

## Article

# Sexual Health and HIV/STI Risk in Gay Refugee Men in Nairobi, Kenya: A Qualitative Study

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**Abstract:** Refugees are often without financial support and some resort to survival sex. Some of these men are gay or bisexual who fled their countries because of actual or fear of death and other persecution, exacerbated by the criminalization of consensual same-sex practices by life imprisonment or death in extreme cases. We conducted qualitative interviews with 12 gay and bisexual men within a larger sample in Nairobi, Kenya, who engaged in survival sex. Thematic analysis indicated eight main themes: Physical dangers, sexual assault, lack of rights and recourse to justice; Emotional difficulties of sex work; Seeing treatable STIs as “normal”, but others like Hepatitis B and C as abnormal, and HIV as the most feared; Recognition of penile symptoms but concerns about sexual health including anal symptoms, such as fistulas and bleeding; good knowledge about HIV but confusions over PEP and PrEP, self-testing, health access to NGO clinics and some hospital clinics but concerns about stigma and discrimination in public clinics generally; and as a result of concerns about public healthcare settings, use of pharmacies for treatment. The data indicate that male refugees from gay repression, as found for refugees from other repressions, face many of the same issues with local variations.

**Keywords:** HIV; STI risk; gay and bisexual men; refugees



**Citation:** Misedah, L.; Ross, M.W.; Wambua, S.; Schick, V. Sexual Health and HIV/STI Risk in Gay Refugee Men in Nairobi, Kenya: A Qualitative Study. *Venereology* **2022**, *1*, 9–22. <https://doi.org/10.3390/venereology1010003>

Academic Editors: Myron Christodoulides and Jacek C. Szepietowski

Received: 1 November 2021  
Accepted: 2 December 2021  
Published: 10 December 2021

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## 1. Introduction

The National AIDS programs and frameworks recognize male sex workers in Kenya as Key Population (KP) because of their high risk of HIV [1]. The sexual health issues faced by sex workers are also well-known and considered occupational risk and safety factors [2]. For example, sex work was associated with a seven and a half times higher risk of unprotected anal intercourse (UAI) with HIV seropositive or unknown status men [3]. Gay and Bisexual male sex workers may belong to one or more stigmatized groups, which may increase their vulnerability to discrimination and extreme violence because of laws and policies that criminalize both consensual same-sex practices and sex work. These factors may also contribute to high-risk behaviors, for example, unprotected anal intercourse (UAI), thus increasing the vulnerability to HIV and other Sexually Transmissible Infections (STIs) [4].

Significant evidence exists of male sex workers who have sex with men (MSSM) sex in East Africa and their disproportionate burden of HIV. For example, a prospective study of 507 MSSM in Nairobi found an HIV prevalence of 40% [5]. The study suggests high risks and vulnerability of HIV among MSSM within the region. In addition, [6] interviewed 26 male sex workers within a sample of 136 sex workers in Kenya, South Africa, Uganda, and Zimbabwe. They found violence, payment refusal, and fear of reporting abuse because of criminalization and police impunity. These factors produced a highly toxic social and emotional environment. As a result, sex workers have no recourse to law, suffer abuse

from the community, including public attacks associated with religious fundamentalism, and are accused of being “not human.” The participants noted that this extends to health services and felt that no one wants to help sex workers.

Although there was no data particularly on MSM refugees, studies of MSSM in Kenya indicated higher HIV and STI behavioral risk factors among MSSM when compared to other MSM [7]. However, various subpopulations may have unique unmet or unknown needs. These studies thus suggest the importance of assessing MSM refugees’ needs and how the intersection of their multiple identities interact with other variables to increase the HIV/STI risk for MSSM refugees. There are also clear differences between refugees from different origins in the same setting, probably relating to recency and vulnerability. Stigma, discrimination, and social and economic marginalization are based on fears, misunderstandings, and stereotypes about refugees. The experiences were like that of participants in our study who experienced multiple-layered discrimination, including ostracization, aimed at refugees, particularly at Ugandans [8]. These factors were also explicitly noted by [9] in a comprehensive review of refugees’ access in conflict-affected settings to sexual and reproductive health services, with most studies reviewed coming from Sub-Saharan Africa (SSA). The review highlighted widespread violence and human rights violations and difficulties accessing scant health services due to stigma, discrimination, and criminalization that affected sex workers’ capacity to engage in HIV/STI prevention and access sexual and reproductive health services. Additionally, in the challenging social and healthcare climate, for male sex workers, there is a double stigma of being sex workers and gay refugees, and sometimes HIV status adds additional layers of this discrimination. In addition, if there is an unfamiliar language, the inability to communicate well may also contribute to the multi-layered stigma.

