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The Mental Health of Male Sexual Minority Asylum Seekers and Refugees in Nairobi, Kenya: A Qualitative Assessment

Lourence Misedah-Robinson[a] , Vanessa Schick[a], Michael W. Ross[b] and Solomon Wambua[c]

ABSTRACT

Very little information exists about the experiences of asylum seekers and refugees who are men who have sex with men (MSM). Therefore, this study explores the psychological distress of MSM asylum seekers and refugees in the Nairobi metropolitan area. We collected data using in-depth interviews transcribed verbatim, coded using NVivo 12 Plus, and analyzed using the six-step thematic analysis framework. Four major themes emerged from the study: psychological distress, traumatic stress symptoms, mental health care access, and coping strategies. Although we did not use any diagnoses, the results indicate that MSM asylum seekers and refugees share mental health problems with other refugees. However, MSM have specific needs that derive from their persecution based on their sexual minority status. The results confirm extant findings, as seen in the discussion, and encourage more research. Further research will inform collaborative, culturally sensitive, and targeted interventions that decrease adverse mental health outcomes for MSM asylum seekers and refugees in the Nairobi metropolitan area.

KEYWORDS

MSM asylum seekers; MSM refugees; mental health

RESUMÉ

Peu d'informations existent sur le vécu des demandeurs d'asile et réfugiés qui sont des hommes ayant des relations sexuelles avec des hommes (HARSAH). Par conséquent, cette étude explore la détresse psychologique des demandeurs d'asile et réfugiés HARSAH dans la région métropolitaine de Nairobi. Nous avons procédé à la collecte de données en effectuant des entretiens approfondis dont les verbatims retranscrits ont été codés à l'aide de NVivo Plus 12, puis analysés suivant une analyse thématique en six étapes. Quatre thèmes principaux émergent de cette étude: la détresse psychologique, les symptômes de stress post-traumatique, l'accès aux services de santé mentale et les stratégies d'adaptation. Bien que nous n'ayons utilisé aucun diagnostic, les résultats indiquent que les demandeurs d'asile et réfugiés HARSAH partagent des problèmes de santé mentale

CONTACT

[a] (Corresponding author) ✉ lourence.misedah@uth.tmc.edu

School of Public Health, The University of Texas Health Science Center at Houston, Houston, TX, U.S.

[a] ✉ Vanessa.Schick@uth.tmc.edu

School of Public Health, The University of Texas Health Science Center at Houston, Houston, TX, U.S.

[b] ✉ mwross@umn.edu

Medical School, University of Minnesota, Minneapolis, MN, U.S.

[c] ✉ solomonwambuad@gmail.com

Key Population Consortium of Kenya [KP Consortium]

avec d'autres réfugiés. Les HARSAH ont cependant des besoins spécifiques qui découlent de leur persécution sur la base de leur appartenance à une minorité sexuelle. Ces résultats confirment ceux des travaux existants, comme le démontre la discussion, et appellent à davantage de recherches. Des recherches plus approfondies contribueront à l'élaboration d'interventions collaboratives, culturellement adaptées et ciblées afin de réduire les effets néfastes sur la santé mentale des demandeurs d'asile et réfugiés HARSAH dans la région métropolitaine de Nairobi.

INTRODUCTION

Sexual and gender minorities (SGM), including men who have sex with men (MSM), are at a higher risk of psychological distress than their cisgender heterosexual counterparts (Semlyen et al., 2016). Some studies have also linked sexual minority–based persecution with a heightened vulnerability to depression, anxiety, and suicide compared with the general population (Shidlo & Ahola, 2013). The minority stress model is a tool that has long been used for understanding stress in stigmatized and disadvantaged groups (Meyer, 2003). According to the model, certain environmental circumstances or sexual minority status can result in various stress processes. Such processes—for example, the expectation of rejection—can result in self-hate and fear of identity disclosure, thus heightening stress and adverse health outcomes (Meyer, 1995).

There is little research on the mental health of MSM within East Africa. However, evidence indicates that MSM status intensifies stress, trauma, and mental health sequelae due to discrimination, violence, and abuse. For example, a third of the MSM in a study in Coastal Kenya met the criteria for depressive disorder, with 42% reporting moderate to severe depressive symptoms (Secor et al., 2015). The distress rates of MSM were thus significantly higher than the estimated 4% among the general Kenyan population (Ferrari et al., 2013).

Globally, many people flee their countries of origin or residence because of persecution, war, and conflict. Consequently, many experience traumatic events and stressors throughout their migration life course that may increase psychological distress (Henrickson et al., 2013). Ample evidence supports the association between fleeing persecution and adverse mental health outcomes, such as depression and post-traumatic stress disorder (PTSD) (Porter & Haslam, 2005). Numerous studies also suggest that pre-immigration traumatic experiences and post-immigration stressors contribute to the adverse mental health of refugees (Steel et al., 2017).

Because of discrimination, physical abuse, and injuries, many MSM flee their home countries, even crossing multiple borders to seek protection from sexual orientation–based persecution (Nilsson et al., 2020). Unfortunately, the vast majority of persecuted MSM lack resources to travel to countries with sexual orientation and gender identity (SOGI)–based protections (such as South Africa), and they flee to Kenya instead (Johnson, 2014). However, sections 162 and 165 of Kenya's Penal Code outlaw same-sex acts. The violations can carry sentences of up to 14 years in prison "for having carnal knowledge … against the order of

nature" (Laws Of Kenya, 2014; Meyer, 2003). Although the laws are rarely implemented, they are used to justify various human rights abuses of SGM, such as housing and employment discrimination, violence, police harassment, and extortion (International Lesbian, Gay, Bisexual, Trans, and Intersex Association (ILGA), 2017; Kenya Human Rights Commission, 2011; Misedah et al., 2021b).

