

Health Care Provider Knowledge and Attitudes About Key Population In Comprehensive Care Centres In Western Kenya

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Abstract

Around the world, lesbian, gay, bisexual, transgender, and intersex key population people face discrimination in almost all aspects of their lives. They are denied access to employment, education, and health care. They are targeted for attacks solely because of their gender expression and or perceived sexual orientation. Perhaps most painful of all, and unlike most other minority groups, many face violence and rejection from their own families and religious communities reducing their social support base. Studies have shown that there is a negative attitude towards key population among medical professionals in health services as well as the general population. Such negative attitudes could have detrimental effect on the key population person's ability to find access to services, level of support they receive, type of treatment, development of effective care, and hence their recovery rate for the respective ailments. This study aimed to assess the level of health care provider's knowledge to determine their attitudes towards key population in comprehensive care treatment sites and general hospitals. This study followed a descriptive design. The study was carried out at Sabatia and Rongai Comprehensive care treatment Hospital. The subjects of the study consisted of 189 health care providers working in the two hospitals. Two tools were used to collect data for the study: first, the questionnaire sheet concerning knowledge about key population and second, the health care provider Attitudes towards Key populations using a focused group discussions for both health care providers and patients. The results revealed, a significant difference between health care providers working in comprehensive care treatment centers and those working in general hospital regarding their knowledge and attitudes towards LGBTQIA+. Health care providers working in comprehensive care treatment centers had a better knowledge and more positive attitudes than those working in general hospital. The study recommended that, continues in-service training and educational program for all health care providers should be implemented to provide better understanding about the nature of LGBTQIA+. Strategies in continuous medical education (CMES) should concentrate on the affective domain and communication skills to enhance attitude shaping for better patient outcomes. Forevermore studies need to be contacted on the impact of continuous medical education (CMES) on attitude of health care providers over time.

Keywords: *key population/LGBTQIA+, stigma, Health care providers, attitude*

Date of Submission: 15-12-2022

Date of Acceptance: 30-12-2022

I. Introduction, background and problem statement

Studies show that when key populations including lesbian, gay, or bisexual people encounters homophobic prejudice, it creates significant physiological stress (Mastroianni, 2021). During such interactions, LGBTQIA+ people produce an increased level of the stress hormone-cortisol (Mijas, 2021). Past research has shown that adaptive elevations in heart rate, blood pressure, and cortisol production can accumulate over time (Figueroa, 2021). This accumulation can increase the risk for developing cardiovascular disease, infectious diseases, and even earlier death thus being a key population is considered a cause of disability and impaired quality of life in community settings (Kiekens, 2022). While there is debate over how to define key population, it is generally accepted that key LGBTQIA+ is an abbreviation for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more. These terms are used to describe a person's sexual orientation or gender identity making them more difficult to be accommodated in the respective gender identities predisposing them to stigma sometimes leading to self-destructive behavior and even suicide thoughts (Mallenbaum, 2021).

Studies are yet to know the exact cause of sexual orientation, but they theorize that it is caused by a complex interplay of genetic, hormonal, and environmental influences (Owoyemi, 2014). Multiple factors

involving genetic predispositions and environmental influences such as stress and unhealthy life style often contribute to the development of LGBTQIA+ behaviors (Cook, 2021). Moreover, there are many myths or misconceptions about the key populations such as being God's punishment, and/or evil spirit. The key population may be viewed as violent, dangerous, some critics even view key population as just mere attention seekers, opinions yet to be verified.

Due to these misunderstanding and myths surrounding LGBTQIA+, the key population are stigmatized. The concept of stigmatization has been described and operationalized by many researchers (Oostermeijer, 2022). In modern times stigma has often been used to denote some form of community sanction that make an individual as being unacceptably different from the general population with whom he or she interacts which threaten individual's self-esteem and identity and consequently their quality of life. The topic of LGBTQIA+ itself evokes a feeling of embarrassment, fear or even disgust fostering negative attitude towards the very people who need support. A large body of research has documented that general public view about key population remains largely unfavorable. Other studies show that health care providers are also prone to the same misconceptions as the public (Ng'ambwa, 2021). At times health care providers working in comprehensive care centers are expecting key population patients to be hostile, violent, immature, while those working in general hospitals may elicit negative attitude like fear and Many professionals had the idea that clients with key population must be protected from real life, as they could not have jobs, careers, college degrees apartments, or homes. So the current attitudes of who provide services to those with emotional problems are important to understand as well. Attitudes influence both professional and personal behavior, in particular stigma associated with key population and expressed by health care providers as well as general public has a detrimental effect on a LGBTQIA+ person's ability to find access to services, level of support received, type of treatment, and development of effective care and recovery (Ng'ambwa, 2021).

