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**“Slowly by slowly makes the journey”:
Coming Out and Mental Health Amongst LGBTQ Rwandans**

By

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**“Slowly by slowly makes the journey”
Coming Out and Mental Health Amongst LGBTQ Rwandans**

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An abstract of
A Thesis Submitted to the
Hubert Department of Global Health in Partial
Fulfillment of the Requirements for the
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Abstract

Negative mental health outcomes among LGBTQ individuals remains a pressing issue with overall impacts on individual and community level health worldwide. Currently, there is a significant gap in research focusing on the mental health influences of the “Coming Out” process among LGBTQ individuals worldwide, but specifically in Kigali, Rwanda. This qualitative study utilizes in-depth interviews with out LGBTQ Rwandans to understand the emic perspectives of participants and how the coming out process has affected their overall mental health. Analysis using grounded theory is utilized in developing the results of this study. The results of the study present evidence that there are various influences on mental health among this population with varying affects, both positive and negative, on mental health. Influences may provide insight into the causes of negative mental health outcomes among this population. Future outreach, advocacy, and health based programs and interventions should consider the coming out process and how it influences mental health among LGBTQ individuals in this population.

**“Slowly by slowly makes the journey”
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Definition of Terms

LGBTQ – Lesbian, Gay, Bisexual, Transgender, & Queer/Questioning. This umbrella term refers to the spectrum of sexualities and non-normative sexualities and lifestyles represented within this population. This may also include sexualities and identities like asexuality, pansexuality, gender fluidity, gender queer, etc. (2015 National School Climate Survey, GLSEN)

Coming Out - When a person with a non-normative sexuality (i.e., gay, bisexual, lesbian, etc) must explore, define, develop acceptance of and disclose said sexual orientation to friends, family, and other straight individuals (Solomon, McAbee, et Al, 2015; Bohan, 1996, p.112).

Coming Out Process – The coming out process is commonly used to describe the lifelong process which a person with a non-normative sexuality (i.e., gay, bisexual, lesbian, etc) must explore, define, develop acceptance of and disclose said sexual orientation to friends, family, and other straight individuals (Solomon, McAbee, et Al, 2015; Bohan, 1996, p.112).

Outness – The extent to which an individual makes their sexual orientation or gender identity known to others. This can be associated with the amount to which a person discusses their orientation/identity or how well known their orientation/identity are known across social contexts (professional/social/familial) (Solomon, McAbee, et Al, 2015).

Closeted – The state of hiding one’s sexuality and/or gender identity from others. As with coming out, this state can be experienced at different levels and is the direct opposite of a state of outness (Villazor, 2013).

Gender Identity – An individual’s internal sense of themselves as being male, female, a combination of the two, or without gender. Gender identity is not something that should be assumed about somebody simply because they look or seem to be a certain gender.

Transgender – An individual whose gender identity does not align with their biologically assigned sex at birth.

PSF – Project San Francisco. Primary site of research and data collection.

HDI – Health Development Initiative. Secondary site of research and data collection.

AFAB/AMAB – Assigned Female at Birth/Assigned Male at Birth – Each of these refers to an individual’s biologically assigned sex, not their gender or gender identity.

MSM – Men who have Sex with Men

WSW – Women who have Sex with Women

Passing – A term typically relating to transgender individuals, though it can also pertain to gay men and lesbian, meaning that they are able to be seen as the gender with which they self-identify. An example of this would be a transgender female (someone who was assigned male at birth) being recognized in public as a female (HHS, 2012).

Chapter 1: Introduction

Statement of the Problem

Lesbian, Gay, Bisexual, Transgender, & Questioning (LGBTQ) individuals, representing between 1-4% of the global population (Drescher, 2008), face increased stigmatization, discrimination, and harassment because of their exemplification of non-normative sexualities and lifestyles (Solomon, McAbee, et al, 2015). These sexualities and lifestyles are not entirely accepted globally, nationally, or locally. Currently, 73 countries continue to criminalize same-sex sexual behavior and attraction (ILGA, May 2016). 37 of these countries exist on the African continent with two, Uganda and Nigeria, having implemented new anti-LGBTQ laws in 2014 (HRC, 2014). Acceptance of LGBTQ individuals or groups by family, friends, or the community at large is typically dependent on the personal beliefs, experiences, or perceptions of the individual (Rodriguez, Lytle, & Vaughan, 2013).

As in other countries around the world, sexuality remains a topic not appropriate for general public discussion. In addition, LGBTQ sexualities and identities remain largely taboo and are typically unaccepted within Rwandan culture for multiple reasons described within this research thesis. Though Rwanda does not criminalize same-sex sexual behavior or attraction (Rwanda. Const. 2003), homosexuality and other non-normative gender identities remain heavily stigmatized (Rwanda. 2013; HRC, 2014). Though same-sex sexual behavior is not criminalized in Rwanda, there exist no anti-discrimination policies protecting LGBTQ populations from discrimination based on sexual orientation or gender identity. Negative attitudes towards LGBTQ persons and the stigmatization (perceived or actual) attached causes a variety of health issues impacting mental, physical, and emotional health and wellbeing of this population (Steele, Daley, et al, 2017; Solomon, McAbee, et al, 2015). The impacts of stigmatization and

homophobia upon this already marginalized population can greatly affect their life course causing significant issues for their health, overall.

Though predominantly impactful in negative ways, it is possible for certain LGBTQ individuals to utilize negative stigma and discrimination as encouragement to act towards equality and advocacy for LGBTQ populations. However, for those who are open about their sexuality, stigma can be even more impactful as homophobic and stigmatic comments and actions may be directed specifically at them, their friends, or their family members (The 2015 National School Climate Survey, 2015). Research has shown that LGBTQ individuals experience the negative impacts of stigma and discrimination on mental health in a variety of ways. For example, women identifying as lesbians have been found to experience adverse and often traumatic reactions from parents and family members in response to their coming out (HHS, 2012). This same research has also shown that women who have sex with women (WSW) experience more severe depression, phobia, and post-traumatic stress mental health disorders than other LGBTQ individuals (HHS, 2012). Health and human services has also reported that gay men have been shown to experience depression and anxiety at a higher rate than the general population with these impacts being more severe for men who remain “closeted”; those who have yet to tell another person about their sexuality (HHS, 2012). However, reactions to coming out can be directed in a positive manner meaning that the LGBTQ person is supported and accepted by friends, family, and social networks. This research study is interested in what the positive and negative mental health impacts (the risks and mediators) of the coming out process are among LGBTQ individuals living in Kigali, Rwanda.

Phenomenon of interest.

The phenomenon of interest for this research thesis is how the coming out process influences the mental health of LGBTQ people in Rwanda. This topic is one that has not yet been studied in the Rwandan context, and as such little is known about the mental health of “out” LGBTQ individuals living in Kigali. The coming out process is frequently used to define the lifelong process which a person with a non-normative sexuality (i.e., gay, bisexual, lesbian, etc.) must explore, express, develop acceptance of and disclose their sexual orientation to friends, family, and other non-LGBTQ individuals (Solomon, McAbee, et Al, 2015; Bohan, 1996, p.112). “Outness” can be better understood by comparing it to a sliding scale in which the two polar ends represent completely out to friends, family, coworkers, associates, etc. and the opposite end represents complete denial or repression of one’s own sexuality/identity, what many refer to as “being in the closet” (Villazor, 2013). However, it is important to note that the process of coming out is likely not linear and may be more similar to a winding trail with several differences in elevation, degrees of difficulty, trails which intersect with one another (where sexuality may conflict with family, religious, or community values), and paths which loop back around to previous points. The coming out process cannot simply be placed within stages or steps that an individual takes in efforts to move from “closeted” to “out”. Instead, this process is dynamic and ever changing for each individual and should be treated as such (Klein, Holtby, et. al, 2014). This research focuses on the process of “coming out” amongst LGBTQ individuals in Rwanda, specifically how individuals cope with their coming out process and the mental health stressors , mediators and impacts this process may cause. As it remains a pressing issue, this

research is also interested in the level at which, reasons for and ways in which LGBTQ Rwandans decide to come out (Solomon, McCabe, et al, 2015).

Background and Justification.

LGBTQ populations exist throughout the entirety of the world including the African continent, and Rwanda specifically. Many health and human rights campaigns, alongside hundreds of research studies, identify the risks, behaviors, and perceptions of LGBTQ persons on different health topics throughout the world (Global Attitudes Survey on LGBTI People, 2016). Beliefs that homosexuality is un-African or that no African can be LGBTQ create an environment in which LGBTQ Africans struggle to balance their identity as an African alongside their sexuality and other values they hold dear (Wahab, 2015). In Sub-Saharan Africa religious conservatives preach homophobic, stigmatic and discriminatory ideologies against LGBTQ persons intending to deepen negative views about LGBTQ individuals (Eleonoradotter, 2014). In regions of the world where homosexuality is criminalized, and even punishable by death, (ILGA, May 2016) it is incredibly difficult for LGBTQ persons to navigate the coming out process; oftentimes it is required that individuals choose to complete this process alone or not at all. However, research has shown that what is actually needed is support and acceptance of friends and family members (Ryan, Russel, et al. 2010). Attempting to understand your sexuality or gender identity alone and without support and acceptance of those closest to you can be extremely difficult and lead to grave consequences for those lacking that support (Solomon, McCabe, et al, 2015). The process of coming out is frightening and can be inherently threatening to the persons own physical, emotional, and mental wellbeing. Disclosure of non-normative sexualities can result in physical harm, censure, or rejection from family and/or friends (Solomon, McCabe, et al, 2015).

Nevertheless, the LGBTQ population in Rwanda has progressed. In the last five years alone Kigali, the capital city, has witnessed the formation of 11 LGBTQ associations and advocacy organizations. Hundreds of thousands of LGBTQ men and women have made the choice to live openly with their sexuality and/or identity through their involvement in one, or more, of these associations. Associations are now able, with the support of NGO's like HDI, to improve the lives through empowerment and expand social networks of LGBTQ persons in Kigali, and around Rwanda (HDI, 2017). As stated before, several studies have been completed focusing on the risks, behaviors, and beliefs of LGBTQ persons in Rwanda and Africa as a whole, however published studies focusing on the mental health of this population are missing.

Deficiencies in the evidence.

Although men who have sex with men (MSM) are consistently recognized as a high-risk population for HIV transmission (Dunkle et al. 2008), provisions have yet to be made to provide equal rights for the health of the LGBTQ population. While evidence on the risk of HIV/STI transmission amongst LGBTQ individuals, particularly MSM, is readily available there is a significant lack of research on the mental health of LGBTQ individuals living in a society that actively stigmatizes and marginalizes them, such as Rwanda. Much of the current literature on MSM in Rwanda, and worldwide, focuses on HIV/AIDS & STI transmission amongst LGBTQ individuals with little attention to the impacts of stigma and homophobia in this context. Globally, this focus on MSM and their risks HIV/AIDS and STI transmission is also true. Ultimately, this lack of focus on stigma, homophobia, and its effects has created a gap in research on their influence on mental health and the impacts LGBTQ Africans face after coming out to others. As mental health among out LGBTQ populations has yet to be addressed in

Rwanda, this research thesis aims to not only begin to fill the gap in literature, but to also present strategies and suggestions for future interventions and research.

Audience

This research will be useful for PSF and HDI in Kigali, Rwanda. The results of this thesis may provide empirical data that support future interventions or capacity building efforts undertaken by PSF and/or HDI to alleviate stigma and its impacts upon LGBTQ populations in Kigali. This research thesis will help to understand the coming out process and any impacts on mental health within the LGBTQ community in Kigali. Researchers, future students, and other public health professionals may also benefit from this thesis as it discusses a topic that has not been extensively researched. Individuals working with research or programs related to LGBTQ individuals and their health in Rwanda could also use the information shared in this thesis as a justification for funding applications or requests for continued support (political and financial).

While the situation in Rwanda is relatively unique, as it is one of only 6 African countries that does not criminalize homosexuality (ILGA, 2016), the results of this study may be utilized, cautiously, in other LGBTQ-friendly environments. Rwanda's uniqueness and relative acceptance of non-normative gender identities and sexualities presented an ideal research location for this study. As such, this research may be utilized in the future during efforts to make these non-normative lifestyles and sexualities more acceptable in Kigali and Rwanda.

Purpose of the Study

This purpose of this thesis is to identify how the coming out process influences overall mental health among LGBTQ Rwandans in Kigali.

Chapter 2: Literature Review

Sexuality: A brief history

According to the American Psychological Association, “there was little formal study of homosexuality before the 19th century” (Morris, 2017). Research that was being conducted focusing on this topic discuss homosexuality as a mental disorder and something that needed to be cured, many citing religious context for the development of this idea. However, researchers like Sigmund Freud and Magnus Hirschfield defied the “norm” and held sympathetic views of homosexuality, and sexual diversity, as something that occurs naturally within a portion of all humans regardless of natural, political, or social borders (Morris, 2017). Researchers in the early to mid-20th century began to analyze homosexuality and same-sex attraction through various theories including the theories of normal variation, pathology, and immaturity (Drescher, 2008). As previously stated, many the researchers during this time did not share Freud and Hirschfield’s views, instead viewing homosexuality as an illness or sickness of the mind that could, and needed, to be cured (Murphy, 1992).

During the mid-20th century, prominent sexologist Alfred Kinsey began his work in attempting to understand sexuality, gender and reproduction. Dr. Kinsey is now known most prominently for his Kinsey Reports and the development of the “Kinsey Scale”; a tool commonly used to describe a person’s sexual orientation based on their individual experiences and responses at a given time. This scale typically ranges from 0, representing exclusive heterosexuality, to 6, representing exclusive homosexuality (Kinsey Institute, 2017). Dr. Kinsey also found that homosexuality, and sexual deviance in general, was significantly more common within the human population than had originally been estimated. Kinsey estimated that nearly 10% of humans exhibited homosexual behaviors or some level of same-sex attraction, though

this figure is now believed to be somewhere in between 1-4% for actual homosexuality (Drescher, 2008).

