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EFFECTIVENESS OF HIV & AIDS PREVENTION COMMUNICATION CAMPAIGNS: THE CASE OF GAY COMMUNITY IN NAIROBI COUNTY

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DECLARATION

This research is my original work and has not been submitted in any other University for a Degree Award.

ABOOK BRIAN

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This project paper has been submitted for examination with an approval from the following University Supervisor

DR. NDETI NDATI

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DEDICATION

This study is dedicated to all individuals and organizations that fight against spread of HIV and AIDS and advocate for safe sex among the MSM.

ACKNOWLEDGEMENT

LGBT (Kenya) has been so fundamental is ensuring the success of this project that will help drive Kenya towards universal access to HIV testing, counseling and give special attention those with greatest vulnerability to infection and with special service needs, like, men who have sex with men.

I appreciate George Barasa's active participation and contribution towards the success of this study especially in data collection. George Barasa is a vibrant gospel artist in Kenya and a self proclaimed Gay activist working at Positive Attitude Kenya. Not to forget Mitchelle Mwanyumba's significant contribution on related research studies and findings. I wish him success in advocating for adherence to HIV/AIDS treatment among fellow MSM.

Both are members of Cosmopolitan Affirming Church (CAC).

Special thanks are due to Dr. Ndeti Ndati (University of Nairobi) for his supervision on this project.

ABSTRACT

HIV prevalence in Kenya's general population is 5.6% yet HIV prevalence among men who have sex with men (MSM) in Kenya is almost three times that among the general population (17%); regardless of knowledge of safe sex and transmission of the disease. As a result, this study examines the effectiveness of HIV/AIDS prevention campaigns targeting the gay community in Nairobi (Kenya). It assesses the knowledge of HIV/AIDS prevention campaigns among the gay people in Nairobi, attempts to find out the protective measures that MSM employ and investigates the effectiveness of channels of communication being used to reach MSM.

In this study, Theory of Planned Behavior (TPB) is used. The research design applied is exploratory research design. The study is purely qualitative and sample size for this study is 50 MSM. Sampling technique employed is snowball sampling and purposive sampling. Data was collected through in-depth interviews and focus group discussions.

From the findings, high prevalence of HIV and AIDs in MSM is mainly due to insufficient access to HIV/AIDS prevention communication campaigns and MSM-tailored information. Accessing health services and information was undermined by factors such as stigma, discrimination, and laws criminalizing sex between men.

For easy access of HIV/AIDS prevention information, this study recommends that the healthcare institutions should create HIV related prevention and awareness messages that are MSM-tailored. To reduce cases of stigma and discrimination, training modules on MSM health needs and rights should be developed and offered as part of the Continuous Medical Education (CME). Also, it is imperative to remove legal barriers that undermine access to HIV-related services such as laws that criminalize consensual sex between men.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS- Acquired Immune Deficiency Syndrome

CCPR- International Covenant on Civil and Political Rights

CDC-Centers for Disease Control and Prevention

CEDEP -Centre for the Development of People

CME - Continuous Medical Education

EATG: European AIDS Treatment Group

GALK-Gay and Lesbian Coalition of Kenya

HIV-Human Immunodeficiency Virus

IOM- Integrated Biological Behavioral Surveillance among Migrant Female Sex Workers

KHRC- Kenya Human Rights Commission

KNASP-Kenya National AIDS Strategic Plan

LGBTI- Lesbian, Gay, Bisexual &Transgender Intersex

MARPs-Most-At-Risk Populations

MoH- Ministry of Health

MSMGF-Global Forum on MSM and HIV

MSM-Men who have sex with men

NACC-National AIDS Control Council

NPHIC-National Conference on Health Communication, Marketing and Media

NASCOP-National AIDS and STI Control Programme

UNAIDS-Joint United Nations Programme on HIV and AIDS

UNGASS- United Nations General Assembly Special Session on Drugs

UNICEF- United Nations Children's Fund

WHO-World Health Organization

WSW- Women who have sex with women

CHAPTER ONE

INTRODUCTION

1.0 Background of the Study

Report by United Nations Programme on HIV/AIDS (UNAIDS, 2010) shows that 34 million people are globally living with HIV/AIDS. On new HIV infections in America, research conducted by Centers for Disease Control and Prevention (CDC) estimated that approximately 1.14 million persons aged between 13 years and above is living with HIV. Out of them, 15.8% are unaware. Further, it estimates that HIV incidence (new infections) is stable at about 50,000 new infections per year (CDC Report, 2013).

Men who have sex with men (MSM) represent about 4% of the male population in the United States. In 2010, MSM accounted for 78% of new HIV infections among males and 63% of all new infections. MSM accounted for 52% of all people living with HIV infection in 2009. In 2010, the estimated number of new HIV infections among MSM was 29,800, a 12% increase from the 26,700 new infections among MSM in 2008 (CDC Report, 2013).

UNAIDS Worlds AIDS Day Report revealed that Sub-Saharan Africa remains the region most heavily affected by HIV/AIDS since about 68% of all people living with HIV resided in sub-Saharan Africa; yet it constitutes 12% of the global

population. Sub-Saharan Africa also accounted for 70% of new HIV infections in 2010 (UNAIDS Worlds AIDS Day Report, 2011).

Kenya's national HIV prevalence is 7.4 % according to National AIDS and Sexually transmitted infections Control Programme (NASCOP) in 2007. NASCOP report on status of HIV/AIDS in Kenya (2013) indicates that HIV prevalence among adults aged between 15 and 64 declined from 7.2 % to 5.6% percent. The prevalence rises to 61% for those of age group 15 to 49 (UNAIDS, 2012). Correspondingly, awareness of HIV status among infected persons aged between 15 and 64 stands at 47 %, up from 16 %. The report points out that Kenya hopes to move towards zero HIV infections from 100,000 annually but admits that the growing gay population and MSM is a hurdle (NASCOP, 2007 and UNAIDS, 2012).

Men who have sex with men (MSM) in Kenya also reflect a range of sexual and gender identities (NACC, Population Council, 2009) while many also have sex with women (Onyango-Ouma et al., 2005).

In 2010, Global Forum on MSM and HIV Reports (MSMGF) indicated that MSM continue to shoulder a disproportionate disease burden when it comes to the HIV epidemic in all regions of the world mainly as a result of poor penetration of key HIV prevention and related services, potentially as a result of criminalization, discrimination and violence (UNAIDS, 2010). Commissioned

study conducted by UNAIDS from developing countries reports that, in the year 2010, fewer than 31% of MSM tested for HIV in the past 12 months and knew their status. Only 33% participants in the study had access to information about HIV, prevention service reach only one in every ten MSM, less than half (44%) had accurate knowledge about HIV and only 54% used condoms the last time they had anal sex with another man (MSMGF and UAIDS Reports, 2010).

It is estimated that 18.2% of Kenyan men who have sex with other men (MSM) were living with HIV by the year 2010. The risk of infection increases with age, with HIV prevalence among MSM aged 25 and over roughly doubling that reported among MSM under age 25 (24.5% vs. 12.2%), (NASCOP,2011).

In 2012, similar trends were still seen among men who have sex with men (MSM). The Gay and Lesbian Coalition of Kenya (GALK) put the number of gays in Kenya at over 100,000 in 2013. On the other hand, NASCOP report on status of HIV/AIDS (2013) in Kenya estimates that there are over 30,000 gay men across Kenya. Nairobi is having the highest number with approximately above 20,000 gays, Mombasa follows distantly having slightly above 5,000 and Kisumu about 5,000. Prevalence among gay men in Kenya stands at 18 percent (NASCOP, 2009 and GALK, 2013).

Research on news reporting reveals that the media significantly increases knowledge levels among general public and helps set a public agenda for the

issues; however, the media is unsuccessful at instigating behavior change because it does not communicate accurately and clearly about risky behavior and prevention skills and often frames information in ways that enhance negative attitudes toward marginalized communities that have been disproportionately affected (Bird,1996,Clarke 1992, Wanta and Elliot, 1995).

1.2 Men who have sex with men (MSM) and HIV in Kenya

IOM (2010) indicates that HIV prevalence among men who have sex with men (MSM) in Kenya is almost three times that among the general population. In 2010, HIV prevalence among MSM was an estimated 18.2 percent.

Condom use among MSM is fairly low but has been on the increase. In 2013, an estimated 69 percent of MSM reported using a condom the last time they had anal sex (which has a much higher risk of HIV transmission than vaginal sex), up from 55 percent in 2011 (UNGASS and Avert Organization, 2014).

According to Avert Organization (2014), sexual relations between men are illegal in Kenya and can carry a prison sentence of up to 21 years. CCPR (2011) confirms that in Kenya, the practice is largely considered to be taboo and repugnant to cultural values and morality of Kenya. This stance leads to high levels of stigma and discrimination towards MSM as well as other members of the lesbian, gay,

bi-sexual and transgender community (LGBT), deterring many people from seeking the HIV services they need.

Despite this, a number of organizations such as the Kenya Human Rights Commission (KHRC) and Gay and Lesbian Coalition of Kenya (GALCK) work to protect and improve the rights of the LGBT community in Kenya.

1.3 Gay And Lesbian Coalition Of Kenya (GALCK)

In Kenya, we have organizations that reach the MSM people and attempt to empower the general public with information, education and communications (IEC) that counter ignorance and prejudice, change attitudes and behaviors and transform Kenya. The most vibrant one is GALCK.

GALCK aims to ensure that all LBGTI people in Kenya are provided with the physical and mental health and social services they need, including any special prevention, diagnosis, treatment and care services that may be required by MSM, WSW, transgender or intersex people (GALK, 2011).

