

Hidden healthcare populations

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Title:

**Hidden healthcare populations: using intersectionality to theorize the experiences of
LGBT+ people in Nigeria, Africa**

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Abstract

Minority population groups are often excluded or marginalized within health systems and in health research and policy. This article argues that theories of intersectionality can help us to understand these issues and develops the concept of “hidden healthcare populations” – using the case of people who identify as Lesbian, Gay, Bisexual, Transgender Plus (LGBT+) in Nigeria, in sub-Saharan Africa. The findings present original qualitative data from a seldom heard population group about instances of abuse, rejection and marginalization by healthcare providers working in public and private healthcare facilities, and the attempts of LGBT+ people to resist and survive in that context. We extend theoretical understandings of intersectionality in global public health, and explore how the concept relates to the social determinants of health. The article has significant implications for policy and healthcare education and responds to a call from the World Health Organisation to generate context-specific data to guide interventions targeted at minority population groups. Additionally, our discussion has wider significance because it highlights the Western-centric nature of much theory in health policy – and offers analysis and reinterpretation that incorporates queer, postcolonial, African perspectives.

Keywords:

LGBT+, health inequalities, HIV/AIDS, religion, intersectionality, decentred policy analysis

Introduction

People who are part of marginalized, minority population groups, whether based on ‘race’ or ethnicity, religion, language, migration status, sexual orientation or gender identity, have consistently been shown to exhibit poor physical and mental health outcomes on a range of measures (Akintunde, et al. 2019; Fish 2006; Hughto, et al. 2015; Marchia 2018; Marmot, et al. 2008; Meyer and Northridge 2007; Wilkinson and Pickett 2010). To compound this, these populations are often deemed ‘hard to reach’ and are excluded from much mainstream epidemiological research – either by design (e.g. not resourcing translation of questionnaires) or by omission (e.g. just not asking about issues such as sexual orientation or gender identity) (Yancey, et al. 2006). Issues of sexual orientation and gender identity are less common as a focus for research on the social determinants of health, and particularly in low and middle income countries. In this article, we use theories of intersectionality to help us to research and understand the experiences and health practices of people who identify as LGBT+ in Nigeria, in sub-Saharan Africa and the implications for health policy. We define LGBT+ as people who identify as Lesbian, Gay, Bisexual, Transgender and/or in other ways that do not conform to cisgender and/or heterosexual societal norms (‘Plus’). Qualitative data about the health experiences of LGBT+ people in Nigeria (particularly lesbians and transgender/gender questioning people) have rarely been reported in academic journals, with some notable exceptions in an emerging body of literature about LGBT+ people’s lives and health in Nigeria (Balogun, et al. 2019; Crowell, et al. 2017; Crowell, et al. 2019; Keshinro, et al. 2016; Okanlawon 2017; Okanlawon 2018; Rodriguez-Hart, et al. 2017). We argue that it is useful to theorize this group as a ‘hidden healthcare population’. We explicate this new concept in this article and offer suggestions for future research and debate.

The World Health Organisation has highlighted the urgent need to generate context-specific data to guide interventions targeted at minority population groups in different settings (WHO 2011) and social science research is a powerful tool in this goal (Nom 2005). The WHO Director-General in his statement marking the Human Rights Day in 2017 declared discrimination in healthcare as unacceptable and a major barrier to development (cf. Badgett, et al. 2014; Graham, et al. 2011). Minority populations can be excluded in a number of ways - politically, culturally, socially and economically – which can weaken their social bonds and deprive them of social support which is vital for good health (WHO 2011).

In the context of post-colonial Nigeria, LGBT+ people are excluded along each of these dimensions: the political and legal system criminalises them through laws inherited from the era of colonialism (Ajibade 2013). These form the basis on which even more stringent laws against LGBT+ people have been brought into statute, most recently through the Same Sex Marriage Prohibition Act (Beyrer 2014; Okanlawon 2019), which not only prohibits a marriage contract or civil union (e.g. living together) entered into between persons of same sex, but also provides penalties for those who aid or abet such a union or its solemnization, prevents the registration of gay clubs, societies and organisations, and prevents public displays of same sex affection (Obidimma and Obidimma 2013; Semugoma, et al. 2012). A lack of clarity about how the law applies to healthcare professionals means that many are fearful to treat LGBT+ people for fear of being perceived as criminal collaborators (Sekoni, et al. 2016). Culturally, only binary gender and heterosexual relationships are recognised, particularly through the lens of the dominant (post-colonial) religions, Christianity and Islam. Despite the colonial legacy of these laws and religions, institutional and legal discrimination has become a politically acceptable method for holding onto what is perceived as culturally 'African' and rejecting Western ideas and values (Ajibade 2013; Dramé, et al. 2013). Religion