MSM asylum seekers and non-MSM refugees may experience traumatic events that cause them to flee. However, there are important differences in their experiences. For example, the United Nations High Commissioner for Refugees (UNHCR) collaborates with various service providers to increase refugees' and asylum seekers' access to reproductive health, HIV, and mental health services. Nevertheless, MSM asylum seekers and refugees are still most likely to experience further persecution because of societal, legal, cultural, and religious norms and practices that outlaw same-sex practices (Misedah et al., 2021b; Ross et al., 2021). The UNHCR acknowledges these disparities and has released various guidelines on working with claims based on SOGI in 2008 and 2012, followed by a more comprehensive report in 2015 (UNHCR, 2012; 2008; 2015). Despite these guidelines, MSM and other SGM continue to face persecution. In addition, unlike other refugees who may benefit from support from refugee communities, MSM asylum seekers and refugees are often alienated and physically abused by other refugees and community members where they live. For example, in 2016, other refugees attacked SGM asylum seekers and refugees at the Kakuma camp. As a result, the UNHCR relocated SGM refugees to Nairobi (Bhalla, 2019). Experiences of discrimination can lead to distrust and fear of disclosing same-sex behavior. Consequently, providers can overlook SGM refugees' and

asylum seekers' specific needs and exacerbate their psychological distress (Bhugra et al., 2011).

Some studies have found an association between adverse mental health outcomes among general refugees in Kenya. For example, a study of Somali refugees in Kenya found a high prevalence of comorbid common mental disorders (Antebi-Gruszka & Schrimshaw, 2018; Im et al., 2022). However, the specific case of MSM asylum seekers' and refugees' migration experiences and the associated psychological distress have rarely been studied. This study's aim was to explore MSM asylum seekers' and refugees' mental health in the Nairobi metropolitan area to address this gap. Increased understanding of the mental health needs of MSM asylum seekers and refugees is critical to develop targeted interventions, policies, and programs to improve their health.

METHODS

Study Design and Setting

This study is a qualitative analysis of a more comprehensive project exploring MSM refugees' and asylum seekers' experiences in the Nairobi metropolitan area. The Nairobi metropolitan area includes the cities of Nairobi, Kiambu, Kikuyu, and Kajiado. The analysis focuses specifically on asylum seekers' and refugees' psychological distress. The study adapted the life story interview (LSI), a semi-structured interview guide with various prompts to explore and collect data on individuals' past and present lives (McAdams, 2007). In addition, we conducted stakeholder mapping to ensure community involvement and the project's success (Newcombe, 2003). We brainstormed to identify stakeholders and local partners, including refugee service providers and SGM-led refugee community-based organizations.

We then mapped, grouped, and prioritized them to identify those with interest and the likelihood of contributing to the project's success. As a result of these efforts, we collaborated with Community Support Initiatives for Refugees, the Refugee Organization for Security and Cooperation in East Africa, the Nature Network, and the Community Empowerment and Self Support Organization to conduct the study. The study lasted for two weeks in the first quarter of 2020. Aspects of this research have also been reported elsewhere (Misedah et al., 2021a,b).

Participants

The participants were MSM asylum seekers and refugees. To participate, they had to be (a) a refugee or asylum seeker, (b) 18 years of age or older, (c) a cisgender male, (d) gay, bisexual, or other MSM, (e) able to communicate in English or Swahili, and (f) a resident of the Nairobi metropolitan area. Participants also had to provide oral consent. The interviewer collected oral consent with Qualtrics using a laptop. In the study, **MSM** referred to men assigned males at birth who engaged in sexual activities with other males regardless of their identity. This included sexual minority men who were gay or bisexual men, men who have sex with men and women (MSMW), and non-gay-identified MSM. We only included cisgender males in the study because research and policies highlight that aggregating transgender and gender non-conforming individuals with cis men or women erases and ignores their specific health needs, further increasing health disparities (Minor Peters, 2016; Poteat et al., 2016). As per the 1951; 2003 Convention relating to the Status of Refugees, we defined **refugees** as people who had fled their country because of persecution based on race, religion, nationality, membership in a social group, or political opin-

ion. **SGM** are recognized as members of a social group based on the 1981 ruling of the Dutch Judicial Department of the Council of State (Jansen, 2013). **Asylum seekers** included those seeking their right to protection in the host country (Kenya) but still awaiting a decision on their protection claims.

Sampling Design

We used purposive sampling to select participants (Tongco, 2007). Purposive sampling is widely used in qualitative studies and is appropriate for hard-to-reach populations, including SGM refugees and asylum seekers (Alessi, 2016; Alessi et al., 2017; Etikan et al., 2016). We estimated our final sample size of 19 respondents based on saturation. The study team debriefed and conducted a preliminary analysis focusing on duration of stay in Nairobi and registration as refugees. Nine participants had received their refugee status in the last year. Therefore, we agreed that there would be no major differences and that no new information was emerging. Thus, we ceased gathering new information from the participants (Suen et al., 2014). We therefore did not make further recruitment attempts.

Data Collection

The identified community-based organization partners sent out emails or text messages to advertise the study. The study coordinator followed up by contacting those interested. Next, the study team screened the participants for eligibility. They also collected other demographic data—for example, native language, nationality, and education—using Qualtrics. Next, the principal investigator (PI) used an interview guide to administer one-time anonymous in-depth face-to-face interviews. Participants were encouraged to

share their narratives with the interviewer by asking follow-up questions and probes. The interviews averaged 80 minutes (range: 32.32–115.20 minutes). Each interview was audio-recorded using two recorders, one as a backup to prevent data loss. Seventeen of the interviews were in English, and two were in Swahili. All interviews were conducted at the participant's residence or a private location to ensure each participant's security and comfort. Each participant received 1,000 Kenyan shillings (Kshs) (US$8.74) for each visit recommended by the community partners. Participants reported that they previously received a stipend of 6,000 Kshs (US$52.63) a month from the Hebrew Immigrant Aid Society (HIAS) refugee trust of Kenya. This was consistent with other researchers' findings that almost half of refugees earned below 10,000 Kshs (US$87.31) compared with the 2015 national average by Kenyans, estimated at 30,861 Kshs (US$262.69) by the government of Kenya (Refugee Consortium of Kenya (RCK), 2015; Kenya National Bureau of Statistics (KNBS), 2015; Meyer, 2003).

