me fear for my life because if people found out I was a lesbian I don't know what would happen"(A 32-year-old lesbian single mother)

Although living in Addis Ababa as an LGB has been indicated as being very hard, some participants who came to the city from other parts of the country indicate that life is easier as an LGB in Addis Ababa as compared to the other parts of the country. One of the main reasons mentioned by LBGs for moving to Addis Ababa permanently was as a result of seeking a better life among people that do not know them.

A 20-year-old gay participant who recently moved to Addis Ababa stated the following:

> *"I came here to Addis Ababa from–City-X because I can have more freedom as a gay man. I come from is a small city where a lot of people know me and there is a lot of societal pressure to hide my gay identity as compared to here. But living in Addis Ababa as a gay person still requires a lot of caution so as not to be identified, because the community takes it very seriously and people take actions against us and attack us if they find out. They think we have a sickness and they can't tolerate us. So we have to be very careful so we live like we are one of them. We can only disclose ourselves to those that are like us."*

The participants of this study reported that the cultural and religious situation in Ethiopia makes the country a difficult place for LGBS to live in. The fact that most people are religious and cultural automatically puts LGBs in an unacceptable position. They further indicated that Addis Ababa is by far a better place to live in among other places in Ethiopia.

A key informant working as an LGBTQ health advocate discusses the impact of the attitude of a heteronormative community on LGBs living in Ethiopia as follows:

> *"Yes, Ethiopia is the worst, to be honest. Living in Ethiopia while being a member of the LGB community is the worst thing that can happen to you. The attitude of the society about homosexuality is based on the norm driven from religion, and in a country where over 98% of the population is religious, the consequences are very harsh if an LGB's sexual identity is exposed. So the community lives cautiously in hiding, it does not mean they don't exist they are everywhere but they hide their true identity not to face harsh social justice. But as compared to other parts of the country, Addis Ababa is far better and that's why a lot of young people flee here because their family will cast them out when they find out about their sexuality. You know the saying 'Kememot-Yishalal-mesembet (it's better to survive a bit longer than to perish right away), that is the case".*

Although living in Addis Ababa was mentioned to be better than other parts of the country, the consequences of being suspected of being a homosexual let alone being exposed in the city was mentioned to have led to physical violence against sexual minorities. As a result, living a double life and hiding sexual identity is deemed a necessity in Addis Ababa.

Among the participants, lesbians indicated that the society wants women to look like women and men like men, and the expression of sexuality other than heterosexuality has social consequences.

A 33 years old lesbian described harassment she faced because she dressed masculine and discusses how society polices women's femininity having zero tolerance if they suspect one to be a lesbian.

> *" I can not explain to you how much harassment I have faced in my life because of people's assumption of my sexuality just from the way I am dressed. I have been punched in the face by a man because he felt uncomfortable with how I looked… he said he thought I was a man sarcastically. And when I was on the floor bleeding from my nose no one felt sorry for me, because they thought I deserved it, saying yes she looks masculine and laughed at me, because my sexuality made them feel uncomfortable. So this is what you face if you don't conform to the cultural expectation of the community, and I would never tell anyone that I am a lesbian, because if I am beaten because they suspect I am a lesbian you can imagine what would happen if I confirmed it for them"*

Key informants that work closely with the LGB community also mentioned that the attitude of the society regarding homosexuality is mainly based on religion. This is because the majority of Ethiopian society is religious. He pointed out that Christianity and Islam, which are the major sects of religion in Ethiopia state that homosexuality is a sin. Also, the community has differentiated negative perception of how someone becomes a homosexual and how homosexuality will negatively affect the culture of the society if LGBs are tolerated.

A 36-year-old queer key informant living in an asylum outside of Ethiopia stated the following on how he believes the country is trying to balance international pressure and cultural pressure regarding LGBs leading the community to live in hiding:

> *"The motto of the government is more of "we are not going to be homophobic because there isn't homosexuality in Ethiopia". So I feel like the strategy is more in silencing us, and Ethiopia is not homophobic in*

any international spaces that is why you don't find official homophobic statements. I believe this is because the government is careful and knows the culture of the Ethiopian people. The recognition has always been there but intentional silencing and calling the act un-Ethiopian if anyone who is not a heterosexual is exposed is really what's happening. But things are evolving because of several underground advocacies, and some discussions are leading to recognitions. Currently, homophobic groups have been officially registered as an organization in the country with the main vision and mission of trying to cleanse the LGB community using narratives such as; being gay is a western influence to destroy religion and culture, depicting gay people as a pedophile that rape to make more gays and the like… so this makes LGBs chose a life of hiding while trying to be themselves where and when they can."

Health care professionals that took part in this study also supported the statements above relating to how living in Addis Ababa, as an LGB is difficult relating their hardship to access SRH. A sexual and reproductive health professional stated the following about how the narratives and attitudes about homosexuality in Africa and Ethiopia have a direct implication on the lives of LGBs living in the continent and the country and particularly their rights concerning SRH:

"I took part in the ICPD meeting that took place in Addis Ababa when talking about liberalizing sexuality in Africa, most African leaders were angered and left the conference in revolt, they state that Africa is not in a place to discuss this and that homosexuality is not an African problem. This is also the narrative in our country when discussing and drafting the National SRH strategy, alternative sexuality is not something that was included in the SRH strategy because it was voted down by majority committee members...And this is why we do not receive LGB patients, they hide because there are consequences if exposed…"

Description of the sexual behavior of LGBs is directly related to the way they live as the socio-cultural and religious attitudes of the community lead them to live a life of hiding. Living a double life increases risky sexual behavior and further negatively affects health access and healthcare-seeking behavior. The following theme further discusses the impacts of social pressure to lead a life of compulsory heterosexuality among LGBs.

4.2.4. SHORT-LIVED RELATIONSHIPS ARE CUSTOMARY AMONG LGBS LEADING TO MULTIPLE SEXUAL PARTNER LIFESTYLE

Risky sexual behavior was reflected among the participants differing along their sexual orientation and personal circumstances. However, all LGB participants described their

romantic and sexual relationships as short-lived predisposing them to have multiple sexual partners, pushing them to sex work as well as marriage with heterosexuals to hide their idenity. The LGB participants indicated that this pattern owes to several factors including having no reason in sustaining a committed relationship that will flourish into having a family, uncertainty of the future relating to their identity being exposed besides and to blend in with the society.

The following quote by a 33-year-old gay participant describes the situation:

> *"…Relationships are the hardest thing to maintain in the life we lead and the society does not understand that the relations we have as something real and meaningful, they just relate them to something sexual. We live a life of hide and seek and always worrying about being caught so that hampers having a long-lasting relationship even when both people in the relationship are really strong and self-aware. So, most of the time one of them even get up and decide to get married when pressured by family and the society so we lead a sort of a serial dating life exposing us to many sexual partners"*

A 23-years-old gay sex worker indicated the following about why he now works as a sex worker after losing a serious relationship reflecting how the influence of the community has made him believe homosexual relations are indeed a sin and that is why they do not last:

> " *I had a boyfriend who lived in country X, I met him online and when he came here we were in an exclusive relationship for a while, but you know a long lasting relationship is not feasible in the life we lead, maybe because it is a relationship of the devil, it never lasts. We stayed together for a year and eight months, we were engaged but living in hiding was difficult so he left me and that broke my heart, so I went back to working as a prostitute because its no use having a serious relationship, to what end?"*

It was further indicated by the participants that relationship that did not last as a result of socio-cultural pressure was a reason to seek multiple partners. This is further elaborated by a quote taken from a 20 years old gay participant:

> *"I date for the enjoyment of life and nothing serious…I wanted to be in a relationship but it's hard to have a serious relationship in the gay community because it is not accepted socially and you have no future in maintaining a serious relationship…."*

On the other hand, some participants indicated that regardless of the difficulty to maintain a relationship, they do not want to engage in sexual relationships with multiple partners, A 32-years-old participant indicated the following:

> "*…Being gay is not all about sex, the society and even those in the gay community reflect that the life we lead does not amount to anything more than sex. But that is not how I understand it, it's about connection… it's beyond sex. But that is only possible with someone who understands and knows himself, which is hard to find in the gay community. As a result, I had only one serious relationship because in the Zega community people just want to date one time as they don't see a future "*

Similar to gay participants, bisexuals pointed out that their relationships with their male partners are short-lived while their hetrosexual relations were long-lived in comparison. A 38-year-old bisexual participants explained this by stating that having a relationship with the opposite sex was easier because it is socially acceptable.

> *"My first male sexual encounter was with my childhood friend… but he had to go back six months after our affair started to his boyfriend where same-sex marriage is allowed, they are still together now. But in our country that is impossible so we knew we had no future…even though I dated other men after him I got married to my first girlfriend and I had a baby with her because of family pressure, but during our marriage, I was still sneaking out to see other men…"*

Short-lived relationships are also a trend among lesbians. A 33-year-old lesbian discussed how relationships are short-lived among the small community of lesbian women, and that some also end up getting married to men because of pressure from family and society.

> *" I had some serious relations wherein one we were engaged and we were living together but one day she decided to be with another woman because there was no more commitment even if we were engaged, and she said people are suspecting that we are more than roommates and we need to end it and move on… these are common stories for us Ls (referring to lesbians)"*

A key informant who works on LGB health right advocacy discussed a story of a gay couple who were beaten to reflect how the community sanctioning these relationships pushes the LGB community to avoid having committed relationship as that could lead to reluctantance and getting caught:

> *"Among many stories, recently a gay couple who rented a hotel room were beaten by the hotel staff then the police were called and we are still looking for their whereabouts. There are serious social sanction and legal*

sanctions that deter LGBs from having committed relations as they increase the risk of being caught so LGBs prefer casual relations that do not increase chance of being caught."

This finding indicates that societal attitude and anticipated consequences deter LGBs from having long-term relations leading them to risky sexual behavior of having multiple sexual partners in their lifetime.

4.3. Perception of Sexual and Reproductive Health Needs among LGBs

This theme is organized in two subthemes in exploring existing perception and awareness regarding SRH needs among LGBs. This theme as a result uses two sub-themes to give the reader a clear understanding of the varying perceptions that were reflected concerning general SRH needs and special needs that are debated as being specific to LGBs under the following subtitles: *Varying perception on general SRH needs among LGBs* and *Opinions on the existence of special SRH needs among LGBs and implications.*

4.3.1. VARYING PERCEPTION ON GENERAL SRH NEEDS AMONG LGBS

The data generated indicates that individual participants had different perceptions of what kinds of general SRH needs they have. The awareness regarding these general SRH needs also varied among the participants.

Among the SRH needs, the majority of the LGB participants emphasized the need for the availability of safe sex materials. While safe sex materials were deemed to be a necessity among all male (gay and bisexual) participants, all female participants (lesbians) did not. Although participants mentioned the need to access safe sex materials such as Dental Dams[1] and Pre-Exposure Prophylaxis (PrEP)[2], accessibility of condoms and water-based lubricants were given emphasis by majority of the participants.

The following statement was provided by a 33-year-old gay participant who discussed some of the general SRH needs of gay men in having a safe sex life.

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[1] **Dental dam** is a thin, flexible piece of latex that protects against direct mouth-to- genital or mouth-to-anus contact during oral sex to reduce STIs.

[2] **PrEP,** or pre-exposure prophylaxis, is an HIV prevention method in which people who don't have HIV take HIV medicine daily to reduce their risk of getting HIV if they are exposed to the virus.

"…Having easy access to safe sex materials like condoms and lubricants is very essential for the gay community, because if these protective materials are available, then high sexual health risks among our population such as HIV could be prevented…"

The need for safe sex products is essential to gay men as their sexual orientation puts them at more risk of contracting HIV and STIs. A key informant who is working on LGB health rights advocacy further elaborated this point.

"There is a need for making safe sex products available and accessible for the LGB community. For example for gay men having anal sex without condoms and lubricants, it puts them at high risk for contracting HIV and other STIs. So even if the health facilities are not able to provide care for LGBs, there has to at least be a safe space where these populations can freely access these products without harassment or shame. But it is very difficult to even import products such as lubricants into this country which means we are consciously leaving this population at risk of getting infections. And once they get infections they will inevitably need care from a health facility which are not accessible."

The health needs of men who are receivers in penetrative anal-penile sex indicated that they are the ones who require these safe products particularly water-based lubricants as a result of their sexual roles which put them at risk of hemorrhoid as opposed to their partners.

A quote taken from a 23-year-old gay sex worker further explains the above:

"When you are gay who plays a bottom role, mostly there is huge health care need for hemorrhoids. And as a gay sex worker, I go out with many men and since these men have money they may have the means to protect themselves, by using PrEP or going to any health care facility around the world, but since I have a bottom role I need lubricants but I may not always use this safe sex material because it is not accessible at pharmacies and when you find it, it is embarrassing to ask because the pharmacists could already guess you are gay. As a result of this, I have been dealing with hemorrhoids for as long as I can remember ..."

As discussed in the above quotation, if these products are not made available, gay men may need health care services from health facilities as they risk contracting STIs, severe cases of hemorrhoids and anal fishers. In case this happens, the sexual health care service needs to be provided by a trained health professional in a health facility that is well equipped having the necessary equipment and drugs. The need for further health care services is discussed by a 32-year-old gay participant as follows:

"The gay community needs to have health facilities that are pro-LGBs at least something similar to drop-in centers (SRH service providers giving protective materials and counseling that are made available for female sex workers in Ethiopia) where we can seek advice, safe sex materials, and care. Because a gay person will contract anal fisher/ cuts, hemorrhoids, and STIs if he is having anal penetrative intercourse without having water-based lubricants and condoms …"

Even though the need for safe sex materials was given priority among all gay and male bisexual participants, more emphasis was given by those playing a bottom role.

The lack of awareness regarding health needs particularly among young men having little to no same-sex sexual experience was reflected as cause for not having safe sex.

A 32-year-old bisexual sex worker indicated the following regarding how his understanding of SRH needs and the need for safe sex materials had shifted since his initial same-sex sexual experience:

"I only came to understand that there is a need for condoms and lubricants for people like me recently. Having safe sex with another man entails wearing a condom and using lubricants. I did not know that during my first few sexual encounters with men and that has caused me to have hemorrhoids… I think that besides making those products available, there is a need to create awareness among young people so that they do not repeat my mistake initially."

Lack of awareness on the need for safe sex materials like condoms and water-based lubricants is also one of the main causes of transmission of STIs including HIV.

A 33-year-old gay participant pointed out the following in relation to the above:

"I have come across many people from the gay community who do not think that they can contract HIV or STIs from anal sex because all awareness creation mediums only discuss these issues revolving around heterosexual sexual relations (vaginal-penile sexual relations), even that is a taboo. So besides safe sex materials, there should also be tailor-made material produced to teach our community in creating awareness on sexual health …"

Concerning awareness of safe sex materials, gay participants mentioned the necessity for having the availability of PrEP and dental dam further reflecting they have better awareness about the need for these materials as compared to lesbians. This need was reflected by a 33-year-old gay participant as follows:

"… We have more vulnerability to HIV than straight people because of the kind of sex that we have, but HIV is the same infection for all, so we just

need to be incorporated into the health system, our existence should be accepted so we can get care, also as we are vulnerable we need PrEP, dental dam, lubricant, and condoms…"

A 23-year-old bisexual sex worker discussed the need for PrEP among male sex workers as it is among female sex workers:

"It is very important to have these kinds of preventive drugs because for me I do not know how and when I may have a sexual experience because of my work, I use condoms all the time but there were times where I was paid a large sum of money to have sex without condoms, in that case, if I had PrEP then I wouldn't worry…"

This was supported by another 32-year-old gay participant:

" Our community is criminalized for having this sexuality and these affairs are done in secrecy. As a result, unsafe sex could happen and if PrEP and PEP (post-Exposure Prophylaxis)[3] are made available it will decrease the risk of contracting HIV which the gay community is very vulnerable to. And however criminalized and made a taboo people are still having sex, they have been for years so the solution is to provide these preventive safe sex materials, these are part of the community and we should not lose any citizen for a care that can be easily made available…"

The above was supported by a statement of a key informant who is a health care provider facilitating networks for the LGB community to get safe health care provision:

"One problem is lack of lubricants and PrEP which is the basic need of people with same-sex orientation, particularly men having sex with men because of their vulnerability to HIV…We use our connections to get PrEP, lubricants, and condoms but the community is too big in hundreds of thousands if not reaching a million, and we can only help very numbered people. There is a limit to what we can do because we are working in hiding."

On the contrary to the above, all of the lesbian participants were either unaware of what kinds of safe sex materials they needed and even believe that they do not need protective materials as their sexual orientation will not expose them to contract any kind of STI. All lesbian participants believe that they do not have SRH care needs let alone special SRH care and service needs.

A 33-year-old lesbian discussed that she has no SRH care needs:

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[3] Post-exposure Prophylaxis (PrEP) is a short-term medicine taken if there was a risk of contracting HIV from having unprotected sex.

"I had a relationship that lasted three years, we were living together and we were engaged but I later found out that she was cheating on me with other women who are our common friends and I have had relations with various women since then, but I never had any health problems…well, we as lesbians do not have any risks as women do in heterosexual relationship… laughs…we do not get wanted or unwanted pregnancy or infections such as HIV, and I have never been to a health center seeking SRH care, I do not need contraceptives or condoms so why would I go?....."

A 32-year-old lesbian also shared similar perspectives on how she does not know if she has any SRH needs, but she was curious to know more about risks related to her sexuality:

"…For safe sex, I make sure I am clean by washing and I also expect the same from my partner, besides that, I have been to the hospital once to see a gynecologist, I went because I was having severe lower abdominal pain, it was my lover whom I was working for who took me there and covered all the expenses. The doctor told me that it could be because I was having too much intercourse, thinking I had a relation with a man and that I should take some time to rest. When I told my lover what the doctor said she sarcastically said people even have sex with men, he does not know what he is talking about… I have never really taken it seriously but I am curious to know if it is possible to have HIV and STIs by having sex with another woman, I wish I could talk to a professional about possible sexual health risks that I could have."

A 27-year-old lesbian sex worker further indicated that she is not sure if she would contract STIs from women by stating the following:

"I go out with women and I talk to my friends who are lesbians about STIs and HIV but there is not anything more we can do but wonder, because we don't know if we can contract infections from each other and even if we could contract infections from eachother, it is not like we can protect ourselves, I mean how, what can we use, there is nothing for women."

However, health providers and key informants believe that lesbians are at risk because of their low level of awareness about the need for safe SRH services. A clinical nurse who works on networking health care providers to LGBs stated the following:

"…We can count the lesbians living in Addis Ababa, their number is very small so we did not start working on the health care needs of these members of the population. When we first started we were only working with males but we came to realize that there is a complete misunderstanding regarding safe sex among lesbians so we started working on this population. They do not think they could get any kind of

STI from having sex with other women. They are also not aware that dental dams exist and are necessary to protect themselves from STIs. Women are neglected members of the population and we are trying to fill that gap, there are many bisexual women and they only use contraceptives leaving them and their female sex partners to getting STIs. This gap exists because there is no tailored education for lesbians."

A key informant living outside of Ethiopia and working as an LGBT advocate for Ethiopians stated the need for awareness of lesbians on their SRH care right:

"*Absolutely, there is an SRH need among lesbian women. Let's create a scenario where a lesbian couple wants to get pregnant, that is not even imaginable in Ethiopia but at least if a lesbian may want to have a safe sex education our health system is absolutely not equipped to handle that question. Our health system has intentionally erased this part, it has erased LGBs. And issues of homosexuality even if seen as deviance they are talked about from only a male perspective, women are not taken as seriously …"*

4.3.2. OPINIONS ON THE EXISTENCE OF SPECIAL SRH NEEDS AMONG LGBS AND IMPLICATIONS

The second major difference in popinion among the participants was on the theoretical conception of if and whether LGBs have any special SRH needs as compared to heterosexuals. And if so, whether these special SRH needs among LGBs require special SRH care and services in response.

The results of this study suggests that the concept of special SRH needs among LGBs is not something the participants have a consensus on. Some participants reflected that they believe they have a particular SRH need concerning their sexual orientation that needs to be addressed differently from heterosexuals. While others said that they do not have any particular SRH need that a health provider has to do differently as compared to heterosexuals or a need for having special health facilities to cater to their SRH needs.