serves as a political and cultural rallying point in a diverse country with many ethnic and regional divides. The narrative of 'moral decadence' by religious leaders in Nigeria is epitomised by LGBT+ identities, labelled as 'deviants'; sexual deviancy is framed as being responsible for the country's social problems and in turn for the nation's economic downturn and, therefore, requiring of firm policing and social control (Epprecht and Egya 2011; Obadare 2015; Okanlawon 2017). In this context, the political classes (with the support of the national media) have taken steps to align legal structures to the religious and social marginalisation. As well as preserving heteronormativity, this measure was framed as countering the perceived threat from Western values (Okanlawon 2018). Economically and socially, there are barriers to equal access to education and employment (Okanlawon 2020). Finally, aspects of the social and public policy underserve and discriminate against the LGBT+ community, such as the health and housing systems. The Nigerian Health system also faces a number of challenges, not least a low physician-client ratio meaning that facilities are overburdened (Kinfu, et al. 2009). However, there are cases where locally developed interventions, that have been sensitive to local power dynamics, have been successful – for instance, the HIV/AIDS lifeline theological curriculum developed as part of the USAID IMPACT project was able to train religious leaders of all faiths to take ownership of and implement HIV/AIDS prevention, care and support programs – which was a key part of the policy story of the reversal of the HIV epidemic in Nigeria (FHI 2007; GHAIN 2012; Sachs 2007).

Theoretical Framework: Intersectionality

The challenges of understanding how different forms of power, privilege and oppression play out in social life have been a foundational preoccupation of (Western) sociologists,

including around gender and 'race'/ethnicity (Du Bois 1903; Martineau 1837). The concept of intersectionality was first coined by Crenshaw, a black American feminist and legal scholar who used the concept to explore the multifaceted expression of oppression experienced by black women in the United States (Crenshaw 1989). She argued that oppression operated in a way that was more than the sum of its parts (i.e. not simply gender plus race) meaning that it was essential to consider how all aspects of identity interacted and reinforced each other. The version of intersectionality proposed by Crenshaw has been adapted and developed many times in the last 30 years to incorporate aspects of identity beyond gender and race and in other historically and geographically-specific contexts (Brah and Phoenix 2004). Indeed, it has been argued that there is strength in the concept's ambiguity – it is both 'catchy and complex' – making it appeal to both empirical researchers and theoreticians and it is a 'good' theory in the sense that it 'compels us to grapple with this complexity in our scholarship' (Davis 2008:76, 79).

As a sensitizing concept for our research with LGBT+ people in Nigeria, its flexibility was a huge strength. At the beginning of the study we literally had no idea where many of our intended participants might be found. AS had previously worked with organisations supporting MSM (men who have sex with men) in the Lagos area and we suspected that their experience may be very different from that of other gender and sexual identities, and from those of different social status, geographical location and religion. We wanted to ensure that we had theoretical tools that could support our investigation of diverse experiences of wider health and healthcare issues, and one that would not reduce our research questions to an axis of men and sexual health or, more specifically, HIV (which is a dominant focus in much health research).

A second strength of intersectionality theory to help inform our study was the concern to 'decentre' the normative subject of feminism, i.e. to be able to offer nuanced rather than stereotyped alternatives to white, Western identities in research and policy. Images of non-Western LGBT+ people in international scholarship are still extraordinarily rare. It was our aim in this study (which was part of a wider investigation of access to healthcare for LGBT+ people in Nigeria), also to decentre the concept of the 'patient' and to explore the health and healthcare experiences of a population that has been legally and culturally erased in Nigeria. Nonetheless, we are aware of our own limitations in this regard in at least two ways. Although for pragmatic reasons we have settled on the terminology 'LGBT+', we recognise that it is problematic in this context (cf. Anderson 1983), as it does not capture the plurality or multiplicity of identities that our participants adopted (as we explore in the findings below). We are also aware that the dominance of the English language globally means that this article is written in this language. This is specifically challenging because Nigeria was colonized by Britain in the nineteenth and twentieth centuries. The experience of our participants is inevitably shaped in fundamental ways by this history, and we are aware how difficult it is to nurture a 'decolonised mind', after the 'cultural bomb' of imperialism that 'annihilate[s] a people's belief in their names, in their languages, in their environment, in their heritage of struggle, in their unity, in that capacities and ultimately in themselves' (Wa Thiong'o 1992), particularly when English is still the official language of Nigeria. We acknowledge some important emerging decolonizing narratives from Nigerian LGBT+ voices and communities, through the use of local and culturally-relevant knowledge and values (Okanlawon 2017).

Finally, a third strength of the concept of intersectionality, is that it has been used widely outside traditional academic settings as a rallying concept in activism and other fields of

praxis to go beyond understanding inequality, to transforming it (Cho, et al. 2013). As Bauer (2014) argues, ‘repeatedly documenting health inequalities that apply to broad segments of a population may serve to reinforce existing notions of the intractability of injustice, while failing to identify intervenable factors that might be candidates for potential solutions’ (Bauer 2014: 11). It is essential to move beyond this to consider and to involve our participants in framing what anti-oppressive services may look like in practice.

