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DOI
10.1080/17441692.2018.1462841

Publication date
2018

Document Version
Final published version

Published in
Global public health

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To cite this article: Eileen Moyer & Emmy Igonya (2018) Queering the evidence: remaking homosexuality and HIV risk to ‘end AIDS’ in Kenya, Global Public Health, 13:8, 1007-1019, DOI: 10.1080/17441692.2018.1462841

To link to this article: https://doi.org/10.1080/17441692.2018.1462841

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Published online: 19 Apr 2018.

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Queering the evidence: remaking homosexuality and HIV risk to ‘end AIDS’ in Kenya

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ABSTRACT
Until recently, HIV in Africa was presumed to be driven by poverty, gender inequality and poor governance. The last decade has seen a shift in global and national public health discourses, especially in eastern Africa where new statistical evidence is used to justify prevention efforts to target Key Populations, i.e. men who have sex with men (MSM), injecting drug users, and sex workers. In this article, we focus on Kenya to examine state, NGO and community HIV treatment and prevention efforts targeting MSM, specifically male sex workers. We combine ethnographic fieldwork with a critical analysis of policy(making) and implementation practices to sketch the contours of the global, national and local forces that have combined to (re)make male homosexual sex to be understood as a practice that contributes to HIV incidence in Kenya. We also show that HIV-related MSM programmes in Kenya primarily enrol male sex workers in HIV treatment programmes, which focus on mainly on treatment adherence and pay insufficient attention to the economic and psycho-social problems experienced by male sex workers. Although upper and middle class MSM are involved in running LGTBI rights-based interventions and in mobilising male sex workers for HIV interventions, they are rarely targeted by those interventions.

ARTICLE HISTORY
Received 22 August 2017
Accepted 15 March 2018

KEYWORDS
MSM; Kenya; epidemiology; sex work; psycho-social support

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downtown River Road area as they hustled for clients. Unlike the other support groups we studied and which were based in health facilities and community-based organisations, the Freedom Corner group was self-organized and without formal leadership. Their aim was to support one another in all matters related to physical and mental health, and in times of economic need. To varying degrees, all had been alienated from their families and relied on this informal group to serve as what Janzen (1987) has referred to as a ‘therapy management group,’ a group of interested and invested individuals who come together to support a person confronted by a health crisis. When Mathenge first came to Nairobi he was poor and sick. It was Carol and the others at Freedom Corner who looked after him; Carol had given him money for transport and food. Although Mathenge’s fortunes had improved and he was no longer involved in the daily care and support practices that unfolded at Freedom Corner, he was still invested in his friend’s health.

As a regular visitor to Freedom Corner, Emmy had also become a de facto member of the men’s therapy management group. From the time of the intervention meeting until Carol’s death more than two years later, she was involved in organising crisis medical care and economic support for Carol and his long-term boyfriend. Since she and Mathenge had the greatest economic resources, it was up to them to try to keep Carol and his boyfriend housed, fed and on medication. A couple of months before the intervention meeting, Carol had been kicked out of an antiretroviral treatment programme at the SWOP clinic, which was located down the road from Freedom Corner. In a fit of frustration, Carol had thrown his ARVs at the SWOP doctor, telling him that to give him medicine without food was just killing him slowly. Although it was a tragic turning point for Carol, it was a story told often by other male sex workers to illustrate the difficulties of taking ARVs on an empty stomach.

After he was expelled from SWOP, Carol stopped both his HIV and TB treatments and quickly deteriorated. His Freedom Corner colleagues began gossiping about him and isolating him, fearing they would be infected with TB. When Carol and his boyfriend disappeared, they began to worry and contacted Mathenge. When they eventually found Carol he was in a very poor state, prompting the meeting. At the meeting, each person offered stories about the various ways they had supported Carol in the past and admonished him for not sticking to his medication. Although they were angry at him and feared being infected with TB, it was also clear that they cared a great deal about him, even loved him. Carol’s defence that day was that he had disappeared to escape the gossip, ‘Some people are talking about me that I have katigo (HIV), and that is why I kept away, to have a peace of mind. I am sick yes, but I have become the main and common story sex workers are talking about.’ Although there were times Carol would speak openly about the sex work he did and his HIV status, he never seemed to accept these facts as the basis of his identity. More than once, he told us that he hated being HIV positive and a sex worker.