Among the above opinion dissect, the majority of gay and male bisexual participants agreed that they have an additional need for special SRH services.

A 32-year-old gay participant stated the following about the importance of having special health care services in place to the gay community:

"*The gay community is more vulnerable because it is a community with people that are living in hiding and that I think is because of our difference from the heterosexual community. I personally have special problems with my sexual experience that are not expected within a*

> *heterosexual relation. As I have told you I have hemorrhoid problems and I have HIV too and this happened because of my sexual experience that is not similar to heterosexuals and I think I need special care from a provider to respond to my specific need."*

A 20-year-old gay participant stated the following reflecting how he also perceives that same-sex sexuality requires care and services that do not exist because they may not be problems of heterosexuals and that there is a need for having new SRH services included.

> "*Our sexuality is not considered 'normal' and that is why it's difficult to get SRH benefits like heterosexuals having appropriate care available to meet their needs. If we were accepted we could be provided with counseling that is specially made to cater to our needs. Among our population, there is a lot more HIV and STIs and we need special SRH education and treatment made available."*

The above opinions were further confirmed by a gynecologist and a professor of SRH:

> "*I believe LGBs have special SRH care needs particularly because they have different sexual orientations and I also assume they may have high HIV risk. Besides, in a cultural society like ours being an LGB is a big burden on its own starting from their homes. So they will require support starting from there. But even as a health professional, I think there is a serious issue regarding acceptance. I highly believe that these members of the population need special psychological care when being provided with SRH services.*

Another provider who is a clinical nurse providing care for LGBs mentioned that he believes there is a special SRH care need among LGBs:

> *"There are special health needs among this population as a result of their vulnerability related to their sexual orientation and the lack of knowledge as well as negative attitude in responding to their particular SRH needs. The government has put different members of the population who are at risk of contracting HIV as key population needing special attention but has ignored LGBs and their special health needs… they do have special SRH needs that are not being catered for."*

It was further mentioned that the already existing sexual health teaching documents including printable materials as well as television and radio content are limited to the safe sex needs of heterosexuals. As a result, the community indicated they have a special need that is not addressed in these educational materials. A 32-year-old gay participant indicated the following regarding the above:

> "*There are health services we need, we are part of the community and if you look at content in the health system, on the HIV roadmap materials,*

other SRH manuals, all are targeting heterosexual sexuality. But when we speak of HIV, anal sex is riskier to contract HIV than vaginal sex. And I believe that has to be addressed unless we deny the existence of that community. And there is no feeling of belongingness. We need special SRH materials prepared that takes our community into account.

On the contrary, other participants contest the need and existence of special SRH needs among the LGB community vis-à-vis the heterosexual community and emphasize the term "special" could be taken out of context further leading to the stigmatization of the community.

A 33-year-old gay participant mentioned the following to indicate there are no special needs theoretically and the term itself is unnecessary as it is used to containerize sexual minorities.

" There is something that the government has put forth as key population by containerizing sex workers, drivers, widows, etc… as vulnerable population but this excludes LGBs because the government does not recognize our existence. However, I am glad because I do not want to be categorized under that as a gay person, I do not even feel comfortable with this compartmentalization in the first place. There is nothing special about our health needs, one thing that is claimed to be peculiar is that we have anal/ or oral sex but that is and has been common among heterosexuals too. So our problems do not require new knowledge it just requires new attitude, our health care does not need a special approach but acceptance."

The above was further supported by a participant working as a clinical psychiatrist:

"I don't think there is a special disease that affects the gay community and for instance, if they have HIV, they can be treated like any other heterosexual and if they want protection and safe practices they can use condoms like any other heterosexual individual, so they don't need special clinics or special kind of professional. So the disease they get is what ordinary people get. But what is seen globally is that they get it in a higher proportion because of their practices, and this is not because they have special needs but because society marginalizes them from accessing what is already available."

An SRH specialist and gynecologist reflected that there is no special need to have a special health facility setup:

"I do not think there is a special setup needed because the stigma and discrimination will exist if you prepare a differentiated space and provide the service separately, so the service should be integrated and these people are human and whatever you use for others you can use for them, their problem is not really something so unique it's the same. Let us for example take cancer, a

heterosexual and a homosexual person could have colon cancer which will be treated the same. So the only thing that needs change is the attitude particularly among providers, the proper attitude, heart, and avail a sympathetic environment. With that in mind, they have to treat them with compassion and confidentiality just like any other patient, and this comes with various training, interactions, and so on. But this can only happen in a favorable environment where providers have legal and policy backup to provide this service boldly.

However putting the already existing stigmatization of the LGB community in mind, some members of the community prefer to have a special mode of health service delivery to cater to their special health needs.

Among many participants who discussed they wish they could have a health service delivery space that is safe and could respond to their special needs was a quote by a 38-year-old bisexual stating the following:

" I hope in the future there are particular departments in health facilities, where we can go to freely without being ashamed and where we can get the services we need by professionals who are working specifically in relation to our needs with a positive and accepting attitude… I would like to have that in my lifetime because I want to be treated freely…"

Whether there is a special SRH need among this population, the fact that the government does not recognize the existence of this population in any heath related policy or strategy documents on the one hand and criminalizing homosexuality on the other has left the special SRH needs of the population unrecognized. This as a result leaves a grey area on availing SRH to the community in health facilities as well as the readiness of health care providers to treat the community.

This silence of the health policy documents is reflected by different health care providers:

"We have an SRH guideline in hospitals but this is under the umbrella of the policies and the national health strategy which does not say anything about LGBs. And this is because the act is illegal and the health sector can not put issues that are illegal in the strategy, so if you don't have it at a governmental level you should not expect it to appear as a guideline in the health facilities and in any of the services…I also had the opportunity to contribute in the drafting of the National RH strategy with the Ministry of Health as part of the RH technical working group and this discussion was raised by some to negotiate LGBs' SRH incorporation as a guaranty to the overall wellbeing of the population, but it was sidelined." (A gynecologist and SRH specialist)

In addition to the above, another gynecologist and professor of SRH mentioned that the SRH health care providers are not provided with education on how to treat LGBs because

it's not in the syllabus. As a result, mentioned how health professionals and the health system are not ready to respond to the peculiar SRH needs of LGBs.

> *"We do not provide training to health professionals on services for LGBs, since it is a crime and I do not think we can incorporate it for the same reason. So there is no access for this community if they have any special SRH needs…I have been working as a gynecologist for many years but if I am approached by a lesbian seeking SRH service, I can not say I am well prepared to respond to the peculiar needs she may have…"*

A clinical psychiatrist articulates how the law is upholding the expectation of the majority by making homosexuality an illegal act and unless the individuals are considered legal the health system will not respond to the needs of the community.

> "*Whatever happens in the country the law and the will of the majority dictate how we live, and we live in a conservative and highly religious society where all religions perceive the act as a sin. So it is highly unlikely that this act will be legalized and as long as the policies including health strategies are dictated by the law-driven from norms approved by society, it is unlikely their needs will be recognized…So LGBs have to get their illegality removed from the law before claiming their right in a health facility where providers are not obliged or educated to give these services"*

4.4. Access and Barriers to SRH Services among LGBs

This theme is presented with two subthemes entitled: *Sexual roles determine perceived access to SRH among LGBs* and *Desecration to treat, mistreat, or deny treatment.* The theme is divided into these subthemes to provide the reader with the context that best reflects the different challenges and barriers hampering LGBs access to getting SRH services.

4.4.1. SEXUAL ROLES DETERMINE PERCEIVED ACCESS TO SRH AMONG LGBS

The majority of the LGB participants mentioned that they are afraid of going both to public and private health facilities because they fear the negative reaction and attitude of the health providers they may face if their orientation is exposed. This fear is reflected from what they anticipate could happen to them if their sexuality is exposed by comparing it to the experience of other LGBs. However this fear is maily rooted in response to the existing legal and social atmosphere of criminalization and homophobia in the country respectively.

This fear of being identified while seeking SRH care is however ranked highest among gay and bisexual men having experience of a bottom/-receiving role in penetrative anal sex. On the contrary gay and bisexual men with top/ penetrator role in penetrative anal intercourse; and lesbians reflect less fear of being identified. It was pointed out by all participants that being identified while seeking SRH care is directly related to having symptoms signifying same-sex sexual orientation. And those having symptoms related to a homosexual experience have more likelihood of being exposed hence the increment of fearful perception in being denied access to SRH care.

Among gay men, those who have verse and bottoms roles all stated that they would choose not to go to a health facility because they are scared of being exposed as a result of symptoms that may have developed as a result of their sexual roles leading to the easy identification of their sexuality.

A 32-year-old gay participant stated the following about how he perceives access to SRH care in relation to his sexual role:

> *"…There is so much stress just thinking about going to a health facility if I get sick, I will not go just to any hospital like those who do not have homosexual symptoms, because how will I explain my myself and symptoms? Imagine, let's say I had penetrative anal sex and I got some ulcer, where will I go and what will I say happened to me when the physicians asks me … so I would rather stay home with my illness because I have heard of too many bad stories in seeking care for people like me"*

Participants further mentioned that they seek health care only when they have to and if they have unbearable pain. In this case, they knew even if they went to a health care facility that they had to lie about their sexual identity and never admit their sexuality even if it was suspected by the physician so as not to risk getting mistreated.

A 20-year-old gay participant who plays a bottom sexual role stated the following about his experience in seeking care as follows:

> *"Having an illness related to our type of sexuality is hard particularly if you have a problem that will reveal your identity, you cannot admit it because it's a crime, I had to go to a health center because of a hemorrhoid problem that I had and the physicians came to examine me and immidiately suspected I was gay as a result of my symptoms. So he kept asking what happened and asked if I was having anal sex, I lied saying I have never done that…I only went because of the severe pain which I needed surgery for…"*

A similar perception was reflected by a 23-year-old male bisexual sex worker in accessing SRH care. He reflected that his sexual role led to symptoms that made it difficult for him to go to a health center seeking care:

> *" I was so sick, I had hemorrhoids for a long time, but I was scared to go to the hospital because… what will I say and how can I talk about who I am and what I did to get sick if I was asked…so I tried other remedies…but later it got worse and I was not able to even sit so I had no choice but to go to a clinic. But the doctor immediately knew my sexual orientation and asked me to tell him the truth, but of course I did not admit I was a bisexual, I was scared because I had heard some bad stories where gay men were mistreated when seeking care."*

The way access to SRH care is perceived among gay and male bisexuals is based on fear of their sexual orientation being identified by their physician as a result of the symptoms they may have acquired as a result of their sexual roles. This fear of one's sexual orientation being identified among males having a bottom role in same-sex relations is confirmed as follows by an SRH specialist and gynecologist.

> *"…I started becoming suspicious… and when I did a physical examination I realized that the patient had some anal sexual experience immediately by the symptoms of a lax sphincter, ulcer, and discharge in the anus. Not only a professional but also a layperson could suspect a similar cause for such symptoms. So I asked what was wrong and when he started telling me his problems but still shying away from the truth, I knew he was struggling to keep his secret…"*

On the other hand, gay and male bisexuals who refer to their sexual roles as top and do not experience penetrative anal sex had a different perception of how accessible SRH services are to them. They all reflected that their sexual roles do not lead them to have symptoms exposing their sexual orientation during a physical examination by a physician. As a result, they do not fear going to health care centers to get SRH care.

A 38-year-old bisexual male who had never experienced penetrative anal sex indicated the following about accessibility of SRH services:

> *" I never needed to go to a health facility seeking SRH care, but if I ever did, I would go to a health center without any hesitation. Because when I go to a health facility, I do not have to reveal my sexual orientation, and how would they know unless I reaveal it my self. There is no need to expose my self, because if I did it would be a different story I don't think I will be provided with any treatement…"*

A 33-year-old gay participant with a top role also stated the following about how his sexual role does not put him in a position to seek care that reveals his sexual identity.

> *" I never went to a health facility needing SRH care other than getting tested for HIV. And I wouldn't say that my sexuality puts me at risk of being identified as gay, but I still would like to get care based on my reality and I wish I could tell my physician my sexual identity to get the best care. However I wouldn't do that because imagine, if the provider has a negative attitude towards gays, which is likely, then he might expose me putting my life at more risk than being sick."*

All lesbians also had a similar perception of having access to SRH care at a health facility. They all said that they do not fear going to a health care facility to seek SRH care because nothing is telling about their sexual identity and they normally have no symptoms that reveal their sexual orientation.

> *"I never needed to go to a health facility to seek SRH care, I mean as a lesbian I don't think I need to go, because I do not have any sexual health risks, but if I ever needed to visit a gynecologist I am not scared of going because unless I tell the doctor I am a lesbian, there is no way of knowing my sexual orientation, and there is no need of telling because that is just asking for trouble."*

A 27-year-old lesbian sex worker mentioned that she went to a health center when she needed SRH care and reflected that no one questened her sexuality:

> *"One time after having intercourse with a client who had long finger nails, I experienced pain and I saw blood when I urinated, so I went to the health center and there was no need to disclose my sexuality to get care. The providers simpley assumed that I had sex with a man… I did not try to correct them. So they run some tests and gave me antibiotics… so I am never scared to go to a health facility, no one questions my sexuality."*

On the other hand, a 32-year-old lesbian participant mentioned how she wishes she could go to a health care provider that she can tell her sexual orientation to openly.

> *" I wish I could talk to a health care provider about my issues openly to know my risks and get proper checkup. But if I tell them my identity, I am scared of what their response could be, I fear that they will judge me and ask me why I would do such a disgusting thing which is also a sin, I feel like they will despise, embarrass and stigmatize me. And I fear they will tell people and soon everyone will know and I will not be able to live within this society after that."*

All health provider participants, except a clinical nurse who is working in the provision of networked care for LGBs, pointed out that they have never come across lesbian clients.

They also discussed that they never asked or suspected a female client seeking SRH care was a lesbian. They all stated that they had no way of knowing, even if they had ever treated one. The following statement by an SRH specialist and gynecologist supported the above statement:

> *"I have treated gay men but not lesbians, I think lesbians use different routes in accessing care… or I even may have probably come across them but they never disclosed themselves to me. I think this is because they don't have to disclose themselves to get treated."*

A similar statement provided by another gynecologist surgeon and assistant professor of SRH reflected that she wouldn't have known if she had treated a lesbian.

> *"Working as a gynecologist for over 10 years, I have never been approached by a lesbian, at least not that I was aware of because they never told me… we just presume that all patients' sexual relation history is that of a heterosexual one. But perhaps if we asked them, it would open a space for them to tell us because it would be good to know their precise sexual relation history to provide the service they require"*

As indicated above access is directly linked to the existence of same-sex sexuality symptoms among participants. This creates not only differences but also a hierarchy along the lines of their sexual behaviors/ roles and gender among LGBs. This means that gender and some sexual roles are less privileging than others in accessing SRH services as they reveal homosexuality that is condemned by the community.

This idea is further elaborated by a key informant who works on Ethiopian LGBTQ rights whilst living in an asylum outside of the country.

> *"Among LGBs, the health care needs may vary as per their circumstances. And some of the health needs of the community members may fit into the heteronormative way of being sick. And they might get health service without explaining anything. For instance, if a gay male who is doing the penetration gets STI around his penis, he can lie and say that he got it from his female partner. But the reality is different for gay men who are being penetrated and having STI around their anal canal, then that conversation will be difficult to have with a physician. And with lesbians, there isn't anything telling, so there is no need to self incrimination."*

As a result, it was found that although LGBs may have a commonality in having barriers to access SRH care as sexual minorities if sexuality is identified or revealed by one's own self, perceived access by the community differs along the lines of sexual roles as well as gender. Male bisexual and gay men who experience no anal penetration as well as

lesbians perceive that they will be able to access SRH as they have no symptoms that could expose their sexual identity. On the other hand, males that experience anal penetration perceive that they have no access to SRH care as the symptoms that are caused by their sexual role are clear identifier of their orientation same-sex which the law criminalizes.

4.4.2. DESECRATION TO TREAT, MISTREAT OR DENY TREATMENT

All LGBs Participants indicated that they believe their access to care is dependent on the attitude of the health care provider once their sexual identity is exposed. They all agreed if they identify themselves as being an LGB to their physician, they fear that it is up to the desecration of that health care provider to decide whether to treat them or not as well as keep their information confidential. All LGBs indicated that they would not disclose their sexuality to health provide by choice. And if they do so, they explained that they expect to either not get treated or encounter mistreatment. They mentioned their worst fear is coming across a physician that may report them to the police or reveal their identity to others nearby where it leads to physical/ verbal harassment.

Among LGB participants, only few discussed how they experienced denial of SRH care by a provider at a health care facility because they revealed their sexual identity. A32-year-old gay sex worker reminisced on his experience about the above as follows:

> *"I was suffering from hemorrhoids because of my sexual role for a long time and one time it got so bad that I decided to seek care at a health center. There, the nurse treated me very well, I did not tell her I was gay but explained that I contracted a hemorrhoid problem by lying and saying I was stationed in a desert area for work and I had constipation leading to hemorrhoid. She then wrote me a referral to a hospital, but there when I discussed my problem with the doctor, I wanted to be honest, to get better treatment and I thought he would understand as he seemed kind. But when I told him my sexual orientation, he got shocked, and murmured 'in Jesus's name', and told me that he is sorry, but he cannot treat me, and that I should try coming back in the afternoon and ask the doctor coming in the next shift to treat me…"*

Although similar cases of treatment denial were not mentioned as being a personal experience of other LGB participants, the majority pointed out that someone they know was either denied treatment or has been mistreated by health professionals while seeking SRH care at a health facility for being an LGB.

"*A friend of mine was denied treatment after he was identified to be gay because of how feminine he looked and when the physician asked him if he is gay, he admitted that he is gay. And there the health provider told him to go to church and try holy water becaus that is the only thing that will heal his illness. This happened because he admitted he was gay but if you just go and never admit your identity they may judge you but they will still treat you." (A 32-year-old gay participant)*

A gynecologist and an assistant professor in SRH mentioned the following statement indicating LGBs may be denied treatment at a health facility as some providers may follow their desecration not to provide care as a result of their attitude towards the community.

"I can tell you it is not possible to raise the issue even among providers it is not a topic of discussion. Many have mentioned to me that they would not want to work on something that challenges their religious and cultural morale on several occasions even though it is unethical to deny care."

In addition to denial of care, when and if a health provider identifies the sexual orientation of an LGB, getting mistreated was also mentioned as a problem. Although it is found that there were instances where an LGB has been treated well by a provider after sexual orientation was exposed, participants mentioned that there were times where they themselves or people they know have been mistreated or have discriminated against by a health provider.

A key informant working as an advocate for the Ethiopian LGBTQ community while living in asylum abroad recalled one experience he and his close friends witnessed before he left Ethiopia.

"A friend of ours was very sick years after contracting HIV/AIDS. He went to a health facility during his final days on this earth, and the health professionals did not feel sorry for him and said that he deserved to die. Although the provides already knew he was dying, getting them to attend to him was very difficult and we had to call them all the time. It was difficult for his friends to come and visit him and to give him comfort on his deathbed because of the discrimination of the entire hospital staff from the guards to the doctors. He would not have died if he was not gay because if he were a heterosexual it would have been easier to access safe sex education, safe sex materials and he wouldn't have been so scared to go to a health facility and get treated early in the first place. How many times do we hear testimonials of people saying they have lived with HIV for over 30, 40 years, but this is a reality only to heterosexual men and women. The government is proudly showing them off and proudly campaigning with them but it is also a country where a 25-year-old is

dying from HIV and that is because he is gay. So this is proof of the differentiation of access to care."

Akey informant who works on health advocacy for the LGB community also discussed his familiarity with the mistreatment of the LGB community when seeking care.

" LGBs cannot freely access health care in Ethiopia particularly if they reveal their sexual orientation. Let me give you an example, we had a case where one guy who is gay went to a hospital because of an injury on his leg, and he had some other problems concerning his sexuality, and when they were doing a physical exam they found out his sexual orientation, and as a punishment, they did the surgery without providing anesthesia. And he came and told us that this happened to him, and this is unethical for health professionals. There is equality on paper for humane treatment by a health professional but the situation is different on the ground."