Despite its apparent potential for understanding health inequalities, intersectionality remains relatively rare as a theoretical choice in the field of health research (Bowleg 2012; Fish 2008). We make the case in this article about its value – and we demonstrate this by applying and developing the theory of intersectionality in the sub-Saharan African context and using it to understand the experience of minority healthcare populations. We argue that it is essential in this historical and geographical context to consider gender diversity and gender presentation, rather than the more binary concept of ‘women’ per se; and unlike Crenshaw’s concept where race played a key role, this factor is much less relevant in sub-Saharan Africa, where sexual orientation, social status, caste, geography, colonialism, religion and education all play key roles in explicating the interlocking systems of privilege and oppression that serve to exclude LGBT+ people from visibility within systems of healthcare.

In operationalising the concept for use in this empirical context, we found the ‘Intersectionality Wheel’ to be a helpful heuristic (Simpson 2009). Developed by the Canadian Research Institute for the Advancement of Women (CRIA/W/ICREF) in collaboration with community groups in Canada, the wheel is a series of concentric circles: the innermost one represents a person’s unique personal situation and history; the second

circle represents aspects of identity, such as gender, sexual orientation and ethnicity; the third represents different forms of discrimination, such as sexism, racism, heteronormativity and transphobia and the outermost circles represents wider societal structures, such as globalization, the legal system, colonialism and the economy.

Methodology

The aim of our empirical study was to collect, analyse and interpret accounts of the everyday health experiences and practices of LGBT+ people in Nigeria.

Study design, ethics and reflexivity: Methodologies drawing on intersectionality generally emphasize: the importance of desegregating data to expose and interrogate diversity, contextual analysis, critique of policies shaping everyday experiences and, finally, implementation of policy initiatives that are framed in intersectional ways (Yuval-Davis 2006), rather than purely paying lip service to diversity. Most studies using intersectionality theory have adopted qualitative approaches, although there have been attempts to engage with what quantitative approaches can offer (Bauer 2014). However, in this context, quantitative investigations were not appropriate or feasible. Even putting aside epistemological questions about whether intersectionality can be explored using ‘additive’ quantitative approaches, when theoretically it rejects these approaches in favour of concepts of ‘interlocking’ dimensions of privilege and prejudice, there was the more pressing question of whether data could be collected at all in this context.

We take a decentred, interpretative approach, seeking to articulate in this article our participants’ experiences and practices in a detailed way. Ethically, these approaches forefront subjectivity, including experience of pain, exclusion, and symbolic or physical

violence. Conceptually, these approaches challenge the idea that it is purely structural forces that shape policy and politics, by focusing on the personal narratives, beliefs and meanings of the people whose life are shaped by laws and (health) policies and shape it in their turn through praxis. While ethnographically inspired methods, such as participant-observation or situated interviews, are perhaps a natural fit for interpretative approaches that seek to understand practices in context, it would not have been ethical to attempt to do this. Engaging with participants within their own community settings would compromise their safety and that of the researcher, so we felt that anonymous one-to-one, in depth interviews were the best approach.

The research was led by AS who is Nigerian who ensured that the African voice remained the central driver in the research. The work was conducted in collaboration with NG and KJ, British academics, who contributed a critical outsider perspective. As a team, we embodied a mix of intersectional identities, which informed our engagement and analysis of the data (Maxwell, et al. 2016). This study was part of a larger programme of work and is being used to inform educational interventions for medical and healthcare students. Given a widespread perception that homosexuality is a colonial import (although there is a growing counter discourse that it is homophobia that is the colonial import), the authors were aware of the perils of introducing training on LGBT+ issues that were perceived to be Western in origin, which was not clear in its anti-imperialism (Epprecht and Egya 2011).

Ethical approval was obtained from the Lagos University Teaching Hospital Health and Research Committee (ADM/DCST/HREC/APP/1887) as well as the University of Birmingham Research Ethics Committee (ERN_16_0373). To protect research participants and researchers, we drew on the National Health Research Ethics Committee (NHREC) guidance

to ethics committees on the ethical review of research within the context of activities that may be unlawful in Nigeria. There was one ethical issue which we were not able to resolve entirely, which was that a possible unintended consequence of such research can be the increased visibility of a population that had hitherto lived a low-profile lifestyle and the subsequent identification of members for rights-based abuses (Baral, et al. 2018; Tun, et al. 2018).