The work of prominent sexologists like Kinsey, Freud and Hirschfield have supported the development of understandings of sexuality that lead to increased acceptance and tolerance of what are commonly known as non-normative sexualities and identities. The last 40 years alone have witnessed significant developments in the acceptance and understanding of these sexualities beyond heterosexuality. This period has also seen an increase in the overall self-acceptance of LGBTQ persons, themselves, alongside general acceptance and tolerance within society. The steps that have been made to encourage greater acceptance and understanding of alternative sexualities and gender identities is well documented through the development of LGBTQ Pride and International Pride month. Since the 1969 Stonewall Riots in New York City, Pride month is now recognized internationally and celebrated on nearly every continent (ACLU, 2017). Celebrations occur in major cities like New York, Hong Kong, Johannesburg, Rio de Janeiro, Sydney, and London among hundreds of others. According to the Library of Congress the purpose of LGBT Pride celebrations is to commemorate those who have been killed due to hate crimes or HIV/AIDS as well as to recognize the impacts that LGBTQ individuals have made in history (LOC, 2017).

Stigma, Homophobia & Discrimination

Though homosexuality has now been internationally accepted by medical professionals as a sexuality existing within all populations, stigmatization, homophobia and discrimination based on gender identity and/or sexuality remain prevalent in many parts of the world (ILGA, 2016). It is important to define the difference between these three phenomena as they often resemble one another and intersect in ways that are complicated and sometimes difficult to

understand. LGBT stigma, commonly referred to as sexual stigma or sexual prejudice, is typically known to be the negative and typically unfair beliefs about sexual orientations other than heterosexuality (CDC, 2016). Discrimination, in this context, refers directly to the unfair treatment that an individual receives because of their sexual orientation and/or gender identity or presentation (CDC, 2016). Finally, homophobia, coined by George Weinberg, refers to an “aversion to gay or homosexual people or their lifestyle or culture” and can also help to describe an individual’s behavior based on this aversion (Merriam Webster, 2017).

Throughout much of the world homosexuality and same-sex attraction remain profoundly stigmatized and LGBTQ individuals face severe discrimination, harassment, and punishments because of their sexuality or identity (HRC, 2015). There are currently 72 countries which continue to criminalize same-sex sexual activity or same sex attraction between consenting adults. 37 of these countries are on the African continent., 3(ILGA, May 2016; HRC, 2014). LGBTQ individuals, and advocates alike, in countries that continue to criminalize or discriminate against LGBTQ lifestyles face physical, mental, and emotional harassment from communities and governments, both local and national. It has even been shown that LGBTQ individuals from countries criminalizing same-sex sexual behavior and attraction face higher rates of violence and victimization as compared to countries which no longer criminalize such behaviors (Equality Rising: 2015 Global Equality Report). While uncommon in most “Western” countries, acts of violence against LGBTQ individuals and advocates do occur in many parts of the world. Instances of honor killings and corrective rape of LGBTQ females, the disruption of annual PRIDE parades and celebrations by protestors and police, and the beating and torture of LGBTQ advocates and reporters, as witnessed in Cameroon in 2013 (Human Rights Watch, 2015) are only some of the examples. As stated above, violent acts against LGBTQ populations

remain rare in “Western” nations, however the Pulse Nightclub shooting in June 2016 showed the World that even “Western” countries are not impervious to the effects of disdain, radicalism, and hatred (New York Times, 2016). Worldwide, homophobia and transphobia remain socially acceptable attitudes (Meyer, 2016) leading to almost daily attacks against LGBT people globally. Of all LGBT individuals, transgender females \ face the most severe forms of discrimination and hate. At least 50 transgender females have been reported as victims of violence that resulted in death since the beginning of 2015 in the United States alone (HRC, 2016; GLAAD, 2017).

While LGBTQ lifestyles and sexualities remain non-criminalized in Rwanda (Rwandan Penal Code, 2012), the presence of institutionalized homophobia and anti-LGBTQ stigma remain significant factors negatively impacting the lives of LGBTQ Rwandans every day (Iradunkunda, Odoyo & Muguongo). Although men who have sex with men (MSM) are consistently recognized as a high-risk population for transmission of HIV and other STI’s (Dunkle et. Al. 2008), provisions have yet to be made to provide equal rights and protections for the LGBTQ populations, particularly with respect to healthcare access and equity in Rwandan society. This lack of equity and increased presence of discrimination, homophobia, and systematic stigmatization remain persistently present for LGBTQ Rwandans and is likely to increase personal distress and negative mental health outcomes. It has been shown that LGBTQ Rwandans, especially MSM and transgender women face harassment, physical violence, and societal persecution due to their sexual orientation and personal identity (Epprecht, 2012). Rwanda’s current laws and policies regarding equal treatment and protection for all citizens are often seen as providing direct protections for all individuals, LGBTQ included. These policies were developed after the 1994 genocide against the Tutsis to ensure that an event of that nature never occurs again in Rwanda. However, Rwanda’s seemingly inclusive and progressive

policies do not directly relate to individuals with non-normative sexual orientations or gender identities. Instead, these populations continue to be discriminated against and harassed while the rest of the world remains blind to the injustices committed. Ultimately, this lack of focus on providing anti-discrimination policies protecting the rights of LGBTQ individuals leaves this population susceptible to adverse health risks and consequences (Iradukunda, Odoyo & Muguongo). As non-normative sexualities and gender identities remain taboo (Iradukunda, Odoyo & Muguongo), the act of “coming out” is relatively uncommon in Rwanda, especially in rural communities. Coming out in this context would likely result in social persecution and loss of family/friends, both crucial pillars of a Rwandan’s social identity, and significant factors in an individual’s success and acceptance amongst the rest of society.

Coming Out

A previously stated, the coming out process is commonly used to describe the lifelong process which a person with a non-normative sexuality (i.e., gay, bisexual, lesbian, etc.) must explore, define, develop acceptance of and disclose said sexual orientation to friends, family, and other straight individuals (Solomon, McAbee, et Al, 2015; Bohan, 1996, p.112). This step in the coming out process may often be seen as the final stage in identity development among LGBTQ individuals. However, this assumption is incorrect as it imposes the idea that coming out exists as a linear process, not something that can revert to an earlier step or phase of “outness” (Solomon, McAbee, et al, 2015). In understanding coming out it is imperative to not ignore the concept that one may choose to revert to an earlier phase of outness.

Support and acceptance from others are often essential for any person while they are attempting to understand their sexuality or identity. In environments like Sub-Saharan Africa and Rwanda, information on this process and on these identities or sexualities is largely lacking.

Information that is available, discussed or shared in public may be grounded in stereotypes or hateful discriminatory comments and may often be promoted by various media outlets (Wahab, 2015). It is also evident that U.S. Evangelicals preaching conservative, and sometimes radical, ideologies add to the growth and development of violent homophobia and stigma in “Christian Africa” (Weiss & Bosia, 2013). These radical ideologies, causing sometimes violent repercussions for LGBTQ person, can be seen most evidently in Uganda. In the last 6 years alone there has been the introduction of a “Kill the Gays” (as it was commonly known) bill and the brutal murder of prominent LGBTQ activist David Kato in 2011 (BBC, 2011).

While coming out seems unlikely for many LGBTQ Rwandans, a significant portion of the population have self-exposed their sexuality/gender identity to others, including family and friends, often times with mixed reactions from both. Though there remains the possibility of negative reactions, these Rwandans have found it important enough to expose their own selves as to aid future generations of LGBTQ Rwandans and adolescents growing up in a society that does not adequately represent them and their needs. As can be assumed, many LGBTQ Rwandans have chosen to abstain from seeking healthcare for fear of exposure of their sexuality or facing the stigma associated with being a member of the LGBTQ community. As sexuality has been deemed a “private matter” by much of Rwandan civil society, the consequences of sharing information about one’s own non-normative sexuality, or having that information exposed, can be severe. Common consequences of coming out, or having one’s sexual orientation or identity exposed, includes increased discrimination in public, denial of housing, denial of employment, being fired from current employment, or even removal or prevention of receiving even basic services (Haste & Gatete, 2015). Some portion of LGBTQ individuals may choose to lead lives

“in the closet”, significantly increasing their risks of negative health outcomes, specifically those related to sexual, reproductive, and mental health (Klein, Holtby, et al, 2014).

Mental Health Impacts

Research on the behavioral risks and consequences of being LGBTQ in non-LGBTQ places has been conducted in a variety of different locations throughout the world. However, much of this research focuses solely on the behavioral risks and increased chances of HIV/AIDS and STI transmission. Yet, it has been shown that the effects of discrimination, stigma, and homophobia on LGBTQ populations is grave and often leads to increased risks of negative mental health outcomes. Particularly, the CDC and HHS report that LGBTQ persons face increased likelihood of developing depression, post-traumatic stress, and anxiety disorders than their heterosexual counterparts (HHS, 2012; CDC, 2014). It has also been shown that LGBTQ adolescents exhibit better health outcomes when they come from families which are accepting, or at least tolerant, of their sexuality and/or gender identity, especially when compared with LGBTQ adolescents from families which are unaccepting or even physically violent towards their LGBTQ children (Ryan, Russel, et al, 2010).

It has been shown that living in places with discriminatory and/or stigmatizing policies or laws, specifically targeted at LGBTQ populations, can have destructive impacts on the mental health and wellbeing of LGBTQ individuals (Hatzenguehler, Mclaughlin, et. Al, 2010). This was shown to have affected the number of reported attempted suicides among LGBTQ teens in the U.S., however the results could potentially be translated to international context as well. Conversely, areas with policies allowing for same-sex marriage realized a reduction in adolescents’ suicide attempts directly following the introduction of inclusive policies (Raifman, Moscoe, et al., 2017). Individuals living in areas that share the same, or similar, values could be

assumed to live happier and more fulfilling lives in this context. For LGBTQ individuals, what is truly needed to support positive mental health and wellbeing is an overall sense of security and acceptance from those around them. This would create an environment in which the individual does not continually fear for their physical safety, emotional and mental wellbeing, and even their life in the most serious instances.

At the time of the study, Rwandan policy had not yet addressed behavioral risks among LGBTQ populations or the mental health risks, both positive and negative, posed by coming out. As such, there exists a significant void in the data on homosexual risk activity in Rwanda (Chapman et al. 2010). Much of the information related to the specific health status of LGBTQ populations is significantly lacking due to the individual's choice not to identify themselves as LGBTQ or to tell their healthcare professionals about their health-related behaviors (i.e. sexual behavior, drug use, etc.) (Rwanda. 2013). Due to the persistent stigmatization of homosexuality in Rwanda, LGBTQ persons and MSM specifically remain a hidden population, despite their centrality in HIV prevention efforts elsewhere on the African continent.

The most commonly understood conceptual model which aids in the explanation of the health and health disparities of LGBTQ persons is the minority stress model. This model helps to provide insight into the impact of homophobia and living in situations and environments of marginalization. The concept entails understanding the relationship and power pull between two factors, the majority and the minority (Dentato, 2012). In this case, the majority are heterosexual Rwandans and the minority is everyone else not identifying as heterosexual; this includes individuals who identify as asexual. This model has primarily been used in the past to aid in understanding the specific health risks of MSM related to their sexual behaviors. However, the model is also useful with gender and sexual minorities other than MSM and can be used to better

understand their specific health risks and potential causes. It should also be noted that minority stress has greater effect upon individuals over time, thus older individuals facing discrimination and stigmatization over longer periods of time may have greater negative mental health impacts (Dentato, 2012). Ultimately, the minority stress model explains that stigma, prejudice, and discrimination creates social environments which are increasingly stressful for LGBTQ persons which eventually causes increased risk of mental health problems (Meyer, 2003). The coming out process is inherently threatening and frightening. It is clear that the disclosure of one's sexual orientation or gender identity poses serious risks for the individual, especially in this context. Such exposure can easily result in rejection (by family, friends, or associates), marginalization, and even physical harm caused by others or even the self (Solomon, McAbee, et Al, 2015). The evidence presents a clear case that LGBTQ mental health is seriously at risk for individuals in Rwanda, where there is a serious lack of mental health care services provided.

Rwandans, and Africans alike, likely find it difficult to truly accept their own identity and sexuality in a society that directly impedes their ability to come to terms with such aspects of a persons' sense of self (Klein, Holtby, et Al, 2014). The effects of discrimination and stigma can be severe and greatly impact the self-respect and confidence of the individual. It is also clear, given the research, that the effects of all types of stigma (perceived, actual, and internalized) are negatively impactful to the overall health and wellbeing of the individual and especially their mental health and wellbeing (Almeida, Johnson, et. al, 2009). Due to the gap in research presented, it is clear that more research is needed to understand this phenomenon among this population.

Research Question

How does the 'coming out' process influence mental health amongst LGBTQ Rwandan's living in Kigali?

Chapter 3: Methodology

Aim of the Study

The aim of this study is to identify how the coming out process influences mental health among LGBTQ Rwandans in Kigali. This study aims to increase understanding of the coming out process and how this process impacts mental health of LGBTQ Rwandans. Specifically, this research will focus on how this process, its complexity's and nuances, affect the mental health of the study population.

Research Design

This study uses a cross-sectional study design, using qualitative in-depth interviews. In-depth interviews were chosen for data collection efforts because of their ability delve into issues and gain a detailed emic perspective of the participant's experiences, perceptions, and beliefs. During interviews participants share their emic (insider) perspective through discussing experiences, opinions, and beliefs they hold. The perspective of participants' views and perceptions is particularly important from LGBTQ individuals living in Kigali as it allowed insight into their lived experiences and personal history, which may be unknown to the researchers.

Study Site

This study was conducted in Kigali, Rwanda. Data were collected between May – August 2016. The researcher worked with Projet San Francisco (PSF), an affiliate of the Rwanda Zambia HIV Research Group (RZHRG) housed within the Emory University School of Medicine and directed by primary investigator, Dr. Susan Allen. All data were collected at either the PSF compound or the Health Development Initiative (HDI) Outreach Center in the Nyamirambo Sector of Kigali. It was evident to the research team that LGBTQ activity and

populations would be much more common within this capital city, especially in contrast to rural locations throughout Rwanda. It has been reported that urban centers tend to hold more accepting attitudes towards sexual minorities and typically lean towards more socially liberal views (Whitehead, Shaver & Stephenson, 2016). As evidence of this point, Kigali is home to 11 LGBTQ associations as well as Projet San Francisco (PSF) and Health Development Initiative (HDI), two prominent advocacy and health organizations working closely with LGBTQ populations. For these reasons research was conducted in the urban location of Kigali, the capital city. Research was conducted in Kigali due to Rwanda's relative lenience on sexual identity deviance, alongside the fact that research has yet to be conducted on mental health among out LGBTQ Rwandans.