As an organization, it aims to reach all LGBTI people in Kenya and the general public with information, education and communications (IEC) that counter ignorance and prejudice, change attitudes and behaviors and transform Kenya. Their IEC embraces arts, entertainment and sports and employs the full range of methods and media: meetings, workshops and courses, counseling sessions,

print, internet, radio, television, film, live performances, exhibitions and other special events, such as information booths at conferences (GALK, 2011).

The organization is out to ensure that Kenya's anti-LGBTI laws are repealed and protective laws for LGBTI people are enacted. In addition, GALCK also provides legal advice and assistance to LGBTI people who are victims of Kenya's existing anti-LGBTI laws or who are victims of physical violence or any form of discrimination that may be related to their known or presumed sexual orientation (GALK, 2011).

1.4 Statement of the problem

In any capital city in the world, men who have sex with men are significantly more likely to have HIV. On average, 13 times more than the general population and nearly one in four, of who are in their capital cities are living with HIV. Adult prevalence rate as at 2012, in Kenya, was 6.1% yet MSMs had approximately 43.0%; thus presenting a barrier towards reduction of HIV/AIDS spread (UNICEF Statistics and UNAIDS World AIDS Report, 2012).

Kenya is home to approximately 100,000 gays (GALK, 2013). Over 70% of MSM in Nairobi and Kisumu knew correct answers to HIV/AIDS knowledge questions. In both Nairobi and Kisumu, about 20-25% of MSM did not believe that they could get HIV from unprotected anal sex; 20-25% did not believe abstinence could protect them from HIV. While one-third of MSM in Nairobi

(30%) did not know there is medical treatment for HIV, nearly one-half (44%) did not know so in Kisumu. Over half of MSM in Nairobi (63%) and 76% in Kisumu had previously tested for HIV. In Nairobi, 8% of MSM who have had a previous HIV test and were willing to share their test results knew they were HIV positive from previous testing and only 33% of the MSM who tested HIV positive in knew that they were infected with HIV (NASCOP, Most-At-Risk Population Report, 2012).

Since 2009, the rate of HIV/AIDS prevalence among MSM appears be on the rise in spite of their knowledge of the disease. This study therefore seeks to investigate the knowledge behavior gap among the MSM and the effectiveness of HIV/AIDS prevention campaigns that target the gay community.

1.5 Objectives of the Study

1.5.1 General Objective

The general objective of this study was to examine the effectiveness of HIV/AIDS prevention campaigns targeting the gay community in Kenya.

1.5.2 Specific Objectives

The specific objectives were;

1. To assess the knowledge of HIV/AIDS prevention campaigns among the gay people in Nairobi.
2. To find out the protective measures that MSM employ.

3. To investigate the effectiveness of channels of communication being used to reach MSM.

1.6 Research Questions

The research questions for this study were;

1. How effective are HIV and AID prevention campaigns that target the gay in Kenya?
2. What are the knowledge levels of the gay in Nairobi with regards to HIV and AIDS prevention measures?
3. Are the channels used to communicate to MSM about HIV and AIDS effective?

1.7 Justification of the study

The findings of this study will be useful in developing training modules on MSM health needs and rights, which can then be offered as part of the Continuous Medical Education (CME) to the gays by Ministry of Health, through the National AIDS and STI Control Programme (NASCOP) and the Kenya Medical Board.

Secondly, the findings will help create awareness of the nature and scope of the gay men's HIV/AIDS issue in Kenya and thus empowering the gay and bisexual communities to participate in safe sex.

Finally, the findings of this study will enable the legislators and relevant ministries to engage in legal and policy reform, ensuring that legal barriers to

accessing health services are removed and policies are put in place to protect and promote the rights of gay and bisexual within health care settings.

1.8 Scope of Study

This study examined the effectiveness of HIV and AIDS prevention campaigns that target MSM that are placed in Nairobi County. In doing this, it assessed the knowledge of HIV/AIDS prevention measures among the gay people in Nairobi, sort to find out the protective measures that they employ during sexual intercourse and investigated the effectiveness of channels of communication being used to reach them.

1.9 Definition of Terms

Anal sex: The insertion of the erect penis into a person's anus, or anus and rectum, for sexual pleasure; anal intercourse.

Assess: To find out (in measurable ways) knowledge, skills, attitudes and beliefs of an individual about a particular practice with the aim of determining its importance and value to the individual's society.

Bisexuals: Sexual attraction towards both males and females.

Communication Channel: A pathway or medium for passing information from one location or individual to another.

Confidence Interval [CI]: Is a type of interval estimate of a population parameter and is used to indicate the reliability of an estimate.

Effectiveness: The degrees to which desired objectives have been achieved and the extent to which targeted problems have been solved in a given project.

Examine: To inquire into or investigate in order to evaluate.

Prevention Campaign: Science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals. It is concerned with threats to health based on population health analysis.

Gay: A Male who has sexual intercourse and exhibits sexual desire or behavior directed towards other males; homosexual. Alternatively, they are referred to as Men having sex with Men (MSM) in this study.

Gay community: A group of people who are homosexual.

Gender: The state of being male, female or intersex.

High-risk behaviors: Sexual activities that increase a person's risk of transmitting or becoming infected with HIV; for example, unprotected anal intercourse.

HIV incidence: The number of new cases of HIV infection within a given period of time.

HIV infection: Invasion of human body tissues by human immunodeficiency virus (HIV) that, in turn, causes acquired immune deficiency syndrome (AIDS).

HIV prevalence: The proportion of individuals in a population who have HIV at a specific point in time; all cases, old and new.

HIV test: Checking the human blood or saliva by using HIV kits in order to detect the presence of the human immunodeficiency virus (that causes acquired immunodeficiency syndrome) in serum, saliva, or urine. Such tests may detect antibodies, antigens, or RNA.

HIV positive: Showing indications of infection with HIV through the presence of antibodies (against HIV) on a test of blood or tissue; synonymous with seropositive.

HIV negative: Showing no evidence of infection with HIV; synonymous with seronegative.

HIV protective measures: Steps taken to guard oneself from HIV infection; for example, correct use of condoms when having sex.

HIV and AIDS awareness: Knowledge or understanding of HIV and AIDS especially with regards to how it is infected, conducting tests and protective measures.

HIV and AIDS knowledge levels: The scale of HIV and AIDS awareness in an individual.

Homosexual: A male person who is sexually attracted and has sexual intercourse with other males.

***Intercrural intercourse*:** This is known as thigh sex; one partner places his penis between his partner's thighs, usually directly under the groin.

Intersex: Is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. For example, a person might be born appearing to be female on the outside, but having mostly male-typical anatomy on the inside.

Lesbian: A female who expresses romantic or sexual attraction to other females.

Heterosexual: A person with romantic attraction, sexual attraction or sexual behavior between persons of opposite sex or gender.

Marginalized communities: Are individuals facing social exclusion and stigma. In addition, resources and national HIV-prevention campaigns are not necessarily geared to their specific HIV prevention, treatment and care needs; for example, homosexuals in Africa.

Most-At-Risk Population: Those groups that have higher than average HIV prevalence when compared to the general population. These groups are more vulnerable to HIV infection due to a variety of factors such as; more frequent exposure to the virus, involvement in risky behaviors, potentially weak social support systems, marginalization, lack of resources, and inadequate access to health-care services; for example, homosexuals in Africa.

Sex: Physical activity that is related to and often includes sexual intercourse

Sexuality: The capacity to have erotic experiences and responses.

Sexual orientation: An enduring personal quality that inclines people to feel romantic or sexual attraction (or a combination of these) to persons of the opposite sex or gender, the same sex or gender, or to both sexes and more than one gender.

Transactional Sex: Sexual relationships where the giving of gifts or services is an important factor. Transactional sex relationships are distinct from prostitution. The exchange of gifts for sex includes a broader set of (usually non-marital) obligations that do not necessarily involve a predetermined payment or gift, but where there is a definite motivation to benefit materially from the sexual exchange.

Unprotected sex: Is sexual activity engaged in by people without precautions to protect themselves against sexually transmitted infections (STIs) such as HIV and AIDS.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter discusses how selected behavioral theories, which you shall see in the theoretical framework section, apply to the study. It focuses on other acknowledged findings about the MSM as most-at-risk-population with relationship to prevalence of HIV and AIDS and identifies the gap that merits the study.

2.1 Theoretical Review

2.1.1 Origin of MSM

In Africa, the first record of possible homosexual couples in history was at 2400 BCE. It was between an ancient Egyptian royal servants and male couple commonly regarded as *Khnumhotep* and *Niankhkhnum* (Murray Stephen, 2004).

The term MSM was created in the 1990s in order to study the spread of disease among men who have sex with men, regardless of identity (UNAIDS, 2011).

According to the UNAIDS Action Framework (2009), the term 'men who have sex with men' (MSM) is used to describe those males who have sex with other males, regardless of whether or not they have sex with women or have a

personal or social identity associated with that behavior, such as being 'gay' or 'bisexual'.

The commonest sexual acts between men are anal intercourse, oral intercourse, intercrural intercourse (thigh sex) and mutual masturbation. Many of these acts are also practiced by male and female partners (International HIV/AIDS Alliance, 2003).

2.1.2 Why Men Have Sex with Other Men

Men have sex with other men for many different reasons. Most men do so from desire, but others do so for money or some other reward, or because women are not available, or because they are forced to. Some men have sex with men because no women are available. Teenage boys in boarding school or adult men in single-sex situations, such as prison or the military, may seek other men for sexual release (International HIV/AIDS Alliance, 2003).