Although the majority of the participants agreed that the desecration to treat, mistreat or even deny treatment to LGBs was that of the health providers. A clinical psychiatrist stated that health professionals vow not to discriminate patients based on any grounds and the above is an unreasonable fear perceived LGBs:

"The health sector has the obligation to provide health service irrespective of the identity of the individual. Justice is a universal ethical principle of medicine, which is treating everyone equally, irrespective of their orientation in this case. And this is in the universal curriculum that every professional has been taught, so when they (LGBs) claim they were not provided treatment because they for example had STI on a particular body part like the rectum or the mouth, mostly they are lying. I am not being judgmental but to my knowledge, no physician would deny treatment just because they have an STI on a different part of the body, it would be an exaggeration, to say the least."

Among the various types of mistreatments, there was also sexual harassment that was reflected as something that caused discomfort and was taken as a lesson to not go back to that particular health facility again.

A 23-year-old bisexual sex worker participant indicated that although a provider was willing to provide treatment after suspecting his sexual orientation, he was sexually approached by this provider.

" ...It was an expected coincidence… I never admitted to my doctor that I was bisexual when he treated me the first time and prescribed me medications to take. He gave me an appointment to come back in two weeks… then he was approaching me sexually… he then told me that he is like me, and asked me to meet him some other time, I said ok because I

was shocked then… I met with him and we had a one-time sexual relation, he paid for my meal and alcoholic beverages which is a big thing for me, but I would not want to go to that health facility again even though I know I could get treated, I was uncomfortable"

Among the LGB participants, another gay participant mentioned that he too unexpectedly encountered a gay health provider. However, his experience was different from the previous participant where he reflected having a provider who understood him led him to have a better-protected life he has today.

The 20-year-old gay participant mentioned the following in explaining the above:

" So when I went to get treated for hemorrhoid, I found out later that one of the health providers among those who were treating me was gay. I realized this when he told me later as I was recovering from surgery. He came and told me not to worry, and he is in this life, he took care of me and gave me so much advice when the other providers were not around, that helped me a lot because as he advised me to always use lubricants and condoms and since then I have never had sexual relations without the recommended safety materials, and I have never been sick after that…"

However, some providers provided care without discrimination which participants called friendly doctors. A 32-year-old gay participant reflected the following:

" …It is not to say all doctors are bad to us, there are some kind ones and our community goes to them once they know about these providers, we call them friendly health care providers"

All providers mentioned that they would provide treatment to LGBs if and when they came seeking care. A gynecologist and an SRH specialist reflected his first encounter of receiving a gay patient in Addis Ababa as follows:

"It is uncommon for LGBs to come because the environment is not conducive for them. But when they feel the health provider is supportive they may approach you and tell you that they are from that community. In my experience, I have received only men and when they feel like their problem could be easily detected and lead to them being exposed as gay they tell you themselves. That is what happened in the first encounter where a man came with a woman and lied saying they are a couple. But he is having STI symptoms and she does not. So they only wanted me to treat him and as I did my physical exam and started asking questions I got suspicious…so I told him I will help him no matter what and that I will keep his secrets… then he admitted to me that he was gay and I treated him in confidence…after that he sent many people from his community for treatment."

Participants particularly, health care providers reflected that although it was uncommon and some of them were never really approached by an LGB patient they were willing to provide care without any discrimination and as per the oath they have made as professionals. However, participants have reflected different opinions on how there were negative encounters when their sexual orientation was identified. Nonetheless, health providers also reflected that other colleagues might not be motivated to provide care to LGBs as it may be opposing to their personal morale. The difference in access however is perceived among LGBs along the lines of their sexual roles that may indicate their orientation if they were to get a physical examination. Having exposing symptoms were the main deterrent in having fearful perception in having access to SRH care.

4.5. Alternatives to mainstream SRH services among LGBs

This theme aims to describe some of the existing alternatives the LGB community is utilizing if and when SRH services provided by mainstream health facilities are inaccessible to them. As a result, the reader will be provided with the findings in two subthemes with the titles: *chain of trust in accessing SRH care* and *holding ceremonies to conduct SRH education.*

4.5.1. CHAIN OF TRUST IN ACCESSING SRH CARE

Driving from the findings of the lived experiences of LGBs in the previous themes, it is visible to see that majority of LGBs have experienced hardship in accessing SRH services if they identified their sexual orientation in mainstream health care facilities. This study has assessed the alternatives these members of the community use to realize a healthy life concerning their sexuality particularly when they feel they cannot freely access SRH care in mainstream health care facilities. With this regard, some LGBs, SRH providers, and key informant participants have respectively discussed how they get, provide, and organize an alternative system of SRH care.

Among LGB participants who had mentioned that they would not go to mainstream health care facilities when and if they ever needed SRH care, indicated how and from whom they get alternative health services.

A 32-year-old gay participant mentioned that he utilizes health care providers who are friendly and are aware of his sexual orientation with the following quote:

> *" I never really needed to go to a health center following the conventional way, I know health care providers I can now call friends, and if I ever need SRH care I would just call them* and *go to where they are working. I have also recommended these friendly providers to other LGB friends."*

A 33-year-old gay participant discusses how he took part in the organization of an underground network interlinking friendly health care providers[4] and LGBs that were seeking SRH care as follows:

> *"In 2013, a few of us who are members of the LGB community came together to devise a solution for the challenges we face including accessing SRH care. We then created a sort of an underground network that has grown since. There are lists of friendly doctors who are non-judgmental and we got them on board to help our community. So when someone who is an LGB has a problem we recommend him to go to a specific health provider we know and that phycisan will provide the necessary treatment without the hustle he would face through the conventional route. We had to do this because it is very difficult for us to get SRH services at a health facility by going in the conventional way which could lead us to trouble by exposing our identity. And if we went by hiding our orientation we will not get satisfactory service and we cannot even call that service because, if I can't tell my doctor my problems then it's as good as just going for a tour of the facility rather than getting a treatment."*

An SRH specialist who also specializes as a gynecologist pointed out that LGBs might keep away from coming to health facilities in the conventional way fearing negative consequences and might use other routes to get access to SRH care. He describes how his first encounter of treating a gay patient led to a chain of trust where other LGBs kept coming to him seeking SRH care.

> *" ... I told a patient whom I suspected was gay that I will keep his information in confidence and I provided him with care. Following that his friends were coming to me to get treated because he told them I will treat them without discrimination. As I had more cases come to me, I discussed the issue with other specialists like surgeons, those that are more enlightened on the matter and I started referring them to these specialists. And the patients go to the specialists I refer them to since they trust me and now they trust them. So this created a chain of transmitted trust."*

This kind of chain of trust is also systematically organized among the LGB community as an underground-networked system to access SRH. These unrecognized organizations are

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[4] **Friendly health care providers** are heterosexual health care providers that LGBs have formed a bond of trust within acquiring health care services.

formed by members of the LGB community from differentiated professional backgrounds serving as an alternative means to access safe SRH services among these sexual minority groups.

A clinical nurse who works as a freelancer in one of these organizations reflected that he is responsible for the facilitation of the network as follows:

> *"I have been volunteering at an underground association for health advocacy network for over five years to help LGBs get SRH care. My task focuses on the provision of education about safe sex and the distribution of safe sex products. It is not as well organized considering the legal context of the nation. But we have a team of health professionals who are themselves LGBs and also 'friendly physicians' that we know who help us in getting our people to get service in the facilities they work in. So we use the internet to do most of our work that is where we provide SRH education about safe sex and create awareness on the risk factor of HIV and other STIs among LGBs. So based on that, members of the community contact us and I link them with the health providers so that they get appropriate treatment at a proper health facility. Also, we facilitate with friendly health professionals, a space for the LGB community HIV testing, and tailored counseling sessions. We provide this service because there isn't a health facility, treatment, and providers that are available to cater to the SRH needs of this population. But there very high demand that we are not able to cater to, and we have only reached a fraction of the population so far…"*

In addition to the above, these networks are assisted by digital platforms (social media and websites) where the LGB community has more visibility by using pseudonyms. Although one of the major roles of social media has been in networking and giving visibility to LGBs, it is reflected by participants that it is used to facilitate the health-related networks and to educate the community that has access to the internet by providing SRH education tailored to the needs of people with sexualities not confirming to that of heterosexuality in local working language. The following statement by a key informant who is a founder of one of these health advocacy digital networking platforms states the following:

> *"We mainly work by promoting sexual health for the LGB community on different media platforms and we post educational content in local working language about sexual health and we do this work, of course, by hiding our identity. This is because, as a result of the existing societal attitude and the law that criminalizes homosexuality, we cannot provide this service openly and this is why social media platforms are essential. So one of the works that we do is linking health professionals that are willing*

> *to help LGBs needing SRH care; we also provide condoms, lubricants for safe sex materials to the community, even though the demand and the supply we have do not match in any way. We do this work in a secure way by using different technologies (which are highly confidential) to identify those that are trying to infiltrate into our network so that they do not cause harm to our community as well as friendly health care providers."*

A key informant also discussed how accessing SRH in the conventional route could expose the LGB community to arrest, harassment and stigma further emphasizing the necessity of seeking SRH care only from trusted sources through the network of the LGB community. The key informant living in an asylum outside of Ethiopia and advocating for the rights of Ethiopian LGBTQs pointed out the following concerning the above:

> *"...So we started working on creating our network with health professions that are willing to be an ally, people who are open-minded to take in clients whenever we need SRH care for them. These are doctors in government hospitals and any other clinic that are willing to help. So when we get a message from someone on social media asking for help, before we refer this person we do a background check. So we will register the names of those seeking care and we make sure they are whom they say they are by using our networks. This is to keep ourselves secure and most importantly the health professionals that are taking a risk to help us. So in this manner, we work on safe sex education and provision of condoms and water-based lubricates, which are almost impossible to get in Ethiopia. We also work on educating the community on how to make their own lubricants from things that they can access more easily."*

Although few LGB participants described that they use this chain of trust or transmitted trust in seeking any kind of SRH care, some participants were not aware of this network. However they pursued other alternatives than mainstream health care facilities.

A 32-year-old gay sex worker mentioned the alternative he used when he was denied care by a health provider at a mainstream health care facility as follows:

> *"Since I was denied care at a mainstream hospital, I knew I had no choice but to go to a traditional healer, I paid 1400 birr to the person who treated me. He did not ask any questions as he worked in hiding as well. He said we caught it on time (the hemorrhoid) and put some kinds of roots on the affected area and gave me an ointment to apply…. and during the following four days, I can say I almost died and came back to life, but the problem was resolved."*

And those who believed they were at risk of catching HIV used an alternative method of getting regular and free HIV testing without fear of being asked any personal questions like being asked to bring their partners.

A 32-year-old gay participant discussed alternatives to non- discriminatory SRH care particularly related to accessing laboratory tests.

> *"I check my HIV status every three months and to do that, I go donate blood at a blood bank. You see that way I help by giving blood and I get discrimination-free HIV, Hepatitis, and STI test, so I go and pick up my result a week after I have donated my blood. You see I know I need to check my status regularly as a young person but in doing so, rather than facing the problem of going to health facilities, I have made it a lifestyle to donate my blood and get tested at the same time. They even call to remind me to donate every three months and I find it to be a better alternative and many of my friends use this alternative"*

4.5.2. USING CEREMONIES AS A PLATFORM TO CONDUCT SRH EDUCATION

The use of substances that are harmful to health such as Khat[5], shisha[6], and cigarettes aided by coffee ceremonies are reflected as one of the ways of getting together among LGBs. Although this is not uniform among every LGB, most participants indicated that these gatherings are common in their community. Some participants mentioned this as an addiction they want to overcome and it was also indicated that these gatherings play a role in increasing the risks of being exposed.

A key informant who is working on health advocacy discussed how these ceremonial gatherings among LGBs could expose their identity with the following statement:

> *"LGBs use shisha and chat chewing ceremonies for getting together and this plays a huge role in affecting their lives in so many negative ways. These platforms leverage the law enforcement bodies for arbitrarily arresting LGBs if they are informed by someone in the community. If LGBs are arrested with their sexual oreientation exposed, they will not demand their rights as they already feel like a criminal as a result of their sexuality…"*

On the contrary, these gatherings, which are considered as high-risk behaviors also serve as a means to get together, network, and discuss certain issues relating to their challenges and keepup with the harsh realities of their lives by using the mentioned drugs. In addition to the alternatives of mainstream SRH services mentioned in the previous subsection, these ceremonial events have been mentioned to serve as a platform for providing an alternative means of SRH education delivery.

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[5] A plant grown commonly in the Horn of Africa where leaves containing a drug called alkaloid Cathinone are chewed to cause stimulating effect

[6] Shisa also known as hookah is an instrument used to smoke vaporized flavored tobacco.

A key who is a co-founder of an LGBTQ rights digital advocacy platform discussed how these ceremonial gatherings are used to provide alternative SRH education:

> *So coffee, Khat and Shisah ceremonies play a big role in bringing together the members of the LGB to have an informal discussion and safe sex education. So what we do is cover the expenses of the coffee ceremony (which could be taking place at one person's house) and we ask them if they can give us one hour and we use that time to create awareness. So we use projectors to teach about sexual health and safe sex. So a few of them would approach us later and tell us about the similarities of the symptoms they have to what we just taught them. So then when the demand for SRH care increased we started approaching friendly doctors we can trust and we link these patients with these physicians so they can access the SRH treatment they require in a safe space."*

A 23-year-old married bisexual discussed how he gets informed from other gay and bisexual males like him by discussing at gatherings amongst each other about sexual health-related issues.

> *" As a community, we discuss amongst each other on our illnesses when we get together, and there are those who are more aware of things, so we learn from one another. We consult amongst one another what has worked for whom and based on that we try to find solutions because going to a health center will not get any solutions to people like us because there is no way we can openly tell our problems, and you know the saying one who didn't tell his problem will not get a solution"*

On the other hand, lesbians mentioned that discussions about health issues with one another are not common. A 32-yeas-old divorced lesbian discusses the following :

> *" I want to ask my friends who are lesbians about some concerns I have regarding my sexuality because I feel like they can understand my problem better and maybe they have a similar experience. But in our community this is not common, the girls just want to meet to forget their problems and we don't have this culture of talking about serious issues, no one talks of their other lives, we get together to have a good time to chew khat and smoke shihah or have drinks so I have no means of getting information relating to SRH…"*

A 33-years-old lesbian further discusses how lesbians do not talk about their health issues or do not really have alternatives to SRH services concerning safe sex education. She believes this is because they do not have SRH risks as much as gays and heterosexuals:

> *"Besides the times I am in a serious relationship, I do not ever reveal my identity or talk about my sexual orientation to other lesbians, it is a taboo to talk about sexual issues, plus I do not think we have SRH health issues*

> *to talk about because as lesbians we have no risks to illnesses or pregnancy and that is why we do not talk about SRH issues, they are not our issue."*

A health care provider also discussed that among LGBs, there are only a few women that are in the network indicating that they are invisible even within the LGB community. This clinical nurse who works with the LGB SRH care network believes that because lesbians are not well informed about SRH health risks they have, they may be even more vulnerable:

> *"Within the LGB community's underground SRH network, there is a much smaller demand from lesbian and bisexual women. And this is because the population size of lesbian and female bisexuals is very small. They do not come to us as much as gays and bisexual males do. And those lesbians who come to us and are more open about their sexuality and are those who are more educated, have good socio-economic status, and can support themselves. But women who are not economically strong, and women that are not educated live hiding, they don't have options and alternatives like the males."*

A key informant who is a founder of the LGB health advocacy platform discussed that the work that they do to network LGBs and physicians in creating an alternative platform for the community to get safe SRH services is not proportional to the high demand of the community. However, it is still necessary to reach as many LGBs members as possible even using ceremonies of risk behavior as a platform.

> *"The coping mechanism among LGBs is platforms like ours and we try to be as accessible as possible to the community and if they know about us they will come to us or talk to their friends to get treated but if they don't have this outlet they will die with their illness honestly. There were times where people contacted us after trying several other alternatives like traditional healers to deal with their illnesses related to their sexuality and by that time they come to us or we go to them and it is already too late to save their lives. So that is why we must reach out and provide safe sex education and safe sex materials, we have to create and utilize all alternatives"*

In addition to these, a clinical nurse who works in the facilitation of alternative networks stated the following about how ceremonial gatherings are essential not only to directly teach the community but to communicate awareness on the existence of the alternative SRH care networks through peer groups.

> *"We use the internet and social media to educate the middle class who can have internet access and we try to reach the lower class that does not have*

> *this means through peer educators in areas we consider as hotspots, we select peer educators in different locations and when these people believe there is an LGB person with SRH need they get them in touch with us. And usually, the peers access LGBs who are in need through different gatherings like that of coffee and Khat ceremonies."*

As a result, the participants reflected on how they utilize risky ceremonial platforms to better equip and benefit the community in responding to the highly demanded SRH services, mainly safe sex education. However, the access to this alternative education are also more accessible to some members of the LGB community than others. The intersectionality of class (based on education and economic status) and gender affectes the accessibility of these alternatives where females, the economically weak and less educated are found further marginalized within an already marginalized group.

4.6. COVID-19 sheds light on the existing systematic marginalization of LGBs

This theme was an emerging topic born out of the current global and national health circumstances. It was deemed essential to discuss the risks and effects of the COVID-19 pandemic among sexual minorities living in Addis Ababa. This theme is further subdivided into two subthemes to better inform the reader about the perception of risks, the existing and anticipated effects among the community arising as a result of the COVID-19 pandemic with the following sub-themes: *LGBs feel more vulnerable to being affected by COVID- 19* and *COVID-19 increases inaccessibility of SRH care*

4.6.1. LGBs FEEL MORE VULNERABLE TO BEING AFFECTED BY COVID- 19

It was indicated that as of March 2019 where the government of Ethiopia declared the first person to test positive for COVID-19, things started changing to the worst for many of the LGBs as it did for the rest of the community. However, LGBs and key informants pointed out that LGBs faced more challenges as their lives are shaped and influenced by their already stigmatized sexual identity.

The majority of the LGBs reflected that their sexual identity has led them to live a life of worry and stress further leading them to develop health risk behaviors such as the consumption of harmful substances such as shisha, cigarettes, and Khat among others. Although these health risk behaviors have served as a means to get together and a

platform for getting safe sex education and peer consultation, they are indicated to be harmful to the respiratory system leaving those that consume them more vulnerable to catch COVID- 19. Hence LGBs reflected that they perceive consuming these substances makes them more vulnerable to catching the COVID -19 virus as opposed to the rest of the population that does not. Although many that are not LGBs may also consume these substances, the participants indicated that LGBs' lifestyle is highly intertwined with the use of these substances as a form of getting together and as a coping mechanism to reduce stress related to their stigmatized sexual identity.

A 32-year-old lesbian discussed how her substance abuse has affected her as follows:

> *"Once I got into this life, my partner who was also my employer at the time introduced me to all the drugs I consume today, and I got addicted. So whenever I make some money I ran to shisha and Khat parlors because that is how I forget my problems by getting together with other lesbians and it has become part of my life. That has affected my health and I know I am harming my self, and during this pandemic, I feel like I am more vulnerable to getting Covid as I hear its a respiratory illness that could harm those with unhealthy lifestyles like mine"*

A 23 years old bisexual sex worker discussed how the use of substances led to his friend losing his life to HIV and that he fears this is a risk to all that are in this life particularly now there is a pandemic:

> "*As a bisexual sex worker, there is a risk for HIV and STIs. Also, it is common to consume different substances like khat, cigarettes, alcohol, and shisha and all this puts us to be more vulnerable to get COVID. You see my friend went out with men for money to pay for his addictions and that became a cycle and he was not using protection most of the time and after he passed away from these complications I got scared for my life, and now I am scared because of this pandemic as it affects those who may have pre-existing conditions like those related to our lifestyle…"*

In addition to the direct vulnerability mentioned above the majority of LGBs and key informants indicated that there is a trend among these members of the community in having multiple challenges that have led them to lead a more vulnerable lifestyle. This mainly relates to economic challenges preventing them from leading a healthy lifestyle. There is a high rate of dropping out from school among LGBs leading to dependence on livelihoods requiring minimum skills including hosting jobs at bars and restaurants, sex work, and the like. As these jobs require maximum interaction with people, such

positions were the ones that were mostly affected by the pandemic leading to the loss of jobs among this population working in these kinds of workforces.