Key Informant Interviews

Upon arrival in Rwanda the researcher began the process to identify persons for involvement in semi-structured key informant interviews. Informants were recruited directly because of their involvement with PSF and/or HDI and included LGBTQ association leaders, employees of PSF, and the director of HDI. Informants also represented desirable characteristics for inclusion in the interviews as each key informant has been significantly involved in LGBTQ advocacy efforts in Rwanda in the past, or currently. Each of the key informants works closely with LGBTQ associations in Kigali and around Rwanda aiding them to gain a larger presence, educate their communities and to become stronger advocates for their own needs. The purpose of these interviews was to provide an overview of the experiences of LGBTQ communities in Rwanda to provide the researcher an idea of the current situation before beginning to prepare the interview guide for in-depth interviews.

Interviews conducted with key informants lasted approximately one hour each and were treated as an informal discussion in which the researcher gathered knowledge about the LGBTQ community in Kigali. Topics discussed included stigma, homophobia, discrimination, physical violence, government attitudes towards LGBTQ communities, and familial acceptance of LGBTQ persons. Interviews were semi-structured as some questions were previously prepared for the interview, however the interview lacked the formality of an interview or discussion guide. Ultimately, five key informant interviews were conducted in the first two weeks of the research project. Data collected in these interviews was not audio recorded, however notes were taken by the researcher and the Kinyarwanda interviewer who also helped with direct translations during interviews when necessary.

[In-Depth-Interviews](#)

After completion of key informant interviews, the researcher utilized the suggestions, key themes, and topics discussed during key informant interviews to create a first draft of the in-depth interview (IDI) guide to be used with LGBTQ individuals recruited for primary data collection. The in-depth interview guide was then translated by PSF employees into Kinyarwanda for purposes of interviewing participants. An English version of the interview guide was maintained throughout the research process in the event that a participant required an interview in English instead of Kinyarwanda. The first version of the IDI guide was piloted with one individual who was recruited through a “gatekeeper” who was closely affiliated with the HDI Outreach Center which houses the primary offices of LGBTQ associations in Kigali. Corrections to the guide were made to the guide after this process; namely, changes in format and wording of questions was completed for better understanding of questions.

This second version of the guide was used for two in-depth interviews. After completion of the two interviews it became clear that further iterative changes were needed to promote better data quality. The format of interview was changed in order to promote better rapport development between the interviewer and the participant and the interview guide was shortened to ensure that all key questions could be answered within 1 hour and to avoid interviewer and participant fatigue caused by long interviews.

During the data collection process a third version of the interview guide was created as the data collection team was approached by LGBTQ individuals who had not yet come out to their family members. As our original eligibility criteria required that participants had come out to at least one family member these individuals were not eligible to be involved in in-depth interviews. However, it was determined that the experiences, perceptions, and views of these participants would provide valuable insight into the coming out process amongst this population. Thus, a third version of the guide was created and translated focusing on the factors and reasons that LGBTQ individuals chose not to come out to family members.

All interview guides were available for interviews in English or Kinyarwanda. Participants requesting an English interview were interviewed by the researcher and those conducted in Kinyarwanda were conducted by PSF or HDI staff members who had received training in qualitative research interviewing from the researcher. Versions of the interview guide for individuals who have already come out to at least one family member and those who have not yet come out to a family member can be viewed in the appendices. Translation of interviews was begun shortly after interviews were completed. When possible, the interviewer was utilized as the translator however, this was not possible for all interviewers. In these instances, other PSF staff members were utilized as translators.

A paper version and audio recorded version of the Kinyarwanda consent form, previously created by PSF, were provided to participants to ensure comprehension of consent, including consent for audio recording interviews. Consent forms were provided in English to participants who requested this and then read through with the interviewer or researcher; to ensure comprehension participants were provided time to ask clarifying questions.

Participant Recruitment

All study participants were recruited via a community gatekeeper. This individual was directly involved with all HDI activities as well as many of the LGBTQ associations and their development. The gatekeeper knows many of the members of the LGBTQ associations as well as all of the leaders for each different association. As such, this individual was seen as an ideal member of the community to recruit members of the LGBTQ community for interviews. The gatekeeper sought interview participants directly via email and SMS messaging as our research required specific inclusion criteria for participation in an interview.

Participants were selected purposively as each retained characteristics meeting the inclusion criteria for participation in the research study. Eligible participants were at least 18 years of age, had already self-disclosed their sexuality or gender identity to friends and/or family members, and self-identified publicly as either lesbian, gay, bisexual, or transgender. Though not an aspect of the eligibility criteria, all participants were members of at least one LGBTQ association based in Kigali. The gatekeeper directly contacted individuals via SMS messaging informing potential participants of the study and its research purposes. Individuals interested in participating expressed their interest to the gatekeeper who scheduled a time and day for the participant to be interviewed for the research study. During enrollment and consent, participants

were reminded of the purpose of the study and incentivized with monetary reimbursements for travel to and from the research site location.

Data Analysis

The research sought to understand the emic perspectives of LGBTQ individual's in Kigali, Rwanda so a grounded theory approach is appropriate. Grounded theory remains a fundamental construct within qualitative researcher. In grounded theory, researchers use the data provided by participants to uncover a theory that may explain the data and phenomenon of interest for the research (Glaser & Strauss, 2009). The purpose of grounded theory is to ensure that any results or theory developed as a result of the research study are based in the data that has been presented and that they stem from the participants' own words (Glaser & Strauss, 2009).

Translation and transcription of interviews began during data collection. All interviews were translated during data collection by PSF staff members while the researcher ensured translations were verbatim and not simply summaries of what was said by the participant. Only five of thirteen interview transcriptions were complete by the end of the data collection phase. The remaining eight interview transcriptions were completed by the researcher after returning to the United States.

After transcriptions were completed the researcher began reading through the transcripts using MaxQDA12 analysis software and creating memos for each transcript. Memos were created by noting the thoughts or questions of the researcher as transcripts were read. These memos aided in the development of codes and a research question. In total, 32 codes were created for analysis of the thirteen transcripts. These 32 codes consisted of 15 base codes and 17 sub-codes that provided further understanding of topics discussed within the IDIs. Two of the codes used in analysis and remarkable: "I am the only one" and "I am who I am". These two

codes are in-vivo codes taken directly from the translated versions of interview transcriptions and thus directly from the participants. The complete list of all codes and their definitions is available in the appendix. The researcher reviewed all transcripts to ensure that codes were applied consistently across all transcripts and to ensure all portions of transcripts that needed coding had been coded. During the final read through of transcripts, the researcher identified quotes throughout all thirteen transcripts that presented commonalities and differences between participants. These quotes guide the results write-up and discussion.

Ethical Considerations

The Rwandan National Ethics Committee provided IRB approval for this study. The study is included within a previously approved project under the Rwanda Key Populations CDC study led by Projet San Francisco in Kigali, Rwanda. Prior to data collection, the researcher also completed CITI Certification for Social and Behavioral Research, Biomedical Research, and Good Clinical Practices. In accordance with current IRB protocol, all participants involved in qualitative research signed an informed consent form before participation in IDIs with the researcher or any member of the research team. Consent forms were provided as verbatim audio recordings alongside written English or Kinyarwanda forms to ensure comprehension and retention of the material. Participants were also provided ample time to read the consent form and ask questions when necessary.

Limitations

Prior to beginning data collection, it was decided that the researcher, interviewer, translator, and participant would all be present during in-depth interviews. Thus, the first two interviews were completed in Kinyarwanda with all four individuals present in the room. This was done in efforts to ensure that proper qualitative interviewing methods and probing were implemented, as the Kinyarwanda interviewers had not yet been trained in qualitative research.

This format created a setting which made development of rapport between the interviewer and participant significantly more difficult. Rapport is imperative in an in-depth interview as it promotes openness and comfort between the participant and interviewer. Translating from Kinyarwanda into English during the interview also caused interviews to last over two hours, causing fatigue for all involved. This fatigue, potentially, affected the data that was provided by the participant and could have also affected the ways in which questions were asked or probed on by the Kinyarwanda interviewer. Because of the factors impeding rapport development between the participant and interviewer it was decided that in-depth interviews would be completed only in Kinyarwanda by trained qualitative interviewers. I then trained three staff members from PSF and HDI on qualitative interviewing methods which allowed the staff member to interview participants on their own without my presence. After reviewing transcripts from these interviews, it was clear that this change in interview format was positive as it allowed the development of rapport between the participant and interviewer and promoted more detailed answers and stories from the participants.

Given the nature of the project and the short timeline it became impossible to utilize the same interviewer and translator for all interviews. As such, some differences in interviewing styles and language translation styles may have affected the resulting data. Effects to the data may have been caused by differences in interview style or probing style of the interviewers. However, participants were all still probed on questions that required more detail and explanation, thus it is unlikely to have a significant impact on the data quality.

The data from this research is also unable to speak to the experiences of LGBTQ individuals who are not a part of associations in Kigali. All 13 participants who were involved in interviews for the study were also members of at least one LGBTQ association in Kigali. Thus,

the sample is biased as these individuals have already reached a certain level of acceptance of their sexuality/identity themselves. This is of importance as this research, and the resulting data, are unable to speak to the experiences of individuals in Kigali who may remain completely “closeted” or secretly LGBTQ. For this reason, more research would need to be conducted on the topic with a broader study population in order to capture views of individuals outside of LGBTQ associations.

Chapter 4: Results

Demographic Characteristics

This study analyzed data from 13 participants who completed in-depth interviews between June and July of 2016. Participants completed a brief demographic survey directly prior to completing IDIs. The demographic characteristics of study participants are shown in Table 1. The average age of participants was 25.4 years with (median of 26 years) with ages ranging between 19-32 years. Two participants (15%) were born female and eleven participants (85%) were born male. Of these participants, 7 reported a female gender identity, 5 a male gender identity and 1 reported feeling gender queer or gender fluid. Based on self-report, 2 participants identified as lesbians, 7 identified as gay, and 4 identified as bisexual. A full table of all demographic characteristics is available in the appendix.

Table 1. Demographic Characteristics

	#	%
Age (n=13)		
18-21	2	15.385
22-24	3	23.077
25-27	5	38.462
28-32	3	23.077
Average	25.4	
Mean	26	
Sex (n=13)		
Male	11	84.615
Female	2	15.385
Gender Identity (n=13)		
Male	5	38.462
Female	7	53.846
Gender Queer	1	7.692
Sexuality (n=13)		
Gay	7	53.846
Bisexual	4	30.769
Lesbian	2	15.385

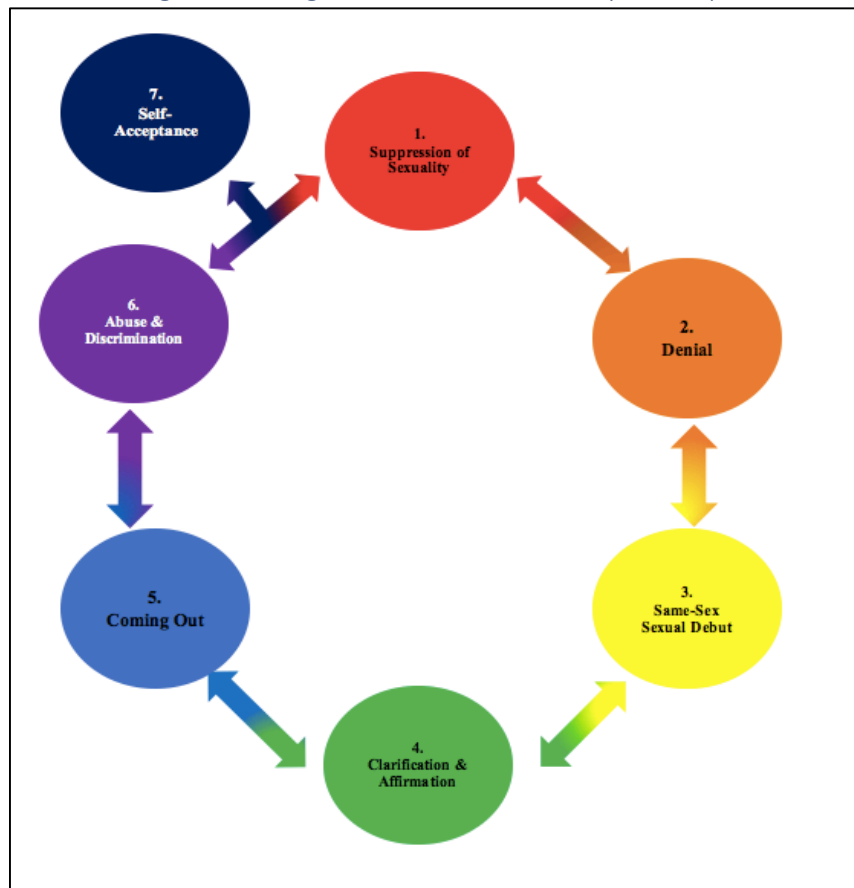
Results: How the Coming Out Process Influences Mental Health

Figure 1. depicts the process of coming out amongst study participants which identified seven “phases” in the coming out process. This process begins with “Suppression of Sexuality” and ends with number seven “Acceptance”. In order to understand how the ‘Coming Out’ process influences the mental health of LGBTQ individuals in Rwanda it is essential to acknowledge that coming out as LGBTQ in Rwanda is typically a non-linear process. Defining the coming out process as a linear process implies that all individuals follow the same steps to get from concealing or denying their sexuality or identity to being open about it. This linearity also assumes that that there exists a finite end to the ‘Coming Out’ process. Instead, it is essential to understand that the “process” is highly individualized and sometimes necessary to organize into steps or phases. Understanding this also requires that understanding that it is sometimes possible for LGBTQ individuals to digress through the process or skip steps in some situations.