Because she was also observing support groups at Kenyatta National Hospital and had good connections with the HIV Care and Treatment Centre there, Emmy was tasked with getting him re-enrolled in their treatment programme. Carol had to go to the hospital daily for his TB treatment, so Emmy and Mathenge also had to make sure Carol had money for transport and food. The other men at Freedom Corner took up collections to support Carol during this period. Once he completed his TB treatment however, he chose not to continue with ARVs for reasons we could never quite comprehend. A couple of months later, Mathenge intervened again, this time enrolling Carol in a treatment programme at the MSM-friendly Liverpool VCT and housing him at the HOYMAS Rescue Centre, where male sex workers and other MSM provided peer-based care for those in crisis. When Carol recovered sufficiently to leave the Rescue Centre, Mathenge rented a room for Carol and his boyfriend. He even bought them a mattress and provided them with food baskets. Despite all this support and the fact that Carol had no less that 10 certificates earned from attending various NGO-sponsored HIV trainings, he once again stopped taking ARVs. The TB came back and he lost a lot of weight. Because of his failure to adhere to treatment programmes at SWOP, the national hospital and LVCT, there were no options left to him in Nairobi, so Mathenge took him to Kiambu District Hospital, located about two hours north of Nairobi. At Kiambu, Carol, who was considered
highly infectious with multi-drug resistant TB, was put into an isolation ward where he died shortly after.

In some ways, Carol’s story is exceptional. He was exceptionally well-connected to the range of HIV interventions targeting MSM in Kenya. Having attended numerous trainings and worked as a HIV peer mentor, he was also exceptionally knowledgeable about HIV treatment and the consequences of poor adherence. The care he received from his friends and colleague sex workers was also exceptional. Yet, his adherence failures, his struggles to remain housed, and the difficulties he faced in finding sufficient food to offset the side-effects of antiretroviral treatment were typical of the problems encountered by other sex workers at Freedom Corner, where everyone was HIV positive and everyone was supposed to be on treatment. Even those who maintained a fairly regular medication schedule rarely took medicines as prescribed, since they were often taken with alcohol and at different times of day, with skipped doses being more the norm than the exception. Those without housing struggled the most because they had nowhere to store their medicines and did not want to carry them with them for fear of scaring off clients.

Carol’s story is also exceptional because he lived and died in Nairobi, Kenya at a time when there was growing awareness of the HIV-related healthcare needs of MSM, in particular male sex workers, and when there was a proliferation of health services directed toward people like him. In this article, we examine the wider context in which Carol died of an HIV-related infection. Elsewhere we have offered an extensive discussion of the ethnographic research conducted at Freedom Corner (Igonya, 2017; Igonya & Moyer, 2016). Here, we provide some general observations from that component of our research, together with an examination of the larger policy, scientific and health service landscape that shaped Carol’s experience as an HIV positive male sex worker in Nairobi. To this end, we examine the global and national forces that contributed to Kenya’s remarkably pragmatic decision to welcome international organisations to work together with Kenyan activists and medical professionals to develop health care services for MSM as a key population.

Sparked by the 2007 UNAIDS campaign, ‘Know Your Epidemic, Know Your Response,’ Kenya was one of the first countries to begin collecting stratified HIV incidence data that considered marital status, socio-economic class and homosexual practices. Kenya and other African countries that completed such ‘Modes of Transmission’ studies produced findings that countered much of the existing epidemiological evidence about HIV in high prevalence settings in Africa. Clusters of higher incidence among certain sub-populations were documented in Kenya, making visible previously unknown risk groups. These included heterosexual people within regular union/partnership (44%); MSM and men in prisons (15.2%),5 and injecting drug users (3.8%) (NASCOP, 2009). This epidemiological evidence changed the way the epidemic was read in Kenya and on a global scale, bringing about ‘evidence-based’ public health interventions targeting key populations, including MSM (Jones et al., 2014).6

Around the time this evidence was challenging presumptions about HIV risk and risky populations, the global funding landscape also underwent a seismic shift prompted both by the global financial crisis of 2008 and the coming into office of President Barack Obama in the United States, the largest single contributor to HIV interventions in Kenya (Kenworthy, Thomann, & Parker, 2018; Moyer, 2015; Simbaya & Moyer, 2013). On one hand, donors began demanding more value for their money; on the other, the United States became amenable to spending donor dollars on programmes targeting homosexuals and sex workers, marking a clear break with the policies of the previous Bush administration (and the Trump administration that would follow). In a highly competitive global funding landscape, the term key population quickly came to be used by international NGOs trying to stake their claim as experts in reaching these newly identified high risk groups. Simultaneously, national and local NGOs did their best to adapt their programmes to appeal to the emerging international donor-speak to qualify for funding (Cf., Biruk, 2014). Organisations that could demonstrate their ability to locate and recruit high-risk populations for research and intervention programmes were in a better position to receive funding to implement those programmes. Another important
aspect of the success of certain organisations was the presumption and characterisation that these groups were ‘hard to reach’ (Moen, Aggleton, Leshabari, & Middlethon, 2011).