Initial transcription was done with NVivo transcription software. However, substantive transcription errors occurred due to dialect differences and certain regional words. Therefore, the PI and an independent consultant transcribed the remaining interviews verbatim to Microsoft Word. The consultant was a community member with current knowledge of the local vocabulary and helped translate the transcripts from Swahili to English. All transcripts were then checked and anonymized where participants had shared any identifying information to protect participants' privacy. Because the study was anonymous, participants were not contacted for a follow-up interview to review and give feedback on the research findings. However, the researchers shared feedback and findings with the community partners.

Data Analysis

We uploaded the transcripts to NVivo 12 Plus for analysis. The analysis was inductive and guided by the study aim based on Braun and Clarke's six-step thematic analysis framework to identify key codes and themes from the data (Braun & Clarke, 2006; Kenya National Bureau of Statistics (KNBS), 2015; Refugee Consortium of Kenya (RCK), 2015). NVivo assisted the researchers in efficiently coding, sorting, and merging the data and offered easy cross-referencing for clarity. The PI conducted the coding using the following steps:

1. **Familiarization :** The PI read and reread the transcripts and listened to the audio files to understand the data.

2. **Coding:** Each file was reviewed in detail, highlighting key ideas, phrases, and words grouped into initial codes. Quotes were then added to existing codes, or new codes were created. Finally, the transcripts were cross-referenced with the interview audio files to clarify and identify codes and assumptions that were not evident. The PI also used NVivo's query function to search for common recurring words that had emerged during initial coding.

3. **Generation of initial themes:** The codes were assessed to identify patterns and then grouped and sorted into common themes.

4. **Reviewing of themes:** The initial themes were reviewed. Then, similar themes were merged into subthemes, and minor themes were collapsed where necessary.

5. **Defining and naming themes :** The themes were manually downloaded to

a Microsoft Excel sheet. The codebook identified the codes and themes and the descriptions for each theme. It also described when to use them and when not to use them.

6. **Write- up:** The codebook was then used to contextualize and write the analysis.

The thematic analysis provided a flexible approach that ensured a rich, detailed account of the participants' experiences. The method also allowed a well-structured system to summarize and prioritize the final data (Braun & Clarke, 2006).

Credibility is critical in qualitative studies to demonstrate the truth of the findings (Lincoln & Guba, 1985; Merriam, 1998). We used various methods to ensure the credibility and trustworthiness of the data. We pilot-tested the interview guide and revised it to ensure it was clear, relevant, and easy to understand. We also used member checks, which are used in qualitative studies to get feedback from participants to ensure that data are accurate and reflective of the participants' narratives. In addition, we used triangulation of sources to cross-check the data, including written documents, meeting minutes, field notes, and literature review (Cope, 2014).

Furthermore, the PI was a doctor of public health candidate majoring in community health, an MSM of Kenyan descent, and fluent in English and Swahili. This enabled him to conduct the interviews in both languages. He also had a shared experience of fleeing SOGI-based persecution and extensive training in working with diverse communities. As a result, participants trusted the interviewer and shared their stories. The interviewer only asked the participants follow-up questions as needed. The connection with the community could have created researcher bias. However,

the research team and community members, having diverse backgrounds and knowledge in qualitative methods, as well as having worked with marginalized and hard-to-reach communities that include MSM within the East and Horn of Africa, extensively discussed the data. Their reviews helped to minimize research bias, thus enhancing the trustworthiness and credibility of the analysis. The data publication followed the "Consolidated Criteria for Reporting Qualitative Research" (Tong et al., 2007).

Ethical Considerations

This study was approved by the University of Texas School of Public Health Institutional Review Board (IRB Number: HSC-SPH-19-1090). The larger study was approved by the University of Minnesota Institutional Review Board (IRB Number: 00000-8209). Although the study was anonymous, the researchers reviewed the transcripts to redact any participants' identifiable information.

RESULTS

Demographic Characteristics

The participants consisted of refugees (n = 18, 95%) and one asylum seeker (n = 1, 5%). The mean age for the participants was 26.21, with the largest group aged 18–24 (9, 47%), followed by the 25–34-year (7, 37%) and 35–44-year (3, 16%) age groups. Participants were Ugandan (15, 79%), Sudanese (2, 11%), Somalian (1, 5%) and Congolese (1, 5%). The mean duration of stay in Kenya was 3.63 years, with the majority (13, 68%) having stayed in Kenya for over four years (see **Table 1**).

The themes and subthemes from the analysis are organized into three broad categories and subcategories, summarized in **Table 2**.

Table 1
Demographic Characteristics of Participants

Description	n	%
Age		
18–24	9	47
25–34	7	37
35–44	3	16
Country of origin		
Democratic Republic of the Congo	1	5
Somalia	1	5
Sudan	2	11
Uganda	15	79
Status		
Asylum seeker	1	5
Refugee	18	95
Duration in Kenya (years)		
1	6	32
4	4	21
5+	9	47
Education		
Primary or lower	4	21
High school	9	48
College (middle-level)	5	26
University	1	5

Table 2
Themes and Subthemes

No.	Theme	Subthemes
1	Psychological distress	Asylum-seeking/refugee registration process Separation from loved ones Physical health
2	Traumatic stress symptoms	Worthlessness Sleeplessness Suicidal ideation Flashbacks
3	Mental health care access	No subthemes
4	Coping strategies	Avoidance Substance use Religion Psychotherapy

Psychological Distress

Participants mainly described traumatic exposures, including the asylum-seeking and/or refugee registration process, separation from loved ones, and physical health as significant stressors in Kenya.