There has been press coverage of refugee male sex workers in Europe [10,11], but few in-depth studies of gay refugees, particularly those males who engage in sex work in SSA. While there has also been much more focus on (MSSM) during the HIV pandemic, with indications of refugees having to have recourse to sex work to survive, most of that focus has been in Europe. Yet not so much is known of refugees’ situation, specifically asylum-seeking gay and bisexual refugees, while awaiting their asylum, refugee, and relocation applications. The position in limbo can last an average of four years, as identified by our larger study [8].

Therefore, this qualitative analysis aimed to describe the sexual health and HIV/STI risk experiences of gay and bisexual refugee males who engaged in sex work in Nairobi, Kenya. Understanding these experiences in this sub-population of MSM is critical for developing and implementing comprehensive targeted programs and interventions to decrease HIV/STI risk among MSSM.

## 2. Methods

### 2.1. Study Design

The study analyzes a subset of qualitative research conducted in early 2020 with 19 MSM asylum seekers and refugees in the Nairobi Metropolitan Area in Kenya. The broader study was part of a continuous assessment of the health needs and experiences of sexual and gender minority (SGM) asylum seekers and refugees in Kenya. The researchers conducted the formative evaluation with community partners and developed an interview guide adapted from the Life Story Interview (LSI) [12]. LSI is a semi-structured in-depth interview guide that follows the format of book chapters to describe various stages of life history. The researchers pilot-tested the initial interview guide with participants and later revised it to ensure ease of interview flow (more details at Supplementary Materials). However, researchers ensured they allowed the participants to freely share their stories with minimal interruption and only used the guide to follow up and probe for some of the questions to answer the research aims. This paper analyzes HIV, STIs, sexual health, and other risks associated with sex work among MSM asylum refugees in Nairobi.

## 2.2. Participants

Individuals were able to participate in the study if they were (a) 18 years or older (b), MSM (c), identified as an asylum seeker or refugee (as defined by the 1951 Refugee convention which describes refugees as individuals forced to run away from their country of origin because of actual or feared abuse because of race, religion, nationality, membership in a social group, or political opinion [13]) (d) resided in the Nairobi metropolitan area, and (e) able to communicate in English or Swahili. Therefore, the study focuses on the experiences of  $n = 12/19$  (58%) subsample who described engagement in survival sex for money, food, or sustenance and other basic needs.

## 2.3. Recruitment

The researchers collaborated with the local partners to advertise and identify potential participants for the study. The study coordinator then screened those who were interested in the study for eligibility. Those who were eligible underwent the consent process. The research team debriefed daily and stopped recruitment after agreeing we had reached “saturation,” with no new information emerging from the data.

## 2.4. Data Collection and Analysis

The PI conducted in-depth anonymous interviews in English and Swahili. The interviews were audio-recorded with two records as a backup to prevent data loss. The interviews were an average of 92 (SD = 16.1) min. All interviews were conducted at a suitable location and time to ensure participants’ safety and comfort. In addition, the research team provided meals for participants, transportation where needed, and 1000 Kenyan Shillings (about \$US 9.00) compensation for their study participation.

The PI and an independent consultant transcribed the data verbatim to MS Word. After this, they were checked for accuracy and to remove any identifying information. Then, data were analyzed using Nvivo 12 plus following Braun and Clarke’s six-step thematic analysis framework [14].

## 3. Results

Among the MSSW, the average age of participants was 28.08 (SD = 6.1). Most participants were from Uganda  $n = 11/12$  (91%). One participant  $n = 1/12$  (8%) had completed elementary school,  $n = 2/12$  (17%) Secondary (O-level),  $n = 4/12$  (33%) Secondary (Advanced-level) and  $5/12$  (42%) college or higher education (See Table 1).

**Table 1.** Demographics.

Description	<i>n</i>	%
Age		
18–24	4	33%
25–34	5	42%
35–44	3	25%
Country of origin		
DRC	1	8%
Uganda	11	92%
Status		
Asylum seeker	1	8%
Refugee	11	92%
Duration in Kenya (in years)		
1	4	33%
4	2	17%
5 or more	6	50%
Education		
Primary or lower	1	8.33%
Secondary (O-level)	2	25%
Secondary (A-level)	4	33.33%
College or higher	5	33.33%

We identified five major themes from the participant's in-depth descriptions of their lived experiences as MSM refugees and asylum seekers in Kenya. The themes included: (a) refugee status and financial constraints, (b) physical dangers, (c) lack of rights and justice, (d) HIV/STIs, (e) HIV prevention (Condom use, Pre-exposure Prophylaxis (PrEP), and Post Exposure Prophylaxis (PEP)), and (f) access to health services. Participant code number follows each quote in parentheses.