Access, recruitment and sampling: The target study population was LGBT+ people living in Nigeria. Given the Same Sex Marriage Prohibition Act of 2013 prevents any political organisation around homosexuality, non-governmental organisations (NGOs) that were known informally to support and advocate for MSM were a good way to begin to access the field and build legitimacy for the research and trust with the study population (Balogun, et al. 2019; Hunt, et al. 2019). As a public health physician, AS had a track record of advocating for the rights of LGBT+ people to health and conducting and publishing ethical research. She was, therefore, trusted by the leadership of two collaborating NGOs – one who worked with MSM and the other with lesbians. Recruitment commenced in Lagos, and further participants were identified using a respondent driven (or ‘snowball’) sampling method, whereby each respondent was asked to recommend other people to talk to, which has been shown to be effective in accessing MSM groups elsewhere in sub-Saharan Africa (Adedimeji, et al. 2019; Crowell, et al. 2017) but had not, to our knowledge, been extended to other parts of the LGBT+ community. The research eventually moved to Abuja, involving two further NGOs, to increase the national representativeness, the variety of ethnic groups and the diversity of LGBT+ identities recruited. The inclusion criteria were that participants should be Nigerian and aged over 18 years. We were clear that we were interested in interviewing people who were part of the LGBT+ community. Cognisant of the limitations of

labels, and that our categorizations may have (albeit unintentionally) been shaped by colonial, medical or social frameworks, we encouraged all participants to self-identify in terms of their gender and sexual identity. Information was collected on the socio-demographic characteristics of each interviewee: age, ethnic group, religion, level of education and occupation, sexual orientation and gender identity. Identifying information such as name and home address or employers address were not collected. Table 1 provides an overview of the demographic and identity characteristics of the participants.

[insert Table 1 here]

Table 1: Participant identity and demographics

Data Collection: Thirty-five, face-to-face interviews were conducted by AS between April and December 2016. Most of the interviews were conducted in English or pidgin English, while a few were conducted in Yoruba (which AS is fluent in) and Hausa (when an interpreter chosen by the interviewee was present). Interviews took place either in a private room at community centres operated by collaborating NGOs or in a hotel at a time and place considered safe by the interviewees. All the interviewees agreed to the conversation being recorded on audiotape. A topic guide with prompts was developed that provided a broad framework for the discussion and the interviews lasted between 30-90 minutes.

A semi-structured interview guide with prompts was used for data collection which was analyzed using constant comparative analysis, in line with principles of constructivist grounded theory (Charmaz 2008). After thirty five interviews were conducted and analysed, the team concluded that data saturation had been achieved, with respect to the central research question about LGBT health experiences and our emergent concept of 'hidden healthcare populations'.

Data Management and Analysis: Interviews were transcribed *verbatim* by AS and immediately anonymized. The audio recordings were destroyed as soon as the transcript has been checked for consistency, to minimize risks to participants of identification. Hard copies of the transcripts were stored in a safe, secured locker at the University of Lagos, Nigeria while electronic copies were stored on an encrypted computer at the University of

Birmingham, UK. Initially, a grounded, bottom-up, approach to analysis was taken (Charmaz 2014). AS kept a fieldwork diary throughout the period of data collection which was used for reflection and early analysis. At least once a month, the full team met to discuss the data and early coding in new transcripts, explore emerging themes, reflect on researcher bias and make decisions on sampling, amendments to the topic guide and ultimately to decide when data saturation had been reached. The data were first open coded line by line, and descriptive categories were developed using constant comparison, memos and diagrammatic representations of the data. This helped to identify six descriptive themes: Experience of, and storytelling about health services within the LGBT community; Psychological stressors in a challenging social environment, resilience and mental health; Adaptive mechanisms and coping strategies when healthcare providers are perceived as unfriendly and healthcare facilities become unsafe spaces; Availability and quality of healthcare services for LGBT people; Intersectionality, health inequity and the LGBT community; LGBT community perception of an inclusive and acceptable healthcare provider. Subsequently we introduced an abductive element to our analysis (Tavory and Timmermans 2014) by interrogating the data using theories of intersectionality. From this, the findings were distilled into one 'master' theme – of a 'hidden healthcare population' and two sub-themes that elucidate the experience of being hidden and hiding: 'experiencing discrimination' which speaks to the structural and institutional impacts of discrimination against LGBT+ people and 'connecting to survive' which speaks to the storytelling, network building and other coping strategies to mitigate the impacts of discrimination. We applied an intersectional lens of analysis within each theme, using it to help us understand the various ways in which health inequalities were perpetuated within the LGBT+ population.

Findings

A hidden healthcare population

The concept of 'being hidden' captures a number of elements of the experience and practices of LGBT+ people with respect to their health. First, it captures the literal sense that they feel that others (particularly healthcare workers) are either passively unaware of LGBT+ identities and are not trained how to care for LGBT+ people, or (particularly family members) actively deny their existence.

Second, it speaks to the additional, invisible emotional and psychological effort that is required for LGBT+ people to access healthcare, often through an active choice to 'hide' (more or less successfully) aspects of their gender or sexual identity. This is often compounded by an absence of a social support from family and friends, or an inability to share this aspect of their lives with them, through pressure to conform to cultural norms.

Third, it speaks to the unacknowledged negative consequences of these interactions, such as damage inflicted through inappropriate or inadequate care, chronic stress through concealment of identity, eroded trust and associated underutilization of healthcare services, or trauma from outright discrimination and abuse at the hands of healthcare providers.