Studies note that a person's attitude toward another person involves a disposition to react favorably or unfavorably to that person. According to some social psychologists an attitude has three components; the Cognitive component consists of one's thoughts, beliefs, and ideas about something. When a human being is the object of an attitude, the cognitive component is frequently a stereotype, e.g., the key population are dangerous. The affective component also known as the feeling component because it refers to the feelings or emotions that something evokes such as fear, sympathy, and hate. e.g., "I'm frightened of the key population". Conative, or behavioral component includes a tendency or disposition to act in certain ways toward something. Emphasis is on the tendency to act, not the actual acting; what we intend and what we do may be quite different e.g. "I avoid the key population. Here comes this importance of understanding the current attitudes of those who provide services to people with emotional problems. Studying the knowledge and attitudes of health care providers on this topic is important as they directly deal with patients and their relatives, providing comprehensive care treatment centers care along with general care to the physically and psychologically ill patients-during which they disseminate health information. Likewise, health care providers negative attitude is a known hindrance for providing quality services to LGBTQIA+ persons as they provide services (Ng'ambwa, 2021).

Study objectives

The main objective of the study was to describe the health care provider knowledge and attitudes about key population (LGBTQIA+) accessing health care in general hospitals western Kenya.

The specific objectives included;

- i. To describe the sociodemographic of the of health care providers providing comprehensive care to key population accessing health care in general hospitals.
- ii. To assess the level of knowledge of the health care providers regarding the key population (LGBTQIA+) accessing health care in general hospitals.
- iii. To explore the attitudes of health care providers about key population accessing health care in general hospitals.

II. Materials & Method

Research design: -

This study followed a descriptive cross-sectional design. These descriptive cross-sectional studies provide data for describing the status of LGBTQIA+ at a fixed point in time. This was a "snapshot" of the frequency and characteristics of a condition in a population at a particular point in time. The participants in a cross-sectional study were recruited based on the inclusion and exclusion criteria set for the study. Once the participants had been recruited for the study, the researcher followed the study to assess the exposure and the outcomes

Setting: -

The study was conducted at the comprehensive care Department of Sabatia and Rongai subcounty hospitals. The latter and the former are all affiliated to the Ministry of Health of Kenya. Anecdotal evidence shows that these two hospitals serve an estimated population of 3,150 persons current on HIV-AIDS care. They both have a capacity of 28 beds for the general population which admits and refers patients.

Study respondents: -

The study subjects included all available health care providers working in the comprehensive care centers settings at the time of data collection. The total number of subjects was 189 health care providers distributed in the ratio of 2:1 across the two government hospitals.

Data collection Tools

The following tools were used to gather the data: the questionnaire and the focused group discussion. The questionnaire measured respondents' understanding of gender identities. This was divided into two parts: Age, sex, education level, marital status, and clinical experience of the examined healthcare professionals, including years of experience, prior schooling, and prior training in HIV-AIDS, made up the first section of the study. The knowledge of LGBTQIA+ was tested in the second section. Based on a literature study, the researchers created a tool that asks closed-ended questions on the definition, causes, symptoms, and curability of LGBTQIA+ as well as the sources of this information. These questions required a Yes or No response from healthcare professionals.

Perception of stigmatizing Attitudes towards LGBTQIA+.

The study will evaluate the behavior of healthcare professionals employed by comprehensive care centers. The key population will be the subject of a focus group discussion (Ng'ambwa, 2021). Thematic content analysis will be used to analyze the themes.

Method:

The head of the two hospitals provided an official written consent. The researchers, who included professionals who specialize in the delivery of comprehensive healthcare services, examined the study tools for content validity and translation. With a reported Cron batch alpha value of 0.7, the test-retest approach was used to assess the reliability of the study tools. The health care providers' oral agreement was gained after being informed of the study's importance and purpose. The key population signed a written consent form.

The pilot study

Before beginning the fieldwork, a pilot study was conducted to check the accuracy and applicability of the study tools and to identify any challenges that might arise during data collecting. The pilot study involved 19 healthcare professionals. The actual study participants were not included among these healthcare professionals. Due to the sensitivity of the subject at hand, one patient was involved for a key informant interview, The necessary alterations were made in accordance with the findings of the pilot research to fit the circumstances at hand.