Sex between men – in particular, anal intercourse without a condom – is one of the ways in which HIV and other sexually transmitted infections are passed on. In every society some men have sex with other men, and some of these men have many sexual partners, including women. This means that anal intercourse without a condom between men also places the men's female partners and their future children at risk of infection (International HIV/AIDS Alliance, 2003).

MSM are 19 times more likely to be living with HIV than the general population in low- and middle-income countries, but only one in 10 MSM worldwide has access to HIV services. This is largely attributed to the fact that stigma, discrimination, and laws criminalizing sex between men undermine access to HIV/AIDS and other health services for MSM (AMFAR, 2010).

2.2 Empirical Review

2.2.1 Global Outlook of MSM, HIV and AIDS

In the world, approximately more than 35 million people now live with HIV/AIDS; 3.3 million of them are under the age of 15. In 2012, an estimated 2.3 million people were newly infected with HIV and 260,000 were under the age of 15. Every day nearly 6,300 people contract HIV—nearly 262 every hour. 1.6 million People died from AIDS in 2012. Since the beginning of the epidemic, more than 75 million people have contracted HIV and nearly 36 million have died of HIV-related causes (UNAIDS, 2013).

Sex between men is thought to account for between five and 10 per cent of HIV infections worldwide. In many high-income countries, incidence of HIV among MSM continues to climb even while overall HIV incidence is in decline (UNAIDS Action Framework, 2009; George Ayala et al, 2013).

In a study conducted among MSM (3748) from 145 countries (from April to August 2012; using multivariable random effects models to examined factors

associated with acceptability of pre-exposure prophylaxis (PrEP) and access to condoms, lubricants, HIV testing, and HIV treatment) it was found that, Condoms and lubricants -were accessible to 35% and 22% of all respondents, respectively. HIV testing was accessible to 35% of HIV-negative respondents. 43% of all HIV-positive respondents reported that antiretroviral therapy was easily accessible. Homophobia and service provider stigma were significantly associated with reduced access to services. Conversely, community engagement, connection to gay community, and comfort with service providers was associated with increased access (Europeans AIDS Treatment Group (EATG), 2013).

2.2.2 MSM in United States of America and HIV/AIDS Risk

HIV/AIDS was first identified among men who have sex with men (MSM) in the USA in the early 1980s (Adrian, D. et al, 2009).

There are approximately 1.1 million people living with HIV/AIDS in the U.S and it is estimated that almost one-fifth (18.1%) of those people don't know they have it. An estimated 50,000 new HIV infections occur each year. Men who have sex with men (MSM) account for the majority of new HIV and AIDS diagnoses although MSM comprise only around 4% of the U.S. male population (U.S. Centers for Disease Control and Prevention, 2013).

In the United States, the number of new HIV infections among MSM has been increasing at a rate of 8% per year since 2001. HIV prevalence across North, South, and Central America, South and Southeast Asia, and Sub-Saharan African ranges consistently between 14 and 18% (Patric Wilson et al, 2013)

2.2.3 MSM in Africa

Reports about anthropology, by contrast, document sex between men across sub-Saharan Africa, both before and after the recognition of HIV. Descriptions of African same-sex behaviors are geographically widespread, and the social contexts in which they occur are diverse. HIV prevalence among African MSM is generally considerably higher than among adult men in the general population (Adrian. D et al, 2009).

Adrian. D et al (2009) notes that important conclusions from behavioral studies of African MSM are that unprotected anal sex is commonplace, knowledge and access to appropriate risk prevention measures are inadequate, and that, in some contexts, many MSM engage in transactional sex. Stigma, violence, detention, and lack of safe social and health resources are widely reported.

Political, cultural, and religious hostility towards MSM thus presents the main barrier to implementing effective HIV research, policy, and health programmes for African MSM. Successes in engagement with and delivery of the few interventions to known MSM are tempered with the recognition that many,

probably most, MSM conceal their behavior for fear of repercussion and remain beyond the reach of such interventions (Moreau, A. et al, 2007; Sanders, E. et al, 2007).

2.2.4 MSM in Sub-Saharan Africa

Sex between men across sub-Saharan Africa was documented, both before and after the recognition of HIV. Descriptions of African same-sex behaviors are geographically widespread, and the social contexts in which they occur are diverse (Epprecht, M. 2008).

More than two-thirds (70 percent) of all people living with HIV, 25 million, live in sub-Saharan Africa—including 88 percent of the world's HIV-positive children. In 2012, an estimated 1.6 million people in the region became newly infected. An estimated 1.2 million adults and children died of AIDS, accounting for 75 percent of the world's AIDS deaths in 2012.

2.2.5 MSM in Kenya and HIV/AIDS Risk

Kenya has always been assumed to be high-risk heterosexual transmission and vertical transmission from mother to child. However, the last four or five years have demonstrated increased risk among other vulnerable populations including sex workers, injecting drug users (IDUs), and MSM (UNAIDS and WHO, 2008).

Focus group discussions have revealed that MSM are from diverse age, occupational, and socioeconomic groups including both unemployed and highly

educated professionals. Studies of MSM in Nairobi have revealed that many men use English-language terms of *gay*, *bisexual*, and *homosexual* to describe their sexual orientation. In Nairobi, a study of 500 MSM revealed 46 percent self-identifying as gay, 23 percent as bisexual, and 16 percent as homosexual; 12 percent self-identified in the Kiswahili term *shoga* which means gay or homosexual (Onyango-Ouma et al., 2005)

Qualitative evidence has also demonstrated emerging numbers of Kenyan MSM who are willing to openly advocate for their preventive health care needs (Sharma et al., 2008).

In East Africa, the lifetime prevalence of MSM practices is between 1 and 4 percent, which is congruent with self-reported same-sex practices among a sample of 486 men in Nairobi (Cáceres et al. 2008; Sharma et al. 2008). Same-sex practices are more common among the coastal cities and towns than in Nairobi (NACC, World Bank, and UNAIDS 2009).

MSM carry a disproportionate burden of HIV in Kenya with an average prevalence of approximately 15.2 percent (95 percent confidence interval [CI]; compared to an HIV prevalence among men of approximately 6.1 percent Higher prevalence estimates tend to be found along the coast where a cohort has observed an overall prevalence of 22 percent (120/553) over five years of accrual

with an incidence rate of 8.8 per 100 person-years. MSM contributes approximately 4.5 percent of Kenya's HIV epidemic (Muhaari, 2009).

Prevalence among MSM 18–24 years of age was 17.7 percent; among those 25–34, it was 26.2 percent; and among those older than 35 years, the HIV prevalence was 25.5 percent. These data suggest that many MSM are already infected by the age of 18, thus highlighting the importance of addressing the needs of young MSM (Sanders et al., 2007).

Recent estimates have been higher, including 9.8 percent based on an assumption of 3 percent of men engaging in male-to-male sex (Van Griensven, 2007). In 2009 it was estimated that 15.2 percent of incident infections are attributable to MSM. This was based on Kenya HIV Prevention Response and Modes of Transmission Analysis. Further, regional prevalence variations saw Nyanza getting 6.0 percent; Nairobi had 16.4 percent and Coast having 20.5 percent. HIV incidence among all MSM was approximately 6.7 percent (NACC, World Bank, and UNAIDS 2009).

2.3 MSM HIV and AIDS Prevention Campaigns Communication Channels

According to National Conference on Health Communication, Marketing and Media (NPHIC, 2013) the successful implementation of campaigns and initiatives for men who have sex with men (MSM) is contingent upon the ability to effectively reach the audience. While knowledge of channel usage is important,

the effective delivery of messages also requires an understanding of message acceptability within a given channel.

Majority of MSM use social media (e.g., Facebook, Twitter) and visit dating and hook-up sites e.g. Adam4Adam, Grindr. Segmenting the audience by demographic (e.g., race/ethnicity, age, income) and behavioral (e.g., HIV testing frequency, risk factors) characteristics will result in a more effective delivery of campaign messages (CDC, 2013).

Readership of print media tended to be low; however supplemental use of print media for specific audience segments was recommended (e.g., local newspapers that target MSM). Partnerships with national and local LGBT organizations are essential for campaign dissemination success. Additionally, engaging nontraditional partners (e.g., adult entertainment industry and bloggers) may also be an effective way to reach MSM, particularly those at high risk for HIV (CDC, 2013).

MSM are most interested in receiving information about HIV from the following locations: the doctor's office, community health clinic, social networking sites, Pride Events, and dating and hook-up sites. There are similarities in the data across demographic audience segmentation, however, within target segments, important characteristics need to be considered. For example, engaging local language radio stations is the best way to reach lower literacy MSM. Behavioral

data indicate that among MSM, testing frequency is associated with use of dating and hook-up sites and desired sources for information about HIV (CDC, 2013).

2.4 Emerging Gaps

From the above findings it is clear that there are MSM in our society and that MSM are from diverse age, occupational, and socioeconomic groups including both unemployed and highly educated professionals.

MSM are 19 times more likely to be living with HIV than the general population in low- and middle-income countries yet, in Nairobi, 20-25% of MSM did not believe that they could get HIV from unprotected anal sex; 20-25% did not believe abstinence could protect them from HIV and 30% did not know there is medical treatment for HIV. This illustrates that they have knowledge of safe sex but only a negligible proportion (one in 10 MSM worldwide) has access to HIV services due to stigma, discrimination, and laws criminalizing sex between men undermine access to HIV/AIDS and other health services for MSM and thus explaining their 43.0% contribution in Kenya's 6.1 % HIV and AIDS prevalence rate.

As a result, this study aimed at examining the effectiveness of HIV/AIDS prevention campaigns targeting the gay community in Nairobi (Kenya). It aimed at achieving this through assessing the knowledge of HIV/AIDS prevention among the gay people in Nairobi, finding out the protective measures that MSM

employ and investigating the effectiveness of channels of communication being used to reach MSM.