Ultimately, the hidden nature of this population group leads to health inequalities, in particular in relation to sexual health and HIV (for MSM and transgender women especially) and mental health (for all members of the diverse LGBT+ community):

Because if you walk into a hospital, when they talk about sex education there is nothing that is talking about those who are same sex persons. They tell you OK to prevent infection from HIV, have protected sex use condoms male and female. They are leaving out the other sexual minorities who are very important like gay men and bisexual men

(R8 34 years, from South-south region, Christian, Employed graduate, Gay, Male, lives in Lagos)

That thing was weighing me down like psychologically I was having the issue everybody here and there attacking me. They are not concerned about my happiness all they are concerned about is marriage, marriage, marriage to a man. I have tried to kill myself before but I didn't die. (R16 30 years, from South-west region, Christian, Unemployed Diploma certificate, Lesbian, Woman, lives in Lagos)

As well as gender identity and sexual orientation, two other personal characteristics emerged as particularly crucial lines of intersection in terms of the extent to which participants felt 'hidden' or were 'hiding': gender presentation and Human Immuno-Deficiency Virus/ Sexually Transmitted Infection (HIV/STI) status.

While many of the participants discussed hiding aspects of their gender identity or sexual orientation to 'pass' as cisgender and straight in (healthcare) situations, those with non-conforming gender presentation, such as 'effeminate' men, lesbian 'toms' and some trans people, found that they had no hiding place. This meant that their exposure to negative attitudes and stigma was present in almost all social situations, and they therefore bore a higher burden of the psychological and emotional stress compared to others in the LGBT+ community, and its health related impacts:

I have never had to tell healthcare worker that I am a Trans person. If they just see me like this even if they are many there they will just ask. It's even the person you think that is responsible that will say hey are you a girl or a boy they will start looking like this "what's that". (R20 25 years, from Northern region, Christian, Sexual Orientation Undisclosed, Trans man, Unemployed Secondary school certificate, lives in Abuja)

Lesbians [can] seek for health services in any facility; I don't think lesbians really have problems like that, unlike MSM. It's only the tom boys when they see them like this they just conclude. They see females that act as chicks and they won't know they are into it and they don't tell people who are not members of the [LGBT+] community so they don't have problems (R14 27 years from the South-west region, Christian, Lesbian, Tom, Self-employed, always lived in Lagos)

Participants explained that they had developed their skills in picking up the subtle signs and cues, such as a disapproving look or a change in countenance of the healthcare provider that represented an early danger sign. In some cases, if their sexual identity was at risk of being exposed they lied to cover it up and protect others. In this case, by pretending that they were a sex worker:

The fear was they will ask you how did you have it? He can't just open up so we had to kind of agree on the trick to use. He went to a private hospital. When the interview was going on, the doctor said he should tell him the truth are you gay? My friend confessed and the doctor still tried to kick against it. He had to tell the doctor that, he sleeps with men to get money to take care of himself, he is staying with his aunt who doesn't take care of him. That was the lie he had to give to escape being asked to bring his sexual partner. (R1 26 years, from South-south region, Christian, Unemployed graduate, MSM, lived in Delta & Lagos)

Known HIV or STI status can catapult a person to the fringe of many of their social networks. Many HIV positive people hide their HIV status and fear discovery. Choosing a health facility to access HIV or STI related services, such as antiretroviral drugs (ARVs) is mediated by

attempt to keep their HIV or STI status a secret from the wider community, including friends, family and the rest of the LGBT community:

Even when I heard of the community centre ----- I didn't want to be seen entering the pharmacy because I have been there and people are like haaaa what is he doing in the pharmacy and people are like they probably want to give him ARVs and I don't want to be so identified I have been getting them from General Hospital. I still have to deal with the crowd. (R5 27 years, from South-west region, Muslim, Unemployed graduate, Gay, Man, always lived in Lagos)

Experiencing discrimination

All participants talked about their fears or experiences of discrimination from staff in healthcare facilities, which caused a great deal of anxiety about accessing services, fear of rejection and fear that their confidentiality would not be respected. They linked this to dominant religious and cultural beliefs:

Sometimes the way they look at you and their body language you feel rejected. (R12 22 years, from south-south region, Christian, Gay, Questioning Trans woman, Student, lives in Lagos)

I think public and private hospital should pass information to hospital that these people are also created by God for me that is enough because if they are trained they would get to know who these people really are because to me what most people that are not LGBT always say these people they are cursed. (R25 26 years, from the south-south region, Muslim, Polytechnic diploma, Unemployed, Gay, Transwoman, lives in Abuja)

In many cases, they reported healthcare professionals refusing to treat them or others in the LGBT+ community, often threatening them with or actually calling the police and in the most extreme cases, this resulted in death:

I carried my friend to one private hospital because he was sick, when the doctor came I told him this person is gay and HIV positive and he said go ... I was begging the doctor, he said there was nothing he could do, he wouldn't treat, we looked for money, carried the person to the village and 3 days later he died (R18 28 years, from the Northern region, Muslim, Sexual Orientation Undisclosed (states that is a sex worker for male 'customers' and 'boyfriends'), Trans woman, Peer Educator, lives in Abuja).