### 3.1. Refugee Status and Lack of Income

Most participants fled their home countries without their property and little or no money. Therefore, they were dependent on financial assistance from well-wishers and the government to meet their basic needs while in Kenya. However, while the financial aid was significant in meeting some of the basic needs in the host country, HIAS discontinued the cash assistance for the refugees. Most participants, therefore, had few opportunities to support themselves. Because of the financial challenges, they thus engaged in sex work to meet their basic needs, including food and shelter. As some of the participants expressed:

We used to get 6000 [shillings] a month from HIAS [HIAS Refugee Trust of Kenya]. In 2018, HIAS decided to cut the funds. There is no more assistance for LGBTI. You had to pay rent and other fees. It was very hard. I decided to involve myself in sex work. I did that in Nairobi here. But it was very dangerous. (Participant 01, 26 years)

Another participant described how discontinuation of the cash assistance impacted their lives:

This is the thing because I've tried my level best too. Cause they were giving us some financial assistance, but it reached the extent when they told us that they were no longer giving out financial assistance. So, for us to stay in Nairobi, we had to sustain ourselves. You must pay rent, you have to eat, you have to dress, you have to drink water. So you have to end up in sex work in that I've tried several types of tips here. (Participant 05, 26 years)

Most participants faced economic constraints that manifested in hunger. Food insecurity, therefore, significantly coerced them into sex work. For example, one participant described the challenges he faced in meeting his essential needs and engagement in sex work as their only choice of survival:

So, providing food and other essential needs in the house is really a tug of war. Personally, sometimes I go to the clubs, going to the streets around Nairobi trying to look for men. I mean men who can have sex with me, and I earn a living. So, I became a sex worker, not because I wanted, but because I needed to live. I need to make a living in Nairobi. I don't have any other income. I don't have money to buy anything, especially the essential ones. (Participant 06, 41years)

Participants' stories highlight the economic constraints, poverty, and food insecurity as some of the drivers for engagement in sex work. While finding a job was necessary for meeting their needs, they faced various challenges, including poor employment opportunities and double employment discrimination because of their refugee and MSM status.

### 3.2. Physical Dangers

All the participants described experiencing various forms of repeated physical and economic violence. The violence included increased vulnerability to physical abuse, economic disfranchisement, and death threats experienced at their client's homes. For example, some of the clients refused to pay them for their services and physically assaulted them. Some clients also threatened to kill the participants and took their belongings, including cellphones or wallets, leaving them stranded or walking long distances to go back to their homes. As a result, some participants were scared of being exposed and further attacked by other community members. For example, one of the participants described his experiences of both physical violence, blackmail, and death threats from his client:

I decided to involve myself in sex work. I did that in Nairobi here. But it was very dangerous. You go there. You can get a client. You go with him, you bargain, I'm going to get this amount reaching there as they are blackmailers, they beat you. They take everything. As you get another one [he] takes you to his home, they stay two or three in the house, but they all want to use you. But since you are already in the house. You cannot do anything. If you do anything, they say we are going to kill you. You agree. Then they do everything they want; they end up not paying you like that. (Participant 01, 26 years)

Participants also experienced frequent forms of sexual violence that included sexual abuse and gang rape by their clients. In addition, several participants described being forced to have sex with other people other than the clients they had negotiated with, who also verbally and physically abused them. For example, one participant described his sexual assault incident when he visited his client:

I got a client, we agreed about the money and then he sent me the money for transport. He told me to use the money I had, and he would give it back to me. I told him I had no money, and he told me to look for the money from some friends. So, I found the money and went. What I found there, they used me [had sex with me], three guys and they say that they won't pay me, I am in their country. They can do whatever they want. They said we were not going to pay you. Do whatever you want. We are not going to pay you. Then they started beating me. (Participant 06, 41 years)

The narratives describe the dangers of sex work and how the violence, including sexual violence, increased participants' risk of sexual trauma, psychological distress, and STIs, negatively affecting their health and wellbeing. These narratives highlight the need for various support mechanisms to ensure safe working spaces, access to appropriate services needed, economic empowerment opportunities, and peer support to decrease the risk of HIV and other STIs.