The key populations frame also allowed the Kenyan state to focus on HIV among MSM, injecting drug users and sex workers without condoning such practices. For example, following the release by the National AIDS Control Council of the Kenyan National AIDS strategic Plan for 2009–2013, which included a focus on key populations, prominent Kenyan religious leaders called for the sacking of the then director, Professor Alloyce Orago, claiming that he was supporting the legalisation of prostitution, homosexuality and drug use. Orago defended himself in the Daily Nation, on 27 March 2009, stating that NACC was ‘not advocating the legalisation of sex work,’ but that, ‘harassment of prostitutes by security personnel would not help reduce HIV infection’ (Ogosia, 2009).

In this article, we examine the way the term MSM has found purchase in Kenya over the last decade among public health officials. We are interested in the ways that the term MSM – a term created by public health officials to draw attention to (homo)sexual practice rather than (homos)sexual identity (Boellstorff, 2011) – gets utilised in the Kenyan national context. Drawing on Carol’s case, we examine this issue on three levels. We begin with an examination of the Kenyan national effort to target MSM as part of its project to ‘end AIDS’ within a global context calling for the elimination of new HIV infections. Next, we consider the ways in which male sex workers like Carol have come to be the focus of MSM interventions in Nairobi. Finally, we offer a brief analysis of our work at Freedom Corner as an illustration of the ways that initiatives led by MSM and sex workers differ from those led by NGOs and medical clinics.

Kenya, and in particular Nairobi, is an important site for studying the way that HIV policies and interventions related to MSM and other key populations have emerged and developed over the last decade in response to new forms of statistical evidence and shifts in international HIV funding priorities. Like most other countries in Africa (and the world), homosexuality is illegal in Kenya. Despite this, there have been numerous efforts within Kenya to make HIV treatment available to MSM, particularly those who engage in sex work, to stem the spread of HIV. Nairobi is also the site of a vibrant gay activist community which has been relatively successful in framing homosexuality as a rights-based issue entwined with public health.

Methods

Our arguments draw on our long-term engagement with HIV interventions in Kenya, including an in-depth focus on HIV support groups between 2010 and 2013 (Igonya, 2017). This paper is based on research conducted with a male sex worker support group – one of eight support groups we studied in-depth. Data for this paper draws on diverse sources, including our fieldwork findings, policy reports, and public media in Kenya, as well as formal and informal discussions with key informants, including policy makers, public health doctors, activists and NGO workers affiliated with organisations that support MSM. This interview material, combined with our observation of numerous NGO trainings and accompanying male sex workers on clinic visits and during activism activities, provides the foundation for the arguments we make regarding the national HIV response and health services directed toward MSM.

We conducted sixteen months of ethnographic research (2011–2012) at Freedom Corner, visiting three times a week in the evenings for approximately three hours per visit, just as the young men were gathering to begin work. Freedom Corner was formed by a group of male sex workers in 2010 in response to their shared disillusionment toward institutionalised support groups sponsored by HIV prevention-oriented NGOs, which they claimed failed to address their social and psychological needs and the human rights issues specific to male sex workers (Igonya & Moyer, 2016). This community-based and led group was unusual in comparison to the other HIV support groups we studied in that it was initiated from the ground up and did not rely on standardised support group practices, such as an emphasis on ARV adherence and living positively.
Data at Freedom Corner was collected primarily through observation and informal discussions – what Geertz (1998) would call ‘deep hanging out’. This approach helped us to build rapport and trust, and the opportunity to observe how the young men interacted socially in the context of their work lives. Sitting at Freedom Corner in between clients, they often discussed the types of sex they had and if condoms and/or lubricant were used, which gave us some insight into risk-related sexual activities. Due to the obvious sensitivities of recording conversations with sex workers in public and the logistical challenges of recording in a loud bar, we relied on note taking and follow-up conversations outside of the bar. Although this has limited our ability to quote people directly, our extensive observations provided ample opportunity to record common practices related to poor adherence, sexual risk taking and the collective handling of health and economic crises. Most findings we report in this article are based on observation of actual practices rather than self-reported behaviour.

Twenty-four HIV positive MSM sex workers between the ages of 25 and 45 years participated in our field study. We conducted more than 200 observation activities and informal conversations (over 300 hours in total). To compliment observation data, we conducted eight in-depth interviews, one focus group discussion with Freedom Corner participants, numerous conversations and informal discussions, and key informant interviews with a SWOP clinician, Ishtar’s programme manager and director, and the directors of HOYMAS and Movement of Men Against AIDS in Kenya.

Finally, we reviewed secondary data sources, including policy papers, NGO reports and survey data, and conducted a review of all published articles pertaining to MSM or homosexuality in The Daily Nation and The Star newspapers between the years 2008–2013, while closely following public debates on MSM and homosexuality as represented in the Kenyan media.