People with mental health conditions or men and transgender women with sexual health conditions often faced the greatest barriers, because it was harder in these contexts to hide their LGBT+ identities. Mental health services are available only in specialised, tertiary health facilities in Nigeria. For LGBT+ people who require this service and make an attempt to access it, interaction with providers can be very unsatisfactory and may worsen their mental health status:

I now explained everything that happened to me to the psychiatrist, he now said 'wait, do you know that this thing you are doing is illegal in this country, if you want to practice all those things your homosexual acts you should travel out of the country, yes. In ICD8 homosexuality was once a mental disorder but now the white men are trying to do what suits them that is why they decided to remove it from subsequent ICDs they produced' ... I had to leave (R5 27 years, from South-west region, Muslim, Unemployed graduate, Gay, Man, always lived in Lagos)

In the gap left from cis/heteronormative health services, NGOs have trained LGBT+ people as peer educators to provide information and educate community members. This has helped in bridging the gap left by the lack of mentors, role models and LGBT+ knowledgeable parents/elders in wider society. Generally, NGO clinics were observed to provide culturally appropriate care and patient satisfaction with services was high:

If I am sick, I will go NGO [non-governmental organisation offering healthcare services to MSM]. They know I am a Trans now and they treat me very well and still, they give me lubricants, condoms. (R21 26 years, from Northern region, Muslim, gay, Trans woman, Unemployed Diploma certificate, lives in Abuja)

A few respondents recounted instances of receiving inclusive care from healthcare providers working in public facilities. Notably, it was highly educated, English speaking participants who recounted these experiences:

There is this pharmacist I had he is a very good pharmacist. I told him I had anal sex he is learned he treated me. I think he felt comfortable more when I opened up to him because he told me I have made it easy for him to know what prescription to give me. He gave me good treatment (R15 28 years, from South-west region, Christian, Employed graduate, Bisexual, Man, lives in Lagos)

I have had to disclose my sexuality to our family doctor at General Hospital. He was just his usual self and he didn't tell anybody. He said oh, really, take good care of yourself ooh many diseases are out there. (R10 22 years, from South-west region, Muslim, Self-employed graduate, Gay, Man, lives in Lagos)

Another dimension of difference in the data was a clear urban/rural divide. Those from rural areas had no access to NGO services unless they travelled to the big cities:

There is no place in [town] they treat MSM that is why MSM in [town] are scared to go to hospital ... they don't do seminar, no lecture, no orientation on how to protect themselves nothing it's only in Lagos here that I see things like that. (R2 22 years, from South-east region, Christian, Awaiting University admission, Gay, Man, lives in Warri & Lagos)

Some participants noted improvement but pointed out that they were not universal:

I wouldn't say there is completely no improvement there is but it's not so significant like that to say organizations can now rely literally on all healthcare facilities within the state to send people to for referrals and things like that (R35 32 years, from South-west region, Christian, Employed graduate, Bisexual, not male/female, lives in Lagos)

The psychological and emotional impact of discrimination was serious with many participants reporting suicide ideation and attempts:

Before if I feel very sad I cry, some months back I attempted suicide. I wasn't working, things were just not balanced for me, things were just going wrong. I was having this issue with my family concerning my sexuality they were just pushing me and I am not ready to come out to them. I know I have to come out to them eventually. I started hearing stories from other people about their attempts to commit suicide; they were saying if I tell you what I did ----- (R3 26 years, from the South-east region, Christian, Gay, Man, Employed graduate, lived in Anambra & Lagos)

Connecting to survive

In order to survive in this context, participants reported changing their practices and reaching out to build safe networks of support, sharing ideas and experiences through oral storytelling. These connections served to both deal directly with the challenges of accessing healthcare by sharing health related information and signposting each other to where they can access safe healthcare services:

Some will say when they go to the hospital to access healthcare the doctor will start preaching to them. You will just hear stories. The nurses or the receptionist in the hospital talking, looking down on them, openly condemning them, pointing at them. (R3 26 years, from the South-east region, Christian, Gay, Man, Employed graduate, lived in Anambra & Lagos)

and more generally to enhance wellbeing, thereby mitigating the adverse effects of marginalisation. This sense of companionship alleviated loneliness, feelings of isolation and afforded people the opportunity to come out of hiding and express themselves openly:

What I do to always make myself happy, I always like myself being in the midst of my fellow LGBT we can discuss so many stories, small, small gossip about our friends, we are always happy if we are just in a group (R24 24 years, from South-south region, Christian, Gay, Trans woman, Employed, lives in Abuja)

The ability to participate in supportive communities was heavily shaped by various factors, such as geography, with rural dwellers finding it more difficult to connect with other LGBT+ people. Illiteracy and/or being Hausa speaking was also major obstacle to finding support:

In Kano they speak Hausa to them if you can't speak Hausa you get somebody that speak English ask them and later will be translating to you. That's a big problem we have in our community. Illiteracy is the worst stigma because most of them have

something they have their handwork they have their business but illiteracy is the worst.