Among the LGB participants, at least one from each sexual orientation were engaged in sex work as a means of income before the pandemic. The majority of LGBs who are sex workers also indicated that they worked at restaurants or bars part-time and they have lost all means of their income as a result of the pandemic. A 32-year-old gay sex worker discusses the challenges he faced as follows:

> *"I was working as a waiter during the day time and I also work as a sex worker at night. As a result of COVID, I was laid off from my part-time job as a waiter, and of course, I can't work as a sex-worker because it's risky and even if I risked my life there are no more clients comming. I have to pay my rent and buy food but I do not have other skills so it's hard and I feel like with the shortage of food, plus being HIV positive, I feel like I may easily get the virus and if I do, I don't have money to get treatment and I don't even have my family to call as collateral if the health facilities require a deposit… you see, being gay itself gets you to be pushed away by your family, I am lonely and I have no one now. And I fear that if I go to a health facility and they find out I am gay when they do physical exam they might not treat me and I have a high chance of dying."*

A 27-year-old lesbian sex worker also reflected how economic challenge could increase vulnerability of catching the COVID-19 virus as follows:

> *"Life has become even more challenging now because the bars are closed and we do not have customers who pay for sex, so I am in a lot of problems and I am now sharing a room with many other girls because they lost their jobs too and I fear that I have more risk of getting the COVID-19 virus because there is no way we can live while social distancing, we do not have money to pay for the luxury of space"*

The above economic challenges among LGBs during the COVID 19 pandemic have been further attested by a key informant who works as an advocate for the Ethiopian LGBTQ community while living abroad in asylum.

> *"The pandemic has impacted the economy. And this has hit the LGB community because a lot of LGBs are out of work and our organization has been raising money and sending to Ethiopia so that people could eat. There are so many young kids that have been pushed out by their family because of their identity and now they have lost their jobs. So most LGBs have no income, no money for rent or food…and this has impacted the LGB community physically, emotionally and mentally."*

The challenges faced by the LGB community as a result of the COVIID-19 pandemic is multidimensional. This is reflected by the different challenges the LGB participants had shared. however, the fact that these populations live marginalized by the community and in hiding to escape prosecution has made different public institutions inaccessible directly or indirectly. This was pointed out as being a source of disempowerment making the community particularly vulnerable at a time that is difficult for all. This is further articulated by a key informant who has been working in health advocacy and the provision of alternative health care networks to the LGB community.

> *"Currently we are posting information on different social media platforms regarding COVID-19 and how LGBs should take care of themselves during this pandemic considering their vulnerability. Because, First of all, the LGB community is an underpowered community where the majority are high school dropouts and this has led them to have a livelihood that makes them dependent on small service provision jobs mainly working as waiters, bartenders and sexworkers. And with this pandemic, they were one of members of the community that were affected highly. This was because almost all got laid off as a result of workforce minimization by restaurants and bars. And sexworkers don't have clients. And when it comes to underlying health problems, they are the most vulnerable to HIV and AIDS which leaves them at a more a vulnerable spot. Besides this, the lifestyle of LGBs usually involves the usage of cigarettes and shisha, something they do to cope up with life, this also puts them at more risk of being affected by the pandemic."*

4.6.2. COVID-19 INCREASES INACCESSABILITY OF SRH CARE

Participants reflected on how they already feel stigmatized by the community and marginalized from services provided by public facilities as a result of their sexuality. Hence it was discussed that they do not feel they can access public facilities if their identity is exposed. Among these public facilities; health services were mentioned as being mainly inaccessible if their sexual identity is exposed. Concerning this, the majority of the participants mentioned that they are scared of getting COVID- 19 virus because they believe it will increase their risk of getting exposed at health facilities that they already lack trust in. As a result, they lack confidence that they will be provided with the proper care without discrimination by opening up about their sexuality if they acquired COVID 19 virus.

A 33-year-old gay participant mentioned the following about his lack of confidence in getting non-discriminatory treatment from health care facilities if he contracted COVID-19 virus by mentioning the following:

> *"This my personal opinion, but I do not trust our health system as it is, because of my personal experience and the experiences of other LGBs I know. As a result, deriving from the already existing marginalization I am sure that I will be discriminated against if I went to the hospital after contracting COVID, where my sexual orientation is exposed, and this is particularly risky because the community believes that LGBs caused the pandemic by angering God"*

A 32-year-old gay participant also mentioned a similar perspective on how it's hard to trust a discriminatory health system and health providers in country and society that has reflected its negative attitude towards homosexuality.

> *"It was shocking to see the attitude of the community concerning COVID 19, and all the religious leaders have gone out on TV blaming homosexuality as being the main cause of the pandemic, they blame us so imagine what kind of attitude health care providers have, they are members of the community so if we needed to get care for catching an illness we are blamed for causing in the eyes of the public… I personally don't believe we will get proper care if they find out our sexuality when we go to health facilities"*

This societal attitude about sins like homosexuality being the cause for the global pandemic was an issue that was mentioned by the majority of the participants as something that created fear of being exposed by the majority. In addition to this, a key informant who works as an advocate for LGB rights to access health care reflected on how the societal attitude affects the community supporting the above quotations:

> *"The attitude of the society about homosexuality particularly related to the norm and religion is very harsh. You don't have to look far back in history, if you just see what is going on in the media in relation to COVID, you can clearly see the attitude of the community towards LGBs. I have respect for the religious fathers but the whole global pandemic is being blamed on homosexuality. They are saying God is punishing the world because of homosexuality (Sedomawiyan) referring to gay people in particular. And this is not limited to religious fathers of Ethiopia you can hear the same attitude from Uganda, Kenya, Ghana, and the like, they all blame homosexuals for upsetting God. But the situation in Ethiopia is worse because there is no space for LGBs to even access health care. After all, the government does not give any space for civil societies and NGOs as compared to other African countries to fight for the human rights of sexual minorities."*

On the other hand, a 27-year-old lesbian mentioned that the health care providers and the health system might discriminate against homosexual men in relation to COVID 19 as copared to women because the community gives emphasis to gays causing the pandemic. She mentioned that she feels that she could access care as anyone else unless she revealed her sexuality herself by stating the following:

> "*I know there is a lot of discussion about COVID 19 being an abomination from GOD to all the sins of humans emphasizing on homosexuality as the main cause. But you see our community never really paid attention to lesbians, it is the same-sex sexuality among men that they find unacceptable, so I never really felt it has anything to do with me… and if I went to a health center for getting infected with COVID I don't think I will be discriminated against because there is no way they will know my sexual orientation … that is unless I was crazy enough to tell them myself."*

The attitude of society towards what is outrageous and given more emphasis seems to be dependent on the gender of the person in question. As the previous lesbian participants mentioned, during the outbreak of the COVID 19, responsibility was put on male homosexuals and not on females with same sex relation. And this reflects access to health care during this time was viewed differently among males and females in the LGB communiy.

An SRH specialist and gynecologist discussed that after the outbreak of the COVID 19 pandemic followed by quarantine there were arising issues that reflected the attitude of the society with regards to sexuality, sexual violence and gender differences.

> *"Now with COVID, we hear on the media about the outrage of the public about the increase of children being raped as they quarantine, and you can see that the public is more concerned about boys being raped and also that how it is normalized by the public that girls are raped than boys. This is also now linked to the narrative of society that homosexuality brought about the COVID pandemic and the rape of males has been attached to that. And the intensity of outrage is not the same when women are being raped every single day. Rape is unacceptable period right, but in a patriarchal community, it tends to favor men because it links it to homosexuality … and this narrative that links homosexuality to rape and blames the LGBs for causing COVID, I think, could make them feel more marginalized and may fear coming to public facilities, such as health facilities, where they may feel that they run the risk of being exposed.*

A queer key informant who works as an advocate for the Ethiopian LGBTQ rights while in asylum abroad discussed the following on how the pandemic has shed a light on the

already existing marginalization of the LGB community living in Addis Ababa particularly in accessing SRH.

> *"You know LGBs are already marginalized, the impact of COVID-19 is on all humans, but the punch and how it hits is different among different people. As a result, COVID-19 is putting light on the already existing marginalization and pre-existing discrimination, for us not to get health service is not a new thing but when there is a national panic then there is a higher chance for us not to get any services, and the psychological impact it has on us is also very huge because it is reminding us that if I get caught then that would be the end of me because my body is rejected in the system that is expected to treat me"*

LGBs living in Addis Ababa reflected that COVID- 19 has affected them economically, where all that did not have professional jobs have lost their source of income. They have also lost their social support platforms and gatherings as social distancing has been recommended during the pandamic. They indicated that they feel more vulnerable to being discriminated against at health facilities because of false social narratives claiming that their sexuality caused the pandemic as God's wrath to humanity. As a result they perceive this narrative may lead them to be mistreated more or not get treatment incase they catch the COVID-19 virus and need health care particularly if their sexual orientation is exposed. In addition, most LGBs reflected that they perceive their lifestyle and preexisting health conditions such as having an HIV positive status leaves them at more risk of catching the virus leading to severe illness and even death.

CHAPTER FIVE

Discussion

Summary of findings

In this exploratory qualitative research, we found that the term LGBs, referring to a coalition of minority sexual identities, tries to bring together differentiated populations having different perceptions about SRH needs as well as access to SRH services. This difference in perception, as well as actual need and access, occurs along the lines of sexual roles as well as gender. LGB participants had a similar perception that access to SRH services in a heteronormative city like Addis Ababa depended on the attitude of the health care providers when and if their same-sex sexual identity is exposed. Health care providers are perceived as a gatekeeper to access SRH service in a heteronormative health facility having desecration to treat or deny treatment with a common presupposition of the existence of mistreatment in between the two extremes.

As an alternative when unable to access SRH services, LGBs consulted each other, self-treated, and went to traditional healers. However, to respond to their SRH needs without the risk of their sexual identity causing them to be mistreated or untreated, LGBs have come together forming an underground network that brings together friendly health care providers that are trusted with LGBs needing SRH care while having symptoms that could reveal their sexuality. This network is facilitated by using digital social network platforms as well as peer educators that do this work in person for those who might not have access to these online platforms.

Among the health needs of LGBs, tailor-made SRH education materials are in demand to respond to the peculiar health need and risk questions, which the already existing hetronormative SRH materials do not address. As a result, some members of the community have organized themselves to craft these materials in the local language and use these them to provide safe sex education wherever they can find this community gathered. Khat and Shiha aided by coffee ceremonies are common platforms in bringing together similar members of LGBs. Although many may consider them as health risks these ceremonial platforms are being used to save lives by aiding in the creation of a space to learn and discuss safe sex for non-heterosexuals.

The marginalization of LGBs in the community relating to already existing socially constructed narratives about homosexuality has surfaced recently where homosexuality was blamed for causing COVID- 19 pandemic as a wrath of God to humanity. Although this was reflected as being a sign of official recognition of the existence of the LGBs which the community felt to be denied of for so long, the recognition was however just a louder echo of pre-existing narratives that homosexuality is un-Ethiopian. This further intensified the marginalization of these groups by increasing the already existing fear of accessing SRH services so as not to expose their sexual identity.

Discussions

In this research, we uncovered that the term LGBs, referring to a coalition of minority sexual identities, tries to bring together differentiated populations having different perceptions about access to SRH services. This study understands that while labelings such as LGB, plays a role in the united resistance of sexual minorities against discrimination globally, it has also blurred the existing differences among the members of this group (National Acadamies of Sciences, 2011). We found that this was particularly true, as this group of people living in Addis Ababa do not share much more than the label that keeps them criminalized and marginalized from health services. Other studies done on the health needs of the LGB community had also indicated that, although LGBs are put as one category, there were differences in the lived experiences among the group influencing their health-seeking behavior (Getnet & Woldekidan, 2019). This was further confirmed by the result of our research where the perception and actual need as well as access to health among this group were divided along the lines of sexual roles and gender differences. As a result, we came to understand that sexuality and access to SRH care among the LGB population living in Addis Ababa requires unpacking of the already existing label in addressing the peculiar sexual health questions of the individuals in accessing SRH care.

It was evidenced that homophopic narrative born out of heteronormative society plays a huge role in suppressing healthy sexual development among LGBs and facilitating the increment of health risk behavior in a country where there are no recognizable SRH care services available for this community.

This is because the description and development of sexual identity among LGBs in Addis Ababa occur in a heteronormative platform where non-heterosexual identity is viewed as something that will lead to the destruction of a functional society that has its foundation upon a patriarchal system where sexuality is directly linked to procreation (Stein, 1989). This system of linking sexuality with societal functionality is not peculiar to Ethiopia but a dominant ideology, which still has a stronghold in the majority of nations as a principle around the globe (Warner, 1999). Claims of same-sex relations being denounced as "un-Ethiopian" are also something that was shared by many African countries, which has led to the reflection of a common narrative condemning homosexuality as being “un-African” (Balcha, 2009) and (Epprecht M. , 2008).

As a result, the study has found that because of heteronormative and homophobic narratives, LGBs struggle in accepting their sexual identity that is contrary to its socially normalized opposite, heterosexuality. In response to this, sexual identity development was found dissected into two among LGBs. This segmentation among the group is based on those who have self-actualized their same-sex sexual identity before first sexual experience and those that claim developing same-sex/ fluid sexual behavior after the first same-sex encounter (Rosario, Schrimshaw, Hunter, & Braun, 2006). Those having actualized same-sex sexual identity from a young age before first sexual encounter reflected stable and static sexual behavior same as their dichotomous opposite, heterosexuality (Baker, 2014). On the contrary, those who developed non-heterosexual identity after first same-sex sexual experience reflected more fluidity as they wished to revert their sexuality. With this regard, even though this sexual identity segmentation was not reflected, other studies done in Ethiopia have reflected that the majority of this population, Men having Sex with Men (MSM) in particular were unhappy about their sexuality and wish to denounce it as a result of the heteronormative societal pressure (Getnet, 2011).

As a result, it was found that these dissections in sexual identity development are shaped by the struggle for self-labeling of sexual identity and sexual development in a heteronormative society. It was also reflected by other studies that LGBs exhibited a desire for a reversal of homosexual sexual identity because of socital pressure. The theory of minority stress indicates that heteronormative social pressure leads LGBs to want to

reverse to heterosexuality so as to feel normal further leading to multiplicity of health risks. These include mental health problems related to depression, substance abuse as well as having short-lived relations and having multiple sexual partners with more risk of contracting STIs (Branstrom, 2017).

Short-lived relations were a commonality among all LGBs as they view long-lasting relationships as a risk factor for getting exposed and serving no purpose, as they do not have a future as that of heterosexual relationships that are tied in marriage and family. This study identified that short-lived relationships among LGBs are reasons for the increase in the number of sexual partners leading to risky sexual behavior.

The risk behaviors among LGBs when living in a heteronormative society that was also common to all LGBs was living a double life where they are themselves behind closed doors and hiding their identity when socializing with the rest of the community. This behavior of the population was also reflected by previous studies conducted among MSM living in Addis Ababa and a study done among Ethiopian lesbians. Both studies indicated that the population are living by hiding in plain sight (Hagos & Hailemariam, 2009) and (Betelhem, 2010).

Members of the LGB community were pushed to enter into marriage with the opposite sex to seem normal and continue to live their other life in hiding. This increases the risk of the transmission of STIs including HIV among the group as well as the public at large as the anticipated clear lines between heterosexuals and other sexualities become blurred. However, this is not to indicate that the LGB community is a population that is transgressing into the heterosexual community with risk behavior, but rather as any member of the community that is experiencing high-risk sexual behavior and marginalized from accessing the necessary SRH services.

Description of sexual behavior among LGBs is also highly reliant on roles during intercourse/ sexual roles. And this is because, in a community that lives having the highest regard for concealment of their sexual orientation, sexual roles play a major role in revealing non- heterosexual sexual orientation when seeking care. Among males, those having receptive roles during anal intercourse referring to themselves as ***Wochi*** and ***Verse***, were found to have increased demand for specialized SRH services but decreased perception in the ability to access SRH care. These members of the community reflect

their high demand for safe sex materials like lubricants and condoms to decrease their sexual health risks such as vulnerability to STIs including HIV; contracting anal fishers; infections; and hemorrhoids that could further reveal their sexuality if they needed SRH care. The above-confirmed similar studies done on 'MSM and their health risks in Addis Ababa' that stipulates the high HIV risk of males having receptive roles during anal intercourse (Hagos & Hailemariam, 2009).

On the contrary, the majority of males having exclusive insertive role, referring to themselves as ***Awchi,*** in anal intercourse did not believe they had similar special needs, risks, or barriers to access SRH care. However, they did emphasize the barrier in accessing safe sex materials like condoms and lubricants further expressing their wish to access SRH care by revealing their identity to get the best treatment even though they did not necessarily need to.

These sexual role-based distinctions among males, as a result, were found to have a direct correlation with the actual and perceived access to SRH based on whether or not their sexual identity would be revealed. This could be because males who do not have receptive roles have lesser risks and symptoms that could expose their sexuality when seeking SRH care. Similar studies done in other developing countries indicated that sexual roles and pattern differentiation among non- heterosexual men is an indication that the socially constructed terminology MSM does not fully address the individual differences among the population. It is suggested that in male sexual relations where sexual dominance is maintained via penetrative role, further parallels with the dominance reflected in heterosexual intercourse where women are submissive and men are dominant (Clark, et al., 2013). Hence the social structure of a patriarchal heteronormative system tends to influence sexual relations and further the systematic disempowerment of the submissive regardless of gender but the simulation thereof.

This is also true as lesbian participants indicated that there is a simulation of a heterosexual power relation among their relationship where the class difference in educational level and financial power reflects power play in their relations. These dominant and submissive roles in lesbian sexual relations were also reflected by lesbian participants concerning the feminine/ masculine gender roles they have been socialized to

since a young age (Kirkpatrick, 1980). However, the majority of lesbians perceived that they did not have SRH care/ service needs or risks because they only related sexual health risks to heterosexual relations. This perception was found to emanate from low awareness of SRH in relation to their sexuality where they were not sure if they could contract STIs from having sex with women and even if they could, they had no awareness on how to protect themselves.

This reflected the huge awareness gap between male and female sexual minorities. Lesbians as a result could be more likely to be affected by STIs as they do not use any safe sex materials. Similar studies also indicated that lesbians were unaware of the fact that STIs could be transmitted in sexual relationships among women, where in fact there is a high rate of STI infection transmission (Power, McNair, & Carr, 2009). Also, there is not much knowledge among lesbians on the existence and need for various safe sex materials such as differentiated latex technologies such as dental dams, gloves and condoms in addition to PrEP and PEP are not (Moore, 1997). Nonetheless, the study also found that there is a curiosity among lesbians to know more about health risks related to same-sex sexuality, which is not yet addressed.

SRH care however was perceived by all women to be easily accessible, as they do not have to reveal their sexuality if and when they needed care similar to males having exclusively penetrative anal sex roles. This was a clear indication that there is a hierarchy among these LGB members where access to SRH care services in a health facility of a heteronormative society is dependent on proving heterosexuality or not exhibiting homosexual identity.

LGBs that perceived they can't access SRH care as their sexual roles may expose them when seeking care, viewed health care providers as gatekeepers whose attitude about homosexuality matters for them to end-up getting treated, mistreated, or even being denied treatment in its totality. Similar studies conducted in African countries indicate discriminatory and judgmental attitudes were one of the main reasons for the LGB community not accessing SRH care (Muller, Spencer, Meer, & Daskilewicz, 2018).

This perception of being discriminated against at health facilities was also confirmed as a possibility by most health care provider participants reflecting the health system does not

recognize LGBs. As the Health Policy, National SRH strategy, and other guidelines of Ethiopia are only addressing heterosexual needs, and health education materials are tailored for heterosexuals, LGBs' sexuality and their access to SRH is unrecognized. These claims indicate that health facilities are not ready to treat LGBs and are systemically heteronormative further marginalizing LGBs.