2.5 Theoretical Framework

2.5.1 Theory of Planned behavior (TPB)

This theory falls under individual health behavior model. The TPB (Ajzen 1985, 1991; Ajzen and Madden 1986) evolved from the theory of reasoned action and is a theory about the link between beliefs and behavior (Fishbein and Ajzen 1975). TPB is suited to predicting behavior and retrospective analysis of behavior and has been particularly widely used in relation to health (Armitage and Conner 2001; Taylor et al. 2007).

According to the theory of reasoned action, if people evaluate the suggested behavior as positive (attitude), and if they think their significant others want them to perform the behavior (subjective norm), this results in a higher intention (motivations) and they are more likely to do so. A high correlation of attitudes and subjective norms to behavioral intention, and subsequently to behavior, has been confirmed in many studies (Icek Ajzen, 1985).

In addition to attitudes and subjective norms (which make the theory of reasoned action), the theory of planned behavior adds the concept of perceived behavioral control. Perceived behavioral control is the perceived ease or difficulty with which the individual will be able to perform or carry out the

behavior, and is very similar to notions of self-efficacy. Self-efficacy is the extent or strength of one's belief in one's own ability to complete tasks and reach goals. (Bandura 1986, 1997; Terry et al., 1993).

Peoples' behavior is strongly influenced by their confidence in their ability to perform that behavior (Bandura, Adams, Hardy, & Howells, 1980).

Many factors, internal and external, can impair or facilitate performance of a given behavior; the extent to which people possess the requisite information, mental and physical skills and abilities, the availability of social support, emotions and compulsions, and absence or presence of external barriers and impediments (Ajzen, 2005).

According to Fishbein & Ajzen (2010), human action is guided by three major kinds of considerations:

Behavioral Beliefs (beliefs about the likely consequences)
Normative Beliefs (beliefs about the normative expectations of others)
Control Beliefs (beliefs about the presence of factors that may facilitate or impede performance of the behavior).

2.5.2 How the Theory of Planned Behavior Works

The theory proposes a model which can measure how human actions are guided. It predicts the occurrence of a particular behavior, provided that behavior is intentional (Ajzen,1988).

The theory of planned behavior is a theory which predicts deliberate behavior, because behavior can be deliberative and planned (Ajzen and Fishbein, 1980).

The model outlined shows the three variables which the theory suggests will predict the intention (precursors of behavior) to perform a behavior.

Model outline for Theory of Planned Behavior

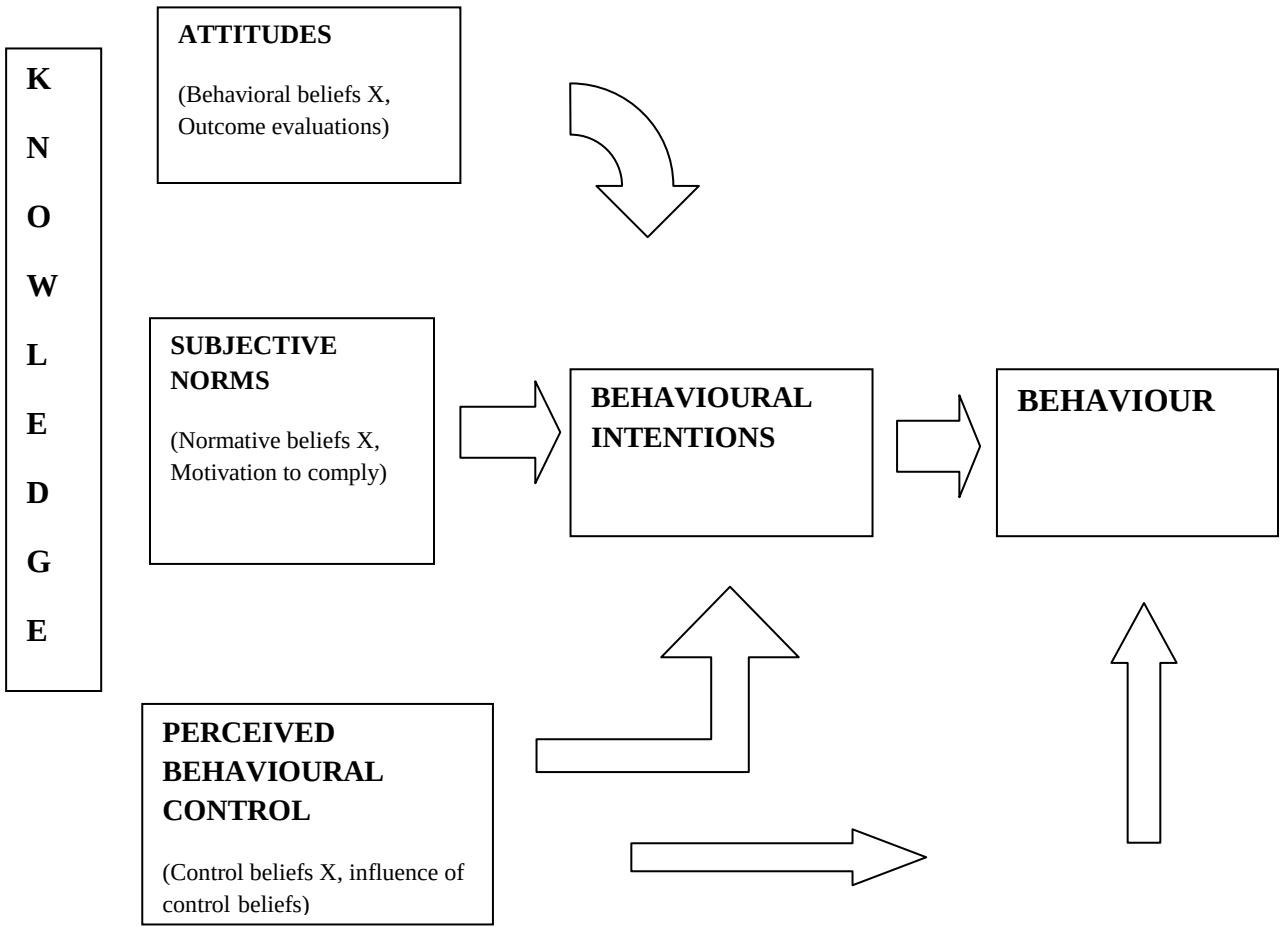

Figure 1: Model of Theory of Planned Behavior (Ajzen, 1991).

TPB builds on the key assumptions that individual self-interest is appropriate framework for understanding human behavior. That rational behavior is the result of processes of cognitive deliberation and internal factors, especially the attitude, play the most important role (Cees. E, Renee. B, and Senter. N, 2007).

This theory has got three major strengths. Several studies found that the TPB would help better predict health-related behavioral intention than the theory of reasoned action (Ajzen, 1988). TPB has improved the predictability of intention in various health-related fields. For example; TPB interventions have been used in smoking cessation (Aveyard et al, 1999), Diet (Beresforf et al, 1997), Alcohol abuse (Cabonari and DiClemente, 2000), Condom use (CDC,1999; Parsons et al, 2000; Redding et al, 2007) and Multiple behavior changes (Kreuter and Strecher, 1996; Steptoe et al, 2001)

Theory of planned behavior can cover people's non-volitional behavior which cannot be explained by the theory of reasoned action (Ajzen, 1999).

Theory of planned behavior as well as the theory of reasoned action can explain the individual's social behavior by considering social norm as an important variable. An individual's behavioral intention cannot be the exclusive determinant of behavior where an individual's control over the behavior is incomplete. By adding perceived behavioral control, the theory of planned

behavior can explain the relationship between behavioral intention and actual behavior (Christopher J. Armitage, 2001).

The theory is useful to explain and predict likely behavior and offer methods for identifying particular influences on behavior that could be targeted for change (Hardeman et al. 2002: 149).

However**,** the theory of planned behavior has got some weaknesses. It is based on cognitive processing and level of behavior change. In particular in the health-related behavior situation, given that most individuals' health behaviors are influenced by their personal emotion and affect-laden nature, this is a decisive drawback for predicting health-related behaviors (Dutta-Bergman, 2005).

In this study, this theory was used to measure how MSM act based on the HIV & AIDS prevention campaigns that target them. Since the theory proposes a model which can measure how human actions are guided and predicts the occurrence of a particular behavior (provided that behavior is intentional), hence it was used to establish the effectiveness of channels of communication being used to reach MSM. Also, sort to find out the preventive measures are they utilize in their sexual activities and their ability to employ other alternative preventive measures.

2.6 Conceptual Framework

Below is a visual presentation that graphically explains the key factors, concepts and variables- and the presumed relationship among them.