(R23 33 years, from Northern region, Muslim, Self-employed graduate, Bisexual, Male, lives in Abuja)

Education and social status was also important offering a wider network of people from whom to draw support and the financial resources to access information, such as through the internet:

Prior to my diagnosis I didn't know any LGBT organization exists so I will think there are also people like this out there who do not know LGBT organizations where they can go to, to get information. Then I was just living my life. To access health information I go online on such but that is because I understood that I could get information from such, there are people who are not aware of getting information online. (R13 25 years, from south-west region, Spiritual, Gay, Unemployed graduate, Male, always lived in Lagos)

Participants talked about the importance of finding strategies to ward off depression:

I wouldn't allow depression, I fight depression, I know it hurts me more when I am depressed. It pains me when someone is insulting me and I can't talk back, I feel more pain so I ignore him. I try to be myself, forget him, feel free, I try to be happy whether there is food or no food to eat. Just laugh. Just be happy (R1 26 years, from South-south region, Christian, MSM, Man, Unemployed graduate, lived in Delta & Lagos)

As well as social networks of support, most of the participants talked about their religious belief as being a cornerstone of their ability to maintain their mental health, believing that their identity was 'from God':

Sometimes, if you think about your life as a trans person, you may be unhappy but if you believe that everything is from God then you will have peace of mind and continue with your life. (R26 18 years, from Northern region, Muslim, bisexual, Trans woman, Unemployed Secondary school certificate, lives in Abuja)

The resistance shared by participants reflected their socially hidden nature and their caution of emerging from the perceived safety of hiding. Only one of our participants, who was also highly educated and economically secure, explicitly stated that he would resist discrimination in healthcare facilities:

But me I tell people I have high self-esteem anywhere I will walk into anywhere I want to walk into if you talk any jargons I will stand up and tell you, are you done? Can I see the next person. That's it I don't allow anybody to intimidate me ooh. I will just walk in and say my own if you are not ok with it show me someone I can meet. (R6 30 years, from South-south region, Christian, Employed graduate, Bisexual, Male, lives in Port Harcourt & Abuja)

Discussion

Our findings highlight that the synergies between postcolonial cultural norms, religious beliefs, social and economic practices, and laws that criminalise those in same sex relationships and those individuals that support them have important implications in the context of healthcare. LGBT+ people participating in this study reported abuse and discrimination during clinical encounters both in public and private health facilities. Our decentred, interpretative approach, however, was able to demonstrate that people are not simply beholden to the social system and institutional structures. They were able to enact

coping strategies – in particular through building networks of support, sharing information via storytelling, and building ‘safe’ communities where they could be themselves. Finally, they develop personal resilience, through educating themselves on the health system, learning to anticipate negative reactions and adjust their behaviour accordingly to avoid conflict, and through making peace with themselves as being ‘from God’. Our intersectional analysis allowed us to recognise that access to these coping strategies was not universal.

Although it was the exception rather than the norm, some of our participants had good experiences of public and NGO facilities that show that inclusive, culturally-sensitive care can be provided even within the discriminatory legal, cultural and religious context, and that some individuals were able to resist discrimination and navigate the system more safely. Our research was able to demonstrate how those from more privileged backgrounds, or those able to conceal parts of their LGBT+ identity were better able to engage productively with the health system. Our own sample did not include any individuals who were political activists, and apart from those who had aligned themselves to NGOs or were working as peer educators, we also saw little evidence within our sample of attempts at enacting wider social change – the focus was survival. However, other research shows that there are spaces in Nigeria where more explicit activism and political resistance is happening in LGBT+ communities, despite its potential to contravene Nigerian law (Okanlawon 2018).

A particular theme that emerged from our data was the ambivalent position that religious beliefs held for our participants. As well as religion being experienced as a justification for discrimination against LGBT+ ‘others’, religious belief was a crucial component of LGBT+ people’s acceptance of the ‘self’ and religious practice a coping mechanism to promote mental health stability. There remain, however, potential issues in seeing religion as an

asset for this hidden healthcare population because this ambivalence can create challenges, with some people experiencing conflict and internalised homophobia (Collier, et al. 2013; Sandfort and Reddy 2013).