This exclusively heteronormative health scheme mainly owes to the law of the country criminalizing same-sex sexuality. It was indicated that the National SRH Strategy as well as other guidelines are drafted and administered as per their hierarchy in the legal system where proclamations (including the Criminal Code/ Proclamation no. 414/2004) dictates health strategies to align accordingly. As a result, the health system's readiness to provide care is highly dependent on the decriminalization of LGBs. In a state where same-sex sexual act is criminalized, the Hippocratic Oath[7] of non-discrimination, an oath made by health care providers not to discriminate, obliges them to provide treatment and keep confidentiality of their LGB patients (Rivoli, 2012). Nonetheless, this is difficult to enforce if and where a care provider fails to provide a non-discriminatory care, as criminalized sexual minorities do not have any legal backing in claiming the right to be provided with SRH care.

The other important push factor for the access of SRHR among LGBs are international human rights agreements that Ethiopia is a signatory to. The 1948 UDHR obliges states to respect all human rights without discrimination (United Nations, 1948). Nonetheless, with the debate between universalism of human rights on the one hand by western states and the relativism of culture by non-western countries that did not participate in the drafting of the UDHR, the issue of sexual identity is reflected to be relative to the culture of the state. As a result, such legal instruments are contended as being an imposition by many African states (Sanders, 2006). However, it has been declared by UN treaty bodies that the human rights of sexual minorities will be protected regardless. As a result, we can understand how the narrative of homosexuality can be contextualized from a wider scope where newly decolonized African states retaliate against the neocolonial cultural imposition of western perspective in the name of universality of morality which African

[7] Hippocratic Oath is the oath written by Hippocrates that health professionals use to vow when they enter the medical profession service to treat patients to the best of their capacity and equally without discrimination.

states were not consulted/participated in the drafting thereof. Hence the united stand of majority of African countries against homosexuality has currently more to do with sovereignty than it does with intolerance of homosexuality, particularly if the history of the diversity of African sexualities' is put into context (Abifarni & Chijioke, 2016).

As Ethiopian law criminalizes LGBs, access to SRH care and services including tailored safe sex education, safe sex materials as well as care without discrimination is not guaranteed. The community as a result uses alternatives to mainstream SRH care to have a safer sex life. Alternatives such as self-treatment, consultation with friends about safe materials and medication, traditional healers as well as seeking care from trusted friendly health care providers were found further confirming other studies done in Ethiopia (Getnet & Woldekidan, 2019).

In addition to the above, this study found that the LGB community has been organizing in creating an underground network to respond to the various challenges the community faces. To respond to the SRH access challenges, digital technology particularly social media is used in facilitating SRH care for LGBs provided by friendly health care providers that work in confidence at mainstream health facilities. For those that are unable to access information digitally, there are peer educators disseminated in areas considered hotspot as an outreach to those seeking SRH services and care. As a result, there is an invisible chain of trust created by the LGB community and friendly health providers in trying to tackle SRH inaccessibility. In addition to health care provision, essential SRH services such as safe sex education and safe sex material provisions are facilitated by the group using different gatherings (Khat and Shishah ceremonies in particular) among LGB groups particularly gays and bisexual males. Although it is common among all LGBs to have Shisha and Chat ceremonies, these alternative networks have so far been limited in reaching lesbians. Lesbians have little to no awareness about the risks related to unprotected sex and this underground network has not reached these members of the community except for a few that are deemed to be of a higher class, educated, and financially well off. In addition, discussing sexuality and SRH needs is seen as a taboo among lesbians further leaving them with low awareness and at risk. Lesbians are as a result further marginalized within the LGB community in

accessing SRH Services. This further indicates lesbians are a marginalized group within a marginalized community.

As marginalized members of the community, we found that LGBs are affected emotionally, economically, and physically needing multidimensional support during the COVID- 19 pandemic. Emotional stress broke out among the LGB community with the outbreak of the pandemic. Participants indicated that they feel the community in Ethiopia has been blaming them and their sexuality for causing the pandemic, as was the case in many other conservative nations (Reuters, 2020). The lack of social support, loss of economic means further amplified by already existing health risks related to their lifestyle (sexual risks and substance abuse related health risks) created fear of vulnerability to the coronavirus (OCHR, 2020). This study also found that the risk of catching the virus increased the fear of going to the health system that they already did not feel like they have access to, if their sexual orientation is revealed. The pandemic, as a result, shed a light on LGBs' preexisting marginalization from social establishments including education, professional workforce as well as health facilities. Studies done outside of Ethiopia also reflected that long-lived marginalization of LGBs resurfaced during the pandemic (Chatterjee, Biswas, & Guria, 2020). However lesbians did not feel the marginalization as a result of COVID- 19 affected them as it did gay and male bisexuals. The social narratives during COVID- 19 outbreak mainly blamed gays for angering God reflecting gender hierarchy in the tolerance of the community in relation to homosexuality. The attitude of heterosexuals or a heteronormative community is indicated by various studies that the attitude of tolerance exists towards lesbians as compared to gay homosexuals (Herek, 1988).

Limitation and Strength

Limitation of the Study

- Although a snowball sampling technique is widely accepted for reaching inaccessible population, in this study, the use of this technique could have brought people from similar circles, limiting the diversity of information.
- Accessing more health professionals and key informants was difficult, as most candidates that were approached were not willing to participate, limiting the diversity of provider opinion on the topic.

Strength of the study

- Though COVID-19 made data collection difficult, it gave the researcher access to further assess the vulnerability and challenges of the population at a time that was difficult for these marginalized populations.
- Person triangulation (involving LGBs, Key Informants, and Health Professionals) increased the trustworthiness of the study.
- Exploring a sensitive topic from a gender perspective by further building on multidisciplinary concepts from legal and public health disciplines assessed the topic's intersectionallity.

Conclusion

The findings of this research imply that the term LGB is merely a label that is attached to differentiated sexual minorities living in Addis Ababa sharing criminalization and marginalization as a commonality from the community and public services if and when sexual identity is exposed.

Access to Sexual and Reproductive Health care and services among LGBs is dependent on seeming heterosexual at mainstream health facilities. LGBs perceiving SRH care as inaccessible if their same-sex sexual orientation is exposed, led them to avoid seeking care at health facilities or be pressured to pretend to seem heterosexual.

This study suggests that sexual roles and gender differences among the LGB community further determines perceived and actual access to SRH care and services. These components relate to sexual role that may lead to symptoms exposing same sex relation during physical examination.

Male bisexuals and gays with exclusively 'insertive' sexual roles, as well as lesbians, as a result of their gender, had an advantage of having less fear of being exposed if and when accessing SRH services. This was because their sexual roles and gender respectively did not lead them to have symptoms that are contradictory to what is expected at a heteronormative health facility during a physical examination. On the contrary 'receptive' role among males may lead to symptoms, which are easy to identify during physical examination and that are contradictory to the heteronormative roles. This further makes perceived and actual access among these groups dependent on the desecration of health care providers to treat, mistreat or deny treatment.

The fear of seeking care if exposed emanates from the law that criminalizes homosexuality aside from discriminatory societal attitudes. The criminalization of the act influenced health policies and strategies from encompassing the needs of LGBs.

This non- inclusiveness of LGBs' health needs in health policy documents puts them at high risk of contracting STIs including HIV and AIDS. This is mainly because they are marginalized from necessary tailor-made safe sex information and protective materials. This study showed the further marginalization of women in an already marginalized

group as they had no awareness about their SRH needs and risks as compared to other LGB community members.

The lack of tailor-made health education materials, unavailability/inaccessibility of safe-sex materials at pharmacies, inaccessibility of non-discriminatory SRH services at health facilities led the LGB community in creating an underground SRH access network further signifying the high demand of the community to access these services.

The underground network linking friendly health care providers to members of the community seeking SRH care indicates the importance of non-discriminatory attitude of health providers and safety. In addition, the production of tailor-made safe-sex education material by these networks implies the heteronormative health system leaves this community unaddressed regardless to the existence of the need.

The nexus between the socially constructed narratives about homosexuality being un-Ethiopian, and heteronormative attitudes affecting access to SRH was highly intensified during the COVID-19 pandemic. This further indicated the fear of resurfacing of preexisting marginalization of the community.

Considering the important role addressing SRH needs of LGBs play in the wellbeing of the LGBs as well as the community at large, policy makers must give emphasis to accommodate the rights of LGBs to access non- discriminatory SRH care and services.

Recommendations

For policy makers

- Decriminalization of consensual same sex act to decrease fear and stigma of LGBs when seeking SRH care and services.
- The Federal Ministry of Health should consider the SRH needs of LGBs as key population.

The health system

- Incorporate the special SRH needs of LGBs into the basic SRH training of health care providers.
- Avail training for health care providers to treat all sexual minorities without discrimination.

Future research recommendations:

- Future study on sexuality and access to SRH services among LGBs should consider incorporating the perspectives of self-proclaimed female bisexual participants.
- In relation to narratives regarding homosexuality in Ethiopia, in-depth historicization and adding the perspective of key informants that are promoters of anti-same-sex narratives will enrich the knowledge on this topic.
- Future research could benefit from a selection of a different study area outside of Addis Ababa. This will not only enrich already existing knowledge that is limited to Addis Ababa but also add new dimensions of knowledge to the topic.

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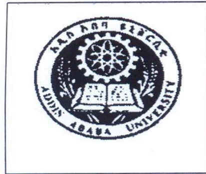
Appendices

1. Ethical Clearance



ADDIS ABABA UNIVERSITY
College of Health Sciences
School of Public Health
Ethical Clearance Form

Version June 24, 2020

Date: /06/08/2020/
Ref. No. SPH/ /2012

Project number /001/

Date of approval (D/M/Y) /24/07/2020/	
Project Title: Sexuality and access to reproductive health care among gay, lesbians and bisexuals in Addis Ababa	
Name of PI: Hannamariam Seyoum	Phone Number: ________
Institution	AAU – College of Development Studies
Department	Center for Gender Studies
Decision of Research and Ethics Committee:	☑ Approved ☐ Approved with Recommendation ☐ Resubmission ☐ Disapproved
Valid until	June 23, 2021

Dean, School of Public Health

Signature: ________

Date: /06/08/2020/

2. Interview guides- English

2.1. IN-DEPTH INTERVIEW GUIDE- LGBs

Title of the study: **Sexuality and Access to Reproductive Health Care Among Lesbian, Gay and Bisexuals in Addis Ababa**

1. Can you tell me a little bit about yourself?
    - Education
    - Work/ occupation
    - Family background/ conditions
2. So you are currently a resident in Addis Ababa, can you please describe how it is living here as an LGB person?
    - Socialization with other people
    - Do you disclose your sexuality/Are you open about your sexuality?
3. Is it ok if you share with me about your current relationship status? Are you currently in a romantic/ sexual relationship?

    3.1. If **yes**,
    - How do you describe your relationship?
        - Marital, cohabitation, serious and will grow to marriage, open relation (multiple sexual partnership) or exclusive relationship?
        - How long have you been in this relation?
        - Can you tell me a little bit about roles in a relationship (sexual, domestic)

    3.2. If **no**,
    - Can you tell me about your past relationship/s?
        - Were you married, living together, engaged, open relationship?
        - How long did this/ these relationship/s last?
        - Can you tell me a little bit about what your relationship dynamics were like and your roles if any (sexual, domestic)
4. What do you think are the sexual and RH health needs of LGBs? (t*o be asked according to the person's orientation*)
    - Counseling services of SRHS
    - Safe sex (provision of condoms, lubricants and other)
    - Contraceptives (bisexuals and Lesbians)
    - Treatment of anal, oral, vulva ulcers
    - Testing and treatment of sexually transmitted infections
    - Counseling for HIV, HIV prophylaxis, HIV treatment and treatment for opportunistic infections
5. Have you ever sought help from health facilities for sexual and reproductive health services?

    5.1. If **yes**
    - Can you tell me about what kind of service you were seeking?
    - How easy was it to get the services? Why do you think this was?
    - Where did you go for care (public/private/informal)
    - Can you describe our experiences?
    - Did you identify yourself as an LGB when you sought the services?
        - Can you describe the reaction of the health workers?
        - What was your expectation?
        - In your opinion, were the health worker/s treating you as per your expectation/ with respect and care?

- Can you mention any challenges you encountered?
- How did you cope with this challenge?

5.2. If **no**,

- Can you tell me the reason why you never went to seek SRH care?
  - You never needed it?/ you were scared?/ you had other ways to acquire health services you need?
- Can you tell me where you would go if you ever needed SRH care? Why?
- Can you tell me a story of an LGB person you know who went to a health facility to seek care?
  - What was their experience?

6. What do you think are the major challenges faced by an LGB person when seeking sexual and reproductive health care?

7. At times when LGBs fail to get the SRH services they require, what alternatives do you think they have to get SRH care and treatment?
   - Can you tell me a story that is important to mention?
8. Now we are coming to the end of our conversation, is there anything that you wish to mention that has not been covered by our discussion so far, any idea you would like to share with regard to SRH.

2.2. IN-DEPTH INTERVIEW GUIDE (HEALTH CARE PROVIDERS/ COORDINATORS)

Title of the study: **Sexuality and Access to Reproductive Health Care Among Lesbian, Gay and Bisexuals in Addis Ababa- perception, experience and suggestion**

1. Can you tell me about your self, your educational background and your professional experience?
   - What is your role in this organization?
   - How long have you served in your current position?
2. Did you get a special training on sexual and reproductive health?
   - Basic/ on job training?
   - Can you tell me the scope of SRH?
3. Who are the main recipients of SRH service in this organization?
   - What kind of care do most of these clients come seeking?
4. Where there times an LGB (homosexual/ bisexual) person came to you seeking SRH services?

   4.1. Yes
   - How commonly do you receive LGB patients?
     - Can you tell me who comes seeking SRH care more among LGBs?
   - Can we discuss about what your communication is like with these patients?
     - Did they openly discuss their sexual orientation?
     - Did they openly discuss about their health needs, challenges and concerns?
     - Did they tell you why they chose to come to this health facility
   - Can we talk about what you did for the patient?
     - Treat him/ her immediately
     - Did you consult with a senior colleague before providing treatment?

- Did you council the patient after the treatment based on his health condition?

2.2. No,

- How can you be sure that you have never been approached by an LGB patient?
- Did any one of your colleagues tell you if he/ she was approached by an LGB person seeking SRH care?
  - **If yes**, can you tell me the story?
- **Use probes from 4.1**
  - **If no**, why do you think could be the reason that LGBs are not coming here?
- Can you discuss with me what you would do if an LGB patient approached you?
- Do you think the health service is ready to provide SRH care for LGBs
  - Why do think this is

5. Do you have an SRH treatment guideline in this health facility?
   - Does this guideline discuss anything about LGB patients?
   - What changes would you suggest for improving the quality of care for LGB patients?
   - What differentiated services do you think should be included if we wanted to provide SRH care to LGBs?
6. So now I am done with my questions, do you have anything more to add? If you feel like there was an important question I failed to ask that is related to our discussion, I am giving you the floor.

2.3. KEY INFORMANT INTERVIEW GUIDE

Title of the study: **Sexuality and Access to Reproductive Health Care Among Lesbian, Gay and Bisexuals in Addis Ababa**

1. Can you tell me about your self?
   - About your professional and educational background?
   - Can you tell me about the work that you are involved with currently?
     - How long have you served in this position? / How long has it been since you have been involved in this work?
     - In the field of work that you are currently involved in/ in the community you are currently working with, how do you describe the kind of influence/ acceptance have?
2. We hear a lot about same sex relation around the world, how do you perceive this?
   - Do you think Ethiopia is any different?
     - Why/ why not
   - How do you see this in relation to what you are currently involved with/ through the lens of your profession?
   - What can you tell me about LGBs living in Ethiopia and particularly in Addis Ababa?
     - Do you have any idea about how large the LGB population is in AA?
     - What is your understanding of how they are perceived by the society?
     - Can you tell me how you came to know about this?
   - As you know different countries have different approaches in accommodating LGBs within the society. How do you think this being done in our context?
     - Can you reflect on what is being done currently? (From your personal/professional understanding)

- ➢ What measures do you think should be taken as a country?
- ➢ What kind of an impact/ influence does the work that you do has in shaping the discussions (narratives) regarding LGBs and same sex sexuality?

3. Can you reflect on the legitimacy of same sex relation in Ethiopia?
   - o Can you reflect on the implementation of this law?
   - o As we know various countries in the world are liberalizing sexual rights, can you reflect on this?
   - o Ethiopia is a signatory to several international human right declarations that promotes the non-discrimination based on sexual orientation, how do you think the country can balance the national laws and international human rights?
     - ➢ Can you tell me the impact of the current law in hampering other rights of LGBs?
     - ➢ Can you tell me what kinds of challenges LGBs may face as a citizen living in this community?
4. Do you think it is possible for LGBs to access basic human rights such as the right to health in Ethiopia, particularly sexual and reproductive health rights?
   - o Do you believe they have a right to health care (SRH)? (Why/why not)?
   - o How should LGB individuals be treated when they seek health care (SRH)?
   - o What special health care (SRH) needs do you think LGBs have?
   - o What challenges do you think they face in receiving SRH care?
   - o How do you think they cope-up with the challenges they may face in relation to accessing SRH care they require?
5. What do you think should be done to avail the necessary health services for LGBs?
6. So now I am done with my questions, do you have anything more to add? If you feel like there was an important question I failed to ask that is related to our discussion?

---

3. Informed consent forms- English

3.1. INFORMED CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY –LGBS

1. Study Information: MA thesis in Gender Studies at the College of Development Studies, Addis Ababa University

Study Title: Sexuality and Access to Reproductive Health Care Among Lesbian, Gay and Bisexuals in Addis Ababa
Participation duration: 60 minutes

Anticipated number of research participants: 9-15

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2. Researchers' contact information

Principal Investigator: Hanamriam Seyoum Alemu
Phone Number: ------
Advisor: Dr. Muluembet Zebenebe
Phone Number: -----

3. Background

We are asking you to take part in a research study. This form explains why we are doing this study and what you will be asked to do if you choose to participate in this study. It also describes the way we (the researchers) would like to use and share the information you provide. In order to decide whether or not you wish to be part of this research study, you should know enough about the risks and benefits of participating to make an informed judgment. Please take the time to read this form. You should ask any questions you have about this form and about this research study. Once you understand the study, you will be asked if you wish to participate.

4. Purpose of the study

The overall objective of this study is to explore sexual and reproductive health care needs and access among Lesbian, Gay and Bisexuals (LGBs) in Addis Ababa. We are doing this research to learn more about how LGBs living in Addis Ababa access Sexual and Reproductive Health (SRH) care, what their SRH needs are, the challenges they may face in accessing SRH services as well as their coping mechanisms. As part of our research, we are conducting in-depth interviews with LGBs living in Addis Ababa, healthcare providers involved in SRH care provision and selected key informants.

5. Confidentiality

If you agree to take part in this study, we will hold an in-depth interview, which will take approximately 60 minutes. In this in-depth interview we will ask about your experience in seeking and attainment SRH care, challenges faced, opportunities and coping mechanisms. With your permission, we will audio record the answers to these questions. The recorded information will not be shared outside of our research team. Your personal identifiers such as name and place of work will not be asked in the interview to assure anonymity. All the information will be kept confidential and recordings will be deleted immediately after being transcribed to further assure anonymity.

6. Voluntary Participation & Withdrawal

Participation in this study is completely voluntary. If you choose to participate in the discussion, you have the right to skip any question that you do not feel comfortable answering, and you may stop answering at any point during the interview. If you decide not to participate in this study, your decision to participate will have no impact on your current or future employment.

7. Risks

The risks of participating in this study are minimal. It is possible that you may feel like some questions are invading your privacy. If you If at any time and for any reason you would prefer not to answer any questions, please feel free to skip a question. If at any time you would like to stop participating, please tell me. We can take a break or stop altogether. There is no any risk if you decide to stop participation in the interview; it will not affect your relationship with the interviewer or the person helped me to contact you. Withdrawal will not affect the care you receive.

8. Benefits

There is no direct benefit to participation in this study; however, the answers you provide may help to inform policymakers and governments about sexual and reproductive health services regarding the LGB community living in Addis Ababa.

9. Compensation

Considering the current COVID 19 outbreak, we will provide you with the necessary personal protective materials such as facemask and alcohol based hand sanitizers. We will also reimburse you for the cost of your travel to the interview site amounting up to but not more than 300 birr. However you will not receive any other benefits for participating in this research project.