Asylum-Seeking/Refugee Registration Process

All participants described asylum seeking, refugee registration, and resettlement as highly stressful. As per the 2006 Refugee Act of Kenya, the Refugee Affairs Secretariat (RAS) is responsible for registering and processing refugees. Therefore, all persons seeking asylum in Kenya must submit their asylum applications to the RAS. They must then attend an interview to determine if they have a well-founded fear of persecution based on the categories provided by the 1951 UN Refugee Convention. The RAS officers make a recommendation to the refugee affairs commissioner, who decides and sends an acceptance or rejection letter. Participants described various challenges upon reaching Nairobi that increased their anxiety and distress. For example, some had to walk about eight miles from the UNHCR offices in Westlands to the RAS Shauri Moyo[1] for registration. Often with no shelter, most were left to camp outside the UNHCR offices, as participant 13 (24 years old) described:

> First, my process, my process gives me a lot of stress. Cause I did eligibility at UNHCR. The next time they were to call me, they never called. I am the one who went there. Uh, I wish I could show you some pictures of where we slept outside the UN. Outside there, like chokoras,[2] you know? We went there and spent about three weeks. So, you are like, now, where should I go? Where should I find the government?

They are telling you to go to Shauri Moyo. Going to Shauri Moyo, they cannot allow you to even step at that door when you do not have an appointment.

Although the UNHCR has tried to expedite claims, it only does so for the most vulnerable, leaving others with a long resettlement process. In addition, the UN General Assembly Resolutions Statute mandates the UNHCR to assist refugees' resettlement[3] to third countries (United Nations High Commissioner for Refugees (UNHCR), 2011). Resettlement is essential for MSM asylum seekers and refugees because some countries they seek protection in criminalize same-sex practices, making it challenging to integrate. The long wait times, therefore, frustrated some MSM:

> I think stress has come because of the delay in the process because I always called the toll-free line. But they [UNHCR] keep telling us that we must be patient. Wait for your case at the UNHCR. You go for the interviews. You sit for the interviews. Years pass, and they do not even call you for resettlement interviews. They keep telling you about the same thing for so many years. The same thing because you have been around for so many years, you just get fed up. It gives you stress, which is mental stress.
>
> *(Participant 4, 26 years old)*

While the participants' descriptions may be like those of other refugees, many expressed specific instances of ostracism and discrimination because of their sexual orientation. For example, one participant described his experience while at the Refugee Registration Offices in Shauri Moyo:

> Reaching Shauri Moyo, those people who work for the Kenyan government, when they hear about Ugandans, they know [assume] that we are all gay. I was just by myself, so when they said I was Ugandan, they wanted to know the other people I went with, but I refused to tell them. So, they told me I should leave the compound or else go back to my country. I had to sleep again outside in a place I didn't know.

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[1] Shauri Moyo is a neighborhood in East Nairobi City where the RAS is located.

[2] Chokora is a Kenyan slang word derived from Swahili. It is used to refer particularly to children experiencing homelessness.

[3] Resettlement is the process in which the UNHCR relocates refugees to a third country when it is the most appropriate and durable solution.

I slept outside, I waited for the next day, and then I went. But they were asking me why I brought my curses to their country.

(Participant 10, 23 years old)

Separation from Loved Ones

Separation from loved ones and the associated loneliness and isolation are common to refugees in general. However, MSM did not have support from their families, who were most often the perpetrators of the abuse that they fled from. As a result, they continued to experience isolation and persecution and were left with little or no support. For example, one participant described his experience when he reached out to his father:

Since the day they [my family] realized I am gay, they disowned me. Even my dad, to see, to call me, nothing. I was really suffering, and I called my dad and told him, dad, I am dying. He told me that I [he] was there, I would have helped you to die.

(Participant 7, 22 years old)

Another participant described the fear of leaving his partner when relocated:

My processes are almost in the last stages. I was even given a flight date … but the biggest challenge now is my boyfriend. I feel so sorry for him. His case was brought here in Nairobi in October, and it has been so bad for us. I contacted UNHCR and told them to put us on the same file. I even changed and said I would wait for him. They said they couldn't add our files together. They also told me they didn't know how long his case will take and so I should leave my case as it is. So right now, I might leave him behind, and it's really stressing me. But I pray for him and will continue to support him if I reach there [country of resettlement].

(Participant 9, 36 years old)

Physical Health

Past traumatic events subjected some participants to multiple stressors while in Kenya. For example, one participant described how his past gang rape led to his AIDS diagnosis after prolonged periods without care.[4] The participant constantly worried about others finding out about his AIDS status, leading to distress and worry about his health:

I went to HOYMAS,[5] and they took my blood, so they told me you have HIV. … My health is so bad because they checked my CD4 count …, and they told me it is 150. I have this stress because sometimes I can sit there and cry because I know I am taking medicine every time. So, I just sit there and cry. That is a big problem for me. Sometimes I say I am not going to have a future. Maybe I will die. So, I am just like thinking. Sometimes I get malaria. I say, oh my God! I am going to die like that. So that is the stress I have.

(Participant 11, 26 years old)

Traumatic Stress Symptoms

We did not seek whether interviewees had received any diagnoses. Nevertheless, participants described various symptoms that indicate traumatic stress resulting from their histories of persecution and lack of needed mental health care.

Worthlessness

Participants reported feeling worthless or hopeless because of their past persecution experiences and rejection by their family and other community members. Some, therefore, felt guilty and responsible for their current plight as asylum seekers or refugees. Participant 6 (41 years old) described his frustration with being unable to provide for himself and others:

When I go back to my room, I sometimes blame myself for being the way I am. I think back in my fam-

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[4] Even though the participant had started treatment, he reported that his CD4 cell count was still below 200 cells per millimetre.

[5] Health Options for Young Men on HIV/AIDS/STI (HOYMAS) is a male sex worker led Community Based Organization whose aim is to promote health and human rights of MSM sex workers, particularly those living with HIV.

ily. I mean, I could be someone. Also, I look at myself like I am useless to the community. First, I am not sick. I should be a productive person. But from sunrise to sunset, I am in my room doing nothing, not earning anything, not being productive. I am looking at myself like I am useless.