**Ethics**

We were granted a permit to conduct research on support groups in Kenya by the Kenyan Ministry of Education, Science and Technology, and ethical clearance by the Kenyatta National Hospital/ Nairobi University. Access to Freedom Corner was carefully negotiated. We first sought consent from the *de facto* group spokesperson who then sought verbal consent from the group before we approached them. Despite receiving rather quick approval from gatekeepers, gaining access to Freedom Corner took much longer. This was partly because the group was not formalised and partly because sex work and homosexuality is illegal in Kenya. At our initial meeting, we explained the research and discussed ethical issues at length. We were granted collective consent from the group to visit the support group space regularly and to engage in informal conversations. Individual consent was also always sought from those who participated in interviews, one-on-one conversations and the focus group discussion.

**Background**

Over the last 30 years, Africa – especially eastern and southern Africa – has provided a living laboratory for a vast array of HIV studies and interventions (Crane, 2013; Elliot, 2017; Geissler & Molineux, 2011). Unlike in North America and Western Europe, until relatively recently, HIV prevention in Africa has focused on the general population, with a special emphasis on populations deemed more vulnerable to HIV infection because of structural factors relating to gender, age, and economic factors: the poor, women, orphans, and transactional sex workers. While the concept of risk and risk groups remained an important part of public health interventions in the West throughout the epidemic, in Africa the concept of vulnerability replaced the concept of risk in the late 1990s, in part as a result of arguments put forth by anthropologists whose research demonstrated the relationship between poverty, gender and economic inequality, and HIV (Farmer, Connors, & Simmons, 1996; Schoepf, 1992). Anthropological research also showed that risk-based discourses tied to public health interventions led to victim blaming and the alienation of intended targets who did not perceive
themselves as belonging to risk groups. Research in Latin America, for example, showed that terms such as homosexual or gay, initially thought to be neutral descriptors of sexual behaviour, were in practice descriptors of an identity category that excluded many men who had sex with men but did not consider themselves homosexual (Parker & Carballo, 1990). Such research led to the invention of presumably more neutral public health categories, such as MSM. Boellstorff (2011) has traced the genealogy of the term MSM, from its roots in public health to the present, while Lorway, Reza-Paul, and Pasha (2009) have similarly demonstrated the way the public health category of ‘male sex worker’ has come to be increasingly linked to sexual subjectivity in Mysore, India. These terms, however, were hardly uttered in Africa during the first two decades of the epidemic, when even the most progressive African leaders insisted that there were no homosexuals in Africa (Epprecht, 2012; Ndjio, 2012), an assertion that was hardly questioned by the international scientific community.

In the early 1980s when HIV first became a public health concern in North America and Western Europe, it was known as a ‘gay disease.’ Because gay men were the most heavily affected and because they made themselves visible through activism, the media and the public were quick to associate HIV with homosexuality (Patton, 1990). Hacking (1985) has written about the way science and states ‘make up people,’ through the evidence gathering epidemiological practices of enumeration, measuring and accounting. Although homosexuals were listed by the American CDC as a ‘risk group’ as early as 1984, forever linking gay men to HIV, in fact, homosexual identities had already been ‘made up’ long before the arrival of HIV, a fact that allowed them to resist epidemiological categorisation (Epstein, 1998). In contrast, the African HIV epidemic first became visible, and therefore knowable, to science and public health policy makers, in the parts of Kenya, Tanzania, and Uganda that border Lake Victoria. Unlike in the West, HIV in Africa affected ‘the general population’ from the outset. Except for sex workers, little attention was given to identifying higher risk sub-populations, and public health interventions have targeted the general population through education, public awareness campaigns and, more recently, test and treat programmes.

We might argue then that the epidemiological profile of the disease shaped the public health response, both in Africa and the West: different epidemics, different responses. However, because we did not have reliable stratified statistical data from Africa until recently, it was impossible, at least epidemiologically, to ‘make up people’ in the way that Hacking suggests (see also, Sangaramoorthy & Benton, 2012). Because global HIV statistics only account for geographic, gender, and age, certain sub-populations remained invisible, including MSM.

**The Kenyan state’s evidence-based approach to MSM: progressive or pragmatic?**

Over two months in 2004, research commissioned by the Population Fund in Nairobi identified 500 men who engaged in homosexual sex across demographics of age, class, and education (Onyango-Ouma, Birungi, & Geibel, 2005). From the outset, this and similar research-based evidence on MSM in Kenya has been couched in public health terms; identity politics and rights based claims were only raised in relation to decreasing discrimination to make it easier to access HIV services. The report’s title, ‘Understanding the HIV/STI Prevention Needs of Men Who have Sex with Men in Kenya,’ leaves little doubt to the public health focus.