### 3.3. Lack of Rights and Justice

Laws, policies, regulations, and enforcement practices that criminalized sex work exacerbated, and The Kenyan laws and regulations outlaw same-sex practices and sex work. The criminalization created negative attitudes and norms that promoted multi-layered discrimination, violence, and abuse of refugee MSSMs. For example, some participants highlighted further ostracism by some clients who called the police and accused them of trespassing into their homes. They were therefore threatened with prosecution and deportation:

He fucked me at night, and he did not want to give me my money. He told me, "I'm a Kenyan." So, he tried to [not to pay] when we were talking. So, he went out, and he locked me inside. So, I was there. I saw the police; he came with the two guys who took me to the police [station]. They told me that I was a thief who had just gone and broken into someone's house. I told them this guy was the one who called me. They didn't want to help me, they told me I was bad, and because I am Ugandan, we will take you back to Uganda, ugh! Like that. (Participant 11, 26 years)

Additionally, some participants expressed fear in reporting sexual abuse to the police because they feared seeking justice against the perpetrators of violence, placing them at further risk of being harassed, detained, and charged with engaging in sex work, which was outlawed:

It happened to me. It was in Kasarani. I was beaten. You cannot go to the police here in Nairobi that you are reporting such a thing. You cannot. I used to cry even in my house. I said, no, I'm doing this. I can't do this. (Participant 01, 26 years)

These narratives highlight no recourse to police or justice for MSM refugee sex workers. On the contrary, MSSM continued to experience violence, arbitrary arrest, and further

threats and discrimination. There were also dangers associated with the probability of being accused of other forms of crime, e.g., trespassing or theft, by clients, further risked exposure to violence, and threat to fair treatment and protection by the authorities and judicial system.

#### 3.4. *The Emotional Difficulty of Sex Work*

Because of societal, cultural, and religious norms and beliefs that outlawed same-sex practices and sex work, some participants had trouble with their identity as sex workers. Some, therefore, struggled to reconcile their identity as sex workers and exhibited internalized stigma against sex worker identity and how they perceived themselves:

I go on my phone and look for someone who can give me some money. I go we have sex, and he [client] gives me something to eat. It sounds like crazy it sounds like I am a sex worker; I don't want to use that word like I am a sex worker; I feel bad. I should be doing sex for happiness. I should not be doing sex to get what to eat. Sometimes, you don't know the challenges you will get; you even force yourself even when there is no love so that you can make something to eat. (Participant 09, 36 years)

Some participants also described psychological distress because they were forced to have sex with people that they were not sexually attracted to. As one participant explained:

The first challenge, you may find a customer or a client or customer. First of all, you do not have any feelings for him. But when you have to have sex with him because you need the money, you know? (Participant 13, 24 years)

Because of the stigma and discrimination, some participants expressed fear of rejection if their partners found out they were engaged in sex work. For example, one participant described his guilt after engaging in sex work to pay his rent and how he withheld the information from his partner because of the fear of possible rejection or ostracization:

But then I really, really, really needed rent. So, I hooked up on Grindr. And then I told the person, you know what, I want money. Because I want to pay my rent and could you please. So, I said the person before I even met the person. So, it's something I've really tried to erase from my mind, but I know I've never done it. I should just own it. And I would want to disclose to the boyfriend. Yeah. Like to say things, like I did this or something. Yeah. I'm like less proud. But it saved me. (Participant 17, 24 years)

The participants' narratives highlight the nexus of various intersectional factors, for example, food insecurity, stigma, and how engagement in sex work created emotional distress, including anxiety of their loved one finding out about their work. In addition, some experienced overwhelming psychological pain because of unpleasant sexual experiences and felt worthlessness and shame for their sex work. The findings, therefore, suggest the need for behavioral skills, knowledge, and social support needed to overcome and deal with unwanted stigma.

#### 3.5. *STIs and HIV*

Refugee MSSM have a heightened risk of HIV and other STIs because of sexual risk, social, and structural factors that may affect their effectiveness for HIV and HIV or other STIs prevention. For example, although participants expressed the desire to have safer sex with clients, some experienced client resistance and financial inducements enticed them to accept more money for nonprotected sex. Sex work also included having sex with multiple partners with unknown HIV or STI status, thus heightening the risk of infection. For example, one participant highlighted Hepatitis as one of the significant challenges they faced:

The ordinary STIs. Our biggest issue is that Hepatitis that is eating us Hepatitis B and C. Listen, KAVI tried to help us get vaccinations, but now I don't know

whether their project is on. But you see, they have their studies, and only the people involved can benefit. (Participant 02, 35 years)

He also continued highlighting some of the common STIs he had been diagnosed with and psychological distress caused by the fear and worry about HIV infection:

The normal STIs I have been diagnosed with syphilis at some point diagnosed with gonorrhea. Some of us were so much scared of STIs (Sexually Transmitted Infection). The normal STIs HIV was my biggest worry now at that time. (Participant 02, 35 years)

Some participants also described being forced to hide their STI diagnosis from their partners. For example, one participant said, "Health problems it was my secret. I had gonorrhea, yea, but I think I got that Gonorrhea from outside the relationship. So, I thank God, I got you done am now okay" (Participant 9, 36 years).