Those with children were overwhelmed with their inability to provide for themselves and their children, who were also persecuted. A 35-year-old participant from Uganda (participant 2) described the discrimination his children underwent and his guilt for his inability to provide for them:

I also feel guilty because even the mother ostracized the kids because I broke the relationship. Even she started dating someone else and started a new life. So, the kids were left alone. Kids were now sent to grandmother, to my mum. Personally, it is psychologically affecting me. I did not even know the word deadbeat dad until I realized many Americans [use the word], you know. I am not into the kids' lives. I am never there. The worry is money, like where they need school fees. They tell me they want 90,000 Kenyan shillings. A refugee without a job, where am I going to get 90,000, honestly?

The stories highlight how rejection and discrimination of MSM asylum seekers and refugees may intensify their feelings of guilt and worthlessness. In addition, those with families and children had heightened guilt and self-hate and felt personally responsible for the persecution of their loved ones.

Suicidal Ideation

Some participants who experienced traumatic events and feared facing further violence and discrimination reported having suicidal thoughts or harming themselves to escape their emotional distress. For example, a 21-year-old participant (participant 8) described trying to commit suicide on multiple occasions while experiencing rape for about a year when he was between 14 and 15 years old:

I tried many ways to kill myself, but I failed. Then, one day, I managed to go out of the camp. Because they had told them, anyone who saw me trying to escape this camp could, they should shoot him immediately. So, I said let me run, and they shoot me, and I die at once. It was also a way to be killed because I was tired of my life. I was tired of living like this with these people raping me, beating me, and making me feel hungry for three days.

For other participants, dealing with unknown health issues contributed to further stress, increasing suicidal ideation. For example, another participant expressed the difficulty and stress he experienced before being diagnosed with Hepatitis B. As a result, he was unable to self-diagnose and get adequate treatment. He thus thought his sickness was a punishment for being gay. Therefore, he contemplated suicide to escape the internal conflict between his health, sexuality, and spirituality:

There was so much going through my mind. You feel the only way you can rest this problem is probably … death starts becoming an option. When you die, you are no more; you have peace. So that is the kind of experience I went through. Death became a wonderful option! When you start thinking through these things, you wonder, are you alone, or is something beyond human explanation eating you? Something that surpasses human understanding. So that was a difficult situation.

(Participant 2, 35 years old)

The participant experiences highlighted are not unusual and underscore how multiple intersecting social-political factors like culture and religion can contribute to MSM refugees' and asylum seekers' vulnerability to internalizing homophobia, which consequently affects their health and wellbeing. Furthermore, continued sexual violence while fleeing persecution and in the host country, without adequate access to treatment or needed services, led to continued untreated trauma, thus increasing some participants' suicidality.

Sleeplessness

Most participants experienced homelessness while fleeing persecution and after arrival in Kenya. Therefore, they had a high risk of harassment and feared for their safety. However, even those in safe houses that provided shelter experienced issues such as lack of privacy and anxiety over past traumatic experiences. One participant described the following:

> My life has not been that easy. It is hard for me to sleep. I do rarely sleep. The beatings that I went through, the sufferings and pain when they keep coming into my mind, I fail to sleep. I must be awake the whole night. This tortures me a lot because I also want to sleep and have enough rest, but I cannot. I know this affects my mind or thinking of my past or future, but I do not know what to do. Those behind all those things in the camp, things when I was in South Sudan, things when I was in Uganda, things on the way, they are terrible!
>
> *(Participant 12, 22 years old)*

Most participants struggled to meet their basic needs, for example, rent and food. Worries about this contributed to their sleeplessness:

> Even sleeplessness. You think about what has happened up to now. You think about what happened. Yeah. Sometimes, it reaches a time when you do not have the money to pay the rent; heh, you cannot sleep.
>
> *(Participant 1, 26 years old)*

Participants' descriptions highlight related issues that affected their sleep. Thus, they needed multiple approaches to address the various underlying factors to improve sleep quality and quality of life.

Flashbacks

Participants had flashbacks of their past traumatic experiences during their migration. For some, their living environments triggered involuntarily reliving their near-death experiences, resulting in constant worry and sleeplessness:

> These are the things whereby I never get enough sleep. And in that not getting enough sleep, I usually get flashbacks. So, I was getting flashbacks of what happened. Those are the things whereby I am ever thinking and thinking and thinking. So, it is hard for me to be like I am not thinking about this.
>
> *(Participant 5, 26 years old)*

Another participant described the psychological distress and social anxiety caused by reliving the murder of his partner:

> Also, um, why did I see my boyfriend being killed [by my uncle] and seeing his body lying there. And this being raped. I also have this, in French, they call it trouble. Like I can be with you now as we are talking. Then, like I see my uncle shooting my boyfriend, you do not know if what you see is true, and what has happened?
>
> *(Participant 8, 21 years old)*

Although not all memories of past trauma are flashbacks, participants described how some events adversely affected their health. The stories underscore the need for a professional evaluation to ascertain the etiology of the flashbacks for adequate care and treatment.

Mental Health Care Access

Adequately addressing mental health problems requires sufficient resources to effectively address individual mental health needs. In addition, because participants had unique needs, there was an even higher demand for effective and culturally sensitive services accessible to participants. For example, most participants described one organization that provides mental health services for refugees in Kenya as their point of mental health care:

There is a clinic or an organization for the refugees. … The organization deals with refugees' mental traumatization, where they sit them down with the counselors. They talk them through their situations, what they went back through at home in Uganda, what they are going through [now] to see how they can overcome [it].

(Participant 4, 26 years old)

Nonetheless, participants described that the services were inadequate and not widely available. For example, one participant described the challenges he and others in his shelter faced when one of their members exhibited symptoms of psychosis. However, the mode of communication and the typical response from organizations was prolonged and problematic, especially when participants needed emergency assistance, as participant 16 (24 years old) shared:

And then another problem is health. We recently had a friend of ours who ran mad, and then we contacted UNHCR, but they did not offer any help. We contacted HIAS[6] and did not get any help. After some … fighting and writing and writing, one of them came out after a long time because we told them this person was sick. They need to go to the hospital.