Within the study population, the coming out process presented in a cyclical format to capture common digression or progression through phases. Each phase represents a different time during the coming out process in which the participants face certain stressors and negative aspects of the coming out process that influence their mental health, or mediators, and positive aspects that influence mental health. Ultimately, the goal of the coming out process is to reach “phase” seven in which the individual has reached a stage whereby there is absence of internal stigmatization, as well as external acceptance of their identity from their social networks and family members. Each stage has a potential to affect the individual’s mental health during the coming out process in either a positive or negative way, and sometimes both. Some “phases”

may also have a greater influence on mental health than others, however it is clear that each plays an integral role in both the coming out process and the overall mental health of the individual. It is this nuance and variation of the coming out process that provides a deeper understanding of how the ‘Coming Out’ process influences the mental health of LGBTQ Rwandans.

Figure 1. Process of coming out among LGBTQ Rwandan Study Participants



Phase 1: Suppression of Sexuality

Coming out typically begins at “Phase 1. Suppression of Sexuality”. Several study participants discussed their experiences while growing up and not having information that related to the feelings of same sex attraction or gender confusion that they were having. Participants

were asked what they knew about homosexuality when they were growing up and they recalled difficulties in understanding their attraction towards other people of the same sex. When they were asked, participants expressed that they “knew nothing” (IDI 7) or that they “didn’t have much information about homosexuality” (IDI 15). Participants expressed that they “knew nothing” (IDI 7) or that they “didn’t have much information about homosexuality” (IDI 15) during this time. Participants wanted to confide in others who could relate to them in the hope of finding some understanding of their feelings, however they were continually faced with the lack of information and general heteronormative views of sexuality that are dominant in Rwandan society. Participants also sought out information from other resources such as newspapers and social media, however, they expressed that most information about homosexuality was negative and stigmatizing. For example, a male participant stated “Okay, honestly I didn’t know much about that [homosexuality] and some information that I had before, like let’s say from the radios, they considered it [homosexuality] to be like a sickness. Something, yeah abnormality” (IDI 12). It was also shared that “our... Rwandans do not appreciate... maybe that type of sexual activity” (IDI 15). Another participant shared that “many of them [community members] they don’t like it. Even they just see it like something which is not acceptable” (IDI 5). These comments demonstrate that even when information or opinions about LGBT sexualities and identities was available to participants they were mostly homophobic, and further stigmatizing and emotionally damaging for LGBTQ individuals.

Participants were asked to share their family members’ perceptions of homosexuality when they (the participants) were growing up. Many participants reported that they felt their family was not supportive of homosexuality, finding it to be unacceptable. This view was shared amongst almost all participants and were even shared by participants whose families were said to

have not openly discussed sexuality or homosexuality. Participants also discussed that they knew their family members had negative views of homosexuality but that their family members also “didn’t have information about it” (IDI 3). Participants felt that this lack of information allowed family members to simply accept the negative community view of homosexuality and LGBTQ individuals. Some participants discussed how homosexuality and other LGBT identities were viewed as “mental disorders” (IDI 10) or “abnormal things” (IDI 11) within their families. One participant also discussed the perpetuation of the Biblical story of Sodom and Gomorrah in detailing how their family members talked about homosexuality while they were growing up, for example, “they [family] used to say that ‘we know that Sodom and Gomorrah [were] destroyed because of this act, so we just see that it cause[s] that [destruction]’” (IDI 2). This overall lack of information about homosexuality, combined with a common refusal to discuss the topic and rely on community views created an environment in which sexuality, particularly homosexuality, remained suppressed and not discussed.

This societal suppression of sexuality led participants to believe that homosexuality must be an atypical behavior that only they were experiencing. Participants discussed that they believed that they were the only person who had feelings for other members of the same sex or who did not identify as their assigned sex at birth. One transgender participant stated “I just thought that it’s just, uh, maybe one person that is like me [transgender]...One person that feels like this” (IDI 1). A male participant expressed that “I felt it [attraction to other males], but uh, I think [thought] it was for me only” (IDI 8). Similarly, another male participant stated “I thought that I am [was] alone being like this [homosexual]” (IDI 10). The deficiency in information about LGBTQ sexuality and identities, coupled with the lack of other LGBTQ individuals as a role model or resource, caused participants to grow up unsure of not only their sexuality and

identity as an individuals in an unaccepting environment. This uncertainty of themselves created feelings of anger, frustration, and desperation among the participants who desperately wanted to be like others and to not have the feelings that they did. A male participant who has not come out to any family members stated “I am not like others. I had so many questions without any answers for them” (IDI 15). Overall, participants shared that, even in their youth, they understood that being homosexual was unacceptable and that to be LGBTQ was “to be cursed” (IDI 12). Each of these examples presents evidence for potential negative mental health outcomes amongst the LGBTQ population in Kigali due to the suppression of their own sexuality and lack of information about homosexuality.

A particular point of interest in this situation presented itself among transgender participants. For the purpose of this analysis, transgender participants are those who self-identified verbally as transgender, including four (n=4) study participants. Transgender participants described their relationship with religion and specifically their relationship with God while navigating their coming out process. A transgender participant states “you always like fight [internally]. I am Catholic, and the Bible says this... so what should I do?” (IDI 7) as they were describing their struggle to understand their identity and cope in society while still maintaining their religious upbringing. This presents a clear struggle that this participant was dealing with in coping with guilt for feeling the way they do, but also trying to maintain the religious values they had been taught. Another transgender participant says “why am I like this? Why has God chosen me to be like this? Why I’m not like the others... why, why, why?” (IDI 1). This exact quote details the participant’s frustration with God and the participant’s belief that God chose them to be like this, but they don’t understand why. A third transgender participant expresses frustration with God stating “I was thinking, oh God what is wrong with you? You

have forgotten to give me the sex of girl. You must give to me a change. To be changed” (IDI 4). This participant questions God and why God would make them the wrong sex, expressing that since this has happened, God must now give to them a change to the “right” sex. Each of these transgender participants explain clear frustration with their religion and with God specifically for making them the way that they are. They express confusion as to why it has happened, confusion as to why God has chosen them to be this way, and desperation for God to change them to the right sex because they have made a mistake.

The experiences that participants detailed during their interviews reflects the suppression of sexuality within Rwandan society. In turn, this suppression caused the lack of information available for participants impeding their ability to recognize that they were not the only LGBTQ person in the World. Each of these experiences detailed also provides the context for negative mental health outcomes. Frustration, anger, desperation, and confusion hindered the development of positive self-identity and sense of self among the study participants resulting in the progression to the next step of the “coming out process”.

Phase 2: Denial of Sexuality or Identity

The second phase of the “coming out” process is “Phase 2. Denial”, whereby some participants actively denied their sexuality or identity. Not only were participants denying their sexuality/identity to others, but also to themselves resulting in negative internal stigmatization. Many participants discussed going through a phase of denial about their own sexuality or gender, often due to not finding clarity in their identity leading to suppression of sexuality (as described in Phase 1). The lack of available information for participants presented a void in which participants continued to think they may be the only person who was LGBTQ, and thus that there was something wrong with them. One female participant sharing a story of having forced sex with her previous boyfriend states “because I just didn’t want to see myself sleeping with, or

having sex with another man and being pregnant. Because I had no feelings with men” (IDI 5).

A gay male participant expresses “I felt that it was something that I could keep as a secret. And I could do it in secret ways and I felt that, I couldn’t tell it to someone and it was not really easy to tell to someone what I do... it was a secret” (IDI 13). Participants discussed their reasons for denying their sexuality or identity. Some expressing that it was in attempts to fit in or “pass” or to convince themselves that they weren’t actually LGBTQ. Before coming out, one transgender participant really struggles with their identity and sexuality, explaining “you really struggle a lot. You lose a lot. Yeah, you try dresses here, and... you try to date, as in my friends really tried to date, and... of course me, I was always in the [sports] teams so we are already friends, and I would try [with males], but I would say ‘if you try to touch me...’ I would really [be mad] ...” (IDI 7). This same participant later explains “you always have these battles in your head. You fight with your... internal system. And you fight with the... the outside. You always, like fight” expressing their struggles with internal stigmatization created by the continual self-denial of their identity.

A male participant, who has not yet come out to any of his family members, shared a set of experiences detailing their continued denial of their sexuality. While the participant recognizes that they are LGBTQ, they continue to deny their sexuality and instead actively work to convince others, specifically their family members, that they are heterosexual. This is all in an effort to help protect themselves from stigmatization and discrimination that they have witnessed other LGBTQ individuals go through. The participant explains:

Case Study 1. (IDI 8)

“I felt like is... is a shame to be known as, as the LGBT individual. And uh, it was not easy to me to, to say about it. Or to be known like... uh homosexual... like LGBT individual”. He states “and since I have things like [masculinity]... I have to keep it [my bisexuality]. No one can know about my...sexuality. Because it is a problem in our society... and I think that it is better to participate in a group who rejects that person [a homosexual] in order to keep mine... and not be discovered by other that I am like that gay” (IDI 8). Additionally, he says “If someone else were to tell my family that I was LGBT, I would deny it” (IDI 8) and “I think that if there is someone, a girl who is interested in me, I accept the relation. They invite me to come and see. We do sex in order to convince others that I am not a bisexual” (IDI 8). He concludes saying “maybe I am stigmatized by myself because I have fear of being discovered by others. Not only my family, but others too” (IDI 8).

Within the “Coming Out” process, as detailed in Figure 1., it is important to note that LGBTQ individuals may revert to an earlier phase in the process in response to the reactions of others or their feelings about these reactions when revealing their identity to others. Though regressing in the process was uncommon among the study population, it did occur with two participants who experienced negative reactions to their coming out from family or friends.

For one participant, they had refused to come out to family members but attempted to come out to their social network some years ago. They stated, “I tried to initiate that conversation [about homosexuality] in groups with other friends, but not directly. Not to tell them that I am part of them [homosexuals]. So, I understand that they do not accept that that...

that kind of sexuality [homosexuality]. Sometimes they say ‘if my friend is like this [LGBTQ], I can stop to speak to them. I can even tell the authorities that this friend is like this [LGBTQ]’” (IDI 8). This participant is essentially “testing the waters” of their friends’ attitudes which provided the participant an opportunity to gain an understanding about what their friends thought about homosexuality. This situation influenced the participant’s decision to conceal their sexuality and only tell other LGBTQ people about their sexuality. The second participant had no control of the way that they came out to their family members. This participant said “One day my partner came to visit me and a member of my family saw us. They saw me with him and we were ‘in the act’ [having sex]” (IDI 11). The participant’s “secret” was exposed and the family member told the rest of the family about what they had seen, resulting in severe stigmatization of the participant within their family. Since this point, the participant has refused to tell any other person who is not also LGBTQ about their sexuality.

Ultimately, participants’ reasons for denying their sexuality or identity were varied. It is evident that, no matter the reason, the denial of an aspect of their identity created issues in self-confidence, self-acceptance, and inhibited the participant from developing their own sense of self in this community. One participant even said “self-acceptancy. It is really hard” (IDI 7). When probed further about internal negative feelings about themselves the participant stated “yes. I was. Discriminating myself”. These examples aid in the understanding that this topic is complex, dynamic and dependent upon external factors not always in control of the participants. Even for participants who were not in complete denial of their sexuality, this denial of sexuality or identity in any form does contribute to a sense of internal stigmatization influencing one’s own mental health outcomes.

Phase 3: Same-Sex Sexual Debut

The third phase of the “coming out” process is the same sex sexual debut, whereby participants experienced their first same-sex sexual encounter. This experience is one of the main influences on acceptance of their own sexual identity. The first same-sex sexual experience for participants was often self-affirming of their sexuality and feelings of attraction for persons of the same sex. The information that was provided to participants during these experiences allowed them to begin a process of coping and acceptance of their sexuality or identity and aided in their progression through the coming out process.

When participants were asked how they felt ready to come out, one participant stated “uhhh... the first thing that triggered it. I fell for a woman. And it was really there. I didn’t, I didn’t know about love, but I ...yeah I... I loved her and I started bringing her home” (IDI 7). Another participant explained that they knew that they were “not like normal boys” (IDI 2) after explaining their first experience of “experimenting” with other males. They explain that it was not penetrative sex, however they experimented and the experience confirmed many of their feelings and attractions towards members of the same sex. Many participants shared experiences like this, some with penetrative sex and others with other forms of sexual experimentation, but the commonality is that all participants felt that the experience made them feel “right”. The action between the two individuals clarified for participants that their attraction was not simply something in their head, but something that could be acted on in a consensual manner.

Participants also talked about having sex with other members of the same sex and stating that they felt that this is what is supposed to happen for them; that this is the way things are supposed to be and that it is “correct”. One transgender participant stated “my best friend... I was telling him [about my sexuality], and then there [was] no problem [for the friend]. I was telling him ‘I’m a gay’, and actually, he is the first one who was [having sex with me]” (IDI 4).

This relationship for the participant was an experience helped the participant to develop their acceptance and understanding that this was their sexuality and identity. They accepted that this was something that was not going to change and even expressed that “I will find a husband. I don’t feel like a man. I can’t fuck one, someone.... I’m trans. I can’t be top; I can be bottom. I am a transgender” (IDI 4) in which they explain that though they were born in a male body they identify as a female and fulfill the sexual “role” of the female. The participant identified this experience as their “ah-ha” moment in which things made sense for them. Previously to this, the participant had explained how their feelings and attractions did not make sense to them. They were told that it is wrong to behave like a girl if you are a boy and that they have to fill the roles of the boy, but they knew it wasn’t correct for them. This experience confirmed that what they were feeling was correct in their circumstances.

The experience of the first same-sex sexual encounter, or same sex sexual debut, presented as an event that had clear impacts on all participants. Each participant discussed that the event clarified how sex was supposed to happen for them. This is also one of the first times that participants learned that there were others who identified in the same ways that they did; either in sexuality or identity. This, alone, had a great impact on participants and encouraged them to move forward through the process of coming out. Having their same-sex sexual debut and moving forward through the process improved participants’ feelings about themselves considerably. As stated before, participants felt that “this is right” or “this is how it is supposed to be” in describing their experiences. They understood that the feelings and attractions they had were not simply made up or unfounded. This event provided concrete evidence for participants that they were correct in feeling what they did while also providing them an understanding that it was okay to be LGBTQ because there were others like them.