### 3.6. STI Symptoms

Participants described various STI symptoms, which included penile discharge and anal discomfort and swelling. One participant described how his experience of penile discharge increased his anxiety and led to screening, particularly after his knowledge of increased susceptibility to HIV because of STIs:

So, when I went to the toilet, I saw some white thing coming out when I was peeing. It scared the hell out of me. And then I was getting all this knowledge about it. But then it showed me the same thing with HIV, so I had to get tested. (Participant 17, 24 years)

Another participant described being forced to engage in unprotected intercourse to get transportation home, which resulted in anal swelling, "And you are there, you need that money. Sometimes you even have no transport back home, you say let me risk, God knows. So, I got some swelling behind, and it took me months to heal it" (Participant 10, 23 years).

Sexual violence can also lead to HIV, STIs, and other injuries. In addition, if untreated, some of the injuries and STIs can result in health complications that may increase the additional risk of getting and transmitting STIs and different adverse health outcomes. For example, one participant described his experience of anal fistula that resulted from rape and lack of adequate care for his condition:

You can't refuse because he paid you so that you could do sex. From there, it can harm you or your life. And then another thing. It can bring sicknesses such as anal fistula, HIV, STIs, yeah! . . . But about, um, this sickness of anal fistula, they said they cannot help me. I'm still looking for somewhere or another organization to help me because it's also a huge issue. (Participant 08, 21 years)

Another participant highlighted some of the STIs risks and consequences of various occupation risks. For example, he described experiencing anal bleeding while having intercourse as a result of his sexual assault:

So, it's like gonorrhea, some of them like syphilis because when you reach here, you just do sex work. And you just get diseases. And even my ass, I told you they raped me, so even now, I don't know if it will be okay. I don't know. So sometimes, if they fuck, it can become bloody, things like that. (Participant 11, 26)

Participants' descriptions of experiencing STI and their symptoms indicate that STIs were significant. MSSM refugees and asylum seekers may have a heightened burden of HIV and other STIs, including syphilis and Hepatitis B and C. While some exhibited STI symptoms, some STIs may be asymptomatic. Thus, those with no signs of infection may not know their illness and increase the risk of infecting others or getting other STI co-infection. Additionally, the STIs symptoms may present in anatomical sites that some could be unaware of. The narratives thus underscore the need for comprehensive screening for effective diagnosis, treatment, and prevention of HIV and other STIs. Finally, popular

mythology about Hepatitis B and C protecting from HIV, and some confusion between PEP and PrEP, indicates areas where patient education may be appropriate.

### 3.7. HIV Prevention (Testing, PrEP, PEP, Condom Use)

#### 3.7.1. Condom Use

Although some participants expressed self-efficacy for negotiating condom use, the participants described force, deception, and threat for unsafe sex. For example, some clients threatened them with violence and harm. As a result, some of the participants were forced to have condomless sex:

Then another one, we went, we had agreed that we should use condoms, he said yes. Reaching his apartment, he was like, Okay, let's have sex. Then I was like, crazy. And he said no because he needed to pay me, so he didn't need to use a condom. And I was like, no, but we agreed. So, I try to be polite to the people most of the time, but they can't understand, they are not, this is my money that you are joking with. So, I was already in his apartment, and he had a lot of dogs outside, so he was like, if you try to go out of that door, my dogs will kill you. So, I ended up having sex with him. (Participant 06, 41 years)

Another participant described inconsistent condom use, including with people unknown HIV or STI status, and the coercion of some clients with higher pay for condomless sex:

Not many times would I be prepared. Sometimes we would not use condoms. You just have sex with a person, and you don't know his HIV status and sometimes take a PrEP medication. So, you find that I'm unsafe if the person is HIV positive or probably blood contact. And aside from that also, there are times where we could use the condoms, but it's not a must because you find that there are some clients who tell you that me, I don't want a condom, but I'm giving you this much, and we look at it, it's almost what you earn per month. So, I would easily give in cause I know how to do it cause these what you call a PEP medication. (Participant 04, 26 years)

The participants' stories highlight the intersectional link between food insecurity and how it leads to increased HIV and STI risk behaviors. Clients cited normative beliefs, for example, reduced pleasure for condomless sex, threatened MSM with violence when they asked to have protected intercourse, or coerced them into higher pay for condomless sex, which increased their risk of HIV and other STIs. The stories underscore the need for outreach to ensure targeted interventions that equip MSMW refugees with adequate behavioral capability and self-efficacy for effective HIV and other STI prevention.

