

Understanding HIV Risks Among Men Who Have Sex With Men in Africa

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In this issue of the *Journal*, Sharma et al.¹ reported the results of focus group discussions regarding HIV risks in relation to emerging group identities, sexual risk taking, and health care usage among 30 men who have sex with men (MSM) from Nairobi, Kenya. This study shows us a rare glimpse into the private lives of Kenyan MSM and the myriad of legal, social, and economic problems confronting MSM in Kenya and likely in many other African countries. These problems include stigma and discrimination, fear of humiliation when accessing health care, concerns about involuntary disclosure of sexual behavior, power differentials between partners in negotiating condom use, fundamental misconceptions about HIV risk, self-medication for sexually transmitted diseases, and low uptake of HIV testing. Because discrimination of MSM is strong in Kenya, the men who came forward to participate in these focus groups are likely a selected population and the problems they discussed may be worse for those outside the focus groups. Obviously, these types of problems are not unique to MSM in Kenya or Africa, but in the African context of strong societal disapproval and risk for legal and other repercussions in case of disclosure they are much more difficult to address. Indeed, in a study among 224 MSM in Kampala, Uganda HIV/AIDS was given a low priority compared with other concerns and was ranked well behind discrimination and lack of acceptance in society.² Findings from the Kenyan and the Uganda studies^{1,2} show the urgent need for HIV preventive interventions in African MSM.

The high levels of unprotected anal intercourse and low levels of awareness of HIV risk in Kenyan MSM¹ suggest that such interventions can have a huge impact on the HIV epidemic in this population. The need and potential for preventive interventions among MSM can also be derived from data recently obtained in a cohort study in Mombasa, another Kenyan city.³

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Among the 285 MSM who enrolled in this HIV vaccine preparedness study, a 24.6% HIV prevalence was found at baseline. The crude HIV incidence density during the first year of follow-up of the HIV negative fraction of the MSM cohort exceeded 8 per 100 person years.⁴ Unsurprisingly, levels of HIV risk behavior in these MSM were high, with more than 75% reporting at least one instance of unprotected anal sex in the past 3 months.³

For HIV preventive interventions to be successful they should include the specific social and legal issues that African MSM face in their daily lives. Emphasis on protection of confidentiality during HIV and STI testing, education and sensitivity training of health care workers, and acceptance of MSM to government and private health facilities are some examples that can be worked on immediately. The improvement of legal and human rights of African MSM will likely take more time, but should be addressed simultaneously.

Even though the study of Sharma et al.¹ is one of the first of its kind in Africa, some important qualitative questions remain unaddressed. It would be valuable for instance to explore to what extent concepts of biologic sex, self-prescribed gender and sexual role identities, and sexual role separation are components in the discourse and sexual arrangements among African MSM. Another area that should be explored is sex with women in addition to men and differential risk perception and protective behavior with women and men. Answers to these questions are not only important to inform HIV preventive interventions but also to guide future research and to better understand the dynamics of HIV transmission in this population. Furthermore, they may help to select and adapt HIV preventive interventions that have been proven to be successful in MSM populations elsewhere in the world. With the HIV research and prevention agenda for African MSM now gaining momentum, these important questions need to be addressed urgently.

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