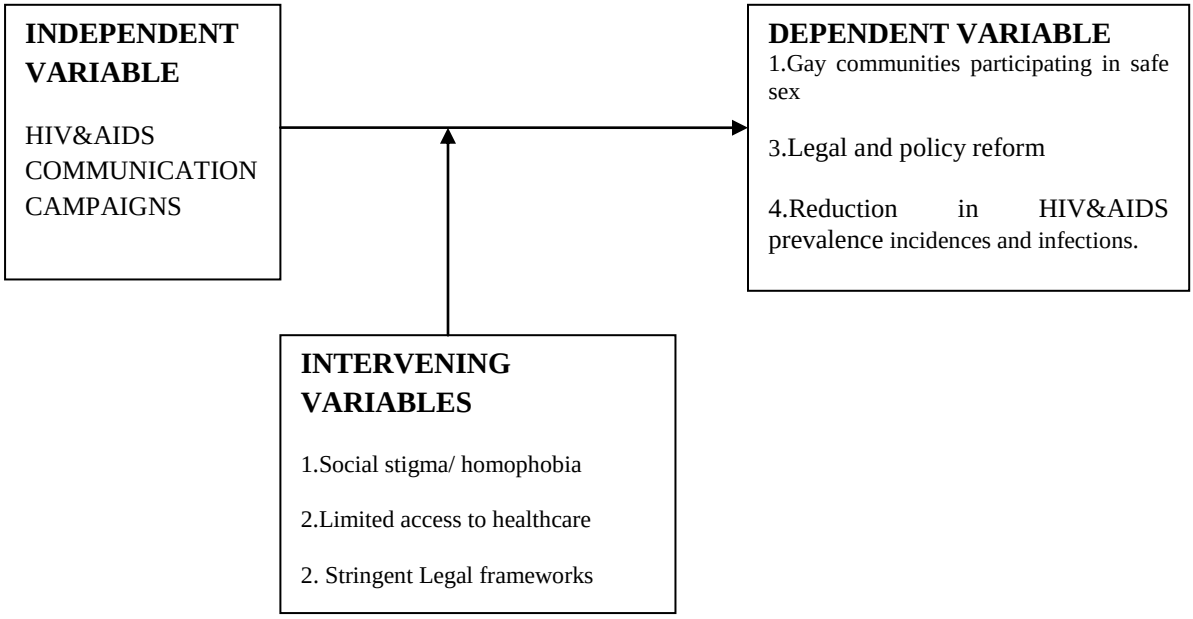

Figure 2: Model of the conceptual framework showing the interplay of the variables in this study.

This study's general objective is to examine the effectiveness of HIV/AIDS prevention campaigns targeting the gay community in Kenya. The independent variable in this case is HIV/AIDS prevention campaigns targeting the gay community.

Gaining information and health facilities will enable the MSM to practice safe sex and hence reducing the spread of HIV/AIDS. In this case, the dependent

variable is the practicing of safe sex by the MSM and hence reduction of HIV/AIDS incidences and infections.

Social stigma, limited access to healthcare and stringent legal frameworks are abstract processes that are not directly observable but link the independent and dependent variables in this study and hence are intervening variables.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents a systematic, theoretical analysis of the methods applied in this study. It encompasses concepts such as research site, research design, study population and qualitative techniques. It offers the theoretical underpinning for understanding the research method that is was applied in this study.

3.1 Research Site

This study was conducted in Hurlingam- Nairobi. Nairobi is the capital city of Kenya and has an area of 694.9 square kilometers with a population of 3,138,369. It is currently the 14th largest city in Africa (GeoHive, 2009).

The male population of age group 10-20 years is 235,723; 20-30 years is 445,685; 30-40 years is 317,082; 40-50 years is 155,010 and 50-60 years is 65,985 (Kenya Open Data Survey, 2014).

In Nairobi, the study was based in Hurligham town in Dagoretti North Constituency. The constituency has an approximate total population of 181,365 (GeoHive, 2009).

The study identified the site because Liverpool VCT, an MSM healthcare providing clinic, is situated here.

3.2 Research Design

The type of research design used in this study was exploratory research design. An exploratory design is conducted on a research problem when there are few or no earlier studies to refer to. The focus is on gaining insights and familiarity for later investigation or undertaken when problems are in a preliminary stage of investigation (Eugene and Christine, 2013).

A research design is the framework or plan for a study used as a guide in collecting and analyzing data. It is a blueprint for conducting a study with maximum control over factors that may interfere with the validity of the findings (Burns and Grove, 2003:195).

Parahoo (1997:142) describes a research design as "a plan that describes how, when and where data are to be collected and analyzed".

3.3 Study Population

The population in this study was MSM of age group 25-35 years located in Hurlingam. The MSM in focus was of diverse occupational and socioeconomic groups including both unemployed and highly educated professionals.

3.4 Sample Size and Sampling Technique

This section explains the approximate sample population size used in this study and is determined based on the expense of sampling and data collection techniques.

3.4.1 Sample Size

The sample size for this study was 50 MSM.

3.4.2 Sampling Techniques

The research sampling technique employed in this study was snowball sampling. Snowball sampling is defined as a technique for gathering research subjects through the identification of an initial subject who is used to provide the names of other actors. These actors may themselves open possibilities for an expanding web of contact and inquiry. The strategy has been utilized primarily as a response to overcome the problems associated with understanding and sampling concealed populations such as the deviant and the socially isolated. Snowball sampling forms how individuals act and interact in focus groups; it facilitates the identification of hard-to-find cases (Faugier & Sargeant, 1997).

For focus group discussions, the study used purposive sampling. Most focus group researches rely on purposive sampling, with researchers selecting participants based on the project and on the potential contributions of participants (Miles & Huberman, 1984).

3.5 Data Collection Methods

In this study, data was collected through in-depth interviews and focus group discussions.

An in-depth interview is a one-to-one method of data collection that involves an interviewer and an interviewee discussing sensitive topics in depth. It is a conversation with a purpose. The researcher's intention is to gain insight into certain issues using semi-structured interview guide and can feel like a conversation for the interviewee if conducted well. The interviewee shares their story and the interviewer's role is mostly to elicit the story (Hennink et al, 2010).

In focus group discussions, a group of people are asked about their perceptions, opinions, beliefs, and attitudes. Questions are asked in an interactive group setting where participants are free to talk with other group members. A focus group discussion (FGD) is a good way to gather together people from similar backgrounds or experiences to discuss a specific topic of interest. The group of participants is guided by a moderator (or group facilitator) who introduces topics for discussion and helps the group to participate in a lively and natural discussion amongst them (Krueger, 1988).

According to Ndeti (2013) these group discussions gather greater breath of ideas, opinions and experiences.

3.5.1 Pilot Study

Pilot study was conducted on five MSM. An in-depth interview was conducted on them to find out the levels of HIV and AIDS awareness, prevention, protective measures that they employ and investigate the effectiveness of

channels of communication being used to reach them. The same participants held a focus group discussion to establish the effectiveness of effectiveness of HIV/AIDS prevention campaigns targeting them.

The primary purpose of this test was to check the possibility attaining the right estimated sample size apart from the validity of the questions to ask during interviews and discussions.

3.5.2 In-depth Interviews

Data was gathered through conducting in-depth interviews with the MSM. It was guided through snowballing sampling and thus the type of data was descriptive.

With regards to this study, this method allows the interviewer to establish rapport with the respondent and clarify questions thus earning trust and getting an insider's view. It provided an opportunity to build and strengthen relationships with MSMs and hence allowed the researcher to clarify ideas and information on continual basis.

3.5.3Focus Group Discussion

Data was gathered through focus group discussions with the MSM. In groups of approximately six, they were asked about their perceptions, opinions, beliefs, and attitudes with consideration to the effectiveness of HIV/AIDS prevention campaigns targeting them.

With regards to this study, this method allowed the MSM to converge in an interactive group setting where participants were free to talk with other members.

MSM from similar backgrounds or experiences were gathered together through FGD to discuss.

3.6 Data Analysis and Presentation

In this study, data analysis relied primarily on words as its unit of analysis and its means of understanding. However, it also used voice tone, loudness, cries, sighs, laughs, and other ways of human communication. The words were spoken in individual interviews (face to face or on the telephone) groups and written. Analysis was done on the spoken words from the interviews, focus groups and conversations or the written words of an account or description.

Qualitative methods of analysis were done from the classification of themes and interconnections.

3.7 Ethical Considerations

The purpose, procedure and benefits of this study were revealed to all the participants. Their responses were purely voluntarily, they had a right not to answer or withdraw at will. Clarification of any question was allowed. Both participants of in-depth interviews and FGD were requested to assent to audio and video recording, and also photo taking. Privacy and confidentiality was assured.

No monetary or any other kind of incentives was provided.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter presents findings of this study, analysis and interpretations of data.

4.1 Data Management and Analysis

50MSMs were identified and interviewed through snowballing. The researcher visited the MSM church for purposive sampling. In this study, they were divided into five focus groups for discussions; each having approximately six participants. After assessing the outcomes of focus groups and interviews; the study grouped similar responses into categories and identified common patterns that can help derive meaning from related responses.

Discussions and interviews were transcribed using free English translation method. Reduction and selection of data was undertaken while ensuring that the selected data contained all-important sequences from the original data material. Transcriptions are in consistency with the recorded data.

The transcription of the focus group discussion was then summarised in a shorter structured summary with reference to the topics addressed in the interview guide for each interview. Responses were classified into underlying semantic themes. Themes were then identified for each question based on the

interview. Unique responses and quotes representative of themes were recorded precisely.

4.2 Results, Analysis and Interpretation

In analyzing and interpreting data that was collected to examine the effectiveness of HIV/AIDS prevention campaigns targeting the gay community in Kenya, the results below are presented:

4.2.1: Assessing the knowledge of HIV/AIDS prevention campaigns among the MSM in Nairobi

Interviews and focus group discussions revealed that few MSM have the knowledge of HIV/AIDS prevention campaigns targeting them. Many preferred HIV/AIDS prevention campaigns and education materials tailored for MSM. A common set of barriers and facilitators that affect their access to information and hence the effectiveness of HIV/AIDS prevention campaigns; this further hampers their access to HIV services among MSM in Nairobi. These factors are grouped into three categories: relationship with healthcare providers; experiences of homophobia and homophobic violence and engagement with a local community of MSM.