Phase 4: Clarification & Affirmation of Sexuality and/or Identity

When participants completed phase three they progressed to the fourth phase of clarification or affirmation of their sexuality and/or identity. This involved feeling that their feelings and attractions towards other persons of the same sex were justified, qualified, and realizing that they were not isolated in their feelings. This clarification and affirmation aids participants in learning to accept their sexuality or identity and to grow and develop from the experience, as a whole. Participants stated, “the acceptance of my sexuality just removed the fear [of coming out]” (IDI 1). Participants also discussed feeling “free” or “untied” as if they had been trapped by concealing their sexuality or identity from others. Affirmation of the way that participants felt towards others also allowed them to move past barriers that had once prevented them from accepting or telling others about their sexuality or identity. One participant said “yeah, I really took that decision because I didn’t want to... I wanted to be in the life where I feel free and I wanted to live in the life where I don’t feel guilty judgement” (IDI 12). At this phase, participants understood that there were others who were “like them” and that identified in similar ways that they did. This introduction to an LGBT social network allowed participants to begin learning more about their sexuality or identity and furthered their development of an identity within the LGBTQ spectrum.

The role of LGBT Social Networks in the coming out process was often described by participants. The benefits of the social network were described as facilitating confidence by having other people to support the participants while they were learning to accept and understand their sexuality or gender identity. Beyond this, participants also discussed how their LGBTQ friends and network were supportive of them as they were going through the coming out process. One participant stated “My, my comrades. The gays. They helped me when my family leaved [disowned] me” (IDI 4). As explained by this quote, it was clear that the LGBT social network

provided not only mental health support, but also provided physical and emotional support for participants. Though many of the factors presented thus far have seemed to be negative influences on mental health for the LGBTQ population, this social support from other LGBTQ individuals presented as a mediator and protective factor for the population. Alongside “protecting” the mental health of participants, having an LGBT social network also provided participants with a sense of protection within society in general. Many participants discussed knowing that they could rely on their LGBT social network if any negative experience were to happen to them.

One participant discusses the first time that they realized they had a non-binary gender identity stating that another individual who was transgender helped them to understand. They shared, “he said ‘you are the same like me’. Then I said ‘how?’. He said ‘you are just like me. You are gay. Your identity is not a boy’” (IDI 1). The participant went on to explain that they began to interact with this person much more and through these interactions they were able to gain a better understanding of their gender identity and sexuality. Another participant described how they began to learn more about their sexuality when they met others who shared the same sexuality. She says “but I started to know just when I was growing up. I just knew about homosexuality when I met others who were like me” (IDI 5). This same participant also shares that “I met some friends who are also lesbians, who they accepted me and took me into their homes. I lived with them and we created a group of homosexuals. Then we started to live as a family and that is the family that I have now” (IDI 5). She shares this statement directly after detailing her experience choosing to leave her family after being victim to physical, mental, and emotional abuse due to her sexuality. This participant’s experience and reliance on her social network presented that the formation of a support network and “familial unit” outside of what

most people would call “typical” was beneficial for the participant. Not only did this family unit present the participant with protection and shelter, it also presented the participant an opportunity to gain further information and understanding about her sexuality while also developing positive and supportive relationships with accepting individuals.

Other participants discussed their involvement in LGBTQ associations in Kigali and explained how they had been helpful for them. One participant says “when I left my family, I used to... to be in different groups. In many different conversations, I became more open and I learned that there are many other people like me. I started to disclose my secret... my sexuality to others. It became easier” (IDI 10). Because the participant came from a more unaccepting family the participant was totally unaware that other LGBTQ individuals resided within Rwanda. However, he explains that after removing himself from the family home that he was able to begin understanding his sexuality and accepting it because he was surrounding himself with accepting and likeminded individuals. These individuals helped the participant to feel comfortable as themselves and to be proud of their sexuality and to feel “normal” in their sexuality or identity.

One participant explained that while they were growing up they understood the concept that someone of the same sex could be attracted to another person of the same sex. He goes on to further explain that he understood that individuals could be attracted to more than one gender creating his first understanding of bisexuality. He says “When I was growing up, I found that it was a kind of relationship like others. Like the men who were attracted or interested in a girl, they could also be interested or attracted to another man. They could create a relationship” (IDI 11). This first understanding allows him the opportunity to develop acceptance of his sexuality and to begin to come to terms with it early in life, something many of the other participants did

not have. However, the participant also discusses that they have their own issues with exposing their sexuality to others after negative experiences being exposed as bisexual among their family, even with the support of their LGBTQ social network. He states “they created some feelings in me. I feel like I cannot tell anyone about my sexuality now. That’s why I said that I could not go on television and say it, even if you were to pay me. That is why it is still a secret now. No one who is not also gay [LGBTQ] knows about my sexuality, other than my family” (IDI 11). Even the support of the social network is sometimes not enough to aid participants in understanding, accepting, and exposing their sexuality to others. For this participant, their negative reactions from their family members against the positive support of friends was not enough to help them to continue through the process, and instead they reverted to the second phase “Denial” in order to cope with negative reactions they had experienced. This denial of sexuality created a stressor on mental health as shown in the quote that unacceptance of the family created clear issues in confidence, acceptance, and a sense of internal stigma within the participant that sometimes cannot be overcome through a supportive LGBT social network.

Participants showed some development of self- acceptance and confidence during this phase and it commonly moved them along to the next phase of the “process” in which they begin deciding who to come out to and how to do so. The fourth “phase” of the process allowed participants the opportunity to develop senses of confidence and self-assuredness knowing that they had a support system of other individuals behind to support them if they fell and received negative reactions to coming out. One participant stated “nothing, no nothing. There was nothing. Because that is me. That is the real me. That is the way that I feel. Yeah, like I cannot, I couldn’t change anything because that [homosexual] is how I am”. The participant shared this after explaining that their family members did not have accepting reactions to their

coming out. Though the participant did care about how their family members perceived and accepted them, they understood that this is something that was not going to change. Through relying on their social group and their understanding that they are not the only individual who is LGBTQ the participant was able to move past this.

Phase 5: Coming Out

After participants completed phase four they progressed to the fifth phase of the coming out process which was when they actually began coming out to others. As has been shown throughout explanations of participants' experiences, coming out is clearly not a linear process and no two approaches defined by study participants were the same. Each individual was faced with choices to make choices based on their own individual circumstances and experiences. Thus, the process was only definable by study participants. As each process was different, this section will highlight some commonalities amongst study participants and their coming out processes.

When describing their coming out processes, participants reported multiple factors resulting in their decision to come out. First, participants discussed their need to be open about their own sexuality or identity in efforts to alleviate feelings of internal homophobia and stigmatization or guilt that they had cast upon themselves. One participant said "I couldn't feel like I am myself. I was pretending. It was a bad internal feeling. I felt like, maybe if I get someone and trust him. I can tell him about my sexuality and it will make me feel more released and more free" (IDI 13). This participant expressed feelings that they had been stigmatizing themselves which was preventing them from living a positive life in which they were proud of themselves and accepting of their sexuality. Another participant shared, "I wanted to be in the life where I feel free and I wanted to live in the life where I don't feel guilty judgement. I was like 'oh, if maybe one relative of mine knows, maybe I will feel like the burden is relieved'. And

honestly, I [always felt] guilty so I didn't want to continue with the same feelings" (IDI 12). This participant's experience shares the common feeling of guilt that participants described throughout their interviews. Participants discussed their family's expectations of them to be successful and to provide children to continue the family legacy. However, participants feared that if they were to come out, then their family may see them as "useless" or incapable of being successful due to the way that society treats homosexuals. Other participants discussed wanting to advocate for and help others who were like them by coming out. One male participant states, "It was just uh, because I know that there were even others like me, and who just still hide themselves. I thought that if I just come out and tell others it can motivate others who still hide themselves to come out also" (IDI 3).

Apart from explaining why participants decided they were ready to come out, they also detailed their decision making process in deciding who to come out to and why. During their first experiences coming out, some participants chose to come out only to one or two of their very close friends instead of their entire social network or family members (sometimes very close friends included a sibling). One bisexual male participant states, "the first one that I told [about my sexuality] was my friend, my friend of a long time. He has been my friend since we were in secondary school... I know that he is a true friend and I know that he can understand me.... and he is not part of the LGBT [community]" (IDI 8). Participants also discussed relying on other members of LGBT associations to understand their identities and sexualities. One male participant says, "the one[s] who knows about my sexual orientation are those who are like me with the same orientation" (IDI 15).

When explaining why participants waited to come out, participants described their fears and stressors they associated with coming out. One transgender participant states "... in

general, it [being Transgender] is not to be a part of [the society]. It is not very accepted” (IDI 2). The participant explains this after being asked what their fears for coming out were when they were in the process of coming out. They expressed their knowledge that being transgender was not accepted within Rwanda and that they would likely be discriminated against if they had come out. They added that, at the time, they understood that they could face violence and severe hate against themselves as a result of coming out.

Fear of family rejection was also a major stressor for participants during their coming out phase. A male participant said “My fear was that if they [family] know about my sexuality they will not accept me. That they will reject me. Automatically I would be stigmatized by others because my family has rejected me” (IDI 11) which brings about the role of the family in societal perception of an individual. The participant’s knowledge that being rejected by their family would result in rejection by society played a critical role in their decision making process while coming out. Another participant echoed this statement, saying “my fears were how they [family] will receive the information... that news. And it felt like they can stop everything. Stop to pay my school fees and other needs” (IDI 14). This statement demonstrates the extent that young people in Rwanda rely on their family for multiple forms of support. As such, rejection from family could result in far greater negative outcomes for participants for some participants. These negative outcomes would affect not only their physical security, but also their emotional and mental health as they cope with having to face independence without any familial support.

Continuing this theme, participants also discussed fears of being not only being rejected or stigmatized, but actually disowned by their families because of their sexuality or gender identity. One participant states “I had fear that I was going to be hated. That I was going to be tossed [disowned] from the family” (IDI 13). This goes beyond losing monetary support of the

family but also losing any connection to the family whatsoever. As stated earlier, family is a crucial pillar in Rwandan society and any person whose family has rejected them, or “cast them away” could be expected to face increased difficulties being accepted by the society as a whole. Another participant who has not come out to their family says “the worst fear is that I would be hated by my family and that I would be disowned.

Beyond a fear of the reactions family members would have, participants also feared how society may treat them if they came out. They discussed not wanting to face the adverse effects of coming out and facing stigmatization, discrimination, and homophobia. A male participant stated that they had even greater fears develop after telling a family member about their sexuality. They stated “they created some feelings in me. I feel like I cannot tell anyone about my sexuality now... That is why it is still a secret now. No one who is not also gay knows about my sexuality other than my family” (IDI 11). The participant explains that the family members’ reactions to their sexuality made them feel that it was impossible that the rest of society could accept them. They explained that, due to their sexuality, family refused to support them anymore and stopped paying their university fees, even though they are a good student. This creation of hopelessness towards the potential for societal acceptance of their sexuality creates a sense of despondence for the participant that was not uncommon among other participants; though this feeling is a seemingly permanent feeling for this participant.

Social Network Reactions to Sexuality/Identity

The reactions of others within the participant’s social network are integral aspects of phase five, coming out (as represented in Figure 1.). For the purposes of this study, the “Social Network” was defined as the individuals who the participant interacts with on a regular basis. Typically, the social network included family members, close friends, and acquaintances. The purpose of defining the social network in this way is to compare coming out to each social group.

It was clear through analysis that a difference did exist between members of the social group. Within analysis, this difference coincided with “closeness” of the participant to the person who they were coming out to. It became clear that being “closer”, typically emotionally or within a strong familial bond, resulted in more polar reactions from a member or members of the participants’ social network. These polar reactions typically resulted in either very strongly positive or strongly negative reactions. This correlates with members of the family and “close” friend having relatively strong reactions on either side of the spectrum. Whereas, members of the participant’s broader social network who were not described as “close” friends tended to have more neutral reactions, though they typically were more negative. This concept helps to explain and understand the volatility of coming out in Rwanda and how individuals may expect one to react to their “coming out”.

Levels of Acceptance Among Family Members

Some participants reported that some family members were more accepting than others to their coming out. Multiple participants explain how their family or friends were shocked or surprised when the participant revealed they were LGBTQ. One participant shared his mother’s reaction saying “she was like ‘What? What?!’ She was really surprised... She said “oh, I don’t believe this, you are just kidding” (IDI 12). This statement alone serves as an example of the concept that some believe no LGBTQ individuals exist in Rwanda. Another participant said “a big part of the family, they don’t support it” (IDI 1). When asked what specifically the participant meant by “a big part of the family” they explained that his father has had negative reactions to the participant’s sexuality since he first knew that the participant was LGBTQ. The participant explained that the father even tried to place blame on the mother and mother’s side of the family resulting in the father threatening to stop supporting the mother. This participant’s experience helps to understand just how deep the resentment towards homosexuality is within

the context of this family in particular. This event and reaction directly resulted in the straining of the relationship between the participant and their mother creating issues that had not existed prior.

Participants shared that some family members thought that homosexuality was some sort of a mental disorder. Other participants also shared that family members thought homosexuality was a learned behavior and that it could “spread” to others. One participant shared his brother's view saying, “He thinks that it is something that we learn and he thought that as long as I live in his house that his children would learn about it. He thought that I could make them homosexual like me.” (IDI 10). The understanding that this participant's brother holds essentially compared homosexuality to a disease or sickness, as it has been described earlier in this paper and in this chapter. This comparison makes the assumption that something is “wrong” with the participant and makes the participants question if they are actually okay. They question their value as they are continually told that they have no value because they are “sick”. Ultimately, it seems that much of the unacceptance of the participants is created because of the general lack of information and knowledge about the topic of LGBTQ lifestyles and identities among the general population, but especially from those who are close to the participant.

On the opposite end of this spectrum, there are family members who were totally accepting of the participant's identity, stating that they knew that the participant was not like “normal” boys or girls and that the participant coming out to them was not that much of a shock; almost as if they had expected it. Another commonality between accepting individuals was that they all shared having experiences outside of Rwanda. Each individual had spent time outside of Rwanda in pursuit of higher education. One participant shared a sentiment about his sister and said “She knows me. She knew me when I was young and a child. She said ‘I knew your

behavior when you were young like a child. You behaved like a girl'. My sister is also more educated and she used to live outside of the country [Rwanda]. I think that is something that probably influenced her reaction because she was not so affected by Rwandan culture and views..." (IDI 10). Another participant shares that during a family "meeting" about the participant's gender identity that an uncle stood up for them and confronted some of their family members. The participant says "but there was an uncle who was living in Sweden, he just stood up and told them 'no, you should not react in that [negative] manner because if he is like that he is like that. And you should just protect him. If you are against him and also the neighbors and society also they are against him. So what are we going to solve? You should just be positive and support him'" (IDI 1). The participant explained that the uncle defending them made them feel a sense of support that they had not felt before which helped them to cope with the negative comments that other family members had said. The support of any family member always presented as a mediator of stress for the participants and encouraging of positive mental health outcomes among the participants.