[insert Figure 1 near here]

Figure 1: Hidden Healthcare Populations – the case of LGBT+ people in Nigeria

The implications of our findings (visually summarised in Figure 1) are that many LGBT+ people (out of both circumstance and choice) are completely hidden from the purview of public policy. Even as an active and trusted researcher in the field, AS had to adopt a snowball sampling strategy to identify participants for this study. We have demonstrated that in public health terms the LGBT+ community is a ‘hidden healthcare community’ – and that for the people in this community, the experience of being hidden and of hiding aspects of the self potentially has a hugely detrimental effect on their physical and mental health (cf. Giannou and Ioakimidis 2019). We have also demonstrated that within the LGBT+ community there are many intersections of oppression – along the lines of gender identity, gender presentation, types of health problem, social status, education and literacy, language and income – all of which have implications for exacerbating health inequalities

While there have been prior interpretative studies with Nigerian gay men and MSM about their health (Emmanuel, et al. 2019; Rodriguez-Hart, et al. 2017), some quantitative studies of transgender women’s health (Jones, et al. 2020; Keshinro, et al. 2016; Kokogho, et al. 2020), and some explorations of lesbian experience (non-health) in Nigeria (Thoreson and Cook 2011), this study is the first, to our knowledge, that uses qualitative data to give voice to Nigerian lesbians, transgender women, transgender men and people questioning their

gender identity with respect to their health experiences. While it is inevitable that there are many people whose voices we were not able to access and whose contribution would have enriched our study, in particular those afraid that their participation may have compromised their safety, or those who were still living in rural communities that we found more difficult to gain access to, we are confident that our findings offer a significant advancement of empirical knowledge about this hidden healthcare population.

In theoretical terms, we have shown that the concept of intersectionality can be transferred productively to both a healthcare context and a sub-Saharan African context, albeit that adaptations need to be made to the theory. We moved quite far from the original theoretical formulation of a gender/race intersection, but we continued, we believe in the spirit of the theory, the journey to create new, alternative normative subjects of research – queer, postcolonial and African ones. Our research suggests a clear case for unbundling the term LGBT+ both in research and in designing public and health policies in ways that are sensitive to the diverse needs of each subgroup – including in research and programme/intervention design and implementation. However, in terms of lobbying and advocacy in the policy spheres, building solidarity between subgroups would strengthen the political voice.

Within the oppressive socio-political context, there is an urgent need for studies to help address LGBT+ health inequalities (Giannou and Ioakimidis 2019). Relevant studies may address how it would be possible to support LGBT+ people, for instance through using religion to achieve mental wellness and reduce the impact of various types of trauma. Local evidence is needed to harness powerful religious and cultural influence for the promotion of health equality through policy making and programme/intervention implementation. At a

national level, legal research is needed to explore the (re)installation of a human right to health, regardless of sexual orientation and gender identity. LGBT+ advocates need robust evidence on the negative health consequences of the criminalizing laws to convince religious and community leaders, who may then be willing to support changes to the law.

The policy implications of our study are far reaching. Health disparities are reported informally among the LGBT+ population in Nigeria but legal constraints make it virtually impossible to gain a sense of the scale of the inequality. Individual level approaches that buffer the impact of the psychosocial stressors are urgently needed but insufficient for long-term change, which would also require wider political initiatives to effect structural change to the Nigerian health system. Multilevel interventions are likely to be required to improve LGBT+ population health outcomes in Nigeria, which may include at the macro level, actions such as repealing discriminatory laws (as some Nigerian activists are campaigning for), at the meso level, professional interventions such as guidance to healthcare professionals about their ethical responsibility to treat all patients equally. Our own work is looking to understand and improve the extent to which new doctors and other healthcare professionals are educated about LGBT+ health issues and care. At a micro-level, confidential support groups for LGBT+ people run in the community might be helpful to increase personal resilience.

Conclusion

Bringing queer, postcolonial and African perspectives of intersectionality to this study of the health and healthcare experience of LGBT+ people in Nigeria has enabled us to document and analyse previously unheard voices in studies of health inequalities. It has allowed us to

frame and understand why LGBT+ people in Nigeria are a ‘hidden healthcare population’, which is a concept which would be transferable to a huge number of different policy settings and countries in the global South (and potentially elsewhere). While developing this overarching concept, our approach ensured that we did not erase the diversity within the LGBT+ community. We were able to show the constraints of socio-political and institutional factors on individual health experiences, while also recognising the intersection of different axes of disadvantage when understanding the resources people have to draw on as they attempt to resist marginalization and to survive in this oppressive context.

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Declaration of Interest Statement

The authors declare no competing interests.

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Identity/demographic characteristics	N (35)
Age	
<25 years	11
25 -34 years	20
>35 years	4
Region	
South east	5
South-south	10
South west	11
North	9
Education	
Primary school	2
Diploma	13
Secondary school	8
Higher education	12
Sexual orientation (self-defined)	
Gay	14
Bisexual	8
Lesbian and Lesbian Tom	8
Questioning	2
MSM	1
Heterosexual	2
Gender identity (self-defined)	
Man	13
Woman	7
Transwoman	10
Transman	2
Questioning Transwoman	2
Neither male/female	1
Religion	
Christian	23
Muslim	11
Spiritual	1
Residence	
Always lived in Lagos	18
Lived in Lagos and other states	4
Always lived in Abuja	6
Lived in Abuja and other states	7
Employment status	
Student	3
Employed	13
Unemployed	19

Table 1: Participant identity and demographics