They admitted to experiencing homophobia and homophobic violence, and that it hampers the effectiveness of HIV/AIDS prevention campaigns and implementation of information communicated. They also suggested that this

situation makes it complicated for them to access medical care and practice safe sex. Homophobia experienced is categorized into two levels; highest levels of perceived homophobia and lowest levels of perceived homophobia.

Most of those who confessed to experiencing homophobic violence admitted that they were experiencing high levels of perceived homophobia with very few admitting to experiencing lowest levels of perceived homophobia. Those who reported lowest levels of perceived homophobia had experienced comfort with medical service providers and this enabled them to easily access HIV/AIDS prevention campaigns, gain knowledge for preventive measures and effectively communicate to the rest of the members. Also, they were; more likely to access lubricants and more likely to access HIV testing if compared to the majority of MSM who reported the highest levels of perceived homophobia.

The conversation is presented below:

Q. Have you any knowledge about HIV/AIDS prevention campaigns that target the MSM in Nairobi?

> **P1:** I only see them in our health care facilities, the clinics and MSM led organizations. *Sijui kwa nini zinafichwa huko?* (I don't understand why they are so undisclosed). Many of us cannot access them in such places especially the hospitals because the healthcare attendants are never friendly. Like now we have the Nairobi City Council facilities, but the

minute you present yourself as an MSM, the doctor will go and tell it to the nurses and everybody other people. So people will come and start saying, *look at this MSM!!!*

P2: Finding them outdoor like other health campaigns is next to impossible. This is because of issues of stigma and discrimination, then, most MSM are not literate of treatment. For example, you find someone, CD4 is low then now they start treatment and they do not adhere to full treatment because of other challenges like over indulgence in alcohol and issues with the family.

P3: MSMs themselves also have a challenge. MSMs that are negative really discriminate those who are positive. In that gay community, we do not have a lot of confidentiality.

P4: They push us away. They discriminate because when I go for the medical examination. You know I used to pause they even have to look behind. And mine was bad by the way because I just noticed that my CD4 was very low. You know when you CD4 is low you are actually very susceptible to the opportunistic infections. Actually now am on second level HIV treatment. In fact that's when Liverpool VCT changed me from first level to second. I had a lot of stress, my muscles were stressing me.

My father was stressing me; stress also comes from your family. Family also contributes a lot.

P5: MSMs themselves also have a challenge. MSMs that are negative really discriminate those who are positive. In that gay community, we do not have a lot of confidentiality. Discrimination of the MSM who are positive by the MSM who are negative; the community itself. Internal discrimination. Meaning that I would not go to an MSM led organization to access health services because you surely will be known by everybody there that you are positive.

A Kenyan male receptive who is HIV positive and in a long distance relationship with a foreign versatile partner had the following remarks;

> *"I have another meeting with him, my man, on September. Aware of my status, he told me, we are going to take preventive measures. But I know it's only going to be in our first intercourse, second and third. After that, it will be without any protection.*
>
> *Surprisingly, I've dated him for many months. He was in Kenya recently (though working with the non-governmental organization) but returned to German. Using a condom is a very big challenge"*

A male receptive engaging in transactional sex but is unaware of his HIV status had the following remarks;

> *I have gone through an anal-tear. I even when through a surgery; but that was with someone who was very rough and extremely big. He paid the hospital bill. Akanilipia first semester fees kwa University. It was kitambo 2006, after I had had an intercourse with a Kenyan. That time I was dating Kenyans but now I don't do Kenyans. Kenyans have a lot of issues which I cannot handle. I like people who are far way because hawani sumbui (are not stubborn). This one has been posted to Bangkok for four years; he'll be coming to Kenya for holidays. So I'm good with that. But the chances of transmitting to a top (insertive) are high for a bottom (receptive).*

Another male insertive who did not reveal his HIV status but was in an unsteady relationship had the following remarks;

> *"HIV is a common factor to both straight people (normal) and us (MSM). We have many cancerous diseases that are worse than it; so I don't understand why Kenyan's exaggerate it. I prefer anal sex without use of condoms but with a lot of lubricants. This thing is addictive and real. Many people are in it. I have slept with high school students, University students and also other men who are working. The 'ladies' (receptive) are so desperate to get partners that they care less about the HIV status of those they sleep around with. So we can choose who we want. I try to avoid those that are positive or too experienced. I like the naïve men".*

Q. Does it affect the way you practice safe sex, healthcare and HIV/AIDS prevention?

> **P1:** It does. It makes it difficult. It has been a challenge because the MSM mostly have specific health conditions. You have heard of Anal-warts? That is a condition. And the minute you present Anal-warts, everybody knows. I got it last year. I couldn't even go to Liverpool VCT for treatment. When I went to Avenue (Private Clinic), even my doctors were like smiling and saying '*what did you do?*' Then I was like, 'exactly what I did'. And I told them don't try to discriminate me.
>
> **P2:** Kenyan's are discriminative, homophobic and uninformed about HIV and AIDS prevention. That makes the different between foreign partners and Kenyans. A Kenyan, the minute you tell him about your status, when positive, he will not even reach that level of having sex; even if with a condom.
>
> **P3**: Another thing, people forget this, every time you have anal sex, there have to be some tearing. No matter how much you use the lubricant. If you are a bottom and not adhering to proper medication basically you are going to infect that top.

The analysis and findings of this study were in concurrent with those of Europeans AIDS Treatment Group (EATG) conducted in 2013. According to their

findings, in a study conducted among MSM (3748) from 145 countries (from April to August 2012; using multivariable random effects models to examined factors associated with acceptability of pre-exposure prophylaxis (PrEP) and access to condoms, lubricants, HIV testing, and HIV treatment) it was found that, Condoms and lubricants -were accessible to 35% and 22% of all respondents, respectively.

HIV testing was accessible to 35% of HIV-negative respondents. 43% of all HIV-positive respondents reported that antiretroviral therapy was easily accessible. Homophobia and service provider stigma were significantly associated with reduced access to services. Conversely, community engagement, connection to gay community, and comfort with service providers was associated with increased access (Europeans AIDS Treatment Group (EATG), 2013).

Homophobia, stigma, and discrimination are social determinants of health that can affect physical and mental health, whether MSM seek and are able to obtain health services, information and the quality of the services they receive (CDC, 2013). The findings and analysis of this study are in accordance with this.

CDC (2013) further points out that Homophobia, stigma and discrimination can: Limit MSM's ability to access high quality health care that is responsive to health issues of MSM, Affect income, employment status, and the ability to get and keep health insurance, Contribute to poor mental health and unhealthy

behaviors, such as substance abuse, risky sexual behaviors, and suicide attempts, Affect MSM's ability to establish and maintain long-term same-sex relationships that reduce HIV & STD risk and finally, Make it difficult for some MSM to be open about same-sex behaviors with others, which can increase stress, limit social support, and negatively affect health. Those who experienced stronger rejection are 3.4 times more likely to have risky sex and 5.9 times more likely to report high levels of depression.

4.2.2 The protective measures that MSM employ against transmission of HIV/AIDS

During the discussions they distinguished themselves according to various roles they play when performing sexual act. The MSM are grouped into three main categories, the Top; plays the male roles, the Bottom; plays the female roles and the Versatile; who plays both the roles depending on the situation. This finding is in accordance to Underwood (2003) who noted that society ascribes sexual roles and positions in anal sex. MSM identify three roles: “Top”, as insertive; “Bottom”, as receptive; and “Versatile”, as insertive or receptive.

Interviews and focus group discussions indicated that few MSM bothered to take protective measures against transmission of HIV/AIDS. Many suggested that it was due to frequent raptures that came along with use of condoms and the perception that HIV/AIDS is mostly transmitted through the vagina.

Few had visited healthcare facilities and hence proper knowledge on access to condoms, condom-compatible lubricants, accessing HIV testing and proper adherence to HIV treatment.

They suggested that MSM-tailored HIV&AIDS prevention communication should be vibrant and done openly just like other campaigns. This would in turn create awareness to the MSM and promoting safe sex. Having that knowledge would make it easy for them to access HIV testing and educate them on proper use of condoms. MSM suggested that sharing information through MSM groups in social sites should be popularized since the access to print media is relatively low. They also suggested that supplemental use of print media (outdoor and indoor) for specific audience segments (i.e. MSM) would be useful. MSM-tailored HIV&AIDS prevention communication was thought to possibly foster good relations and transparency among the MSM relationship.

The conversation is presented below:

Q. Do you exercise protective measures against transmission of HIV and AIDS?

> **P1:** I told you of Jock*. I told him I was positive. But we only used a condom once. After that he told me, "Ah! I don't care; I have to have you the way you are".
>
> I asked him, you are not worried that I might transmit the virus to you?
>
> He was like, "Ah! Whatever!" So it's a very big challenge because we used condoms, one to three times. After that, that is put aside.

P2: There is still that perception that gay men do not transmit the infection.

P3: Only once. After that, he got tired and refused.

P4: It especially depends on the roles played by the partners. The bottom will still demand on the use of condoms, but a top wouldn't take it seriously. He will just say, "Oh! You are a bottom so I don't think it's necessary".

P5: Many of us do not love condoms. Using it is cumbersome and keeps tearing. But why should you strain yet this thing is sweeter and tighter with plenty of lubrication without condoms?