Despite the general awareness about mental illness among general refugee populations, participants' stories highlight the service gap and other challenges in accessing mental health services. Furthermore, while some of the safe houses utilized forms of social support that were helpful to the participants, they were not equipped to provide mental health care to their members. In emergency cases, the care gap could result in more anxiety and stress for an already vulnerable group and, additionally, significantly affect participants' quality of life.

Coping Strategies

In response to the experiences and difficulties of persecution, the participants described various coping mechanisms, such as affirmative church support through safe houses, art, and psychotherapy. Others included avoidance and substance use.

Avoidance

Some participants developed avoidance as a coping strategy to deal with stressors. For instance, participant 8 (21 years old) described how not thinking about the past traumatic experiences as an escape from the past trauma affected his physical and emotional well-being:

I could not share my story or the story of my life with anyone. I did not want those things to come back to my mind. Yeah, I started a good life. I started making friends and laughing. I just wanted something to make me forget what I had faced.

For some, it was uncomfortable to relive certain experiences during the interview. However, out of concern for their well-being, participants were reminded to share whatever they were comfortable sharing:

Some things happened that I cannot even mention. I do not feel like saying now. When they keep coming to my mind, I sometimes feel like I am losing my mind. I do not. I feel like they really take me down— okay—I just want to forget.

(Participant 12, 22 years old)

Participants' denial or minimization of persecution led to various coping mechanisms to decrease their stressors. Some, therefore, had untreated trauma that could continue to adversely affect their health and well-being.

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[6]HIAS is global Jewish nonprofit organization that provides humanitarian aid to refugees and asylum seekers. Its African office is based in Nairobi, Kenya.

Substance Use

Some participants used drugs and alcohol to cope with daily stressors. For example, one participant expressed how the pressure of being a community leader resulted in him using marijuana to calm his social anxiety:

> Sometimes your friends tell you to go to Kakuma [refugee camp, to get assistance] where the sunshine is like God is chasing the sun from heaven, you know! So that is why we smoke. Like me, I will not lie, sometimes I take weed, but not because I like it, but sometimes I see it as the only thing which can make me peace[ful]. Because, as a leader. I cannot cry and make promises [to] them [other refugees and asylum seekers]. So, I must hide somewhere. I do my thing; I smoke, and I feel okay. I get guts. I be hard.
>
> *(Participant 13, 24 years old)*

Although some participants described alcohol and drug use as a coping mechanism, one participant notably showed resilience abstaining from using drugs and alcohol:

> Most of the time, people, my friends, have tried to drink. They have tried to cope [by] drinking. I love having fun, but I am like, I will not use drugs. I'm not going to let this situation define me. I am a way much better person.
>
> *(Participant 17, 24 years old)*

Some participants also used opioids, particularly for pain management, because of sustained injuries from past persecution experiences. For example, participant 12 (22 years old) talked about how his head injuries had resulted in pain killer dependency:

> Should I say I am addicted to painkillers, because that is a must I have to take every night to rest. When it comes to my head, my skull and this fracture prompt me to take painkillers to kill the pain. I buy painkillers just at a shop, but it is a clinic at that main as you come to that place of ours. I just mentioned painkillers, and they give me painkillers.

Participants' stories highlight self-medication using drugs and/or alcohol to deal with anxiety, stress, and other mental health symptoms. Participants also described how opioid use for pain management could lead to addiction and overdose if repeated over long periods.

Religion

Although participants described religious norms, practices, and attitudes as significant sources of persecution, some highlighted how religious practices, such as prayer, were critical for dealing with past trauma and coping with stress. For example, one participant shared how his self-care included prayers and forgiving his persecutors as an essential step in his recovery:

> So, for me, the people that I do love, God was the first person whereby he is the person who did guide me to run away from there then up to here in Kenya. He was the first person and the friend who received me here in Kenya. So, as God is the first, I tend to go through prayers most of the time. So that may be like, I can forgive. And then I bring people back to me.
>
> *(Participant 5, 26 years old)*

Participants talked about the Metropolitan Community Church (MCC) in Nairobi. The church provided an affirming, safe space where all SGM felt welcome and connected to other community members. One participant expressed how he had previously disconnected from religion because of his negative experiences with homophobia and how MCC assisted him in reconnecting to his faith:

> The gay church is in town [Nairobi, Central Business District]. It happens every Sunday from 2:00 to 6:00 p.m. So, yeah. It is an open church because the pastor is gay. And then the other ministers are also gay. Also, all the congregation, I guess so. So, it is like, you go there, and you feel accepted because growing up,

some issues made me leave the church. So, I feel like a point where I am at good peace with religion.

(Participant 17, 24 years old)

Despite most participants' negative experiences with religion and the trauma caused by religious-based persecution, they described religion as a source of motivation in dealing with and healing from past traumatic events throughout their immigration life course, including forgiving persecutors (e.g., family members). Participants also emphasized the importance of affirming and accepting religious organizations in helping them reconnect with their religion. Additionally, some participants described how prayer and sharing with others provided the support they needed to deal with daily stressors, leading to more positive spiritual experiences, self-awareness, and confidence, with no significant differences for those identified as Christian or Muslim.

Psychotherapy

Culturally sensitive services that considered various intersectional factors were limited for participants. Nevertheless, some were able to get psychotherapy from a local refugee service organization:

> I want to be far from Nairobi because it is not very far from home. At any time, anything can happen. So that is just stressing me out. So, I have been attending psychotherapy sessions. … At least they are helping me slowly by slowly.

(Participant 10, 23 years old)

Another participant also expressed how the sessions helped him overcome some of his stressors over time:

> I have been attending the [therapy] sessions to overcome what I went through in life to be calm and forget about what I went through and start [afresh]. [The sessions] which help through talking are not a one-day thing. It took several months, but I am done.

