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Note

Sexual Identity and Risk of HIV/STI Among Men Who Have Sex With Men in Nairobi

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ALTHOUGH THERE IS GREAT regional variation, a significant proportion of those with human immunodeficiency virus (HIV/AIDS) globally are men who have sex with men (MSM) due to the high efficiency of transmission via anal intercourse.[1] This relatively small number of individuals may be disproportionately at risk of HIV transmission vis-a-vis the wider population, particularly in countries where social or legal retribution accompanies public disclosure. Recent short-term estimates suggest that of the approximately 82,300 new HIV infections in Kenya in 2005, 4.5% were in MSM.[2,3] The incidence among these men may be even higher, as the models assumed that only 1% of the male population had sex with men and did not account for male sex workers in this population.[2]

The success of HIV/sexually transmitted infections (STI) education, prevention and treatment programs for MSM will depend on understanding the diversity of identities, roles, and situations in this subpopulation.[4] By the late 1990s, a growing body of scientific literature revealed that some men in Africa had sexual intercourse with men, that some of these men also had sex with women[5–9] and that these men were at significant risk for HIV/STI.[5–9] In Kenya, researchers lamented the lack of data on MSM and suggested that in the absence of social sanction or legal rights,[10] MSM in Kenya would deny having male sexual partners, engage in clandestine sex, and take social cover in marriage.[11]

In 2002, a few men in a study of male genital hygiene and sexual behavior, self-identified themselves as MSM and provided an opportunity to reach more MSM to identify characteristics and the context of STI/HIV risk behavior of MSM in Nairobi, Kenya.[12] Among 486 men enrolled in the study, 12 men (2%) self-identified as MSM and were asked to recruit other MSM through snowball sampling techniques. Thirty of thirty-six men recruited gave written consent to answer a short demographic questionnaire, participate in focus group discussions (FGDs) on HIV/AIDS risk behavior and to taping the discussions. The institution review/ethic boards at the Kenyatta National Hospital/University of Nairobi, Kenya, and University of Washington, Seattle, approved formative research on male genital hygiene practices and HIV/AIDS risk behavior. The 30 participants ranged in age from 19 to 35 years old and represented different ethnic groups. Two men were married with children, 12 were employed, and 29 were Christians. No names or other identifying information were used or recorded. Two male trained social scientists conducted the FGDs in Kiswahili, one of the official languages of Kenya, with three groups of 8 to 12 MSM (n = 30) aided by a field guide. Although one social scientist facilitated the discussions, the other served as an observer and noted points of discussion and nonverbal communication. An independent transcriber entered discussions, in English in Microsoft Word. Two independent readers identified and coded recurrent themes. After standardization of codes, only themes that cut across all three FGD and direct quotations that illustrated collective experiences were considered.

The major themes identified in the FGDs included (a) emerging group identity, (b) the context of sexual risk taking, and (c) low health care utilization. Direct quotations supporting these themes are presented in Table 1.

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TABLE 1. Representative Quotes by Theme

Emerging group identity

1 Me, I have a wife. My wife doesn't know but I use her as a cover up."
2 "Even if they say what is in you, you have already accepted that you are a homosexual."
3 "If people know that you are gay and you accept it and show them that it doesn't affect you, [then] with time people will understand you and get used to it, they will even become your friends and all that."
4 "You show them that you are a hard core and show them so they can start fearing you. Otherwise, just keep quiet."
5 "We have tried to be open . . . At the beginning of this year we met someone who was appointed by the Attorney General to research about AIDS [who] responded negatively. We even sent our proposal to this Ghai [Constitution Review] commission and, in that document I never saw anything about that, so, Kenyans . . . pretend as if its doesn't exist."