10. Questions

You will be offered a copy of this consent form to keep. If you have study-related questions, you can contact me/ the principal investigator (Hanmariam Seyoum) at **----** or my advisor Dr. Muluemebet Zenebe, from the Addis Ababa University, Center for Gender Studies at **-----**.

11. Statement of consent and signatures

I, have read (or someone has read and explained to me) the information in this consent form. I understand why this study is being done, what will be done and the risks and benefits as described in this written summary. I understand that I can skip questions I do not want to answer in the group discussion. I appreciate that my participation is voluntary and that in case I do not participate in, or withdraw from, the study my employment will not be compromised. I understand that I can call the office in charge of research at if you have any questions about the study or about your rights.
I hereunder impress my signature as proof of my consent to participate in this study.
Signature of Participant: ________________________ **Date:**___________________
For Data Collection Team: I have explained the features of this study to the respondent and to the best of my knowledge and conviction she/he has understood its purpose, procedure, benefits and risk issues.
Name of Interviewer:_____________________ **Date and Signature:**______________

3.2. INFORMED CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY-HEALTH CARE PROVIDERS

1. Study Information: MA thesis in Gender Studies at the College of Development Studies, Addis Ababa University

Study Title: Sexuality and Access to Reproductive Health Care Among Lesbian, Gay and Bisexuals in Addis Ababa
Participation duration: 60 minutes

Anticipated number of research participants: 3-5

Sponsor/Supporter: self

2. Researchers' contact information

Principal Investigator: Hanamriam Seyoum Alemu **Phone Number:** -------

Advisor: Dr. Muluembet Zebenebe **Phone Number:** -------

3. Background

We are asking you to take part in a research study. This form explains why we are doing this study and what you will be asked to do if you choose to participate in this study. It also describes the way we (the researchers) would like to use and share information you provide. In order to decide whether or not you wish to be part of this research study, you should know enough about the risks and benefits of participating to make an informed judgment. Please take the time to read this form. You should ask any questions you have about this form and about this research study. Once you understand the study, you will be asked if you wish to participate.

4. Purpose of the study

The overall objective of this study is to explore sexual and reproductive health care needs and access among Lesbian, Gay and Bisexuals (LGBs) in Addis Ababa. We are doing this research to learn more about how LGBs living in Addis Ababa access Sexual and Reproductive Health (SRH) care, what their SRH needs are, the challenges they may face in accessing SRH services and their coping mechanisms. As part of our research, we are conducting in-depth interviews with LGBs living in Addis Ababa, healthcare providers involved in SRH care provision and selected key informants.

5. Confidentiality

If you agree to take part in this study, we will hold an in-depth interview, which will take approximately 60 minutes. In this in-depth interview we will ask about your experience regarding SRH care provision. With your permission, we will audio record the answers to these questions. The recorded information will not be shared outside of our research team. Your personal identifiers such as name and place of work will not be asked in the interview to assure anonymity. All the information will be kept confidential and recordings will be stored in a password protected database.

6. Voluntary Participation & Withdrawal

Participation in this study is completely voluntary. If you choose to participate in the discussion, you have the right to skip any question that you do not feel comfortable answering, and you may stop answering at any point during the interview. If you decide not to participate in this study, your decision to participate will have no impact on your current or future employment.

6. Risks

The risks of participating in this study are minimal. It is possible that some questions maybe sensitive. If you at any time and for any reason would prefer not to answer any questions, please feel free to ask to skip the question. If at any time you would like to stop participating, please tell me. We can take a break or stop altogether.

7. Benefits

There is no direct benefit to participation in this study; however, the answers you provide may help to inform policymakers and governments about sexual and reproductive health services regarding the LGB community living in Addis Ababa.

8. Compensation

Considering the current COVID 19 outbreak, we will provide you with the necessary personal protective materials if face-to-face interview are conducted. However you will not receive any other benefits for participating in this research project.

9. Questions

You will be offered a copy of this consent form to keep. If you have study-related questions, you can contact me/ the principal investigator (Hanmariam Seyoum) at ---- or my advisor Dr. Muluemebet Zenebe, from the Addis Ababa University, Center for Gender Studies at -----.

10. Statement of consent and signatures

I, have read (or someone has read and explained to me) the information in this consent form. I understand why this study is being done, what will be done and the risks and benefits as described in this written summary. I understand that I can skip questions I do not want to answer in the group discussion. I appreciate that my participation is voluntary and that in case I do not participate in, or withdraw from, the study my employment will not be compromised. I understand that I can call the office in charge of research at if you have any questions about the study or about your rights.
I hereunder impress my signature as proof of my consent to participate in this study.

Signature of Participant: ____________________ Date:________________

For Data Collection Team: I have explained the features of this study to the respondent and to the best of my knowledge and conviction she/he has understood its purpose, procedure, benefits and risk issues.
Name of Interviewer:_______________________ Date and Signature:________________

3.3. CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY – KII

1. Study Information: MA thesis in Gender Studies at the College of Development Studies, Addis Ababa University

Study Title: Sexuality and Access to Reproductive Health Care Among Lesbian, Gay and Bisexuals in Addis Ababa
Participation duration: 60 minutes

Anticipated number of research participants: 3-5

Sponsor/Supporter: self

---

2. Researchers' contact information

Principal Investigator: Hanamriam Seyoum Alemu **Phone Number: -------------------**
Advisor: Dr. Muluembet Zebenebe **Phone Number: ------------------**

3. Background

We are asking you to take part in a research study. This form explains why we are doing this study and what you will be asked to do if you choose to participate in this study. It also describes the way we (the researchers) would like to use and share information you provide. In order to decide whether or not you wish to be part of this research study, you should know enough about the risks and benefits of participating to make an informed judgment. Please take the time to read this form. You should ask any questions you have about this form and about this research study. Once you understand the study, you will be asked if you wish to participate.

4. Purpose of the study

The overall objective of this study is to explore sexual and reproductive health care needs and access among Lesbian, Gay and Bisexuals (LGBs) in Addis Ababa. We are doing this research to learn more about how LGBs living in Addis Ababa access Sexual and Reproductive Health (SRH) care, what their SRH needs are, the challenges they may face in accessing SRH services and their coping mechanisms. As part of our research, we are conducting in-depth interviews with LGBs living in Addis Ababa, healthcare providers involved in SRH care provision and selected key informants.

5. Confidentiality

If you agree to take part in this study, we will hold an in-depth interview, which will take approximately 60 minutes. In this in-depth interview we will ask about your knowledge/expertise/ perception regarding LGBs living in Addis Ababa and their access to SRH care particularly in relation to the work that you are involved with. With your permission, we will audio record the answers to these questions. The recorded information will not be shared outside of our research team. Your

personal identifiers such as name and your position at your institution will not be documented in the interview to assure anonymity. All the information will be kept confidential and recordings will be stored in a password protected database until they are transcribed and permanently deleted from database.

6. Voluntary Participation & Withdrawal

Participation in this study is completely voluntary. If you choose to participate in the discussion, you have the right to skip any question that you do not feel comfortable answering, and you may stop answering at any point during the interview. If you decide not to participate in this study, your decision to participate will have no impact on your current or future employment.

6. Risks

The risks of participating in this study are minimal. It is possible that some questions maybe sensitive. If you at any time and for any reason would prefer not to answer any questions, please feel free to ask to skip the question. If at any time you would like to stop participating, please tell me. We can take a break or stop altogether.

7. Benefits

There is no direct benefit to participation in this study; however, the answers you provide may help to inform policymakers and governments about sexual and reproductive health services regarding the LGB community living in Addis Ababa.

8. Compensation

Considering the current COVID 19 outbreak, we will provide you with the necessary personal protective materials if face-to-face interview are conducted. However you will not receive any other benefits for participating in this research project.

9. Questions

You will be offered a copy of this consent form to keep. If you have study-related questions, you can contact me/ the principal investigator (Hanmariam Seyoum) at ---- or my advisor Dr. Muluemebet Zenebe, from the Addis Ababa University, Center for Gender Studies at ---.

10. Statement of consent and signatures

I, have read (or someone has read and explained to me) the information in this consent form. I understand why this study is being done, what will be done and the risks and benefits as described in this written summary. I understand that I can skip questions I do not want to answer in the group discussion. I appreciate that my participation is voluntary and that in case I do not participate in, or withdraw from, the study my employment will not be compromised. I understand that I can call the office in charge of research at if you have any questions about the study or about your rights.
I hereunder impress my signature as proof of my consent to participate in this study.

Signature of Participant: ________________ Date:______________

For Data Collection Team: I have explained the features of this study to the respondent and to the best of my knowledge and conviction she/he has understood its purpose, procedure, benefits and risk issues.

Name of Interviewer:__________________________ Date and Signature:-
____

4. Amharic Interview Guides

ጥልቅ ቃለ-መጠይቅ I

ከኤል. ጂ. ቢ. ግለሰብ ጋር የሚደረግ ጥልቅ-ቃለ መጠይቅ

1. እስቲ ስለእራስዎ ትንሽ ሊነግሩኝ ይችላሉ?

· ስለ ትምህረት ሁኔታዎ

· ስለ ስራ ሁኔታዎ

· ስለ ቤተሰብ ሁኔታዎ

2. በአሁኑ ወቅት የአዲስ አበባ ነዋሪ ነዎት፤ እስቲ እንደ አንድ ኤል.ጂ.ቢ ነዋሪ በዚህ ከተማ ዉስጥ መኖር ምን ይመስላል?

· ማህበራዊ ኑሮ

· ኤል.ጂ.ቢ መሆንዎን በግልፅነት ያሳወቋቸው ሰዎች አሉ?

3. በአሁኑ ጊዜ የፍቅር ጓደኛ/ ግንኙነት አለዎት?

3.1. አዎ ከሆነ፡-

- ግንኙነትዎን እንዴት ይገልፁታል?
- ጋብቻ፤ አብሮ መኖር፤ ለመጋባት በማሰብ ቃል ኪዳን፤ በአንድ የፍቅር ጓደኝነት ያልተወሰነ
- ለምን ያህል ጊዜ በዚህ ግንኙነት ዉስጥ ቆይተዋል?
- በዚህ ግንኙነት ዉስጥ ያላቸሁ ድርሻ ምን እንደሆነ ሊነግሩኝ ይችላሉ?

3.2. የለም፤ በአሁኑ ጊዜ ምንም አይነት የፍቅር ግንኙነት የለኝም ከሆነ፡-

- ከዚህ በፊት የነበረዎ የፍቅር ግንኙነትን እንዴት ይገልፁታል?
  - ጋብቻ፤ አብሮ መኖር፤ ለመጋባት በማሰብ ቃል ኪዳን፤ በአንድ የፍቅር ጓደኝነት ያልተወሰነ
  - ለምን ያህል ጊዜ በዚህ ግንኙነት ዉስጥ ቆይተዋል?
  - በዚህ ግንኙነት ዉስጥ የነበራቸሁ ድርሻ ምን እንደነበረ ሊነግሩኝ ይቸላሉ?

4. የኤል.ጂ.ቢ ማህበረሰብ የስነ-ግንኙነት እና ስነ-ተዋልዶ ጤና ፍላጎቶቸ ምን ምን ናቸው?

· የስነ-ግንኙነትንና የስነ- ተዋልዶን ጤናን በተመለከተ የምክር አገልግሎት

· ከግብረ-ስጋ ግንኙነት ጥንቃቄ ጋረ በተገናኘ ኮንዶም እና ሉብሪካነት በቀላሉ ማግኘት

· የተለያዩ የእረግዝና መከላከያዎቸን በቀላሉ ማግኘት

· በግብረ-ስጋ ግንኙነት ምክንያት ሊፈጠሩ ለሚቸሉ ቁስለቶቸ ህክምና ማግኘት

· በግብረ-ስጋ ግንኙነት ለሚተላለፉ ማንኛዉም ኢንፌክሽኖች የምርመራ እና ህክምና አገልግሎቶች

· ኤች.አይ.ቪን በተመለከተ የምክር፣ የህክምና፣ የፕሮፍሌክሲስ አገልግሎት እንዲሁም አጋጣሚን ተጠቅመው የሚያንሰራሩ ኢንፌክሽኖች ህክምና

5. የስነ-ግንኙነት እና ስነ-ተዋልዶ ጤናን በተመለከተ ወደ ማንኛዉም አይነት የጤና አገልግሎት መስጫ ሔደው ያውቃሉ?

5.1. አዎ ከሆነ፦

· ምን አይነት የስነ-ግንኙነት እና ስነ-ተዋልዶ ጤና አገልገሎት ለማግኘት ነው የሔዱት?

· አገልግሎቱን ለመግኘት ምን ያህል ቀላል ነበር?

· አገልግሎቱን ለመግኘት የት ነበር የሔዱት (የመንግሰት/ የገል/ መደበኛ ያልሆነ የጤናአገልግሎት መስጫ)?

· ያጋጠመዎትን ሁኔታ/ የነበረዎት ተሞክሮ እንዴት ነበረ?

· ይሕንን አገልገሎት ለመጠቀም በሔዱበት ወቀት ለጤና ባለሙያዎ ኤል.ጂ.ቢ መሆንዎን በግልፅ ነግረዋቸው ነበር? ለምን?

- የጤና አገልገሎት ባለሙያዎ ለጠየቁት አገልግሎት የነበራቸው ምላሽ እና አመለካከት እነዴት ነበር?
- ምን አይነት ምላሽ ጠብቀው ነበር?
- ·በእርስዎ አመለካከት የጤና ባለሙያዎ የሚያስፈልግዎትን የጤና አገልግሎት በትህትና እና አክብሮት ሰጥተዎታል? ይህ የሆነበት ምክንያት ለምን ይመስለዎታል?

· ይህንን አገልግሎት ለማገኘት ሲሞክሩ አጋጠመዎት የነበሩ ተግደሮቶች/ ችግሮች ከነበሩ ሊገልፁለኝ ይችላሉ? 5.2. መለሱ ሔጄ አላውቅም ከሆነ፤ ለምን እንዳልሔዱ ሊነግኝ ይችላሉ?

· መሔድ አላስፈለገኝም/ መሔድ በመፍራት/ የሌሎችን ተሞክሮ በማየት/ ሌላ ጤናዬን የምተብቅበት መንገድ በመኖሩ

· መሔድ ያስፈለገዎ እንደሆነ፤ የት ይሔዳሉ? ለምን?

· እስቲ የስነ-ግንኙነት እና ስነ-ተዋልዶ የጤና አገልግሎት አስፈልጓቸው ወደ ጤና አገልገሎት መስጫ የሔዱ እና ስለ ተሞክሯቸው የነገርዎ ኤል.ጂ.ቢ. ሰዎች ካሉ፤ ስለተሞከሮአቸው ምን ተሰማዎት?

6. በአጠቃላይ የኤል.ጂ.ቢ ማህበረሰብ የስነ-ግንኙነት እና ስነ-ተዋልዶ የጤና አገልግሎት በሚያስፈልጓቸው ጊዜ ይህንን የጤና አገልግሎት ለመግኘት አስቸገሪ/ አዳጋች ሊያደርጉበቸው የሚችሉ ተግዳሮቶች ምን ናቸው በለው ያስባሉ?

7. የኤል.ጂ.ቢ ማህበረሰብ የስነ-ግንኙነት እና ስነ-ተዋልዶ የጤና አገልግሎቶቸ ለማግኘት አስቸገሪ/ አዳጋቸ የሆነባቸው እንደሆነ ምን አይነት አማራጮችን ይጠቀማሉ?

· ከዚህ አኳያ የሚያውቁት የግለሰብ ተሞክሮ ካለ ሊነግሩኝ ይችላሉ?

8. ውይይታችን ወደ መገባደጃው ደረሷል፤ ነገር ግን እስከአሁን በተነጋገረንባቸው ሀሰቦች ዙሪያ

ያላነሳናቸው ጠቃሚ ናቸው ሚሏቸው ሀሰቦች ካሉ ሊያጋሩኝ ይችላሉ?

- ማጠቃለያ ይስጡ ፤
- ምስጋና ያቅርቡ፤
- የቃለ-መጠይቅ ማስታወሻ ይያዙ።

ማስታወሻ፡ - ኤል. ጂ.ቢ የሚለው ቃል እነደየተሳታፊው ስነ-ግንኙት ሁኔታ በአማራጭነት የሚመረጥ ይሆናል።ለተመሳሳይ ፆታ አፍቃሪ ሴቶች- ሌዝቢያን፣ ለወንዶች -ጌይ እና ለሁለቱም ፆታ አፍቃሪዎች ደግሞ ባይሴክሸዋል የሚለውን ጠያቂው ይጠቀም። ልዩ አጠራር በተጠያቂው የተመለከተ እነደሆነ፤ ያንን ቃል ጠያቂው ይጠቀም።

ጥልቅ ቃለ-መጠይቅ II

ከጤና አገልግሎት ሰጪዎች ጋር የሚደረግ ጥለቅ ቃለመጠይቅ

1. በመጀመሪያ ስለእራስዎ በጥቂቱ ይንገሩኝ፤ ስለ ትምህረት ሁኔታዎ እንዲሁም ስለተሰማሩበት የስራ ሁኔታ ይንገሩኝ

○ በዚህ ተቋም ዉስጥ የስራ ድርሻዎ ምነድን ነው?

○ በዚህ የስራ ድርሻ ላይ ለምን ያህል ጊዜ አገለገሉ?

2. በስነ- ግንኙነት እና በስነ-ተዋልዶ ጤና ዙሪያ ልዩ ስልጠና አግኝተዋል?

○ መሰረታዊ ስልጠና /በስራ ላይ ስልጠና

○ የስነ-ግንኙነት እና ስነ-ተዋልዶ ጤና አላማ እንዲሁም ማእቀፍ ምን ምንን ያካትታል?

3. በዚህ ተቋም ውስጥ የስነ- ግንኙነት እና የስነ-ተዋልዶ ጤና አገልግሎት ተጠቃሚዎች ማን ናቸው?

○ እነዚህ ተጠቃሚዎች በዋናነት የሚያገኙዋቸው አገልግሎቶች ምን ናቸው?

4. የስነ- ግንኙነት እና የስነ-ተዋልዶ ጤና አገልግሎቶችን ለማግኘት በመሻት ኤል. ጂ. ቢ የሆነ ተገልጋይ ወደ እርስዎ በመምጣት እነዚህን አገልግሎቶቸ ለማግኘት ጠይቅዎት ያውቃል?

4.1. አዎ

○ ኤል.ጂ.ቢ የሆኑ ተገልጋዮች የስነ- ግንኙነት እና የስነ-ተዋልዶ ጤና አገልግሎቶችን ለማግኘት ወደዚህ ተቋም መምጣት ምን ያህል የተለመደ ነው?

○ አብዛኛውን ጊዜ ይህንን አገልግሎት በመሻት ወደዚህ ተቋም የሚመጡት የትኞቹ የኤል. ጂ.ቢ ማህበረሰብ አባላት ናቸው?

○ ከእነዚህ ተገልጋዩች ጋር ያለዎት ንግግር/ ግንኙነት ምን ይመስላል?

○ የስነ-ግንኙነት ሁኔታቸውን በግልጽ ነግረዎት ነበር?

○ በስነ- ግንኙነት እና በስነ-ተዋልዶ ዙሪያ የጤና አገልግሎት ፍላጎታቸውን፤ የሚያጋጥሟቸውን ተግዳሮቶች እንዲሁም በዚህ ዙሪያ ያሉ ሀሳቦቻቸውን በቀላሉ ሊያጋርዎት/ ለመግለፅ ችለው ነበረ?

○ ለምን ወደዚህ የጤና ተቋመም ለመምጣት እንደመረጡ ነግረዎት ነበረ/ ካልነገርዎት ለምን ይህንን ጤና ተቋም የመረጡ ይመስለዎታል?

○ ምን አይነት የጤና አገልግሎት እንደሰጧቸው ሊነግሩኝ ችላሉ?

➢ የሚያስፈልጋቸውን የጤና አገልግሎት ወዲያዉኑ ሰጧቸው?