Despite widespread knowledge about the Population Fund study among the policy makers and medical practitioners we interviewed, it did not have an immediate effect on Kenyan HIV prevention policies when it was published. For the most part, this largely qualitative evidence was ignored in Kenya. In 2006, Eileen Moyer, this article’s second author, attended a workshop on gender, HIV and health in Nairobi soon after the report was published and during which one of its co-authors, Harriet Birungi, summarised the findings. It was clear to everyone in attendance that this was cutting edge research, but no one knew what to do with it. Remarkably, in the discussion that followed, those present expressed their surprise that many participants in the study were middle-class men and college students. Workshop attendees, particularly those from East Africa, were perplexed because they
assumed good middle class boys would have no reason to be homosexual. Even in that room of notably progressive thinkers, it was clear that for many of them homosexuality was ‘un-African.’ Several people remarked that they must have learned about homosexual sex in boarding schools, which were a British invention after all. Others suggested they would grow out of it once they reached manhood. No one raised questions about the poorer men in the study. It was assumed they did it for economic reasons, which seemed understandable to most people. This idea – that it is acceptable for men to have sex with other men for money, but not for pleasure or by choice – resonated with arguments about heterosexual transactional sex in Kenya and has continued to shape the way Kenya implements its MSM programmes over the last decade, most of which target male sex workers rather than middle class MSM.

It was only in 2009 that HIV interventions have begun to target MSM in Kenya. At the time there was also an increase in research on MSM carried out in partnership with the Kenyan Ministry of Health. We have identified four factors have made it feasible and desirable for the Kenyan Ministry of Health to partner with development organisations to conduct research and focus prevention activities on MSM. The first was the publication of stratified epidemiological data which drew a link between male homosexual sex and increased HIV incidence. The data was collected at the impetus of UNAIDS, but Kenyan epidemiologists at the National AIDS & STI Control Programme (NASCOP), were extremely keen to have better statistical data to shape the national response to HIV and they, together with NACC, played a key role in interpreting the data and translating it into national policies. The second was increasing international funding for prevention activities targeting key populations, including MSM. This funding – provided mainly by the United States, the UK and the Netherlands in Kenya – followed the above-mentioned epidemiological evidence with the objective of limiting new infections. We stress this to highlight the importance of scientists, activists and others in Kenya in developing a national focus on MSM that preceded the shift in international funding priorities. This was not simply a case of a global policy being forced on an African country, or Westerners exporting/promoting homosexuality. The third factor was the growing politicisation of MSM and homosexual identities in Kenya, arising at least in part because of interventions, including HIV interventions, that brought them together under a shared subject position. The fourth factor, which backfired in neighbouring Uganda, was international pressure from Western countries for African countries to decriminalise homosexuality.

The interventions targeting key populations that proliferated in Kenya after 2009 defined MSM as being at higher risk and hard to reach. Discussions with key informants at the then Liverpool VCT and Kenyatta National Hospital, both of which have periodically offered psychological support group and HIV services to MSM over the last decade, indicated that it was the norm to separate MSM into two groups: sex workers and non-sex workers. While non-sex workers were usually afforded access to psychological support, sex workers, who were presumed to be most at risk, were generally targets of HIV research, interventions, and services. Overall, there were also many more sex workers targeted by the various MSM interventions we surveyed; presumably they were much easier to reach because they were on the street, unlike their better educated and employed counterparts. As one health worker put it: ‘In Kenya, the poor are thought to have “problems,” which can be addressed through education and training, while the middle-classes are thought to have “issues,” which are better addressed through counselling and psychological support.’

What seems paradoxical is that, in general, male sex workers are easier to reach than non-sex workers, most of whom have other means of employment or family wealth; middle class MSM are the actually hard to reach populations, and yet little effort is being made to reach them even though several of the MSM-oriented organisations employed educated middle/upper-class MSM to do the actual recruiting. We see this as largely a consequence of how HIV and HIV risk groups continue to be imagined by donors, but also by the middle-class Kenyans in charge of HIV programming in Kenya: HIV is as a disease of poverty, and publicly funded interventions should target the economically marginal. This not only prevents Kenyan public health officials from formulating a coherent programme to reach the middle classes, MSM or otherwise, it also prevents the middle
classes from accessing public health services for fear of risking their class-based respectability. The decision to respond to the evidence of higher HIV incidence among MSM by primarily targeting sex workers was, according to those we interviewed, not the initial intent, but rather a result of them being easier to reach. Considering the pressure on local NGOs to identify sufficient MSM to meet donor targets (Lorway, 2017), those hired to mobilise participants went for those who were easiest to find, the so-called ‘low hanging fruit’ (Cf., Reynolds, 2014).