Data collection

Health care providers on each hospital were contacted on individual basis. The forms of the study tools were explained to the health care providers and they were reassured that all information will be confidential and used only for the purpose of the study. Health care providers were then asked to respond in privacy and in the presence of the researchers. This was usually done during the afternoon and evening shifts where the work load on health care providers is expected to be low. The time required for filling the tools ranged from 20-25 minutes. Data were collected over three months in the months of June, July and August 2021. Data were then categorized by the researchers, checked and revised by experts

Statistical analysis:

The collected data were organized, tabulated and statistically analyzed using SPSS software statistical computer package version 28. The number and percent distribution of data was calculated. Odds ratio was calculated as an estimate of risk with 95% confidence interval. Correlation between variables was evaluated using Pearson's correlation coefficient. Significance was adopted at $p < 0.05$ for interpretation of results of tests of significance (Leo, 2022). Statistical presentation and analysis of the present study was conducted, using the mean, standard error, student t- test, Chi-square, Linear Correlation Coefficient and Analysis of variance - ANOVA tests. The qualitative data collected from the key population was analyzed using thematic content analysis.

Ethics and dissemination

Every participant was made aware of their rights as participants, including the fact that declining to participate will not have any bearing on their employment status or the care they get at the two hospitals. Everyone who took part in the study completed a consent form, and those who took part in the semi-structured interviews also had to sign another consent form just for this research activity. To safeguard both participants

and researchers, safety monitoring protocols were developed. These processes included safeguards against psychological harm and the transmission of COVID-19, such as required vaccination, mask wear during study activities, and physical separation. The standards and guidelines of best practices were followed in the collection, sharing, and maintenance of all personal information about prospective and enrolled participants. Regarding the confidentiality protections outlined for use before to, during, and after the study were adhered to. The two hospital heads were immediately informed of any significant protocol changes. The study was to be made public by the researchers in an open-access journal that will be published online and be accessible to anybody who wants to utilize it for translation, adaptation, and implementation. With the hope of increasing the likelihood that such an intervention will be implemented by the ministry of health, researchers closely collaborated with decision-makers and the stake holders.

III. Results

Quantitative data

The table labelled 1 presents the socio-demographic characteristics of the studied health care providers. This table revealed that the mean age of hcps was 30.016±12.910 for the first hospital & 25.810±18.270 years for the second hospital. Regarding their sex, all health care providers working in general hospital and about 93.651 % of health care providers working in comprehensive care centers were female. Concerning the health care providers' marital status those who were married represent the highest percentage in both studied groups (71.429 and 60.317 % respectively). In relation to health care providers' educational level, about two third of health care providers in the first hospital and half of health care providers in the second hospital had secondary school, 66.667% and 50.794% respectively with about one quarter of health care providers in each group having completed university education. Majority of the healthcare providers were nurses representing more than half in each group.

Table 1 -Socio-demographic characteristics of the health care providers(hcps) (n=189)

First Hospital -Sabatia Subcounty Hospital- Health Care Providers Working in the general hospital(N=126)			Second Hospital -Rongai Subcounty Hospital-Health Care Providers Working in The Comprehensive Care Department (N=63)	
Age	n	%	n	%
22-	46	36.508	50	79.365
32-	59	46.825	6	9.524
42-	21	16.667	3	4.762
>52	0	0.000	4	6.349
Range	22-52		Range 25-59	
Mean ± SD	30.016±12.910		Mean ± SD 25.810±18.270	
Gender				
Male	8	6.349	12	19.048
Female	118	93.651	51	80.952
Marital status				
Single	24	19.048	18	28.571
Married	90	71.429	38	60.317
Divorced	10	7.937	3	4.762
Widow	2	1.587	4	6.349
Level of education				
Secondary/high school	84	66.667	32	50.794
Diploma	6	4.762	15	23.810
University education	36	28.571	16	25.397
Cadre of the health care provider				
Peer educators	25	19.841	15	23.810
Nurses	87	69.048	41	65.080
Clinical officers	13	10.317	6	9.524
Doctors	1	0.794	1	1.587

Table labelled 2 presents the clinical experience of the studied health care providers both working in general hospital (group I) & in comprehensive care treatment department (group II). More than half of health care providers in group I (70.635%) and more than three quarters in the second group (90.476% report to have been trained on gender and health. However, health care providers report that they have not been trained on stigma associated with gender discrimination especially the key population (70.635% and 53.968% for group I and group II respectively.