#### 3.7.2. PrEP

Participants indicated knowledge and willingness to use biomedical interventions such as PrEP. For example, some of the participants described experiencing initial side effects. However, they continued to have the willingness to take PrEP as part of their prevention practices and their access from some of the local MS led clinics and initiatives in Nairobi:

It was actually in August last year; now, it is like five months that I have been taking PrEP. When I started taking them, I was not feeling okay. I felt like I needed to take a lot of water, and I wanted to vomit; they were not good for my health, but they told me to keep on keep on you will get used. I got used now life is normal. I take my PrEP very well, and I hope I will keep on. I get PrEP from Hoymas, but I was advised, but in case they get finished, I go to a nearby hospital, and that is what I do. (Participant 09, 36 years)

Despite experiencing some side effects, some participants described routine PrEP access and continued risk reduction, including condom use for enhanced HIV prevention:

I went to HOYMAS (HOYMAS is a MSSW led community-based organization (CBO). They have a clinic that offers HIV/STI prevention (testing, PrEP, PEP)

and anti-retroviral for their clients with HIV.) [Health Options for Young Men on HIV/AIDS/STI], they told there if you fall sick, have any sexual disease, you can come and get it, you can be treated here. So, I used to go there. Then they also told me about PrEP. They said if you are sexually active, you can use PrEP, but you have to also condoms. Yeah. So I used to go for PrEP since 2016, the time I started survival sex here in Nairobi. (Participant 01, 26 years)

### 3.7.3. PEP

The ability for participants to continuously take PEP depends on their knowledge and understanding of the importance of adherence for effectiveness. Participants described various local service providers that provided peer education outreach to increase PEP uptake, particularly for survivors of sexual assault:

We have clinics like HOYMAS. We have LVCT, Sokoni arcade, and other hospitals. Like Kawangware SWOP clinic. So just in case of such cases, they can meet with the peer educators that can lead them up to the doctors. The peer educators can also follow up on their patients to see if they were really sexually violated. Uh, with the help of the medical doctors, they can be given what we call the PEP medication to suppress the virus in their body just in case they were sexually violated. (Participant 04, 26 years)

Although participants expressed some awareness and knowledge of PEP, in general, some described the knowledge gap as some participants confused PrEP and PEP interchangeably:

I've been trained to use lubricants, but right now, they're no longer available; the lubricants. So you have to use condoms, and if you have any condom burst, you have to be there. This thing, cause they, that's when I don't know how to verify this because they say PrEP and PEP. PEP, this is the thing that when you're at risk of getting HIV, and it helps, when you know you have got any condom burst with the person that you don't know their status, then you have to take it for a whole month so from there, yeah. (Participant 05, 26 years)

### 3.7.4. Testing

Although participants expressed the availability of some local MSM-led service providers that provided testing services, some of the services were not particularly sensitive to the specific needs of refugees and asylum seekers. Nevertheless, some refugees benefited from the increased expansion of HIV prevention services, including self-testing kits. However, some participants lacked the self-efficacy to adequately conduct the test, resulting in false-positive results and increased psychological distress:

I used the self-kits. So, then I tested myself. I actually told everyone; I'm going to test myself with the self-kit. And then, when I checked the result, they were positive. So, I fidgeted. And then I had to run very fast because the doctor told me, like when I was removing the Swipe, I touched where you're supposed to rub in the gums, so I contaminated it. So, yeah. So, I got scared. (Participant 17, 24 years)

Because of the heightened risk of HIV and other STIs and structural barriers, including economic constraints that may affect MSW refugees from adequately accessing frequent HIV and additional STI testing, there is a need for increased programs for self-testing. However, the programs require practical training for using the kits, adequate linkage to care for further or confirmatory tests, and appropriate links to care for those with positive results.