The various ways that middle class MSM are obscured in Kenya’s HIV response points to what we mean by our title, ‘queering the evidence.’ Kenyan public health officials have effectively employed an evidenced-based framing to justify focusing on MSM to prevent new HIV infections and help the nation achieve the global target of ‘Zero New Infections,’ but they have not acted on the evidence that middle class MSM are also at risk. Simultaneously, recruitment strategies employed by community based organisations (and generally sanctioned by donors), have resulted in a data pool made up primarily of male sex workers but presumed to be representative of all Kenyan MSM, thereby queering the evidence on MSM that has been produced since 2009.

**Targeting men who have sex with men in Nairobi**

International partnerships between the Kenyan government, Kenyan civil society organisations, and diverse European and North American partners have led to the emergence of several donor-funded HIV programme specifically targeting key populations in Kenya, including MSM. These programmes are concentrated in Nairobi and Mombasa. Nairobi is considered a hub for MSM, many of whom have moved to the capital city to escape persecution in their rural homelands. There were several MSM programmes operating at the time of our research. The discreet clinic run by Sex Workers Outreach Programme (SWOP) was located nearby Freedom Corner and offered HIV services to female and male sex workers in the city centre and also served as a base for a long-running research collaboration between the University of Manitoba and University of Nairobi. HOYMAS (Health Options for young Men AIDS and STIs), with John Mathenge at the helm, was (and still is) the only male sex worker led organisation. They received funding from numerous donors and also maintained a research collaboration with SWOP/ University of Manitoba. Other organisations that provided MSM-friendly services included the New Partners Initiative – Scaling-up HIV/AIDS Prevention (NPI-SHAP), based at the Liverpool VCT (now LVCT Health) and funded by the United States Centers for Disease Control; the USAID-funded, AIDS Population and Health Integrated Assistance (APHIAplus); the Kenya AIDS NGO Consortium (KANCO), funded by the UK-based AIDS Alliance among others; and Ishtar-MSM, a community-based organisation targeting MSM sex workers initiated by a Catholic priest in 1999 but led by MSM and funded by several international donors, including amfAR. Although most of these organisations were interested in protecting and promoting the rights of MSM and other sexual minorities, their funded programmes focused primarily on increasing access to health services for sexually transmitted infections and HIV, access to antiretroviral treatment, the provision of PreP, and encouraging behaviour change, mainly the use of condoms and lubricants, and antiretroviral treatment adherence.

Our research, showed that despite the increase in donor-funded programmes providing HIV services to MSM, male sex workers, particularly those who were HIV positive, rarely received the economic or psychological support they needed to thrive. As Carol’s story at the opening of this article demonstrates, although free antiretroviral treatment was available to them, the marginal day-to-day existence of many male sex workers often resulted in erratic treatment adherence and consequent HIV-related illnesses. Our observations of support groups targeting the general population, as well as the discussions we had with health service providers made it clear that HIV positive male sex workers generally had greater health and care needs than did other HIV positive people. Although stigma was reported by others living with HIV, homophobia increased the likelihood of rejection from entire kin networks, which meant that few male sex workers could rely on family to help pay medical fees or care for them when they were sick. Their psychological needs were
also enormous. They reported feeling socially isolated, demoralised, angry, sad and frustrated. They also lamented the difficulty of maintaining long term relationships and longed for love. Economic precariousness made it more or less impossible to plan for the future. The many trainings targeting them did not provide the job opportunities they longed for. Very few of them were hired as peer educators, but they were paid small allowances – not enough to get them off the street. Because their needs were often entwined with their sexual and work lives, such needs were impossible to address in standard support group settings, not least because most of them preferred to keep their HIV status secret from other sex workers who might steal their clients.

According to the interviews we conducted with support group leaders and counsellors at LVCT and Kenyatta National Hospital where MSM clinics and support groups were operating, the particular challenges faced by male sex workers, especially in comparison to MSM who did not engage in sex work as their primary means of income, was the main reason for separating the two for support group meetings. They also reported that it was almost impossible for clinic-based support groups to meet the economic and psychological needs of male sex workers, which tended to exceed their financial resources and expertise. The main objective of clinic-based support groups was to encourage adherence to antiretroviral treatment. In all of the health facility support groups we observed, adherence was normalised to such an extent that participants were routinely reprimanded when they shared stories about failing to take their medicines as directed (Igonya & Moyer, 2013). Yet the precarious living circumstances of many sex workers, which often involved the lack of a permanent domicile and work-based pressure to consume excessive amounts of alcohol, made it difficult for them to take a pill every day at the same time, let alone follow the other prescriptive practices of positive living: eating a balanced diet, avoiding alcohol and tobacco and avoiding stress. In fact, our observations of the men like Carol who worked at Freedom Corner suggest that rather than living positively, most of them were were just getting by, living negatively as it were, and quite precariously at that, albeit with impressive economic and psychological support from one another. They routinely drank cheap alcohol to excess, smoked cigarettes, skipped meals, slept rough, and engaged in unsafe sexual practices, including forced and group sex in contexts where their agency was extremely constrained. These were not issues that treatment-oriented support groups were capable of handling.