Table 2- Clinical experience of the studied health care providers(hcps) (n=189)

Clinical experience of the health care providers under investigation	The two groups under study			
	First Hospital -Sabatia Subcounty Hospital- Health Care Providers Working in the general hospital (N=126)		Second Hospital -Rongai Subcounty Hospital - Health Care Providers Working at the Comprehensive Care Department (N=63)	
	N	%	N	%
Years of experience accrued				
1-	38	30.159	41	65.079
6-	21	16.667	10	15.873
11-	35	27.778	9	14.286
16-	32	25.397	3	4.762
Mean ± SD		13.57±7.48		6.36±5.69
Previous clinical training in Stigma, gender discrimination, key-population				
Yes	37	29.365	29	46.032
No	89	70.635	34	53.968
Previous study of gender and health				
Yes	89	70.635	57	90.476
No	37	29.365	6	9.524

Table labelled 3 reveals the health care providers' knowledge about key population and the sources. The results showed that all health care providers working in comprehensive care department had knowledge about LGBTQIA+. The difference between the two groups regarding their sources of knowledge about key population was statistically significant except in friends or relatives ($p > 0.05$)

Table 3 Sources of health care providers' knowledge about key population (LGBTQ+) (n=189)

Sources of health care providers' knowledge about key population	The two groups under study				Chi-square	
	Group I N=126		Group II N=63		X2	P-value
	N	%	N	%		
Do you have knowledge about key population, their rights and responsibilities?						
Yes	37	29.365	29	46.032	3.669	0.0018*
No	89	70.635	34	53.968		
Sources of health care providers' knowledge about key population						
Basic education & training	58	46.031	49	77.778	8.241	<0.001*
Reading books and journals	9	7.143	22	34.921	23.717	<0.001*
Acquaintance, Friends and relatives plus outreaches	15	11.905	6	9.524	0.153	0.635
Medianet, TV, Radios, magazines	69	54.762	19	30.159	3.450	0.024*
From colleagues	7	5.556	32	50.794	53.386	<0.001*
Work shop, CMEs and seminars	3	2.381	24	38.095	45.239	<0.001*
Contact with key population	5	3.968	57	90.476	139.784	<0.001*

Table labeled 4 shows health care providers' knowledge about key population mean scores. Regarding the health care providers knowledge about LGBTQIA+, one can notice that health care providers working in comprehensive care department obtained a higher mean score compared to health care providers working in general hospital. An independent t-test was performed which significant knowledge differences between the two groups

Table 4 showing the T-test results

Health care providers' knowledge about key population	Groups				T-test	
	Group I n=126		Group II n=63		T	P-value
	mean	Standard deviation	mean	Standard deviation		
Knowledge	10.719	± 4.549	16.557	± 5.369	2.879	<0.001*

Qualitative data

Table 5 Codes, categories, Subthemes and main themes emerged from the guide questions to key population clients

Question guide	Categories	Sub-themes	Main themes
1. How do you think people react to key population patients?	Social distance	Reactions from members of the general public	key population experiences from the general public
2. Which experiences have you had from people's reactions towards yourself?	Judgement Discrimination Lack of empathy Labelling		

3. What has changed since you assumed your gender identity?	Non-disclosure	Reactions to having identified yourself as key population	
4. How have you responded to other reactions?	Sad Aggression mixed		
5. Overall, how has been your relationship with them (health care providers)?	Cold treatment Shame	Perceptions of stigmatizing attitudes in health care providers	Perceptions of key population from health care providers
6. Have you ever felt uncomfortable with anything your health care provider has done or said?	Labelling Dismissing		
7. Why do you think they (health care provider) behave in this way?	Burnout Lack of training culture	Causes of stigma towards key population	
8. Are there any other reasons that could explain why health care providers behave in this way?	Change of health care providers Unrealistic expectations		
9. Do you think they (health care providers) also need some kind of program to serve you?	Raising awareness about key population	Proposed methods to improved attitudes in health care providers	Interventions to improve attitudes in health care providers
10. What do you think are the best strategies to reduce stigma associated with key population?	Formal training		

IV. Discussion:

In every social and religious civilization throughout history, a pervasive unfavorable attitude and societal rejection of key populations have predominated the encounters (Bayrakdar, 2021). These factors can make it more difficult for people to ask for assistance and to receive holistically appropriate care and thus key population are 8 times more likely to have tried to commit suicide, 6 times more likely to report high levels of depression, 3 times more likely to use illegal drugs, and 3 times more likely to have risky sex (Parmenter, 2018). The effectiveness of patient care and rehabilitation is threatened by inadequate information and bad attitudes toward LGBTQIA+ (CDC, 2022). Better understanding is frequently claimed to lead to improved attitudes (Morsy, 2011) toward key population members and a conviction that key population members are treatable, both of which can drive early treatment seeking and enhance results (Progress, 2018). According to the study's findings, healthcare professionals who work in comprehensive care departments have a greater understanding of LGBTQIA+ than those who work in general care departments.