One of the HIV male receptive (bottom) in a relationship with a foreign man, had the following remarks;

> *''Rarely; I visited only once. I was found to be positive. Being on treatment does reduce the chances of transmitting. If you are not on treatment, you can transmit quicker. But for a top it will take a lot of time. For example, for my partner (a German), I initially told him, of course we talk about sex, then I told him, you know by the way, I have been positive like all my life. So telling me to have HIV&AIDS test once again is a waste of time. And this is not the worst''.*

Another interviewee who plays the role of being versertile had the following comments:

> *'It does not help. The MSM can as well spread the disease knowingly without disclosing the status. Especially if, for example, I feel threatened when disclosing my status. If you enter into my comfort zone, I am bound to feel threatened and therefore being secluded by my sexual partners because of my status and therefore opt not to disclose my status. If I get noticed, I will have to travel to other regions like Kisumu, Kitale and Mombasa. Disclosing my status in a relationship cannot help'.*

One of the HIV positive MSM attributed non-condom use to 'spontaneity' of sex in a specific situation (was caught up in the moment, situation or mood). He had the following comments;

> *"I was transmitted to by someone. It was really my mistake. I know the person who transmitted to me. You know we nowadays have gay orgies. Like in 2006, we went to a party and this happens a lot in MSM parties...gay men's parties. People sleep around with each other while partying. Before long we were in an all out fuck session. So we got drunk, I think I had sex with three different people at the same night. The issue of HIV infection had crossed my mind but I didn't push the issue. I was so drunk and excited. Now tuka kaakaa (we stayed for long) me I din't know I had it. In fact, that's why we need a lot of advocacy on Pre-Exposure Prophylaxis (PrEP). If you take it within the next 72 hours, it will actually prevent you from getting the virus. But many MSM do not know about those treatments. So I ended up positive because I was not literate and not doing the work that I am currently doing".*

For success in HIV prevention campaigns and education materials tailored for MSM, segmenting the audience by demographic (e.g., race, ethnicity, age, income) and behavioral (e.g., HIV testing frequency, risk factors) characteristics will result in a more effective delivery of campaign messages (CDC, 2013). These findings were in accordance to the findings identified in this study.

Also, the findings in this study show that in use of condoms and other HIV and AIDS protective measures among MSM, their roles in the relationship matters. It is in harmony with Jenny E., and Simon Rosser (2011), findings that link non-use of Condoms among Men-who-have-Sex-with-Men with the various roles-in-sex that Receptive and Insertive play during sexual intercourse.

Some HIV-positive MSM assume the role of receptive partner to reduce risk of HIV transmission. Increased awareness among MSM of HIV status and variation in risk potentially makes role-in-sex an important factor in decisions about whether to use condoms. Knowledge of this may influence individual perceptions of HIV risk and affect condom use behavior (Parsons et al. 2003; Belcher et al. 2005).

Frequently mentioned reasons among MSM for non-condom use or as obstacles to condom use include; dislike of condoms, enjoyment of skin-to-skin feeling and concern about diminished pleasure. Others are Unavailability or breakage of condoms and 'spontaneity' of sex (Carballo-Diéguez and Bauermeister 2004).

These statements support the findings of this study on concern about pleasure and the fact that it affects the use of condoms.

Inconsistent disclosure and ascertainment of HIV status appears more risky than consistently adopting or not adopting a strategy (Horvath, Nygaard and Rosser 2009; Parsons et al. 2005). Findings of this study support their proposition.

4.2.3 The effectiveness of communication channels being used to reach MSM

Interviews and focus group discussions indicated that the channels used to reach them are not sufficient; most of them not aware of any HIV/AIDS prevention campaigns that were targeting them except for those that had visited MSM-led organizations and few clinics that had the posters. Majority of the MSM also linked the ineffectiveness to the fact that medical centers addressing their health needs were not well spread in the country; were unavailable in *mashinani and slums*.

They suggested that preventing this would be effective through advocacy and Community-delivered healthcare services, or those provided at a Community Based Organization's (CBO) office or a CBO-run clinic. Also, negative perception about MSM has led to concealed information communication and therefore not effective to the majority who cannot access.

The conversation is represented below:

Q. What are the effective channels of communication being used to reach MSM?

P1: We have nothing. Basically what we need to have is an advocacy. A good advocacy strategy for combined eventual-technologies; meaning that we are doing adherence counseling and treatment literacy.

P2: Doing away with stigma, segregation, homophobic tendencies that are even displayed through the media.

P3: We need communication that directly targets us plus those who perceive us negatively. Only through that, we can achieve complete success.

P4: Another thing is about inaccessibility to medical care and communication reach is that most of these clinics which offer HIV/AIDS treatment to MSMs are located in the cities. For example in Eldoret, there is not clinic there, the entire Rift Valley, Kisumu there is only one-*Maigo*, Mombasa only one-*Pema*. And you know one day *huko Mashinani*, one day you might have sex with a number of men and MSMs travel a lot.

One of the MSM who is a post-graduate student at a local private University and works in an NGO had the following remarks;

> *"Another challenge we have in Kenya, I have to be very honest, and I'm going to do a fellowship on capacity building and capacity strengthening of key population by the organization and especially the MSM led organizations. Most of them only focus on advocacy on condom but not the lube. They are not tailor made for the MSM. MSMs themselves do not have treatment literacy knowledge. The treatment literacy level is actually very low. When you talk about adherence to drugs, many do not. No appropriate communication information that targets us, teaches us how to properly use condoms and the lube. Most HIV prevention communication focuses on condoms for the ordinary population".*

These findings were in coherence with findings from Global Men's Health and Rights Study (2014); it states that CBO-run clinic have helped MSM access services without facing stigma and discrimination, eased the financial burden of accessing HIV services, and provided tailored services that attended to the unique and complex issues faced by MSM.

On the other hand, MSM groups in social sites should be popularized since the access to print media is low. Majority of MSM use social media (e.g., Facebook, Twitter) and visit dating and hook-up sites e.g. Adam4Adam, Grindr. As a remedy for low readership and access of print media, it recommends supplemental use of print media for specific audience segments was recommended (e.g., local newspapers that target MSM). Partnerships with

national and local MSM led organizations are essential for campaign dissemination success. Additionally, engaging nontraditional partners (e.g., adult entertainment industry and bloggers) may also be an effective way to reach MSM, particularly those at high risk for HIV (CDC Report, 2013).

Also, the findings were in harmony with those from Centre for Popular Education and Human Rights, Ghana (CEPEHRG, 2013) that indicated that public discussions around sexual orientation are often beset with misinformation and mistaken perceptions of the LGBT community and hence increased homophobia, homophobic violence and increased incidences of criminalization of homosexuality. This prevents effective communication of MSM-tailored information.

According to C-Change Program (2013), tailor made information to the MSM effectively reaches them and creates an impact. It suggests that messages could be put on dominoes, as this was a popular game among gay and straight men, use of range of slogans and phrases, use of cartoons since they elicit enthusiasm and use of media to include online, radio, TV, booklets, leaflets, posters, and flipcharts. Use of tailor made information was and appropriate media to reach the MSM was in accordance to the findings of the study.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter contains a summary of key findings, the conclusions and recommendations that are based on the objectives of the study.

5.1 Summary

HIV prevalence among men who have sex with men (MSM) in Kenya is almost three times that among the general population (17%) because of low access to MSM-tailored information and health campaigns. MSM are often not aware of the particularly high risk of sex with a person who has recently become infected.

On assessing the knowledge of HIV/AIDS prevention campaigns among the MSM in Nairobi; homophobia, stigma, and discrimination are social determinants of health that can affect physical and mental health, whether MSM seek and are able to obtain health services, health information and the quality of the services they receive. Such barriers to health need to be addressed at different levels of society, such as health care settings, work places, and schools in order to increase opportunities for improving the health of MSM.

Perceptions of homophobia in the community, and past experiences of homophobic violence, are negatively related to access to services. There is need

for the health care organizations to conduct interventions to improve public discourse about homosexuality, dispel popular myths, and highlight the relationship between societal attitudes and access to much needed services. They should also engage policy makers to educate them on the levels and impact of violence faced by MSM people.

The protective measures that MSM employ against transmission of HIV/AIDS are equally important in preventing HIV and AIDS. MSM-tailored HIV&AIDS prevention communication should be vibrant and done openly just like other campaigns. This would in turn create awareness to the MSM and promoting safe sex through tailor made messages that target them directly. Having that knowledge would make it easy for them to access HIV testing and educate them on proper use of condoms. MSM suggested that sharing information through MSM groups in social sites should be popularized since the access to print media is relatively low.

The effectiveness of communication channels being used to reach MSM groups also matters. Use of social sites should be popularized since the access to print media is low. Majority of MSM use social media (e.g., Facebook, Twitter) and visit dating and hook-up sites. MSM are more likely to experience depression due to social isolation and disconnectedness from health systems, which can make it harder to cope with aspects of HIV such as adherence to medication.

5.2 Conclusion

While health communication with gay men is a relatively new field, there are many important successes to draw from and still more accomplishments to look forward to. In Kenya, we have reached critical stages of addressing HIV/AIDS prevalence and the chance of addressing MSM as MARPs should not be neglected. Addressing HIV among MSM is a difficult task in most parts of the world but mostly in Sub-Sahara Africa. Through improving relationships between MSM and healthcare providers, addressing homophobia and homophobic violence, providing health facilities and facilitating engagement with MSM, it will be possible to envision an AIDS-Free future for MSM in Kenya.

5.3 Recommendations

5.3.1 Developing training modules on MSM health needs and rights

Training modules on MSM health needs and rights should be developed. Developing these modules should be in a way in which they are offered as part of the Continuous Medical Education (CME) to the gays by Ministry of Health, through the National AIDS and STI Control Programme (NASCOP) and the Kenya Medical Board.

Part of the rights and needs should emphasize on access to and promotion of consistent condom and water-based lubricant use. *See Appendix A, B and C (Page 67, 68 and 69).*

Training and sensitization of health-care providers to avoid discrimination against MSM should as well be incorporated. These modules will, apart from creating awareness on safe sex among the MSM, facilitate in improving relationships between MSM and healthcare providers. Good relationship between the MSM and medical practitioners will encourage confidential, voluntary HIV screening, care, treatment and support services. Training modules provide safe virtual and/or physical spaces for MSM to seek information and referrals for care and support.