Though many accepting family members had spent time outside of Rwanda, not all family members who were accepting had done so. One participant details their wife's acceptance of their gender identity and sexuality after they came out to them. The participant explained coming out to their wife, saying:

Case Study 2. (IDI 2)

"you know, it is true. That is why I just don't want to hurt you or maybe to make you very bad. I wish you could just go and live in the [home] village and I could just go on to live my life" (IDI 2). The wife then says "you know what? I used to hear about it. I knew before that you are a homosexual. Though, I was not sure because you never told

me the truth” (IDI 2). She continues, “I have no problem to live with you, even if you are homosexual. I am ready to live, to stay with you” (IDI 2). The participant says “if you are fine with it, I have no problem. But you should know that I am homosexual, you will see maybe other men and that I am a wife like you” (IDI 2). When asked why the wife continues to live with the participant, even after they have come out as a transgender female the participant says “we are just loving each other” (IDI 2).

For this participant, in particular, having the support of someone as “close” to them as a wife was positively influential for their mental health and developing acceptance of themselves. The participant expressed that being open about their identity with their family members encouraged them to be open with their community as well.

A topic of particular interest is that female members of the family, particularly on the maternal side of the family, were reported to be more accepting and tolerant of the LGBTQ individuals’ sexuality or identity. Participants discussed how sisters and mothers reacted in positive ways and explained to the participant that they had “known” that the participant was “different” and not like “others”. One participant stated “the way that they [mother] see me, [they know] it will never happen that I will change. They [mother] just accept [it]” (IDI 1). Another participant said of their sister “she was normal. She accepted it easily and... because she was already thinking because of my [different] behavior. She accepted it” (IDI 10). Results also showed that it was much more common for the participant to have first come out to a female family member than a male family member when coming out to family, however this was not explored further during data collection and would need more research to gain an understanding of why.

While the two polar ends of the spectrum were the typical reactions from family members there were two participants whose family's acceptance was nuanced in a way. For one of the participant's their family's form of "acceptance" was to hold out hope that the participant would be heterosexual again sometime in the future. He shares "my family knew about it, my sexuality. They accepted that, but with hope that maybe I will change one day. They tried to make conversations with me when they asked me 'tell us, you can... you can be attracted by a girl'" (IDI 14). He explains that "my family accepted that. They accepted that because they can't change that" and "they decided that because they gave me my right. They accepted my right to be" (IDI 14). However, they held onto the hope that one day the participant would stop being homosexual and instead be heterosexual. The second participant discusses a "Rwandan proverb" to explain their family's "conditional acceptance". He says that the proverb is "if you just give birth to something that you don't like, you will just accept it and carry it. Not because you wish to have it, just because you have seen it like that" (IDI 3). Another participant includes this in their description of their family's acceptance of them, however their family actually is accepting of them and their identity. They say "you know the people when they, I know they like me [because] I am their heart and blood. They don't like me like that because I am a gay" (IDI 4). The "proverb" essentially relates to the obligation to keep or accept someone because it is your blood and your responsibility; it is a biological part of your family. Not actually because you want to keep it or that you accept it, you simply have to as a "Rwandan".

Levels of Acceptance Among Friends and Acquaintances

Close friends also had reactions similar to family members as they were polar and varied depending on "closeness" to the participant. Participants talk about confiding in "close friends" as the first member of their friend circle who they told about their sexuality or identity. For almost all of these individuals, their "close friend" or "best friend" was not also LGBTQ, at least

not at the time that the participant came out to them. One participant explains his close friend's reaction, saying "he was, um surprised when I came [out] to him and told him I'm a gay. He was laughing but finally he said 'that's good'" (IDI 1). The same participant also says of their friend group "for them, they were no problem, because some of them they just somehow already knew about it [the participant's identity]" (IDI 1). A male participant says of his close friend "when he knew about my sexuality he was surprised but he accepted and he told me "it's your choice. It happens. Even if I am not like you it cannot stop our relationship. So go ahead, it is your choice" (IDI 8). Another participant says "yeah, really those friends of mine who we grew up together, we are really close. I think they had really started suspecting it. They accepted it. I think that most of them are educated and open minded" (IDI 12). Another participant even discusses how their close friend advises and provides them a type of counsel saying "he advised me that 'okay, if you are interested in men, then try to be care[ful]... and know what to do and know what... know what you have to do and know what you have to avoid'" (IDI 14), providing a sense of protection and support to the participant. Though almost all of the participants discussed how their close friends accepted them and their sexuality or identity, there was one participant whose closest friend were completely unaccepting. The participant explains their friends' reaction saying "Yeah, I lost them. One of them is a born again [Christian]... So she is always 'you have never been like that [nickname]. You can't be like that. You can't be like that'" (IDI 7).

While family members and close friends tended to have more polar reactions, general friends and acquaintances of the participants tended to be more neutral about the matter, though leaning slightly to more negative reactions. One participant explains how their friends believed it was peer pressure that was changing their sexuality. They explain "it was something strange

for them. They even used to tell me ‘you know; this is just peer pressure. You are not homosexual but if you just, like, but because you have friends who are homosexuals they are those who influence you to be homosexual’. So they could not accept that I am really a lesbian because they would say that this is just something ‘learned from others’” (IDI 5). Another participant explained that knowing their friend group’s views on homosexuality had kept them from coming out to them. They share, “I tried to initiate that conversation in groups with other friends, but not directly. Not to tell them that I am part of them [the LGBTQ community]. So I understand that they do not accept that that... that kind of sexuality” (IDI 8). Another participant explains that even if your friends do seem to accept you, they may not want to be seen in public with you. He says “even other people when you are walking with your friends, sometimes your friends will not want to walk with you because others will be looking at you like you are smart [well-dressed] and your friends don’t want others to think that maybe you are smart like them. They don’t want others to think that maybe they are gay” (IDI 13). Another participant explains the reactions of their work colleagues, sharing “my colleagues uh... were surprised when they heard about my sexuality. Some accepted that... others refused to accept that” (IDI 14). All in all, general friends or acquaintances tended to take a more neutral stance on the participants’ identities and sexualities, however some leaned more negative and seemed to be easily swayed to a negative view. The perception of the community and the rest of society on them and the fact that they have an LGBTQ friend or colleague seemed to be an important factor impacting their reactions and behaviors towards the participant.

Effects of Coming Out for Participants

Ultimately, after coming out to family and friends several participants shared that they could be “free” and that they could now be their true selves after they had come out to the important and close people in their lives. One participant shared “okay, I can now go out and be

part of what they are saying” (IDI 1) in reference to confronting others who had continually accused them of being LGBTQ and addressing homophobic and stigmatic comments said in public. Another participant said “I could be free” (IDI 11) in reference to being their true self when they are with other LGBT association members. This sense of freedom was expressed to make the participants feel better about themselves and to aid them in developing future relationships as they felt that they were no longer hiding anything from others. The participant’s ability to represent themselves as they feel they are supposed to be was important for participants and allowed their expression to match how they actually feel. This affirmation and ability has been shown to promote positive mental health amongst LGBTQ populations in research around the world and could also be true for this population.

Phase 6: Abuse & Discrimination

After completing phase five of the coming out process, participants progressed into Phase six in which participants described their experiences facing events of abuse and/or discrimination as a result of their coming out. Events described by participants were caused by individuals who were unaccepting to the participant’s sexuality or identity and were not uncommon among family members, previous friends, or society as a whole. The experiences of participants are varied, as with their coming out process, but they paint a clear picture that abuse and discrimination, in all their forms, among this population are clear issues.

When asked if participants had any examples of times when they were discriminated against that they could share, one participant said, “it happened. To be treated differently, especially when we [LGBTQ persons] are in a public place. Especially when we are out in a... different night clubs. They used to... when we dance they will say that we are like females. And they start to [be physically aggressive]” (IDI 10). All participants, even those who were very accepting of their own identity and sexuality shared experiences similar to this in which

they were actively discriminated against because of their sexuality. At times, the perpetrator(s) of discrimination would even say “because you are gay” when explaining why they were acting that way. Participants reacted to these acts and statements against them differently, however a majority of the reactions that participants had related negatively to their feelings about themselves. Participants described feeling “really low” or down about themselves because of the abuse and discrimination occurring to them.

Workplace discrimination was also not uncommon among the study population. A male participant shared a story about being fired from a job because he is gay. He said “I worked there [one] full day. Then they [employer] came to know my sexuality. The following Monday morning they called me and told me to never come back here” (IDI 12). The participant continued their story by explaining their boss’s response to the participant questioning the reasons for his firing. He says “and he [the boss] told me ‘yeah, there are some people who told our boss that you are one of the gays. Those people who sleep and sex. It is something that he [the boss] really hates. Don’t ever come back or step foot at our institution again’. Since then, I stopped work and I was not even paid for the day of work that I completed” (IDI 12). Several participants relayed stories similar to this and they explained that this is not uncommon in Kigali. They explained that employers use the notion that “gays are lazy and bad workers” as an excuse for firing the employee. However, participants verbalized that they understood the reason was simply because the employer didn’t agree with the sexuality or because the employer was afraid of how it would look for them to employ someone who is LGBTQ.

Participants also explained that getting a job as an openly LGBTQ person was difficult as employers would simply deny their applications or potential employment. One participant shared “when you ask for a job... the people look at you. Not what you can offer them, your

qualifications... They look at your appearance... They be like ‘oh, this guy who looks like a girl? How can he work?’ so you cannot find a job” (IDI 13). This participant explained further that employers share the thought described earlier that LGBTQ people are sick and that they “no longer have a brain” (IDI 13). Again, participants explained that these events made them feel bad about themselves and impacted the way that they viewed themselves. However, they explained that what was more impactful was the fact that they would be unable to provide for themselves. Thus, confirming the notion that they are “useless”.

Verbal harassment and discrimination was also common among the study population. Participants shared statements that they have heard directed at LGBTQ persons or at themselves. Some of these statements included “ah, look it is a gay... look at that gay” (IDI 12) and “look at him, he is a gay. He is walking like this because he is the man of the gay... of gays” (IDI 14). Participants also discussed the use of the word “Umutinganyi”. This word, in Kinyarwanda, literally means a homosexual or gay person, however participants discussed its use in hateful and stigmatic methods. One participant says “oh, those ones. You know those ones, the umutinganyi” (IDI 7) while describing their school’s negative perceptions of homosexuality and homosexual individuals. Participants explained that, though they are proud of their identity as and LGBTQ person, they faced severe verbal discrimination and abuse in public if people knew about their sexuality. One participant stated that the harassment even made them “refuse to go out because I didn’t want to hear those things... so I can just stay inside and tell them [family] that I can watch a movie, and not go to the market” (IDI 1). Participants discussed developing a need to recede from society and interact only with other LGBTQ people or family members. Participants expressed that, because of the things that were said to them in public, they faced

depression and “feeling bad” about themselves which presented as clearly negative mental health impacts.

Among this study population, most participants did not have overtly negative experiences while coming out to others. However, some participants did experience abuse and discrimination from their family and friends because of their sexuality or identity. Some participants even discussed becoming victims of physical abuse because of their sexuality or identity. Violence described came from multiple sectors of the participants’ social network, but primarily from the ultra-negative and unaccepting or intolerant members of their families. Physical abuse and harassment included actual acts of violence against study participants as well as threats of physical harm from individuals or groups wishing to do the participants harm because of their sexuality or identity. One female participant details her experience coming out to her family and boyfriend and the physical, emotional, and verbal abuse that was inflicted upon her. She says:

Case Study 3: (IDI 5)

“First I had a fear personally to tell my boyfriend. We used to just meet, and sometimes I show him that I don’t have any feeling when I am with him. So I decided to tell him. When just I told him about my sexuality, first of all I told him “I just don’t feel happy when I am with you. I don’t have feelings with other men or boys”. I just came out telling him that... my sexuality. Then he beat me very very very hard. And [he] even took steps to tell my mother. So when he went to tell my family. My mother invited me. I went there, I found that both of my parents were there. They asked me about it. I told them the truth about my sexuality. So they were so scared and surprised and immediately

they just called my elder brother. When my elder brother reached there and they told him about my sexuality, and what happened with my boyfriend. So my elder brother said ‘this is unacceptable. It doesn’t happen in our family. This is the first person that we have that is a homosexual. She must take a decision now. If she can’t marry this man, she must not be here in our family’. Then from that moment I didn’t even pass one week in the family.” (IDI 5).

After this the participant seeks counsel from a close friend who consoles the participant. The participant shared that the friend “understood” her sexuality and that she felt like she could no longer live with the family. However, the friend encourages the participant to remain living with the family as to be an educational resource or source of information to help the family to understand her sexuality and possibly grow to be tolerant of it. The participant agrees and remains living with the family for some time. However, all is not well. The participant continues the narrative and shares:

“Then I continued to stay there but I was not able to share food with my brothers and young sisters. They should just take their part, they can just, the table and I must stay far from them when we reach time to eat. And again, when my mother came from the job, she was not even able to greet me like the other children. She would just come and pass like she didn’t see me. So I just stayed there like that. Finally, I was fed up with that situation and I decided to leave the family”. (IDI 5)

Case study 3 explains the range of negative reactions that occurred to the participant after she came out to family members. Though this is the only story that was shared other participants explained that they had heard about this type of event happening to other LGBTQ friends of

theirs. Participants discussed friends of theirs having been expelled from their families and they no longer have any interaction with their family members. One participant tells the story of how their father and father's family reacted to their coming out. They shared that the father said "if you continue to be like this, never come here again. I don't want to see you here again in this house" (IDI 1). The participant also shared that the grandmother (their father's mother) said to the participant's father "if he [the participant] just comes here again. If just I know that this boy has come here again, I don't even see yourself [the father] at my home. You [the father] will not be even my child. We don't, we don't want to see him in our family" (IDI 1), showing just how deep rooted homophobic and stigmatic views can be within a family. The participant explained that since this happened they have not had further contact with their father, or even the father's side of the family. They are only in contact with members of the family from the mother's side of the family. Multiple participants explained that it is difficult to know that there are family members who do not want to know them or be in their life because of their sexuality, but they stated that "I have to live my life" and "I have to be free" in order to move on from it.