In the support group and training sessions for male sex workers that we observed, opportunity was rarely given to participants to engage in discussions related to the above topics or topics otherwise meaningful to them (Igonya, 2017; Igonya & Moyer, 2016). Instead, they were regularly subjected to informational sessions that adamantly underlined the need for treatment adherence and using condoms at all times to avoid re-infection – information they could have recited by heart and often did impart to one another at Freedom Corner when men like Carol encountered health crises. Given the lack of an institutional space where their economic and psychological needs could be adequately addressed, the male sex workers at Freedom Corner came together to support one another.

**Freedom corner: community-led support for male sex workers**

HIV positive male sex workers faced a triple stigma in Nairobi due to their HIV status, their sexual practices, and the way they earned a living. They were vilified in the media and by religious leaders. Those who were open about their sexuality were targets of verbal and physical abuse from fellow citizens. At odds with Kenya’s pragmatic public health approach to combating HIV infections among key populations, the country’s anti-sodomy and anti-prostitution laws meant that police routinely harassed the male sex workers at Freedom Corner. In addition to homophobia and the threat of police harassment, male sex workers who were HIV positive reported being stigmatised in health care settings and among family and friends, many of whom blamed them for their infections, as well as among their colleague sex workers, who regularly used knowledge of another’s HIV status to steal clients.
Freedom Corner provided a place where male sex workers could meet with one another in a relaxed atmosphere. There was much laughter (and occasionally tears) in the evenings as people greeted one another and caught up on each other’s news. During our research at Freedom Corner, HIV was rarely spoken about directly or in public health terms, but this did not mean that they were not aware of the HIV risk inherent to their jobs, of the consequences an HIV positive diagnosis would have on their ability to earn a living, or of the HIV-related illnesses that some of their colleagues suffered. It was not uncommon for those who were on treatment to announce when they were taking their pill, swallowing it with a flourish, a sheepish smile and a sip of warm beer. Discussions about how to provide care and economic support to those who were ailing or those who had been recently initiated on antiretroviral treatment were also common. Because many of the men could not turn to their families for support when they were ill, they considered the support group the only family they had. As one member, Gladwell, told us:

You know this is my family. Today it is me and tomorrow it could be someone else … Also, this person could help you in other ways. We are all in the same business, he could be sick today and I may be sick tomorrow; I have to help because one day I may need help. If I do not help who will help me?

In most cases, the men at Freedom Corner offered more comprehensive care and support to one another than most economically marginalised families can offer kin in Kenya (Moyer & Igonya, 2014). When members were visibly sick they would be encouraged by their peers to seek out the readily available HIV services or encouraged to take their antiretroviral treatment. Discussions about caring for those who were sick focused on visiting and psychological support, as well as helping to ease the economic burden by buying food for those who did not have money, paying hospital bills, taking in those who were homeless and, in the worst case, contributing towards funeral expenses. The men also received and provided one another with nursing care and direct monetary support when needed, despite most of them having serious economic and skill limitations.

During the period we conducted fieldwork, we witnessed the support group come together to save the lives of three different colleagues, taking them to hospital, paying hospital bills, providing food, and nursing care while in the hospital, and making sure they were housed with other members when they were discharged from the hospital and cared for while recuperating. Rather than berating those who had stopped taking their antiretroviral treatment (as normally happened in clinical settings, where those with poor adherence might be denied future treatment), they supported them to continue with treatment and helped them to navigate barriers to be reinstated in treatment programmes. They fully recognised the challenges to adherence for those who were unhoused, depressed or dealing with substance abuse issues, and would offer encouragement instead of disparagement. When they failed, as with Carol, they were bereft and often angry.

When one young man started taking antiretroviral medicines and his skin turned darker as a side effect, he grew fearful and abandoned the drugs, taking off to the village. His colleagues went after him and supported him to continue with medication. In another case, they extended financial support to the mother of a member who agreed to take care of her son following the request of his fellow support group members. According to Katrina, ‘We do not want his mother to feel we have given her a burden … so we contribute some money every week and at the end of each month we send it to the mother until he gets better.’

The care that members of the Freedom Corner group provided to one another was exceptional, exceeding what their families, public health facilities, or privately-run clinics offered them. This was partly a consequence of economics. Given the marginality of male sex workers’ day to day lives, the thing they most often needed when they were ill and unable to work was economic support. None of the HIV programmes providing services to MSM could offer cash to their patients, and rarely could their families do so. In fact, most of the sex workers would send money to relatives when possible. But it was also because clinic-based programmes did not always have the expertise or knowledge to address the specific challenges confronting HIV positive sex workers, challenges that went well beyond physical health.
Conclusion

Ending AIDS among MSM in Kenya will only be achievable if these economic and specific psychological challenges are taken seriously. We would argue that support groups led by fellow MSM who have experience with sex work such as HOYMAS and the one we observed at Freedom Corner are much more likely to achieve this than are state or NGO-run programmes which do not involve peer experts in support groups. The quality of support, care, acceptance and love that peers are willing to provide to one another will be difficult to replicate in routine clinical settings, a fact which seems particularly important as Kenya prepares to roll out universal health coverage and absorb many of its successful key populations programmes into public sector health services (Jay et al., 2016).