(Participant 4, 26 years old)

Most participants lived in safe houses and shelters run by refugee organizations or as part of a group of refugees who communally contributed to the shelter's upkeep. Participant 16 (24 years old) expressed how the safe house provided social support through various activities and support systems that helped him cope with his experiences:

> But I thank God now I have people around me to talk to, you know, have psychosocial support sessions, where we come, and share stories. These experiences help us, you know, relieve our minds. Yeah.

Participants' descriptions underscore the importance of therapy and social support. Because of the unique challenges participants faced, ever-changing policies, and persecution in Kenya, the participants required culturally sensitive services that provided targeted and flexible psychological support.

DISCUSSION

This analysis has aimed to contribute to an enhanced understanding of the mental health needs of MSM asylum seekers and refugees. The results provide a link to previous work identifying the complex interplay of continued persecution exacerbated by experiencing multiple layers of discrimination due to sexual identity by numerous actors: family, government, international organizations, police, religions, health care providers, gangs, non-gay refugees, and neighbours (Misedah, 2021; Misedah et al., 2021b). In our findings, we identified similarities to other refugees' experiences—for example, distress caused by the asylum and refugee application processes (Sinnerbrink et al., 1997; Li et al., 2016). However, MSM, particularly those who were Ugandan, faced specific multi-layered challenges. They were mostly assumed to be gay and thus faced further challenges that significantly contributed to their adverse mental health.

Psychological Distress

Consistent with previous research, we found multi-layered factors contributing to stress among MSM refugees and asylum seekers living in the Nairobi metropolitan area. All participants experienced financial stress and described difficulties in meeting their basic needs (e.g., food and shelter) while in Kenya. Additionally, post-migration challenges, such as the stressful asylum application process and inadequate access to health care, can lead to increased mental health distress. Other challenges, including language barriers, unstable housing, and discrimination, can further increase pressure and stress (Nicol et al., 2014).

Asylum and Refugee Application Process

All participants described the refugee application process as one of their major stressors. After travelling by bus for roughly 14 hours and facing language barriers because they could not speak Swahili, they stated that they had to navigate an unclear system in unknown territories. Some studies have linked language barriers to increased distress for refugees (Hynie, 2018). Additionally, Kenya's penal code still criminalizes same-sex behavior (Laws Of Kenya, 2014, s. 162(a), (c)), leaving MSM asylum seekers and refugees prone to negative attitudes, norms, and cultural practices that further disenfranchise them. For example, participants said some local officers ostracized and verbally abused and shamed MSM asylum seekers and refugees for being gay. Prolonged psychological distress increases the risk of other adverse health outcomes, such as coronary heart disease (Cohen et al., 2007). Although numerous studies have found MSM to have higher depression rates than their heterosexual counterparts (Ulanja et al., 2019; Mulqueeny et al., 2021), lim-

ited research about the experiences of MSM refugees and asylum seekers with depression is available. Nevertheless, consistent with other emerging research, our study indicates the need to understand further specific mental health disparities among MSM refugees and asylum seekers in Kenya.

Additionally, while resettlement is one durable solution most MSM hope for, unlike refugee status, resettlement is not considered a right (UNHCR, 2011). Processing times depend on various factors for host country policies. Policies may limit the number of refugees accepted each year. The time to vet and relocate refugees after their resettlement case submission may take two years or longer (National Immigration Forum, 2020). In our study, most refugees had been in Kenya for over four years, highlighting the long wait times before relocation. Therefore, MSM asylum seekers and refugees continue to experience prolonged persecution, increasing exposure to trauma and distress (Bentley & Dolezal, 2019). Other studies have also identified long wait times and complicated resettlement processes as significant stressors for refugees (Leiler et al., 2019; Silove et al., 1997; Steel et al., 2011).

Separation from Loved Ones

Evidence suggests that rejection negatively affects the mental health of MSM (Jones et al., 2010). The situation may worsen for MSM asylum seekers and refugees who continue to be rejected and isolated in their host countries by other refugees or the communities they live in (Pincock, 2020; Zomorodi, 2016) . For example, although family members caused most participants' early persecution experiences in our study, separation from oved ones caused anxiety and stress. Other studies have also reported that worrying about loved ones, including fam-

ily or friends, is a significant stressor for refugees (Miller et al., 2018).

Most researchers have also focused on the MSM participants, not their partners or children, and how their separation affects their lives. Nevertheless, studies indicate that many MSM also have sex with women. In addition, some marry because of cultural and family pressure (Onyango-Ouma et al., 2005; Smith et al., 2015; Tamale, 2014). Furthermore, those with (MSM) partners encountered a flawed system that did not process their paperwork together. Therefore, some participants had increased anxiety and stress because of the loneliness caused by the separation. Additionally, some participants lost their families, witnessed loved ones' deaths, or narrowly escaped death themselves. While not participants in our study, the burning of two MSM at Kakuma refugee camp in April 2021, which resulted in second-degree burns, and the subsequent death of one of the refugees a few months later highlight the constant trauma that MSM asylum seekers and refugees continue to go through in Kenya (Lavers, 2021).

Traumatic Stress Symptoms

We did not conduct any formal psychological assessments or diagnoses. However, some participants reported experiencing psychological distress, for example, depression. Our data suggest that the refugee application process and economic factors, such as unemployment and sexual violence, were significant stressors for MSM asylum seekers and refugees. Our data also indicate that many MSM asylum seekers and refugees suffer from untreated cumulative lifetime trauma that started in their teenage years and persisted after arrival in Nairobi (unpublished data). In addition, even though we did not formally assess PTSD, some participants, particularly those who had experienced sexual

violence, described signs of PTSD as per the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for PTSD (American Psychiatric Association, 2013). The criteria include (a) stressors, (b) intrusion of symptoms, (c) avoidance, (d) negative alterations in mood, (e) alterations in arousal and reactivity, (f) duration, (g) functional significance, and (h) exclusion. All study participants experienced heightened stress, resulting in more psychiatric symptoms. Previous studies have linked such experiences to ongoing trauma. For example, one study found that refugees resettled in Western countries were 10 times more likely to develop PTSD than their age-matched counterparts in their countries of origin (Fazel et al., 2005). An assessment of SGM asylum seekers from 29 countries (including Africa) found that 66% with sexual violence histories had more PTSD symptoms than those without sexual violence histories (Hopkinson et al., 2017).