➢ አገልግሎቱን ከመስጠትዎ በፊት ከበላይ የስራ ባልደረባዎችዎ ጋር ተነጋግረው ነበረ? ○ የእኚህን ተገልጋይ የጤና ሁኔታ ባማከለ መልኩ የምክር አገልገሎት አግኝተው ነበረ?

4.2.የለም

○ አንድ ኤል. ጂ. ቢ የሆነ/ች ተገልጋይ የጤና አገልግሎት ለማግኘት ወደአረስዎ መጥቶ አለማወቁን በምን እረግጠኛ ለመሆን ይችላሉ?

○ ሌሎች የስራ ባልደረባዎችዎን ኤል.ጂ.ቢ የሆነ/ች ተገልጋይ የስነ- ግንኙነት እና ስነ-ተዋልዶ ጤና አገልገሎት ለማግኘት ወደእነርሱ መጥተው እንደሚያውቁ ነግረዎት ያውቃሉ?

➢ አዎ፡ እስቲ ታሪኩን ይንገሩኝ

- ከእነዚህ ተገልጋዩች ጋር የነበራቸውን ንግግር/ ግንኙነት እንዴት ነበር የገለልዎት?
- የስነ-ግንኙነት ሁኔታቸውን በግልጽ ነግረዋቸው ነበር?
- በስነ- ግንኙነት እና በስነ-ተዋልዶ ዙሪያ የጤና አገልግሎት ፍላጎታቸውን፤ የሚያጋጥሟቸውን ተግዳሮቶች እንዲሁም በዚህ ዙሪያ ያሉ ሀሳቦቻቸውን በቀላሉ ለመግለፅ ችለው ነበረ?
- ለምን ወደዚህ የጤና ተቋመም ለመምጣት እንደመረጡ ነግረዎቸው ነበረ/ ካልነገርዎቸው እርስዎ ለምን ይህንን ጤና ተቋም የመረጡ ይመስለዎታል?
- ምን አይነት የጤና አገልግሎት እንደሰጧቸው ነግረዎት ነበረ?
- የሚያስፈልጋቸውን የጤና አገልግሎት ወዲያዉኑ ሰጥተዋቸው ነበረ?
- የጤና የምክር አገልገሎት አግኝተው ነበረ?

➢ የለም አልነገሩኝም፡
- ኤል.ጂ.ቢ የሆኑ ሰዎች ወደዚህ የጤና አገልገሎት ማእከል መጥተው የማያውቁበት ምክንያት ምን ይመስለዎታል?

○ እስቲ አንድ ኤል.ጂ.ቢ የሆነ/ች ሰው የስነ- ግንኙነት እና ስነ-ተዋልዶ ጤና አገልገሎት ለማግኘት ወደእርስዎ ቢመጣ/ በትመጣ ምን እንደሚያደርጉ ይንገሩኝ፡፡

○ ይህ የጤና አገልግሎት ተቋም ለኤል.ጂ.ቢ ተገልጋዮች የስነ- ግንኙነት እና ስነ-ተዋልዶ ጤና አገልገሎት ለመስጠት ዝግጁ ነው ብለው ያምናሉ?

➢ ይህ የሆነበት ምክንያት ለምን ይመስለዎታል?

5. በዚህ የጤና ተቋም ውስጥ የስነ- ግንኙነት እና ስነ-ተዋልዶ ጤና አገልገሎት መመሪያ አለ?

○ ይህ መመሪያ ኤል.ጂ.ቢ ተጠቃሚዎቸን በተመለከተ ያስቀመጣቸው ነጥቦቸ አሉ (የሚያስታውሱ ከሆነ ሊነግሩኝ ይቸላሉ)?

○ ኤል.ጂ.ቢ ለሆኑ ተጠቃሚዎቸ የተሻለ የስነ- ግንኙነት እና ስነ-ተዋልዶ ጤና አገልገሎት ለመስጠት ያስቸላሉ የሚሏቸው የማሻሻያ ሀሳቦቸ ምንድን ናቸው?

○ ኤል.ጂ.ቢ ለሆኑ ተጠቃሚዎቸ የተሻለ የስነ- ግንኙነት እና ስነ-ተዋልዶ ጤና አገልገሎት ለመስጠት ብንፈልግ ምን አይነት የተለዩ አገልግሎቶቸ ሊጨመሩ ይገባል ብለው ያስባሉ?

6. አሁን የውይይታቸን ማገባደጃ ላይ እየደረስን ነው። ነገር ግን እስከአሁን በተነጋገርነው ላይ ለመጨመር የሚፈልጓቸው ነጥቦቸ ካሉ ወይንም መነሰት ኖሮበቸው ሰይነሱ ቀርተዋል የሚሏቸው ሀሳቦቸ ካሉ ሊነግሩኝ ይቸላሉ?

▪ ማጠቃለያ▪ ተሳታፊውን ያመስግኑ▪ የተሳታፊውን አጠቃላይ መረጃ ያሰባስቡ

ጥልቅ ቃለ-መጠይቅ III

ከቁልፍ አስረጂዎቸ ጋር የሚደረግ ጥልቅ ቃለመጠይቅ

1. በመጀመሪያ ስለእራስዎ በጥቂቱ ይንገሩኝ፤ ስለ ትምህረት ሁኔታዎ እንዲሁም ስለተሰማሩበት የስራ ሁኔታ።

○ በዚህ ስራ ላይ ለምን ያህል ጊዜ ሲያገለገሉ ቆዩ?

○ ይህ አገልግሎት ለማህበረሰቡ ምን ያህል ተደራሽነት አለው/ ተፅኖ ሊፈጥር ይቸላል በለው ያምናሉ?

2. በአሁኑ ጊዜ በአለም ዙሪያ ተመሳሳይ ፆታ ግንኙነትን በተመለከተ የተለያዩ አመለካከቶቸን እንሰማለን። እረስዎ ይህንን እነዴት ይመለከቱታል?

○ በኢትዮጵያ ያለዉን የአመለካከት ሁኔታ ከሌላው አለም ሀገራት ጋር ሲነፃፀር እንዴት ይለያል? ይህ የሆነበት ምክንያት ለምን ይመስለዎታል?

○ የተመሳሳይ ፆታ ግንኙነትን አሁን ከሚሰሩት ስራ አንፃር እነዴት ይመለከቱታል?

○ በዚህ ሀገር ዉስጥ የሚኖሩ ኤል.ጂ.ቢ ማህበረሰብ አባላትን በተመለከተ ብዙም በግልፅ የሚታወቅ ነገር የለም። ነገር ግን ከረስዎ ስራ ጋር በተገናኘ በተለይም በአዲስ አበባ ስለሚኖሩ ኤል.ጂ.ቢ ማህበረሰብ አባላት ምን ሊነግሩኝ ይቸላሉ?

➢ ቁጥራቸውን በተመለከተ

➢ ማህበረሰቡ ስለእነሱ ያለውን አመለካከት በተመለከተ

○ የተለያዩ ሀገራት የኤል.ጂ.ቢ ማህበረሰብ አባል የሆኑ ዜጎቻቸውን በመቀበል የማስተዳደር አቋም አላቸው፤ ይህንን በተመለከተ በዚህ ሀገር ውስጥ ምን አይነት ነገር እየተደረገ ይገኛል በለው ያምናሉ?

➢ ከሙያዎ/ ልምደዎ በዚህ ጉዳይ ላይ ምን እየተሰራ ይገኛል በለው ያምናሉ?

➢ ምን አይነት ነገሮቸ መደረግ አለባቸው ብለው ያምናሉ?

- ➢ እርስዎ የተሰማሩበት ስራ በዚህ ዙሪያ ለሚሰሩ ነገሮችህ እነዲሁም ለሚደረጉ ውይይቶች ምን አይነት አስተዋፆ አለው/ ይኖረዋል ብለው ያምናሉ?

3. አሁን ደግሞ የተመሳሳይ ፆታ ግንኙነት እና የኢትዮጵያ ህግ ዙሪያ የለዎትን አመለካከት ሊያካፍሉኝ ይችላሉ?

   ○ የህጉን አፈፃፀም በተመለከተ ምን ሊነግሩኝ ይችላሉ?

   ○ በአለም ዙሪያ ብዙ ሀገረት የስነ-ፆታ መብትን (የተመሳሳይ ፆታ ግንኙነትን ጨምሮ) እነደ አንዷ የሰብአዊ መብት በማካተት በህግ መደገፍ እየጀመሩ ይገኛሉ። በዚህ ዙሪያ ያለዎት አመለካከት ቢያጋሩኝ?

   ○ ኢትዮጵያ የተለያዩ ኤል.ጂ.ቢ ማህበረሰብ አባላትን መበት የሚገልፁ አለም አቀፍ የሰብዊ መብት ስምምነቶችን መፈረሟ ይታወቃል። እነዚህን ስምምነቶች ከሃገር በቀል ህጎች ጋር ለማስማማት ይቻላል? እነዴት/ ለምን?

      ▪ በአሁኑ ጊዜ ያለው ህግ የተኞቹን የ ኤል.ጂ.ቢ መብቶች ይገድባል?

      ▪ ኤል.ጂ.ቢ ማህበረሰብ አባላት በዚህ ማህበረሰብ ውስጥ ሲኖሩ ሊያጋጥሟቸው የሚችሉ ችግሮች ምን ሊሆኑ ይችላሉ?

4. ኤል.ጂ.ቢ የማህበረሰብ አባላት የተለያዩ መሰረታዊ ሰብአዊ መብቶችን በቀላሉ ለማግኘት ይችላሉ ብለው ያስባሉ? ለምሳሌ መሰረታዊ የጤና አገልግሎቶችን፤ በተለይም የስነ-ፆታ እና የስነ-ተወልዶ ጤና አገልግሎቶችን?

   ○ እነዚህን መሰረታዊ የጤና አገልግሎቶችን፤ በተለይም የስነ-ፆታ እና የስነ-ተወልዶ ጤና አገልግሎቶችን የመግኘት መብት አላቸው ብለው ያምናሉ?

   ○ የኤል.ጂ.ቢ የማህበረሰብ አባላት የተለያዩ ጤና አገልግሎት መስጫዎች ሲሄዱ እንዴት ሊስተናገዱ ይገባል ብለው ያምናሉ?

   ○ የተለየ የስነ-ፆታ እና የስነ-ተወልዶ ጤና አገልግሎት ፍላጎቶች ይኖራቸዋል ብለው ያስባሉ?

   ○ እነዚህን የጤና አገልግሎቶች ለማግኘት አዳጋች ሊያደርጉባቸው የሚችሉ ተግዳሮቶች አሉ?

   ○ እነዚህን የጤና አገልግሎቶች ለማግኘት ተግዳሮቶች ካጋጠሟቻው ምን አይነት አማራጮችን ሊጠቀሙ ይችላሉ?

5. ኤል.ጂ.ቢ የማህበረሰብ አባላት መሰረታዊ የሆኑ የጤና አገልግሎቶችን ማግኘት አለመቻል በእነሱ፤ በቤተሰባቸው እንዲሁም በአጠቃላይ በማህበረሰቡ ላይ የሚኖረው ተፅኖ ምን ሊሆን ይችላል?

6. ኤል.ጂ.ቢ የማህበረሰብ አባላት መሰረታዊ የሆኑ የጤና አገልግሎቶችን (በተለይም የስነ-ፆታ እና የስነ-ተወልዶ ጤና አገልግሎቶችን) ማግኘት እነዲችሉ ምን መደረግ አለበት ብለው ያስባሉ?

7. አሁን የውይይታችን ማገባደጃ ላይ እየደረስን ዘነበ። ነገር ግን እስከአሁን በተነጋገርነው ላይ ለመጨመር የሚፈልጓቸው ነጥቦች ካሉ ወይንም መነሰተ ኖሮበቸው ሰይነሱ ቀርተዋል የሚሏቸው ሀሳቦች ካሉ ሊነግሩኝ ይችላሉ?

- ▪ ማጠቃለያ▪ ተሳታፊውን ያመስግኑ▪ የተሳታፊውን አጠቃላይ መረጃ ያሰባስቡ

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5. Amharic Informed Consents

ለጥልቅ ቃለ መጠይቅ የተዘጋጀ የእሺታ ቅፅ- ለኤል. ጂ. ቢ ማህበረሰብ

ስለጥናቱ መግለጫ፡ በአዲስ አበባ ዩንቨርሲቲ የስነ-ፆታ ተቋም የድህረ ምረቃ ፕሮግራም የሚደረግ የመመረቂያ ጥናት

የጥናቱ ርዕስ፡ Sexuality and Access to Reproductive Health Care among LGBs in Addis Ababa

መግቢያ

አሁን የምንጠይቅዎት በጥናቱ ውስጥ እንዲሳተፉ ነው። በዚህ ጥናት ለመሳተፍ ፈቃደኛነትዎን ለመወሰን እንዲችሉ በጥናቱ ውስጥ በመሳተፍዎ ሊያገኟቸው የሚችሏቸውን ጥቅሞች እና ስጋቶችነን በደንብ ሊረዱ ይገባል። በዚህ መሰረት ይህ ቅፅ ለውሳኔዎ በቂ ግንዛቤን በመስጠት ይረዳል ።

ስለጥናቱ በቂ ግንዛቤ ካገኙ በኋላ በጥናቱ ለመሳተፍ ፈቃደኛነትዎን እንጠይቃለን። ይህንን የእሺታ ቅፅ ከመፈራረምዎ በፊት ምንም አይነት ጥያቄ ቢኖርዎ ወይንም ግልፅ ያልሆነልዎትን ነገር ቢኖር ከመጠይቅ ወደኋላ እንዳይሉ። ይህንንም ለማድረግ በቂ ጊዜ ወስደው ለማሰብ እንደሚችሉ በቅድሚያ መግለፅ እንፈልጋለን።

የጥናቱ ዓላማ

የዚህ ጥናት አጠቃላይ አላማ የስነ-ፆታ እና ስነ-ተዋልዶ ጤና አገልግሎት በአዲስ አበባ ውስጥ ለሚኖሩ የኤል. ጂ. ቢ ማህበረሰብ አባላት ያለውን ተደራሽነት ለማጥናት ነው። ይሕንንም ለመረዳት የአል. ጂ. ቢ ማህበረሰብ አባላት ይህንን የጤና አገልግሎት እንዴት እና ከየት ለማግኘት እንደሚችሉ፤ የሚያጋጥሟቸው ተግዳሮቶች እና ያሉትን የመፍትሔ አማራጮች ያጠናል። ለዚህም ምላሽ ለማግኘት ጥናቱ በአዲስ አበባ ውስጥ ከሚኖሩ የኤል.ጂ.ቢ. ማህበረሰብ አባለት፤ ከስነ-ፆታ እና ስነ-ተዋልዶ ጤና አገልግሎት ሰጪዎች እና ከተመረጡ ቁልፍ አስረጂ የማህበረሰብ አባላት ጋር ጥልቅ ቃለ-መጠይቅ ያደርጋል።

ሚስጥራዊነት

በዚህ ጥናት ውስጥ ለመሳተፍ ፈቃደኛ ከሆኑ ለ60 ደቂቃ ያህል ጥልቅ ውይይት የምናደርግ ይሆናል። በዚሕም ቃለ-መጠይቅ የስነ-ፆታ እና ስነ-ተዋልዶ ጤና አገልግሎት ዙሪያ ያለዎትን ተሞክሮ እንዲሁም ተያያዥ የሆኑ ተግዳሮቶች እና የመፍትሄ አማራጮች ዙሪያ የመወያያ ጥያቄዎችን የምንጠይቅዎት ይሆናል።

በእርስዎ ፈቃድ ይህንን ቃለ-መጠይቅ በመቅረፀድምፅ እንይዘዋለን። ነገር ግን ይህ የተቀረፀ ቃለ መጠይቅ ከዚህ የምርምር ቡድን ዉጪ ለማንም ይፋ የማይደረግ ሲሆን ወዲያውኑ ወደ ፅሁፍ ተገልብጦ ከመቅረፀ ድምፁ የሚሰረዝ ይሆናል። በተጨማሪም የርስዎን ማንነት በሚስጥር ለመያዝ ስምዎትንም ሆነ ማንኛዉንም ማንነትዎን አመላካች ማስረጃ በቃለ መጠየቁ ጊዜ የሚነሱ አይሆንም።

በፍቃደኝነት ተሳትፎ ማድረግ እና ተሳትፎን ማቋረጥ

በዚህ ጥናት ውስጥ መሳተፍ በእርስዎ ሙሉ ፈቃደኛነት ላይ ብቻ የተመሰረተ ነው። በጥናቱ ለመሳተፍ ከወሰኑ በውይይቱ ጊዜ የሚነሱ ማንኛዉም ጥያቄዎችን ለመመለስ ምቾት ካልተሰማዎት ጥያቄው እንዲዘልዎ መናገር ይችላሉ። በማንኛውም ጊዜ መልስ መስጠት የማቋረጥ መብትዎ ተጠበቀ ነው።

ስጋቶች

በዚህ ጥናት ውስጥ ከመሳተፍዎ ጋር የሚኖሩ ስጋቶች በጣም ውስን ናቸው። ነገር ግን አንዳንድ የምንጠይቅዎት ጥያቄዎች የግል ህይወትዎን የተመለከተ ሆነው ለመመለስ ምቾት ላይሰጥዎት ይችላሉ። ማንኛውም ጥያቄ እንደዚህ አይነት ስሜት የሚፈጥርብዎ ከሆነ ጥያቄውን ያለመመለስ/ መዝለል ይችላሉ። መጥፎ ስሜት የሚቀሰቅሱ ከሆነ እረፈት ሊወስዱ ወይንም ቃለመጠየቁን በማንኛዉም ጊዜ

ሊያቋርጡ ይችላሉ።

ክፍያ ወይም ጥቅማጥቅም

እዚህ ድረስ ለመምጣት ያወጡትን የጉዞ ወጪ እስከ ብር 300 ድረስ የምንሸፍን ይሆናል። የኮቪድ 19 ወረርሽኝን እና ወቅታዊ ሁኔታን ግንዛቤ ውስጥ በማስገባት የአፍ እና አፍንጫ መሸፈኛ ማስክ እና የሚወስዱት የእጅ ማፅጃ አልኮል የምንሰጥዎ ይሆናል። ነገር ግን ከዚህ ውጪ ሌላ የሚያገኙት የገንዘብ ወይም ሌላ የጥቅማጥቅም ስጦታ አይኖርም። ቢሆንም እረስዎ ሚሰጡን መረጃ በጥናቱ ርዕስ ዙሪያ ለህብረተሰብ ሳይንስ እውቀት ከፍተኛ ሚና የሚጫወት ሲሆን ለሌሎች ጥናቶችና ለፖሊሲ ቀረፃ አነደማስረጃነት ያገለግላል።

ጥያቄዎች

በዚህ ጥናት ላይ ከመሳተፍዎ ጋር በተገናኘ ማንኛውንም አይነት ጥያቄ ካለዎት የዚህ ጥናት ዋና ተመራማሪ ሐናማርያም ስዩምን በተንቀሳቃሽ ስልክ ቁጥር --- ወይንም በአዲስ አበባ ዩኒቨረሲቲ መምህር እና የምርምር አማካሪ ዶ/ር ሙሉመቤት ዘነበ በተንቀሳቃሽ ስልክ ቁጥር --- በመደወል ማናገር ይችላሉ ።

የቃል እሺታን የማረጋገጫ ስምምነት/ ስልጣን

በዚህ የእሺታ ቅፅ ላይ የተገለፀውን አንብቤአለሁ (ሌላ ሰው አንብቦልኛል እንዲሁም አብራርቶልኛል)። ይህ ጥናት ለምን እየተካሄደ እንደሆነ ተረድቻለሁ። ጥናቱ ምን እንደሚያካትት እና በፅሁፉ እንደተገለፀው ያለውን ጉዳት እና ጥቅም ተረድቻለሁ። በቃለ-መጠይቅ ውስጥ ከሚቀርቡት ጥያቄዎች መካከል መመለስ የማልፈልጋቸው ጥያቄዎች ካሉ ማለፍ (አለመመለስ)እንደምችል ተረድቻለሁ። በጥናቱ ውስጥ የምሳተፈው በሙሉ ፈቃደኛነቴ በቻ መሆኑን በመረዳት፤ በዚህ ጠናት መሰተፍ ባልፈልግ በማንኛውም ጊዜ ተሳትፎዬን ማቋርጥ እንደምችል አውቄአለሁ።