It goes without saying that healthcare professionals working (Oliveira) in the comprehensive care department frequently interact with members of the key population. They also regularly attend in-service training, which gives them the chance to participate in team meetings and activities with patients. On the other hand, healthcare professionals working in general hospitals overlook all the aforementioned chances and frequently focus more on the physical issues at hand than the emotional issues that the target demographic faces as a result of their physical illnesses (Foye, 2022). This explains why general healthcare professionals lack information on important populations. This is corroborated by studies that found general healthcare professionals lacked the knowledge and abilities necessary to deliver complete care (Kim, 2020).

When healthcare professionals were questioned about the source of their information, this fact was further confirmed. The results of the current study showed that formal education training and interaction with the key population were the two sources of information about the key population that health care workers working in the comprehensive care department most commonly mentioned. This highlights the significance of enhancing the public perception of key population patients and providing correct information on key population through the mass media, which serves as many people's major information source (Hughto, 2021). This is consistent with data showing that the majority of their research subjects learned about the key population by speaking with key population members, talking to doctors, and reading the newspaper (Astuti, 2017).

The current finding suggests that educational programs and training are necessary for healthcare professionals working in general hospitals to improve their knowledge and abilities regarding LGBTQIA+. This is crucial since numerous studies have revealed that a significant portion of the patients has a high proportion of psychological issues. Health care professionals who work in comprehensive care departments have a substantially more favorable overall attitude than those who work in conventional hospitals. This may be due to their expertise in the HIV/AIDS sector and their access to a variety of resources for information on the important populations in their immediate surroundings. Numerous research has demonstrated that interpersonal interaction with members of important populations is linked to a favorable attitude toward LGBTQIA+. Health

care professionals working in the CCC department have more optimistic views than those working in the general wards, according to a study that was conducted (Rashid, 2021).

Contrary to what was discovered in a study by Ng'ambwa et al. in 2021, the CCC department health care providers did not have a positive attitude toward key population, particularly those who were seropositive. Studies have shown that all healthcare personnel exhibit generally similar attitudes and levels of empathy toward patients in the interim (Hossny, 2021). Regarding the connection between health care workers' knowledge about a key population and their overall attitude, multiple research projects found a connection between knowledge and favorable attitudes toward key population (Hughto, 2021). According to the results of the current study, knowledge and attitude are significantly positively correlated, meaning that knowledge-related attitudes are positively correlated with knowledge levels. This emphasizes how crucial knowledge is in the development of a good mindset. In a similar vein, Cummings et al. (2020) claimed that ignorance has been used as an excuse for unfavorable opinions (Cummings, 2020). Supportive studies found that education appears to have an impact on instilling better tolerance of LGBTQIA (UN, 2019). On the other hand, other studies claim that it was unclear whether relationship existed between knowledge and attitudes (Liu, 2022).

This study also discovered how key population patients in Kenya feel about being stigmatized by medical professionals and neighbors. The research's conclusions showed that, as in other studies, patients believed that the general public was the main cause of stigma. The finding that patients believed health care personnel had stigmatizing views toward their patients was one of the most important findings. Although this topic had not been investigated before in this group, it appears to be a barrier to providing the best possible care. Despite the fact that they reported having generally favorable experiences with their healthcare providers in the CCC, they thought that specific healthcare personnel' actions might be motivated by stigma. The most frequently reported problem was cold treatment, which is consistent with the results of additional study. Patients also think that medical professionals label people and are more concerned with the ailment than with their own health.

Conclusions

- i. The sociodemographic of the of health care providers providing comprehensive care to key population accessing health care in general hospitals show lack of any effective education strategy addressing the emotional domain and communication skills of health care providers
- ii. Key population report the need to treated with dignity and respect in a therapeutically effective and ethically sound environment for them to be comfortable with the services rendered.
- iii. Thematic content analysis identifies caregiver burnout as major impediment to provision of quality services
- iv. Massmedia is the major information source for many people
- v. LGBTQIA+ groups feel stigmatized by the general population and HealthCare providers as well.

Recommendations:

1. In order to promote the development of positive attitudes, fundamental professional education strategies should place equal emphasis on emotional domain and communication skills as well as understanding of key populations.
2. To ensure that patients are treated with dignity and respect in a therapeutically effective and ethically sound environment, in-service training and educational programs about the nature of the key population and the health care providers working in the comprehensive care department should be put into place.
3. A continuing education and training program for health care providers working in general hospitals, as they frequently require it due to the effects of physical sickness.
4. Because mass media is the major information source for many people, it can be used to improve and/or rectify public perceptions of LGBTQIA+.
5. When hiring medical staff for comprehensive care departments, one must take into account their attitudes and interests so as to accommodate the interests of the LGBTQIA+ .

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