We found many incidents of suicide attempts by participants (6/19). For some, their persecution began while in high school, exposing them to early aggression. As a result, many had adverse mental health outcomes, including depression, suicide, and self-harming behavior. In addition, because of continuous heightened multi-layered persecution, some had a high risk of adverse health outcomes while in Kenya. Our findings are consistent with those of other researchers who have reported increased suicidal ideation among SGM refugees compared with those who faced non-SOGI-based persecution (Hopkinson et al., 2017). Notably, during our data collection in Nairobi, an MSM refugee committed suicide outside the UNHCR offices in the Nairobi office (Bhalla & Goldsmith, 2020). Even though this person was not a study participant, his death highlighted the importance of our study and the need for further studies

to explore and understand MSM refugees' mental health and asylum seekers in Kenya.

Health Care Access

Other researchers have previously documented that MSM did not seek services due to fear of perceived or actual discrimination (Malebranche et al., 2004). Furthermore, although efforts are made to provide therapy for SGM refugees, some researchers have noted barriers to mental health access. These include language barriers and, in some instances, cultural norms that stigmatize emotional expressions of distress (Kahn et al., 2018). In our research, we found that participants were less likely to seek care when needed because of perceived and actual discrimination in health care settings, increasing their likelihood of poorer health outcomes than their heterosexual counterparts; this is consistent with findings from other studies (e.g., Ogden et al., 2019).

Further research is needed on MSM refugees' and asylum seekers' specific mental health challenges and their broader effects. Some researchers have found a significant association between social support and mental health outcomes for SGM (Ross et al., 2021). Notably, SGM without social support or local social networks were found to have poorer mental health outcomes than their counterparts with more social backing, thus underscoring the importance of social support in mediating mental health outcomes for SGM (Cain et al., 2017). Additionally, evidence suggests that participation in underground ball scenes in African American ballrooms and house culture provided positive affirmative spaces that helped SGM express themselves and positively impacted their lives. For example, some studies have found that ballrooms and house culture helped MSM become resilient and adhere to new therapies (Kubicek et al., 2013). Notably, our study found some forms of resiliency and meaningful support from safe houses and social support structures, as seen in some of the ball and house cultures, with some organizations modelling their shelters following house culture. However, further research is needed to explore the impact on MSM refugees' lives and well-being.

Recommendations

Our findings suggest the need for culturally sensitive and targeted services that meet the immediate needs of MSM asylum seekers and refugees. Additionally, although SGM and related refugee organizations provide some assistance to their members, they are primarily underfunded and rely on support from friends and well-wishers. Therefore, participants would likely benefit from evidence-based interventions that address MSM refugees' and asylum seekers' specific mental health needs. The UNHCR (staffed mainly by locals) and other Kenyan governmental agencies may also benefit from further diversity training, coordination, and support to ensure that MSM receive culturally sensitive services during the registration process, which the participants identified as a significant source of stress. The providers must also be aware of the diverse and individual needs of the participants to ensure they are keen on various issues—for example, language and cultural barriers that may affect their health care access. MSM are also not a homogenous group and may have varied mental health challenges. Knowledge and informed targeted services sensitive to various needs would thus be critical in decreasing mental illness symptoms while enhancing the psychological well-being of MSM asylum seekers and refugees.

LIMITATIONS

This study had some limitations. First, the participants were purposefully selected and were primarily urban Ugandan refugees attached to the partner SGM asylum seekers and refugee–led community-based organizations. Although many participants indicated having gone to Kakuma refugee camp, some differences existed between those who lived in the camps and those who lived in urban centres. For example, our study participants lived in shared shelters with access to various services from the Nairobi metropolitan area rather than living in tents. They experienced high vulnerability to physical violence from other refugees and a lack of culturally sensitive services. However, as our research was qualitative, we did not intend the results to be generalizable. Instead, the goal was to explore and yield results transferable to understanding the mental health of other MSM refugees and asylum seekers. Second, data were self-reported, and therefore recall bias may have occurred. Furthermore, since we did not conduct psychiatric evaluations, we do not know if the participants met diagnostic criteria for psychological distress, for example, anxiety, stress, or PTSD.

CONCLUSION

Limitations notwithstanding, this study is one of the first to explore the mental health of MSM asylum seekers and refugees. It therefore adds to the emerging body of evidence examining the mental health of MSM asylum seekers and refugees. Our findings provide proof of continued traumatic events and post-immigration stressors experienced across borders, leading to increased distress for MSM asylum seekers and refugees. In addition, MSM participants also had mental health symptoms.

The results have implications for informing other urgently needed research to understand the migration stressors of MSM asylum seekers and refugees in the East and Horn of Africa. In addition, further research will equip various stakeholders, including the government, service providers such as the UNHCR, and their partners, to better understand the health needs, make policy changes, and develop targeted culturally sensitive interventions to decrease psychological distress and improve MSM asylum seekers' and refugees' well-being.

ABOUT THE AUTHORS

Lourence Misedah-Robinson is a Postdoctoral Research Fellow at The University of Texas Health Science Center at Houston School of Public Health. He can be reached at lourence.misedah@uth.tmc.edu.

Vanessa Schick, PhD, is an Associate Professor at the University of Texas Health Science Center at Houston School of Public Health. She can be reached at vanessa.schick@uth.tmc.edu.

Michael W. Ross is a Professor of Family Medicine and Community Health at the University of Minnesota. He can be reached at mwross@umn.edu.

Solomon Wambua is a National Coordinator at the Key Population Consortium of Kenya [KP Consortium]. They can be reached at solomonwambuad@gmail.com.

ORCID

Lourence Misedah-Robinson https://orcid.org/0000-0002-6528-1742
Michael W. Ross https://orcid.org/0000-0002-5718-9989

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