The context of sexual risk taking

6 "Like for me, most of the clients that used to know me tell me I am old. So I bring other boys 22, 20, 19."
7 "It's lack of money and if you get someone who is rich and promises [that] you may be stay together [in a] sort of marriage and [he will] give you maybe 10,000 Ksh [≅130US$] . . . He uses you and [not the] condom . . . for that matter, he has AIDS and you do not use condoms. After you get used to him, you just get AIDS."
8 "It is known that it [same-sex relationships] is there today. You see, men are more like prostitutes wanting new and more boyfriends. You find that he has reduced the cash he gives you. Because [gay] people are not many and they like different people, so if I get someone today and then I get a better one, I will shift to the other one."
9 "There is the lower class that is composed of sex workers, the middle class, and the higher ones high up in the higher class. The lower class does not maintain a relationship because most are sex workers and they will have sex for money. The middle class cohabit and maintain their relationships, but the top ones, they come down for sex and then go off."
10 "Like him, he has a permanent friend. When his friend knows me he has to sleep with me and maybe ask me if have another friend. I introduce my friend to him. So, it goes around and you can blackmail a person because he is using you."
11 "You have to [have sex] so that you can be released otherwise they [police] will not or [do it] with watchmen because the watchman will give you security at night."
12 "Because no one wants to talk about it . . . Even the pastors in church they are shying [away] when they preach . . . These seminars about AIDS . . . talk about there is a woman and a man relationship that is in HIV . . . so it's the language to tell that there is HIV in men to men relationship, its not there."

Low health care utilization for STI/HIV

13 "If I have gonorrhea it will be very hard to say [who] I got it from. When [I] am asked "Where is it?" I will have to say, "It is in the back." You know they will chase you away. You look strange, you see. That is why some end up dying because maybe you are afraid or you cannot go to private hospitals because you do not have money. "How did you get [gonorrhea] in the back?" They will start asking. Some think you are joking or are mad. So that's why [you] go to the counter, say you have gonorrhea, get the medicine and you go."

Emerging Group Identity

The men said that in Kenya, MSM were from diverse age, occupational, and socioeconomic groups. Some men presented themselves as heterosexual men through marriage (quote 1). Others were comfortable with their sexuality and did not fear discovery (quote 2) or disclosure (quote 3). Still others presented a strong nonnormative public persona to command respect (quote 4). Whereas in 1998–9, researchers could not reach MSM, some of our discussants lobbied for the inclusion of their rights in the Kenyan Constitution, which in 2002 was under review by the Constitutional Review Commission (quote 5).

Context of Sexual Risk Taking

Though emerging as a group, the men reported high-risk sexual behavior related to power differentials by age and wealth in their same sex relationships, perceived marginalization and nondisclosure. Relationships among MSM varied in type and duration but remained contained within a tight circle of male friends, acquaintances and, for some, paying clients. A combination of love and money fueled their same-sex relations. Though with intimate "friends," poor men engaged in sex work and often took a commission for introducing "fresh" or "young" men to their paying clients (quote 6). Younger and poorer men were unable to negotiate condom use (quote 7) and left the relationship only when more desirable romantic and financial opportunities presented themselves (quote 8). Men in a high socioeconomic class usually led double lives as married men with children while having clandestine sex with boyfriends (quote 9). Most of their relationships did not last long because they lost interest in current partners, desired variety or younger men, or feared disclosure. Some men blackmailed closeted or married men who feared disclosure (quote 10) or provided sexual favors to avoid prosecution or get security (quote 11). Lack of information on their risk of STI/HIV acquisition and issues around condom negotiation were a serious concern in all 3 FGDs. The groups believed that most MSM do not know their risk for HIV/AIDS (quote 12).

Low Health Care Utilization

The men often suspected a STI (particularly gonorrhea) based on the signs or if they received partner notification or had sexual partners who repeatedly infected them. However, many participants delayed seeking treatment for STI from a clinic fearing possible embarrassment and stigmatization because of their evident nonnormative sexual behavior (quote 13) in spite of two focus groups identifying one sympathetic doctor each. The men did not like volunteering for HIV counseling and testing because "there are many stigmas, in this case, . . . the homosexual stigma and the HIV stigma." Additionally, they did not have the necessary resources to deal with positive results. They feared that they would "die psychologically" or literally out of "stress" and "fear" and that it would be "a lonely death [with] no one there to help you" as both family and employers rejected MSM, particularly if they were also suffering from AIDS.