5.3.2 Create awareness of the nature and scope of the gay men's HIV/AIDS issue in Kenya

This can preferably be done through making available all the HIV-related prevention information, care and support services for MSM. The MSM should be informed of detection and management of sexually transmitted diseases through the HIV-related prevention information.

It is effective to engage religious leaders, HIV organizations, healthcare organizations, and media in radio debates and other forums to ensure that messages sent to the broader community are not homophobic. Creating awareness of the nature and scope of the gay men's HIV/AIDS issue in Kenya will empower the gay and bisexual communities to participate in safe sex.

It is therefore necessary to conduct interventions to improve public discourse about homosexuality, dispel popular myths, and highlight the relationship between societal attitudes and access to much needed services. They also engage policy makers to educate them on the levels and impact of violence faced by LGBT people.

5.3.3 Legal and policy reform

Legislators and relevant ministries should engage in legal and policy reform to enhance promotion and guarantee of human rights apart from removal of legal barriers that undermine access to HIV-related services such as laws that criminalize consensual sex between men.

To prevent discrimination and homophobic violence, healthcare organizations should conduct interventions to improve public discourse about homosexuality, dispel popular myths, and highlight the relationship between societal attitudes and access to much needed services. They also engage policy makers to educate them on the levels and impact of violence faced by MSM people.

According to CDC (2013), gay men who have good social support from family, friends, and the wider gay community—have: higher self-esteem, a more positive group identity, and more positive mental health. In turn they take preventive measures against the spread of HIV and other STIs.

MSM and their family and friends can take steps to reduce the effects of homophobia, stigma and discrimination and protect their physical and mental health. One way to cope with the stress from stigma and discrimination is social support.

Legislators should as well put up a policy reform geared towards ensuring that legal barriers to accessing health services are removed and policies are put in place to protect and promote the rights of gay and bisexual within health care settings. The policies should also encourage empowerment of gay to participate equally in social and political life.

Further research could also be conducted to determine the effectiveness of HIV & AIDS prevention campaigns targeting the gay community.

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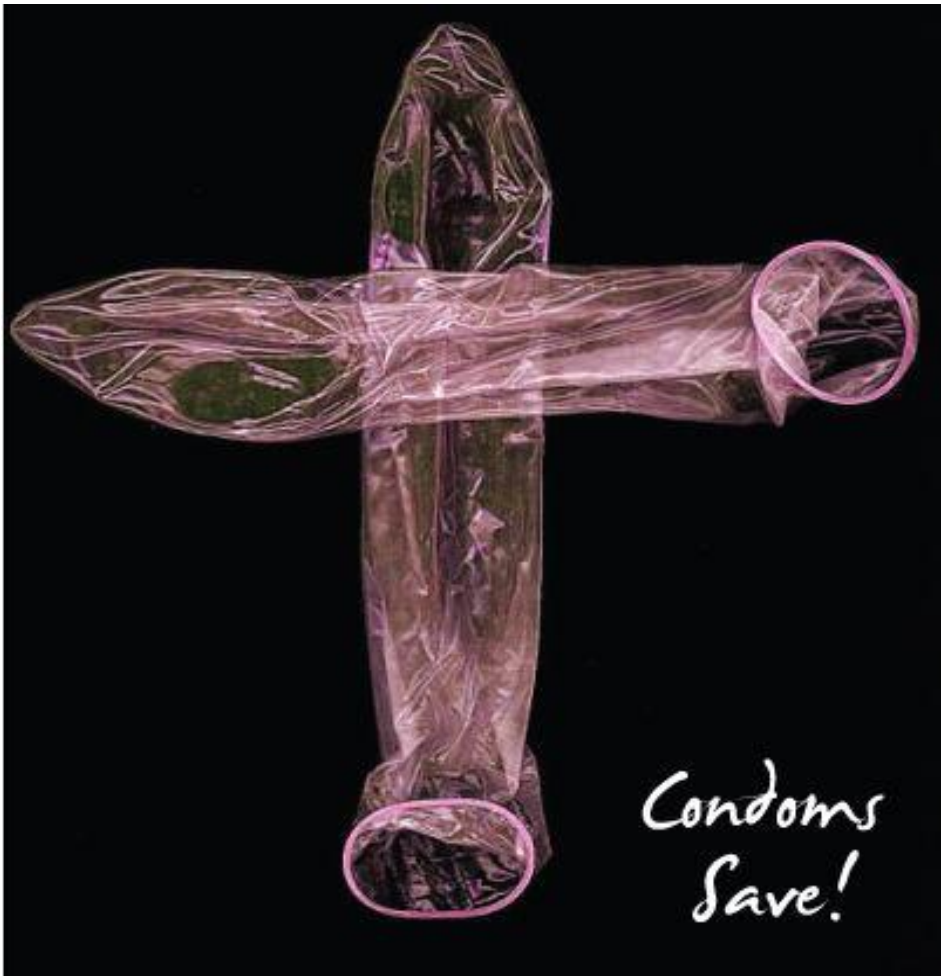
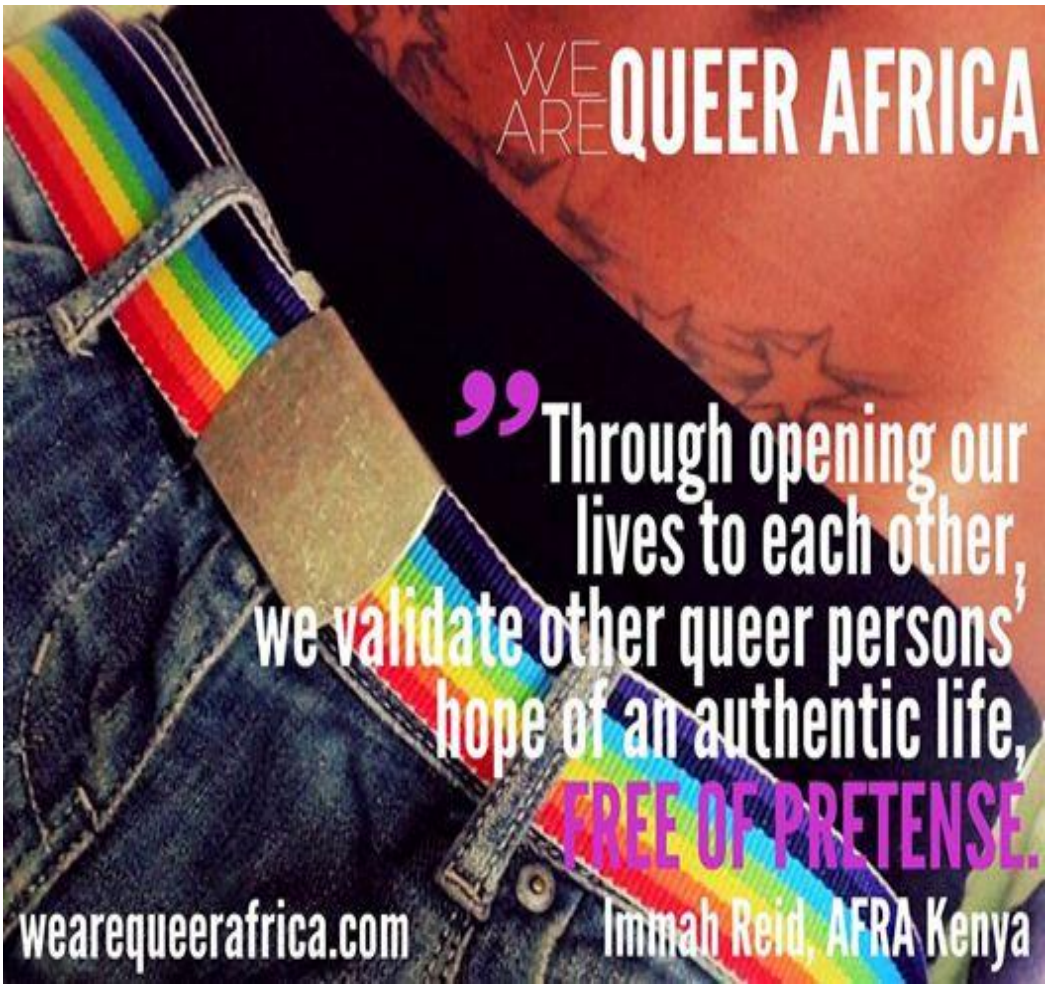
APPENDIX A



APPENDIX B


WE ARE QUEER AFRICA
"Through opening our lives to each other, we validate other queer persons' hope of an authentic life, FREE OF PRETENSE.
Immah Reid, AFRA Kenya
wearequeerafrica.com

APPENDIX C


DEMANDEZ ET VOUS RECEVREZ
KONTAKtez-nous pour pig-menter vos sexe-party avec du matériel à des prix vraiment cochons
On est FACILE et ABORDABLE, pis ON LIVRE en plus !
YOU DEMAND WE SUPPLY
KONTAK us and pig out on our wholesale priced sex party supplies.
We're CHEAP and we DELIVER
Tel 514-527-0928 ext. 24
Text 514-941-SEXE (7393)
ACCM
KONTAK
accmkontak.com
facebook.com/kontak
outreach@accmontreal.org
Un intervenant peut aussi être présent lors du party afin de répondre à tes questions sans aucun jugement, et offrir à toi et à tes invités de l'information au sujet de la santé sexuelle.
An outreach worker can also attend your party to offer sexual health information and answer questions without judgment.