ስለጥናቱ ማንኛውም አይነት ጥያቄ ቢኖረኝ ዋና ተመራማሪዋን ወይንም የምረምር አማካሪዋን በመደወል ጥያቄዎቼን ማቅረብ እንደምችል ተረድቻለሁ።

በዚህ ጥናት ለመሳተፍ ሙሉ ፍቃደኛነቴን ከዚህ በታች ባስቀመጥኩት ፊረማዬ/ የጣት አሻራዬ አገልፃለሁ።

የተሳታፊ ፊረማ/ የጣት አሻራ ____________________________

ቀን____

ለጥናቱ መረጃ ስብሰባ ቡድን

ለጥናቱ ተሳታፊ ስለጥናቱ ባህሪ ባለኝ ሙሉ እውቀት አበራርቼላቸዋለሁ። እርሳቸውም የጥናቱን አላማ፤ ሒደት እንዲሁም ጥቅሞች እና ስጋቶች መረዳታቸዉን ከልቤ አምኛለሁ።

የቃለ መጠይቅ አድራጊ ስም:____

የቃለ መጠይቅ አድራጊ ፊርማ:____

ቃለ መጠይቅ የተደረገበት ቀን:____

ለጥልቅ ቃለ መጠይቅ የተዘጋጀ የእሺታ ቅፅ- ለጤና አገልግሎት ሰጪዎች

ስለጥናቱ መግለጫ፡ በአዲስ አባባ ዩንቨርሲቲ የስነ-ፆታ ተቋም የድህረ ምረቃ ፕሮግራም የሚደረግ የመመረቂያ ጥናት

የጥናቱ ርዕስ፡ Sexuality and Access to Reproductive Health Care among LGBs in Addis Ababa

መግቢያ

አሁን የምንጠይቅዎት በጥናቱ ውስጥ እንዲሳተፉ ነው። በዚህ ጥናት ለመሳተፍ ፈቃደኛነትዎን ለመወሰን እንዲችሉ በጥናቱ ውስጥ በመሳተፍዎ ሊያገኟቸው የሚችሏቸውን ጥቅሞች እና ስጋቶችነን በደንብ ሊረዱ ይገባል። በዚህ መሰረት ይህ ቅፅ ለውሳኔዎ በቂ ግንዛቤን በመስጠት ይረዳል ።

ስለጥናቱ በቂ ግንዛቤ ካገኙ በኋላ በጥናቱ ለመሳተፍ ፈቃደኛነትዎን እንጠይቃለን። ይህንን የእሺታ ቅፅ ከመፈራረምዎ በፊት ምንም አይነት ጥያቄ ቢኖርዎ ወይንም ግልፅ ያልሆነልዎትን ነገር ቢኖር ከመጠይቅ ወደኋላ እንዳይሉ። ይህንንም ለማድረግ በቂ ጊዜ ወስደው ለማሰብ እንደሚችሉ በቅድሚያ መግለፅ እንፈልጋለን።

የጥናቱ ዓላማ

የዚህ ጥናት አጠቃላይ አላማ የስነ-ፆታ እና ስነ-ተዋልዶ ጤና አገልግሎት በአዲስ አበባ ውስጥ ለሚኖሩ የኤል. ጂ. ቢ ማህበረሰብ አባላት ያለውን ተደራሽነት ለማጥናት ነው። ይሕንንም ለመረዳት የአል. ጂ. ቢ ማህበረሰብ አባላት ይህንን የጤና አገልግሎት እንዴት እና ከየት ለማግኘት እንደሚችሉ፣ የሚያጋጥሟቸውን ተግዳሮቶች እና ያሉትን የመፍትሔ አማራጮች ያጠናል። ለዚህም ምላሽ ለማግኘት ጥናቱ በአዲስ አበባ ውስጥ ከሚኖሩ የኤል.ጂ.ቢ. ማህበረሰብ አባላት፣ ከስነ-ፆታ እና ስነ-ተዋልዶ ጤና አገልግሎት ሰጪዎች እና ከተመረጡ ቁልፍ አስረጂ ማህበረሰብ አባላት ጋር ጥልቅ ቃለ-መጠይቅ ያደርጋል።

ሚስጥራዊነት

በዚህ ጥናት ውስጥ ለመሳተፍ ፈቃደኛ ከሆኑ ለ60 ደቂቃ ያህል ጥልቅ ውይይት የምናደርግ ይሆናል። በዚሕም ቃለ-መጠይቅ የስነ-ፆታ እና ስነ-ተዋልዶ ጤና አገልግሎት በመስጠት ዙሪያ ያለዎትን ተሞክሮ እንዲሁም በኤል.ጂ.ቢ ማህበረሰብ አባላትና የስነ-ፆታ እና ስነ- ተዋልዶ ጤና አገልግሎት ዙሪያ ጥያቄዎችን የምንጠይቅዎት ይሆናል።

በእርስዎ ፈቃድ ይህንን ቃለ-መጠይቅ በመቅረፀድምፅ እንደዘዋለን። ነገር ግን ይህ የተቀረፀ ቃለ መጠይቅ ከዚህ የምርመር ቡድን ዉጪ ለማንም ይፋ የማይደረግ ሲሆን ወዲያውኑ ወደ ፅሁፍ ተገልብጦ ከመቅረፀ ድምፁ የሚሰረዝ ይሆናል። በተጨማሪም የርስዎን ማንነት በሚስጥር ለመያዝ ስምዎትንም ሆነ ማንኛዉንም ማንነትዎን አመላካች ማስረጃ በቃለ መጠየቁ ጊዜ የሚጠየቁ አይሆንም።

በፍቃደኝነት ተሳትፎ ማድረግ እና ተሳትፎን ማቋረጥ

በዚህ ጥናት ውስጥ መሳተፍ በእርስዎ ሙሉ ፈቃደኛነት ላይ ብቻ የተመሰረተ ነው። በጥናቱ ለመሳተፍ ከወሰኑ በውይይቱ ጊዜ የሚነሱ ማንኛዉም ጥያቄዎችን ለመመለስ ምቾት ካልተሰማዎት ጥያቄው እንዲዘልዎ መናገር ይችላሉ። በማንኛውም ጊዜ መልስ መስጠት የማቋረጥ መብትዎ ተጠበቀ ነው።

ስጋቶች

በዚህ ጥናት ውስጥ ከመሳተፍዎ ጋር የሚኖሩ ስጋቶች በጣም ውስን ናቸው። ነገር ግን አንዳነድ የምንጠይቅዎት ጥያቄዎች ስሜታዊነት ሊፈጥርብዎ ይችላሉ። ማንኛውም ጥያቄ እንደዚህ አይነት ስሜት የሚፈጥርብዎ ከሆነ ጥያቄውን ያለመመለስ/ መዝለል ይችላሉ። መጥፎ ስሜት የሚቀሰቅሱ ከሆነ እረፈት ሊወስዱ ወይንም ቃለመጠየቁን በማንኛዉም ጊዜ ሊያቋርጡ ይችላሉ።

ክፍያ ወይም ጥቅማጥቅም

የኮቪድ 19 ወረርሽኝን እና ወቅታዊ ሁኔታን ግንዛቤ ውስጥ በማስገባት የአፍ እና አፍንጫ መሸፈኛ ማስክ እና የእጅ ማፅጃ አልኮል የምንሰጥዎ ይሆናል። ነገር ግን ከዚህ ውጪ ሌላ የሚያገኙት የገንዘብ ወይም ሌላ የጥቅማጥቅም ስጦታ አይኖርም። ቢሆንም እረስዎ ሚሰጡን መረጃ በጥናቱ ርዕስ ዙሪያ ለህብረተሰብ ሳይንስ እውቀት ከፍተኛ ሚና የሚጫወት ሲሆን ለሌሎች ጥናቶችና ለፖሊሲ ቀረፃ አነዷማስረጃነት ያገለግላል።

ጥያቄዎች

በዚህ ጥናት ላይ ከመሳተፍዎ ጋር በተገናኘ ማንኛውንም አይነት ጥያቄ ካለዎት የዚህ ጥናት ዋና ተመራማሪ ሐናማርያም ስዩምን በተንቀሳቃሽ ስልክ ቁጥር --- ወይንም በአዲስ አበባ ዩኒቨርሲቲ መምህር እና የምርምር አማካሪ ዶ/ር ሙሉመቤት ዘነበ በተንቀሳቃሽ ስልክ ቁጥር --- በመደወል ማናገር ይችላሉ ።

የቃል እሺታን የማረጋገጫ ስምምነት/ ስልጣን

በዚህ የእሺታ ቅፅ ላይ የተገለፀውን አንብቤአለሁ (ሌላ ሰው አንብቦልኛል እንዲሁም አብራርቶልኛል። ይህ ጥናት ለምን እየተካሄደ እንደሆነ ተረድቻለሁ።ጥናቱ ምን እንደሚያካትት እና በፅሁፉ እንደተገለፀው ያለውን ጉዳት እና ጥቅም ተረድቻለሁ። በቃለ-መጠይቅ ውስጥ ከሚቀርቡት ጥያቄዎች መካከል መመለስ የማልፈልጋቸው ጥያቄዎች ካሉ ማለፍ (አለመመለስ) እንደምችል ተረድቻለሁ። በጥናቱ ውስጥ የምሳተፈው በሙሉ ፈቃደኛነቴ በቻ መሆኑን በመረዳት፤ በዚህ ጠናት መሰተፍ ባልፈልግ በማንኛውም ገዜ ተሳትፎዬን ማቋርጥ እንደምችል አውቄአለሁ።

ስለጥናቱ ማንኛውም አይነት ጥያቄ ቢኖረኝ ዋና ተመራማሪዋን ወይንም የምረምር አማካሪዋን በመደወል ጥያቄዎቼን ማቅረብ እንደምችል ተረድቻለሁ።

በዚህ ጥናት ለመሳተፍ ሙሉ ፍቃደኛነቴን ከዚህ በታች ባስቀመጥኩት ፊረማዬ/ የጣት አሻራዬ እገልፃለሁ።

የተሳታፊ ፊረማ/ የጣት አሻራ ______________________________

ቀን____

ለጥናቱ መረጃ ስብሰባ ቡድን

ለጥናቱ ተሳታፊ ስለጥናቱ ባህሪ ባለኝ ሙሉ እውቀት አበራርቼላቸዋለሁ። እርሳቸውም የጥናቱን አላማ፤ ሒደት እንዲሁም ጥቅሞች እና ስጋቶች መረዳታቸዉን ከልቤ አምኛለሁ።

የቃለ መጠይቅ አድራጊ ስም:____

የቃለ መጠይቅ አድራጊ ፊርማ:____

ቃለ መጠይቅ የተደረገበት ቀን:____

ለጥልቅ ቃለ መጠይቅ የተዘጋጀ የእሺታ ቅፅ- ቁልፍ አስረጂ ማህበረሰብ

ስለጥናቱ መግለጫ፡ በአዲስ አበባ ዩንቨርሲቲ የስነ-ፆታ ተቋም የድህረ ምረቃ ፕሮግራም የሚደረግ የመመረቂያ ጥናት

የጥናቱ ርዕስ፡ Sexuality and Access to Reproductive Health Care among LGBs in Addis Ababa

መግቢያ

አሁን የምንጠይቅዎት በጥናቱ ውስጥ እንዲሳተፉ ነው። በዚህ ጥናት ለመሳተፍ ፈቃደኛነትዎን ለመወሰን እንዲችሉ በጥናቱ ውስጥ በመሳተፍዎ ሊያገኟቸው የሚችሏቸውን ጥቅሞች እና ስጋቶችነን በደንብ ሊረዱ ይገባል። በዚህ መሰረት ይህ ቅፅ ለውሳኔዎ በቂ ግንዛቤን በመስጠት ይረዳል ።

ስለጥናቱ በቂ ግንዛቤ ካገኙ በኋላ በጥናቱ ለመሳተፍ ፈቃደኛነትዎን እንጠይቃለን። ይህንን የእሺታ ቅፅ ከመፈራረምዎ በፊት ምንም አይነት ጥያቄ ቢኖርዎ ወይንም ግልፅ ያልሆነልዎትን ነገር ቢኖር ከመጠይቅ ወደኋላ እንዳይሉ። ይህንንም ለማድረግ በቂ ጊዜ ወስደው ለማሰብ እንደሚችሉ በቅድሚያ መግለፅ እንፈልጋለን።

የጥናቱ ዓላማ

የዚህ ጥናት አጠቃላይ አላማ የስነ-ፆታ እና ስነ-ተዋልዶ ጤና አገልግሎት በአዲስ አበባ ውስጥ ለሚኖሩ የኤል. ጂ. ቢ ማህበረሰብ አባላት ያለውን ተደራሽነት ለማጥናት ነው። ይሕንንም ለመረዳት የአል. ጂ. ቢ ማህበረሰብ አባላት ይህንን የጤና አገልግሎት እንዴት እና ከየት ለማግኘት እንደሚችሉ፤ የሚያጋጥሟቸውን ተግዳሮቶች እና ያሉትን የመፍትሔ አማራጮች ያጠናል። ለዚህም ምላሽ ለማግኘት ጥናቱ በአዲስ አበባ ውስጥ ከሚኖሩ የኤል.ጂ.ቢ. ማህበረሰብ አባለት፤ ከስነ-ፆታ እና ስነ-ተዋልዶ ጤና አገልግሎት ሰጪዎች እና ከተመረጡ ቁልፍ አስረጂ ማህበረሰብ አባላት ጋር ጥልቅ ቃለ-መጠይቅ ያደርጋል።

ሚስጥራዊነት

በዚህ ጥናት ውስጥ ለመሳተፍ ፈቃደኛ ከሆኑ ለ60 ደቂቃ ያህል ጥልቅ ውይይት የምናደርግ ይሆናል። በዚሕም ቃለ-መጠይቅ ከስራ ድርሻዎ/ እየሰጡ ከሚገኙት የማህበረሰብ አገልገሎት አንፃር በአዲስ አበባ ነዋሪ ለሆኑ የኤል. ጂ. ቢ ማህበረሰብ ያለውን የስነ-ፆታ እና ስነ-ተዋልዶ ጤና አገልግሎት ተደራሽነት ዙሪያ የመወያያ ጥያቄዎችን የምንጠይቅዎት ይሆናል።

በእርስዎ ፈቃድ ይህንን ቃለ-መጠይቅ በመቅረፀድምፅ እንይዘዋለን። ነገር ግን ይህ የተቀረፀ ቃለ መጠይቅ ከዚህ የምርመር ቡድን ዉጪ ለማንም ይፋ የማይደረግ ሲሆን ወዲያውኑ ወደ ፅሁፍ ተገልብጦ ከመቅረፀ ድምፁ የሚሰረዝ ይሆናል። በተጨማሪም የርስዎን ማንነት በሚስጥር ለመያዝ ስምዎትንም ሆነ ማንኛዉንም ማንነትዎን አመላካች ማስረጃ በቃለ መጠይቁ ጊዜ የሚነሱ አይሆንም።

በፍቃደኝነት ተሳትፎ ማድረግ እና ተሳትፎን ማቋረጥ

በዚህ ጥናት ውስጥ መሳተፍ በእርስዎ ሙሉ ፈቃደኛነት ላይ ብቻ የተመሰረተ ነው። በጥናቱ ለመሳተፍ ከወሰኑ በውይይቱ ጊዜ የሚነሱ ማንኛዉም ጥያቄዎችን ለመመለስ ምቾት ካልተሰማዎት ጥያቄው እንዲዘልዎ መናገር ይችላሉ። በማንኛውም ጊዜ መልስ መስጠት የማቋረጥ መብትዎ ተጠበቀ ነው።

ስጋቶች

በዚህ ጥናት ውስጥ ከመሳተፍዎ ጋር የሚኖሩ ስጋቶች በጣም ውስን ናቸው። ነገር ግን አንዳንድ የምንጠይቅዎት ጥያቄዎች ስሜታዊነት ሊፈጥርብዎ ይችላሉ። ማንኛውም ጥያቄ እንደዚህ አይነት ስሜት የሚፈጥርብዎ ከሆነ ጥያቄውን ያለመመለስ/ መዝለል ይችላሉ። መጥፎ ስሜት የሚቀሰቅሱ ከሆነ እረፈት ሊወስዱ ወይንም ቃለመጠየቁን በማንኛዉም ጊዜ ሊያቋርጡ ይችላሉ።

ክፍያ ወይም ጥቅማጥቅም

የኮቪድ 19 ወረርሽኝን እና ወቅታዊ ሁኔታን ግንዛቤ ውስጥ በማስገባት የአፍ እና አፍንጫ መሸፈኛ ማስክ እና የእጅ ማፅጃ አልኮል የምንሰጥዎ ይሆናል። ነገር ግን ከዚህ ውጪ ሌላ የሚያገኙት የገንዘብ ወይም ሌላ የጥቅማጥቅም ስጦታ አይኖርም። ቢሆንም እረስዎ ሚሰጡን መረጃ በጥናቱ ርዕስ ዙሪያ ለህብረተሰብ ሳይንስ እውቀት ከፍተኛ ሚና የሚጫወት ሲሆን ለሌሎች ጥናቶችና ለፖሊሲ ቀረፃ አነጿማስረጃነት ያገለግላል።

ጥያቄዎች

በዚህ ጥናት ላይ ከመሳተፍዎ ጋር በተገናኘ ማንኛውንም አይነት ጥያቄ ካለዎት የዚህ ጥናት ዋና ተመራማሪ ሐናማርያም ስዩምን በተንቀሳቃሽ ስልክ ቁጥር ---- ወይንም በአዲስ አበባ ዩኒቨረሲቲ መምህር እና የምርምር አማካሪ ዶ/ር ሙሉመቤት ዘነበ በተንቀሳቃሽ ስልክ ቁጥር --- በመደወል ማናገር ይችላሉ ።

የቃል እሺታን የማረጋገጫ ስምምነት/ ስልጣን

በዚህ የእሺታ ቅፅ ላይ የተገለፀውን አንብቤአለሁ (ሌላ ሰው አንብቦልኛል እንዲሁም አብራርቶልኛል። ይህ ጥናት ለምን እየተካሄደ እንደሆነ ተረድቻለሁ። ጥናቱ ምን እንደሚያካትት እና በፅሁፉ እንደተገለፀው ያለውን ጉዳት እና ጥቅም ተረድቻለሁ። በቃለ-መጠይቁ ውስጥ ከሚቀርቡት ጥያቄዎች መካከል መመለስ የማልፈልጋቸው ጥያቄዎች ካሉ ማለፍ (አለመመለስ) እንደምችል ተረድቻለሁ። በጥናቱ ውስጥ የምሳተፈው በሙሉ ፈቃደኛነቴ በቻ መሆኑን በመረዳት፤ በዚህ ጠናት መሰተፍ ባልፈልግ በማንኛውም ጊዜ ተሳትፎዬን ማቋርጥ እንደምችል አውቄአለሁ።

ስለጥናቱ ማንኛውም አይነት ጥያቄ ቢኖረኝ ዋና ተመራማሪዋን ወይንም የምረምር አማካሪዋን በመደወል ጥያቄዎቼን ማቅረብ እንደምችል ተረድቻለሁ።

በዚህ ጥናት ለመሳተፍ ሙሉ ፍቃደኛነቴን ከዚህ በታች ባስቀመጥኩት ፊረማዬ/ የጣት አሻራዬ እገልፃለሁ።

የተሳታፊ ፊረማ/ የጣት አሻራ ______________________________
ቀን____

ለጥናቱ መረጃ ስብሰባ ቡድን

ለጥናቱ ተሳታፊ ስለጥናቱ ባህሪ ባለኝ ሙሉ እውቀት አበራርቼላቸዋለሁ። እርሳቸውም የጥናቱን አላማ፤ ሒደት እንዲሁም ጥቅሞች እና ስጋቶች መረዳታቸዉን ከልቤ አምኛለሁ።

የቃለ መጠይቅ አድራጊ ስም:____

የቃለ መጠይቅ አድራጊ ፊርማ:____

ቃለ መጠይቅ የተደረገበት ቀን:____