Discussion/Conclusion

This small exploratory study demonstrates that MSM in Kenya can be reached even through a structured questionnaire administered in a clinic-based interview. Since then, studies that specifically targeted MSM and used more sophisticated methods such as respondent driven sampling[13] and capture-recapture method[14] reached approximately 500 MSM in Nairobi and along Coastal Kenya respectively within a short period. The willingness of these men to participate in research bodes well for HIV prevention efforts in this smaller but more at risk population provided they are treated with respect and dignity.[15]

Although the snowball sampling techniques used in this study captured fairly vocal and emancipated men who are likely not representative of this community, insights such as association of vaginal but not anal sex with the risk of HIV/AIDS transmission (quote 12), self-medication for STI (quote 13), and very little voluntary seeking of HIV/AIDS counseling and testing in this population support conservative estimates of disproportionate risk for HIV/AIDS among MSM and of continued risk to their male and female partners.[15] For these reasons, it is imperative that MSM receive public health attention without waiting for resolutions of debates regarding origins of homosexuality, ethnocentric terminologies, and human rights.[16]

The arguments for nonhealth programs such as addressing stigma and discrimination remain strong[17] because, as is the case among these men, the lack of social support appears to create psychosocial distress related to homophobia and discomfort with sexuality.[16,18] As in Nigeria, the men lived double lives to maintain their family reputation and to stay safe and did not find suitable counsel from their religious leaders.[16] These stressors foster behaviors with higher transmission risks such as sexual subordination based on economic or race differentials and low utilization of health services.[19] In the absence of public health attention, MSM underutilize preventive/medical services and receive suboptimal health care, inaccurate risk assessment and inappropriate counseling.[20,21] Nondisclosure along with public health disinterest further inhibits their utilization of HIV/STI testing and prevention services while maintaining their perception of low-risk.[16,22] MSM who do not know their HIV status and believe they are at low-risk may unknowingly place themselves and their male and female sex partners at higher risk of HIV acquisition. Likewise, their partners may not be aware of the sexual partnerships and may not initiate or accept any HIV prevention strategies.[16]

The nascent movement observed in this 2002 study has since unfurled to include websites where MSM in Kenya can meet each other and learn about health care services.[23] One NGO run clinic offers STI/HIV testing and counseling for this subpopulation in Nairobi. The Kenya National HIV/AIDS Strategic Plan 2005/6–2009/10 has identified MSM among those vulnerable to HIV/AIDS, stated related funding requirements and have created a results framework that mainstreams rights. However, outside of a few research sites, the plan is yet to see fruition.[14]

This would be the right time for the Kenyan public health sector to work on the reduction of stigma and discrimination,[18,19] and to facilitate provision of appropriate STI/HIV awareness and condom programs for MSM.[14,16,20–22] This would include ascertaining the HIV/AIDS prevalence in this subpopulation,[24] offering counseling that routinely addresses safer sex with both male and female sexual partners and, considering comprehensive health care for men at all patient-doctor interactions to better address care and prevention of HIV/AIDS and STI and related health conditions. Further research should examine the preparedness of the health sector in managing the health of MSM and perhaps also with women to suggest areas of improvement. In the interim, it is imperative that other bimultilateral, nongovernmental, and research organizations work in concert with MSM to help them realize their human and sexual rights to allow them to live a safer life.[17] If the HIV/AIDS prevention programs in Kenya continue to ignore MSM, then these men, and their partners, and by extension, the general population may continue to be at unnecessarily increased risk for STI/HIV acquisition.

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