### 3.7.5. Healthcare Access

Participants accessed services mainly from MSM-led clinics or other MSM-friendly healthcare providers in Nairobi. However, some participants expressed the hesitancy by some of the clinics in providing care to those who were undocumented:

But now, here you are, even Hoymas might be scared of looking after someone not registered with UNHCR (United Nations High Commission on Refugees) because they feel they might be blacklisted for helping someone who is not registered to be in the urban center. So sometimes they will not touch that person. That is the biggest one I would tell people. Where is your alien card? Where is your asylum seeker pass? (Participant 02, 35 years)

Those seeking services from other providers noted stigma and discrimination, which affected their health-seeking behavior. For example, one participant said, “Nearby hospitals will not help you. They are homophobic. You need a hospital that is working on LGBTI. (Participant 09, 36 years)

Another participant described how they self-diagnosed and medicated when they experienced STI symptoms:

No, you see, when I got Hepatitis, I thought I had got a normal disease that could be handled because the problem at times I do self-medication. The problem was because when I feel my dick is itching, I know maybe it is candidiasis, so I get cream, and sometimes it goes. Once I feel some kind of discharge, I get I just go out to the pharmacy or wherever it is. (Participant 02, 35 years)

There are services available for HIV testing, PrEP/PEP, and Hepatitis B and C, but a concern is that these services will be penalized if refugees can't produce proof of refugee status. Participants make a distinction between “normal” (treatable) STIs and viral STIs. Self-diagnosis and medication via pharmacies may be used. Problems may occur taking medication that needs to be taken with food because they may have no food.

#### 4. Discussion

This analysis is the first known assessment of the HIV/STI risks of MSSM in Nairobi, Kenya. These qualitative data paint a picture of multiply disadvantaged refugee MSM forced to flee to their neighboring countries because of death threats from their families and the community and, in many cases, a legal death or long prison sentence encouraged by governments and some fundamentalist religious organizations [15–17]. In addition, upon arrival in Nairobi, they faced layers of discrimination from the criminalization of same-sex behaviors that resulted in widespread victimization and abuse by the police and members of the community they lived in, including other refugees. These factors increased their vulnerability and likelihood of MSM refugees engaging in sex work to meet their basic needs.

There are also apparent differences between refugees from different origins in the same setting, probably relating to recency and vulnerability. Therefore, most MSSM experienced stigma, discrimination, and social and economic marginalization based on fears, misunderstandings, and stereotypes about refugees. The experiences included multiple-layered discrimination and ostracization aimed at refugees, particularly Ugandans reported in our larger study [8]. As a result, they were most likely to have inadequate access to HIV/STI care and treatment because of their actual or perceived fears of discrimination [8,18]. These factors were also explicitly noted by [9] in a comprehensive review of refugees' access in conflict-affected settings to sexual and reproductive health services, with most studies reviewed coming from Sub-Saharan Africa (SSA). The review highlighted that sex workers' capacity to engage in HIV/STI prevention, and access sexual and reproductive health services are severely undermined by social and structural determinants, including widespread violence and human rights violations, the collapse of livelihoods, and traditional social structures. These factors thus increased sex workers' vulnerability to HIV and STI infection [19,20].

Despite increased scale-up of MSM services, MSM were still more likely to have inadequate access to HIV and STI prevention, treatment, and care. For example, Okall et al., 2014 in Kisumu, Western Kenya, reported that 60% of MSM were not comfortable visiting public clinics and that safe and confidential services and health education were required [21]. Similarly, Graham et al. (2015) in Coastal Kenya noted in a qualitative

study of 30 gay, bisexual, and other MSM participants that stigma and discrimination were consistent themes emerging in their study. Their participants used known and trusted providers and very selectively disclosed their gay or bisexual behavior or transgender identity. They also noted that connection to lesbian, gay, bisexual, and transgender (LGBT) organizations, self-acceptance, goal setting, and LGBT social identity and altruism were facilitators of engaging in HIV-related care. As a significant amelioration of these issues, Elst et al., 2013 reported positive outcomes from a 2-day workshop with healthcare workers in Kenya, including sensitivity training to reduce homophobia and increase knowledge of LGBT providers [22].

STIs and HIV are other significant risks in this hostile environment, not least because of clients coercing them into condomless sex, lack of effective lubricants, and lack of recourse to police for justice [23]. Participants distinguished between “normal” STIs such as syphilis and gonorrhea, which were seen as treatable, and “abnormal” STIs such as Hepatitis B and C. HIV was seen as much more life-threatening and feared. In addition, several participants noted issues with anal symptoms, including tears and fistulas. Therefore, services for this key population should include diagnosis and treatment of sexual health issues beyond infections, such as anal damage. Ross, Larsson, Nyoni, & Agardh, 2017 have noted in Tanzania that MSM are prepared to go to clinics with “plausible deniability” of homosexual behavior because symptoms are penile [24]. Where symptoms are anal or oral, it is almost impossible to deny that the patient is MSM, leading to a refusal to treat or negative reactions from the provider.