Participants also faced emotional and mental abuse from their social networks, friends, coworkers, and the general public. A male participant discussed the expectations of his family saying "so they were like, 'ah now he is alone and he cannot produce other children'. Yeah, so I made them feel bad because what they expected of me, maybe was not what I was going to do" (IDI 13). Having children and continuing "the family legacy" is something that was describe as important in multiple interviews. It was something that many participants stated was a reason that participants' family used as a reason to be unaccepting of the participants' sexuality or identity. However, multiple participants brought up that just because they are LGBTQ doesn't

mean that they are unable to have children. In fact, several of the participants expressed interest in having children and a family at some point.

Another participant discussed how even saying that he is gay affected him emotionally and mentally, saying “Before, it was not easy for me to say that [I am gay], but sometimes it used to destroy my immunity [self-confidence] (IDI 14). The participant explained that holding in their sexuality from others and not acting as their “true” identity resulted in them feeling physically and emotionally bad because they felt they were lying to themselves. Another male participant described how knowing his social group’s views of homosexuality actually kept him from coming out to them. He says “I used to initiate that conversation [about homosexuality] in groups with other friends, but not directly. Not to tell them that I am part of them [LGBTQ people]. So I understand that they do not accept that that... that kind of sexuality” (IDI 8). He even shared something his friends had said, saying “Sometimes they say ‘if my friend is like this I can stop to speak to them. I can even tell the authorities that this friend is like this.’ When I understood that, I knew that I could not say it about my own feelings” (IDI 8). The participant reiterated that their fear for coming out to others was that they would be rejected and unaccepted by friends and family, and this statement from their friend concretized that fear and decision to not tell anyone.

It is clear that the participants faced a considerable amount of emotional distress and abuse because of their sexuality, whether out or not. The stressors within these study participant’s statements show the how influential guilt can be when it is placed on the individual by a family member or even by themselves. At times participants shared that they felt like they were wrong for feeling the way they did and that because of this they created internal stigma and homophobia within themselves. Participants also discussed that they felt a sense of shame for

being LGBT because of the fear of humiliating or embarrassing their family members by their sexuality or identity. Each of these factors and effects of abuse and discrimination on the study participants influenced each of their mental health statuses in, mostly, negative ways.

Phase 7: Self -Acceptance.

The final phase of the “coming out” process, as detailed in Figure 1., is the phase in which participants reach a state of acceptance. This state includes both acceptance of self and acceptance from others, especially those most influential to the participant (i.e. close family members and close friends). Most participants were able to navigate the coming out process successfully and had begun to realize a sense of pride in themselves, their sexuality, and in their identity as a whole. As stated before, the coming out process is a continual non-linear process and thus participants must continue to come out in various contexts and deal with the differing effects of this. Thus, participants will always be faced with the reactions of others to their sexuality or identity. However, this process, and reaching acceptance, seems to improve the participant’s ability to manage negative reactions from others and to move on past these.

Study participants who had reached the acceptance phase of the process described a sense of pride in themselves and acceptance of their identity. They detailed how they were “proud” of who they were and explained how they had reached a point in life where they understand who is important in life and how they’ve gotten these people to be accepting, or at least tolerant, of them and their sexuality/identity. This process is clearly difficult, as explained by one participant who said “you know, self-acceptancy... it is really hard” (IDI 7). This was not the only participant to express sentiment like this; many participants expressed how difficult it had been for them to reach a state of acceptance of their sexuality or identity. As detailed in earlier chapters, participants fought with self-doubt, guilt, anger and confusion about their sexuality/identity.

These feelings, coupled with the lack of information and general suppression of sexuality, detailed in Phase 1, created nearly impossible odds to overcome. However, the development of this sense of acceptance, which relates directly to their pride and understanding of their sexuality/identity, relates directly to positive mental health among the participants.

Participants also discussed being happier after having gone through their “coming out” processes, even those who had received negative reactions. Participants explained that they were happy that they had told others about their sexuality/identity because now they were “free” and they understood that there were others like them. One participant said “okay, maybe now I can be [more] open and take it because I have found some others like me” (IDI 1). This participant explained this statement further and said that they were proud of their identity as an LGBTQ person and, though it used to be difficult to face harassment and stigma, they felt that because they now knew others who were LGBTQ that they had support and would be able to face the stigma and harassment as a proud LGBTQ person. Other participants expressed sentiments like “it was like normal things” (IDI 10) when asked how their lives were now after they had come out. For participants with accepting reactions from friends and family members they simply continued on as before, but now more open. Those who faced more reactions that were more negative explained that they have now removed themselves from those individuals who were more unaccepting and instead only surround themselves with positive and accepting friends and family members.

Another interesting characteristic of some of the participants was that some expressed that they simply “did not care” what others thought about them anymore. Participants expressed that they still face stigma and harassment from others; family members, friends, and society members included. However, they expressed that because they have reached this point in their

lives when they know that there are supportive individuals in their lives that affirm their identity they don't need to worry about the opinions of others. One participant said "yeah, it [harassment] happens sometimes, but I just don't care" (IDI 3) in direct reference to discrimination and stigmatization against him. A second participant shared "I guess that I don't care, or maybe I don't notice other people treating me differently. I accept that it happens sometimes, but I don't pay attention to it" (IDI 14). Another participant expressed the topic of "bi-polarity" among Rwandan's and their views on certain subjects. They stated "The people from Rwanda, they are like crazy. Maybe one day they are talking [negatively], talking some bullshit. Next day [nothing]" (IDI 4). The participant explained that people typically want to get a reaction from them; that they say things or do things to the participant simply to get a reaction so that they have the ability to further harass or discriminate against the participant. However, the participant expressed that they began to understand this quickly, and thus refuse to react to them when they behave like this. The participant expressed that "I just leave them, I let them be" (IDI 4) in order to move past it.

Similar to participants who expressed that "I don't care", some participants began to remove value from the negative things that were said to them by family members or friends in order to move through the phases. Specifically, one participant, whose mother expressed negative reactions to her son's sexuality, explained "my reality is that I don't give value to what she tells me [anymore]. It doesn't matter" (IDI 12). The participant explained that the mother does not understand, or even try to understand, the situation that they are in and is only concerned with her reputation in the community. Other participants, with similar friends or family members, expressed that "it is my life" or "it is my life, I can't change" when explaining why they aren't concerned with their friends or family's opinions. This understanding aided

participants in reaching the final stage of the cycle and developing a sense of acceptance for themselves, even if they had not gotten acceptance from friends and family. When asked if their family's negative reaction made them change their view of themselves or their sexuality one participant said "Nothing, no nothing. There was nothing. Because, that is me. That is the real me. That is the way that I feel. Yeah, like I cannot, I couldn't change anything because that is how I am" (IDI 13). The participant explains their state of acceptance of themselves and their identity and further explains that if others cannot accept them then they are not in their life.

Though each participant's coming out and the experiences and reactions they faced were different, there was commonality among participants in getting to acceptance. All study participants have not yet reached this final phase of the process in which they are out to friends and family and have reached a state of acceptance. However, these strategies proved positively influential to the participants' mental health and their development of identity as an LGBTQ person in Kigali. These strategies could be useful and beneficial to other populations of LGBTQ individuals living in, or around, Kigali. during their process to reach acceptance of themselves and their identity.

Chapter 5: Discussion

Findings

The findings from this study identified a clear “process” that participants go through as they have come out to family, friends, and their community on their sexual identity. While Rwanda lacks much research on the LGBTQ population (Chapman et al. 2010), data from the study explained that LGBTQ individuals were able to manage this lack of information and navigate through the process to reach a state of self-acceptance. For many participants, their family and friends were also able to reach a state of acceptance, or at least tolerance, of the participant’s sexuality or identity. These study results contribute the emic perspectives of each of the as it related to their coming out process and influences on mental health. This research aims to provide some insight into the processes that LGBTQ individuals go through during their coming out to family and friends in Rwanda; the choices they make, potential reasons for these choices, and reactions they have been faced with. Each of these issues is also closely related to the overall mental health of participants during this period of time as emotions, feelings, and reactions directly influenced the way that participant’s felt about themselves internally, but also how they felt as an individual within this community. This research may be able to inform future programs or educational curriculums for institutions like HDI or PSF who are engrained within the development and betterment of the LGBTQ population in Kigali.

The general lack of information about coming out as LGBTQ in Rwanda and the suppression of sexuality was a first issue that was presented within the research. Participants discussed not knowing much about homosexuality while they were growing up and how that made them feel that they must be the only person who was having these feelings of attraction for persons of the same sex. Transgender participants also faced particularly difficult trials as there remains little information directed towards them, specifically. It could likely be understood that

participants had to deal with feelings of depression and hopelessness during this time as well. Programs focused on developing an understanding of sexuality and promoting communication on the topic within the community could be a good first step in addressing this issue. Community led discussions about LGBTQ issues and acceptance were common recommendations by participants, and the researcher believes that this could be a positive step towards promoting acceptance and addressing the issues surrounding this suppression of sexuality within the community.

The next phase described in the process was a phase of denial among the participants. Each participant went through a time in their process in which they actively denied their sexuality or identity, not only to others but also to themselves. Due to events participants explained in their interviews, it is likely that participants experienced increased stress, confusion, and lower self-confidence because of their continued denial of part of their identity. Participants in this phase explained the reasons for their continued denial of sexuality or identity, quoting negative sentiments from family members and discriminatory statements made by society as reasons contributing to their fear of letting others know about their sexuality. LGBTQ associations in Kigali could be a key player in developing acceptance among the LGBTQ community. Associations have direct contact with members of the community who are LGBTQ and thus have access to individuals who could serve as mentors or speakers for community events designed to promote acceptance of self within the community. Associations could also develop advocacy workshops around topics like LGBTQ health, resources for coming out, mental health and others that would aid LGBTQ individuals living in, and around, Kigali. This type of a program could be positively influential for the overall mental health of the community as a whole.

Typically, participants remained in their denial phase until their same-sex sexual debut (noted as Phase 3 in Figure 1.). This experience was “eye-opening” for many of the participants for various reasons. Improving this issue requires the creation and implementation of programs focused on developing an understanding of LGBTQ sexualities and identities. Programs in this format could address this issue by making it more evident that LGBTQ individuals exist within the community. Individuals could be identified through LGBTQ associations to act as “spokespersons” that could “represent” the various LGBTQ communities (gay, bisexual, lesbian, & transgender). This would promote a community understanding that LGBTQ individuals do exist within the community at large. Addressing this issue, however, must be done in a manner that is sensitive and safe for all those involved especially those LGBTQ members would be exposed through representing the communities. Inclusion of government and community level leaders would be essential in ensuring the safety of all involved in this program. It would also be of benefit for community health centers to be involved in this process for the provision of health related material. This material would be considerably beneficial for participants who are beginning to explore their sexuality physically and with other persons.

After the same-sex sexual debut, participants entered a phase of clarification and affirmation in which they began to understand that their feelings of attraction for people of the same sex would not simply subside. Participants typically became involved in associations at this point and broadened their LGBTQ social network and support system. Utilizing the role of associations in Kigali, programs should focus in on developing associations and empowering them to educate and involve members in advocacy efforts and in addressing health issues among the population, specifically mental health. Negative mental health outcomes related to internalized stigma, guilt, and anger presented clearly among almost all participants, and as such

is a topic that must be addressed in order to promote better health outcomes. Associations and LGBTQ social networks could be key stakeholders to address and include within the development of programs focused at promoting LGBTQ health among individuals in Kigali. Providing associations with comprehensive education and instructional material to ensure that all members and visitors of the associations are informed of safe sexual practices and the importance of non-discrimination would also be an essential function of any type of education and advocacy program.

Next, was the coming out phase. This phase presented the most information in understanding participants' reasons for coming out, fears about coming out, and understandings of the people who participants chose to come out to. Participants shared that some communities were more accepting than others, however they did not explain this in detail and were not probed by the interviewer. Thus, this is a topic that requires further research to generate an understanding of the phenomenon. Participants shared that their primary reasons for coming out was that they did not want to "keep the secret" any longer. They felt that they were being held down by concealing their sexuality. Participants presented an understanding that this hiding of their sexuality was negatively influential to their overall mental health. A topic of interest, which requires further research, is that female members of the family, particularly on the maternal side of the family, were reported to be more accepting and tolerant of the LGBTQ individuals' sexuality or identity. When asked who participants first came out to, they often responded that they came out to their sister(s) or mother. This response was not probed on further and thus is not fully understood. In order to gain a better understanding of this concept, more research is needed within the study population.

During the coming out phase, participants expressed that there was a great need for support. Participants expressed that judgmental and discriminatory reactions from friends and family during their coming out resulted in them feeling worse about themselves and creating a more severe lack of confidence in them. In order to aid the LGBTQ population during their coming out processes it is recommended that LGBTQ associations receive greater support and funding from outside organizations, like HDI and PSF, to develop their capacity to aid greater populations through outreach and education to young LGBTQ individuals. A beneficial role to fill, either in the associations or in HDI, could be to hire a “grants writer” who could serve solely to find, apply for, and manage funds received from grant programs. As there are numerous LGBTQ advocacy organizations around the world, like the Human Rights Campaign (HRC), International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), and Global Equality, funds and grants are readily available for improving the lives of LGBTQ individuals around the world. Funds raised through grants or fundraising could also be used to safely publicize about the LGBTQ associations or to provide social events for members or even “recruitment” events in which current members could bring LGBTQ individuals they know who are not currently a part of an association. Understanding that an association is present and able to help and provide support could be very positively influential for young adolescent LGBTQ individuals, or even adult LGBTQ individuals struggling with their identity.