As this article goes to press, the HIV care landscape in Kenya is once again in transition, and once again this can be linked to a change in leadership in the United States. The Trump administration implemented several executive decisions in 2017 which will limit possibilities of spending US funds to prevent HIV among sex workers. HIV funding has also been curtailed overall, and to date the White House has failed to appoint an advisory committee on HIV. Internationally, UN agencies, including the World Bank and the World Health Organization are pressuring Kenya, which has been re-categorized as a middle-income country, to invest greater national resources in health care via its national insurance fund and a universal health coverage plan. Simultaneously, the growth of social media and an increasingly dissatisfied educated middle class has led to growing demands for better public health services, inclusive better pay for doctors, nurses and other health workers. According to many, including Kenyan queer activists, public tolerance toward MSM has also improved, and the Kenyan High Court is currently deliberating a case to decriminalise homosexuality, with Mathenge as the lead complainant.

As the Kenyan state and civil society organisations re-position themselves to respond to these various shifts, we would encourage them to keep in mind the specific needs of MSM and other socially marginalised people, including sex workers, drug users, prisoners and people living with HIV. Historically, universal health plans have often succeeded in providing basic services for the economically marginal while continuing to exclude the socially marginal. Given the number of socially marginalised people who are infected with HIV in Kenya, the state must consider how these people will be reached if HIV services are absorbed into mainstream medical care.

In this article, we have argued that the emergence of new statistical evidence, combined with shifting donor funding streams, local activism, and international pressure have combined to change the state HIV response in Kenya over the last decade. Previously, little effort was put into targeting what have come to be known as key populations: MSM, sex workers, and injecting drug users. Today, Kenya continues to be driven by a strong nationalist desire to end AIDS in the country by stopping new infections, particularly among the newly defined high risk groups. Although statistical evidence also makes visible higher risk among the middle classes, comparatively less effort has been made to target them. We have suggested that this is because both donors and the state continue to see HIV as a disease of poverty and because it is much easier to recruit street-based male sex workers for intervention projects and studies.

Our research has also shown that while there are more HIV-related services available to MSM and male sex workers in Nairobi, the services on offer often fall short of providing the economic and psychological support that most male sex workers would need to remain adherent to HIV medications taken for treatment and prevention. If the objective is truly to end new infections among MSM in Kenya as a key component of the national effort to eventually end AIDS in the country, then greater effort will be required both to reach middle class MSM who rely on their class position to maintain their privacy, and to provide more comprehensive services to male sex workers, ideally by working together with community-led initiatives like the one we documented at Freedom Corner and at HOYMAS. HOYMAS, in particular, which opened its own clinic 2017 and began offering a wide range of health services to MSM, inclusive HIV and STD services, offers a very good model of a community-led intervention. Because they work with sex workers however, their funding from the United States is in jeopardy.
Notes

1. ‘Inactive’ is the preferred term used by sex worker activists who are not currently engaging in sex work to support themselves. As is commonly said among them, ‘once a sex worker, always a sex worker.’
2. Carol is a pseudonym, self-selected by the research participant. In our work we employ female pseudonyms for male sex workers (at their suggestion), while using the pronouns he and him. The objective is to invoke the gender play and fluidity we often observed in practice during our research.
3. Health Options for Young Men on HIV/AIDS/STI.
4. Sex Workers Outreach Programme.
5. These two groups are combined under one heading with the assumption that men who contract HIV in prison do so as a consequence of having sex with men, either by choice or force.
6. The making up of key populations also justified continued spending on prevention activities just as funding streams were being diverted to antiretroviral treatment.
7. Although Prof. Orago is no longer the director at NACC, he was not dismissed for his vocal support of key populations programming.
8. This collaboration has since dissolved.

Acknowledgements

We would like to thank John Mathenge and the men from Freedom Corner for their assistance with this research. Additionally, we would like to thank Dr Sobie Mulindi from the National AIDS Council, Dr David Bukusi from Kenyatta National Hospital and Lucy Mung’ala, who previously worked at LVCT. We would also like to dedicate this article to the memory of Fabian Wangare, the one we could not save.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by H2020 European Research Council [grant number 647314]; Nederlandse Organisatie voor Wetenschappelijk Onderzoek [grant number W 01.65.317.00].

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