Additionally, HIV testing is critical for early detection of HIV and linkage to required prevention services. The CDC, therefore, recommends that MSM should get tested for HIV at least once a year [25]. However, Muraguri et al., 2015 observed that more than 60% of MSM in a study of 273 male sex workers had not tested for HIV in the past year. Moreover, compared to MSM who did not engage in sex work, their study also found specific high-risk behavior, including higher receptive and unprotected anal intercourse. However, our study found that MSSW had access to HIV testing. Nevertheless, some of our participants were HIV seropositive, some resulting from sexual violence. On the other hand, while there were efforts to expand HIV testing through the provision of self-testing kits, reliance on self-testing kits while having the advantage of avoiding visiting a clinic or hospital may lead to incorrect use and give false results.

Some researchers have previously reported Kenyan MSM’s willingness to take PrEP. For example, 83% of HIV-negative MSM in a cross-sectional study in Nairobi expressed willingness to take PrEP [20,26]. However, in general, PrEP uptake was low partly because of low knowledge and myths about PrEP [27–29]. This was concurrent with our study, where the participants were also aware of and accessed PrEP and PEP from local MSM clinics and community centers. However, our participants were sometimes confused by an unclear understanding of their benefits and side effects.

Healthcare access was prevented by both refugee status (perceived as not being eligible for public services) and risks of discrimination, rejection, and lack of confidentiality in many clinics [30]. As has also been noted in neighboring Tanzania, this leads participants to seek care in pharmacies by either asking pharmacists what might be appropriate or buying a medication recommended by peers. Nevertheless, many communities and hospital clinics run by NGOs would provide treatment without discrimination in Nairobi.

None of the STI, HIV, and anal damage that participants report can be divorced from the risks of sex work itself, driven by the need for survival sex in an unfriendly environment. Almost pervasive anti-homosexual and anti-refugee stigma and discrimination significantly narrow the number of clinics available and their location. As a positive development, sensitivity training to reduce homophobia and increase knowledge about MSM and other key populations is effective and should be expanded [31].

Physical dangers, sexual abuse, emotional distress, and lack of recourse to justice all play a part in the STI/HIV risks in the setting where these refugee MSSM operate. Furthermore, social and political discrimination amplifies the need for survival sex, leaving

these refugee MSSM with little agency to protect themselves from client coercion. In much of Sub-Saharan Africa, these intersections of factors have generated a specific model for dealing with MSM whose health and human rights are compromised [32].

The study had some limitations. First, most participants were recruited based on their membership or affiliation with the local partner NGOs. Additionally, the findings were self-reported by participants and may therefore have self-reported bias. Nonetheless, the study provides data needed to understand the intersection of various identities, stigma, and discrimination and how these factors increase the vulnerability of MSSM to HIV/STIs [33,34]. Therefore, the study has implications for future studies, programming, and policies to ensure targeted interventions for MSSM refugees in Kenya.

## 5. Conclusions

Refugee MSSM in Kenya are at high risk of STIs (including Hepatitis B and C) and HIV and anal conditions such as fistulas or tears. They are exacerbated by violence, sexual assault, and the inability to insist on sex with a condom. Our data confirm reports in the press and from other sources about refugee MSSM. While these data are from gay-identified MSM forced to flee for their lives by anti-gay violence in East Africa and from a large urban setting, they have relevance to the situation of MSSM who refugees in other parts of the world are also. Expanding STI clinics to extend to sexual health, including anal conditions, and the long but productive path to decreasing homophobia in communities and practitioners will, directly and indirectly, respond to the STI, HIV, and sexual health needs of gay refugee MSM in East Africa.

**Supplementary Materials:** The following are available online at <https://www.mdpi.com/article/10.3390/venereology1010003/s1>.

**Author Contributions:** Conceptualization, L.M., S.W. and M.W.R.; methodology, L.M., M.W.R. and V.S.; formal analysis, L.M.; investigation, L.M. and S.W.; resources, M.W.R.; data curation, L.M.; writing—original draft preparation, L.M. and M.W.R.; writing—review and editing, L.M., M.W.R., V.S. and S.W.; supervision, M.W.R. and V.S.; project administration, L.M. and S.W.; funding acquisition, M.W.R. All authors have read and agreed to the published version of the manuscript.

**Funding:** Funding for data collection was received from the University of Minnesota–Joycelyn Elders Chair in Sexual Health Education.

**Institutional Review Board Statement:** The study was approved by the University of Texas Health Science Center at Houston, School of Public Health Institutional Review Board (IRB) Number: HSC-SPH-19-1090), and the University of Minnesota Medical School, IRB Number: 00000–8209).

**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the study.

**Data Availability Statement:** The data presented in this study are available on request from the corresponding author. The data are not publicly available to protect the privacy of study participants.

**Conflicts of Interest:** The authors declare no conflict of interest.

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