Next, participants described the consequences of their coming out which generally resulted in stigmatic and homophobic actions against the participant. Primarily, participants discussed the multiple incidences in which they were discriminated against because of their sexuality or gender identity; often resulting in threats of physical violence, being refused housing, or the wrongful termination of employment. In combatting this, it is essential that

Rwandan policy makers develop anti-discrimination policies that directly relate to discrimination of an individual based on sexual orientation (real or perceived) or gender identity. The adoption of anti-discrimination policies, in all sectors of Rwandan life, is crucial in preventing discrimination and unequal treatment from continuing to occur in the future. Though Rwanda has adopted anti-discrimination policies, there is no text that directly correlates to preventing discrimination based on sexuality or gender identity. Thus, this policy is needed to protect the physical safety, emotional well-being, and overall rights of this population.

The last “phase” of this process that participants described was the “Self-Acceptance” phase. Participants described this time as a point in their life when they accepted that their sexuality or gender identity was something that they could not, and did not want to, change. It is recommended that more resources be made available for individuals undergoing this process. Organizations that are focused on improving the overall health of the LGBTQ population in Kigali should focus in on helping individuals get through this coming out process and reaching a point of acceptance within themselves. This could be done through the provision of resources and educational materials directly to LGBTQ individuals involved in the organizations, or through associations as not all individuals are involved in the organizations focused on improving LGBTQ health. Participants in this study expressed that reaching this point allowed them to finally feel “free” and like they were able to finally be themselves, something that they had been hiding for their entire lives. Aiding LGBTQ individuals to get to this point would greatly reduce the amount of time that LGBTQ individuals spend in each phase and, in turn, reducing the negative mental health influences they face at each point.

Conclusion

In conclusion, this study shows that LGBTQ Rwandan participants faced various influences on overall mental health during the “Coming Out” process in Kigali. Influences like stigma, discrimination, denial, and suppression of sexuality were shown to be negative influences on the mental health of participants. Conversely influences like coming out, clarification, affirmation, and acceptance by family, friends and the self were shown to be positive influences on mental health, overall. While more research is needed to understand the full list of influences on mental health alongside the roles of certain family members in the coming out process, it is evident that the coming out process, does influence the overall mental health of LGBTQ Rwandans. The mental health influences described and the process that participants have gone through should be considered during future planning and implementation of programming aimed at improving the mental health and overall livelihoods of LGBTQ individuals living in Kigali, Rwanda.

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Appendix

Table 1. Demographic Characteristics

	#	%
Age (n=13)		
18-21	2	15.385
22-24	3	23.077
25-27	5	38.462
28-32	3	23.077
Average	25.4	
Mean	26	
Sex (n=13)		
Male	11	84.615
Female	2	15.385
Gender Identity (n=13)		
Male	5	38.462
Female	7	53.846
Gender Queer	1	7.692
Sexuality (n=13)		
Gay	7	53.846
Bisexual	4	30.769
Lesbian	2	15.385
Religion (n=13)		
Religious (n=10)	10	76.923
Christian	7	53.846
Protestant	1	7.692
Catholic	3	23.077
Pentecostal	2	15.385
7th Day Adventist	1	7.692
Muslim	3	23.077
Non-Religious (n=3)	3	23.077
Education Level (n=13)		
Primary	1	7.692
Secondary	9	69.231
Some University	2	15.385
Bachelors	0	0.000
Masters	1	7.692
Length of Time in Kigali (n=13)		
0-5 Years	3	23.077
6-10 Years	2	15.385
11-15 Years	0	0.000
16-20 Years	2	15.385
21-25 Years	4	30.769
26-30 Years	2	15.385
Mean	15.8	
Median	20	
Employment (n=13)		
Employed	9	69.231
Unemployed	4	30.769
Neighborhood (n=13)		
Kicukiro	2	15.385
Nyamirambo	3	23.077
Kacyiro	1	7.692
Nyarugenge	5	38.462
Kimironko	2	15.385

Appendix-1: In-Depth Interview Guide (Out to Family Member(s))

In Depth Interview Guide

Topic: A qualitative assessment of the experiences of LGBT individuals and their vocalization of sexuality to family and friends.

Research Question:

What are the factors which affect the acceptance of minority sexualities in Kigali, Rwanda?

Kigali, Rwanda

Adrian King, GFE 2016

May 23, 2016 – July 29, 2016

Inclusion Criteria

To be considered for participation in an in-depth-interview participant must:

1. Be at least 18 years of age on or before the date the IDI is conducted;
2. Live within the city limits of Kigali, Rwanda;
3. Self-identify as non-heterosexual (LGBT);
4. Have come out to their family (at least one member) as LGBT;
5. Be a Rwandan citizen.

Introduction

Hello, my name is Adrian King. I am a student at Emory University in Atlanta, Georgia. I am working with Project San Francisco here in Kigali. Our research is trying to understand the community's views of homosexuality in Kigali. You are being invited to participate in an interview being conducted as a part of this research. This research is a collaboration between Emory University, Project San Francisco (PSF) & Health Development Initiative (HDI).

This interview is designed to help us to understand your perspectives and beliefs related to LGBT issues and your experience as an LGBT individual. You will be one of several people who are interviewed for this research and participants will vary based on several factors including age, education, income, etc. This is in efforts to ensure that we gain perspectives from individuals with different backgrounds and experiences. I am here to listen to your opinions and views to gain an understanding of your experience in Kigali. Your input will give valuable insight into this topic and I hope that you will answer these questions honestly and from your own experiences. This topic has not yet been studied fully in Kigali, so your participation is very valuable. Your participation in this interview is voluntary. At any time, if you feel uncomfortable you can choose not to answer any question or to end the interview.

I would like to record our discussion today. It is likely that I will not be able to write quickly enough to take notes on all of your views and opinions. Recording the discussion will guarantee that all of your responses are available for our research. The recording of our discussion will be converted into a written format, however your name or any identifying factors will not be included. Our discussion, the recording, and your answers will all remain confidential and

nobody who is not working with the project will hear the recording or have access to our discussion or your answers. Research will not have your name on it and all documents linked to our discussion will be de-identified. Lastly, no one will know who took part in this project. Do you have any questions about recording the discussion? Do I have your permission to record our discussion?

Do you have any other questions or concerns before we begin?

Demographics: *First, I would like to start by gathering some basic information about you. These questions will be used to help me gain a better understanding of your unique situation and how your perceptions/views may have been formed or developed.*

- A. What is your birth date? (Ensure that the birth date is provided in dd/mm/yyyy form)
- B1. What is the highest level of education that you have achieved?
- B2. What is your current profession or form of employment?
- B3. What religious belief(s) do you follow?
- B4. How long have you lived in Kigali?
- C. What is your sexuality? (Are you gay, bisexual, or lesbian?)
- D. What is your Gender Identity? (Do you feel that you are a male or female?)
- E. What neighborhood in Kigali do you live in?
- F1. How old were you when you began feeling attracted to people of the same sex?
- F2. How old were you when you accepted that you were LGBT?
- F3. How old were you when you first came out to someone else?
- F4. How old were you when you first came out to another family member?

Section 2: *Next, I'd like for us to talk about what you knew about homosexuality when you were growing up. These questions are related to experiences before you told others about your sexuality.*

- 1. When you were growing up, what did you know about homosexuality?
- 2. When you were growing up, what was your view of homosexuality?
 - a. How do you think that your family felt about homosexuality?
 - b. What did you know about how society treated homosexuals?
- 3. Before you came out, how did you feel about being attracted to people of the same sex?

Section 3: *In this section, I'd like to find out about the process that you went through while you were coming out. I will ask questions about the decisions that you made when coming out to your family and friends. This subject can be emotional for some, so if there comes a point that you need a break just let me know and I'll be happy to pause the interview and give you time.*

- 4. Before you came out, what fears did you have about telling others your sexuality?
- 5. What made you decide that you were ready to tell others about your sexuality?
 - a. Who did you decide to tell first about your sexuality?
 - i. How did you come out to this person? (What did you tell this person?)
 - ii. What was their reaction to you coming out?

6. How did your family member(s) react when you came out to them?
 - a. What do you think influenced their reaction?
 - i. How did it make you feel about your sexuality?
7. How did your social group react when you came out to them?
 - a. What do you think influenced their reaction?

Section 4: *In this section, I will ask the final questions for our interview. I'd like to ask some questions related to the way that you've been treated in the community and to discuss some of the steps that should be taken in order to further the equal treatment of LGBT individuals in Kigali. Please answer these questions to the best of your ability and with your own opinions and/or views.*

8. Can you tell me about a time that you felt like you were being treated differently because of your sexuality/gender identity?
 - a. How often do you feel like you are treated differently because of your sexuality?
9. How can LGBT lifestyles be made more acceptable to the community in Kigali?
 - a. How would the process to change community views and opinions of homosexuality in Kigali start?
 - b. Who needs to be involved in this process?

Closing:

Thank you so much for your time today. I really appreciate your participation in this research and everything you have shared today is very useful for our project. Do you have any questions or anything that you'd like to add that we haven't discussed at this time?

If you need to contact me for anything after this email, please feel free to email Adrian King at Adrian.king@emory.edu. Thank you again for your participation and I hope you enjoy the rest of your day.

In Depth Interview Guide

Topic: A qualitative assessment of the experiences of LGBT individuals and their vocalization of sexuality to family and friends.

Research Question:

What are the factors which affect the acceptance of minority sexualities in Kigali, Rwanda?

Kigali, Rwanda

Adrian King, GFE 2016

May 23, 2016 – July 29, 2016

Inclusion Criteria

To be considered for participation in an in-depth-interview participant must:

6. Be at least 18 years of age on or before the date the IDI is conducted;
7. Live within the city limits of Kigali, Rwanda;
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9. Be a Rwandan citizen.

Introduction

Hello, my name is Adrian King. I am a student at Emory University in Atlanta, Georgia. I am working with Project San Francisco here in Kigali. Our research is trying to understand the community's views of homosexuality in Kigali. You are being invited to participate in an interview being conducted as a part of this research. This research is a collaboration between Emory University, Project San Francisco (PSF) & Health Development Initiative (HDI).

This interview is designed to help us to understand your perspectives and beliefs related to LGBT issues and your experience as an LGBT individual. You will be one of several people who are interviewed for this research and participants will vary based on several factors including age, education, income, etc. This is in efforts to ensure that we gain perspectives from individuals with different backgrounds and experiences. I am here to listen to your opinions and views to gain an understanding of your experience in Kigali. Your input will give valuable insight into this topic and I hope that you will answer these questions honestly and from your own experiences. This topic has not yet been studied fully in Kigali, so your participation is very valuable. Your participation in this interview is voluntary. At any time, if you feel uncomfortable you can choose not to answer any question or to end the interview.

I would like to record our discussion today. It is likely that I will not be able to write quickly enough to take notes on all of your views and opinions. Recording the discussion will guarantee that all of your responses are available for our research. The recording of our discussion will be converted into a written format, however your name or any identifying factors will not be included. Our discussion, the recording, and your answers will all remain confidential and

nobody who is not working with the project will hear the recording or have access to our discussion or your answers. Research will not have your name on it and all documents linked to our discussion will be de-identified. Lastly, no one will know who took part in this project. Do you have any questions about recording the discussion? Do I have your permission to record our discussion?

Do you have any other questions or concerns before we begin?

Demographics: *First, I would like to start by gathering some basic information about you. These questions will be used to help me gain a better understanding of your unique situation and how your perceptions/views may have been formed or developed.*

- B. What is your birth date? (Ensure that the birth date is provided in dd/mm/yyyy form)
- B1. What is the highest level of education that you have achieved?
- B2. What is your current profession or form of employment?
- B3. What religious belief(s) do you follow?
- B4. How long have you lived in Kigali?
- F. What is your sexuality? (Are you gay, bisexual, or lesbian?)
- G. What is your Gender Identity? (Do you feel that you are a male or female?)
- H. What neighborhood in Kigali do you live in?
- F1. How old were you when you began feeling attracted to people of the same sex?
- F2. How old were you when you accepted that you were LGBT?
- F3. How old were you when you first came out to someone else?

Section 2: *Next, I'd like for us to talk about what you knew about homosexuality when you were growing up. These questions are related to experiences before you told others about your sexuality.*

- 10. When you were growing up, what did you know about homosexuality?
- 11. When you were growing up, what was your view of homosexuality?
 - a. How do you think that your family felt about homosexuality?
 - b. What did you know about how society treated homosexuals?
- 12. When you were younger, how did you feel about yourself because you were attracted to people of the same sex?

Section 3: *In this section, I'd like to ask some questions about your reasons for not telling others about your sexuality. I will ask questions about people you've already come out to and also those who you have not come out to. This subject can be emotional; if there comes a point that you need a break just let me know and I'll be happy to pause the interview and give you some time.*

- 13. What fears have you had about telling others about your sexuality?
 - a. What are the most influential reasons for you not telling others about your sexuality?
- 14. If you have told others about your sexuality, who have you told?
 - a. Why did you tell this person, or these people?
- 15. How do you think that your family members would react if you came out to them?
 - a. Why do you think that they would react like this?

16. Which family member(s) would you come out to?
 - i. Why would you come out to them?
17. How do you think that heterosexual members of your social group, that you haven't told about your sexuality, would react if you came out to them?
 - a. Why do you think that they would react like this?

Section 4: *In this section, I will ask the final questions for our interview. I'd like to ask some questions related to the way that you've been treated in the community and to discuss some of the steps that should be taken in order to further the equal treatment of LGBT individuals in Kigali. Please answer these questions to the best of your ability and with your own opinions and/or views.*

18. Can you tell me about a time that you felt like you were being treated differently because of the community's perceptions of your sexuality or gender identity?
 - a. How often do you feel like you are treated differently because of your sexuality?
 - b. Have others in the community ever accused you of being LGBT?
 - i. What reasons did they provide for their accusations of you being LGBT?
19. How can LGBT lifestyles be made more acceptable to the community in Kigali?
 - a. How would the process to change community views and opinions of homosexuality in Kigali start?
 - b. Who needs to be involved in this process?

Closing:

Thank you so much for your time today. I really appreciate your participation in this research and everything you have shared today is very useful for our project. Do you have any questions or anything that you'd like to add that we haven't discussed at this time? If you need to contact me for anything after this email, please feel free to email Adrian King at Adrian.king@emory.edu. Thank you again for your participation and I hope you enjoy the rest of your day.