

Social context, sexual risk perceptions and stigma: HIV vulnerability among male sex workers in Mombasa, Kenya

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Knowledge about sexual practices and life experiences of men having sex with men in Kenya, and indeed in East Africa, is limited. Although the impact of male same-sex HIV transmission in Africa is increasingly acknowledged, HIV prevention initiatives remain focused largely on heterosexual and mother-to-child transmission. Using data from ten in-depth interviews and three focus group discussions (36 men), this analysis explores social and behavioural determinants of sexual risks among men who sell sex to men in Mombasa, Kenya. Analysis showed a range and variation of men by age and social class. First male same-sex experiences occurred for diverse reasons, including love and pleasure, as part of sexual exploration, economic exchange and coercion. Condom use is erratic and subject to common constraints, including notions of sexual interference and motivations of clients. Low knowledge compounds sexual risk taking, with a widespread belief that the risk of HIV transmission through anal sex is lower than vaginal sex. Traditional family values, stereotypes of abnormality, gender norms and cultural and religious influences underlie intense stigma and discrimination. This information is guiding development of peer education programmes and sensitisation of health providers, addressing unmet HIV prevention needs. Such changes are required throughout Eastern Africa.

Keywords: Kenya; male sex work; men who have sex with men; HIV/AIDS; HIV prevention

Introduction

Sex between men occurs throughout cultures and societies, although its recognition and public visibility vary markedly (Murray and Roscoe 1998). In many parts of Africa, there is evidence showing that same-sex relationships have been an unspoken part of these societies for many years (Evans-Pritchard 1929; Werner 1987; Kiama 1999; Niang et al. 2003; Allman et al. 2007). Within the African context, male-male sexuality is, however, popularly associated with European or Western influence (McKenna 1996; Murray and Roscoe 1998; Niang et al. 2003) and there is widespread denial that it has roots in traditional African society. Sex between men is thought to account for between 5 and 10% of HIV infections globally (UNAIDS 2006) and was estimated to contribute 5% of new HIV infections in Kenya in 2005 (Gouws et al. 2006).

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In Kenya and Senegal, where overall HIV prevalence is 7 and 1%, respectively (UNAIDS 2008), HIV prevalence among men having sex with men has been estimated at 38 and 22%, respectively (Wade, Kane, and Diallo 2005; Sanders et al. 2007). Such levels of infection are attributed to a combination of biological, behavioural and socio-cultural factors, which together create considerable risk for acquiring and transmitting HIV (Allman et al. 2007; Geibel et al. 2008; UNAIDS 2008). Several, mainly Western, studies reveal high biological vulnerability to HIV; this due mainly to highly efficient transmission via unprotected anal sex and extensive sexual partner networks (Roehr, Gross, and Mayer 2001; Shallock and Moore 2003).

Limited available evidence suggests that sex between men in African settings is commonly unprotected and partner numbers are high (Niang et al. 2003; Onyango-Ouma, Birungi, and Geibel 2005; Lane et al. 2006; Sanders et al. 2007). These studies also showed that men who have sex with men in this setting also frequently have sex with women (Niang et al. 2003; Geibel et al. 2008).

The law in Kenya criminalises same-sex sexual activity (Government of Kenya 2008), making it difficult for HIV prevention programmes to fully address male sex work. Section 162 of the Penal Code states that ‘any person who has carnal knowledge of any person against the order of nature; or ... permits a male person to have carnal knowledge of him ... is guilty of a felony and is liable to imprisonment of 14 years’. Additionally, section 165 specifies that any ‘male person who ... procures another male person to commit any act of gross indecency with him or attempts to procure the commission of any such act by any male person ... is guilty of a felony ...’.

Other former British colonies in Africa such as Malawi, Nigeria, Uganda and Zambia also criminalise consensual male-male sexual activity, often for ‘unnatural offences’. Legislation in these countries reflects UK domestic law-making from the Victorian period (Baudh 2008). Besides the legal implications, men have to contend with several layers of stigma stemming from sex work and same-sex activities. In the public view, male-to-male sex is often conceived as undermining and challenging powerful assumptions about masculine behaviour and what it means to be a ‘real’ man (Costigan and Foreman 2002).

Adding to this is the fact that political, civil and religious leaders frequently make unambiguous public statements that same-sex behaviour is incompatible with traditional ‘African’ culture (Murray and Roscoe 1998; Kiama 1999; Allman et al. 2007). In Kenya the issue of homosexuality evokes much debate and is emotionally charged. Two former Kenyan presidents are on record disputing the existence and practice of homosexuality, stating that it was ‘un-African’ and ‘even in religion, it is considered a great sin’ (Kiama 1998). Leaders across sectors ‘close ranks’ on this issue, condemning same-sex relationships and invoking religious and cultural reasons to justify their opposition.

Prejudice against men having sex with men, oftentimes expressed as homophobia, limits opportunities for learning about risks of HIV infection and may lead to alienation from HIV prevention and care programs (Onyango-Ouma, Birungi, and Geibel 2005). In most of Kenya there are no health services that adequately address the diagnosis and treatment of sexually transmitted infections (STIs) for members of these population groups. Furthermore, effects of this neglect are exacerbated by socio-economic vulnerability in these settings (UNAIDS 2006).

In Kenya, there has been a near exclusive focus on preventing HIV transmission through vaginal sex or from a mother to her child. There is a long history of providing outreach services to sex workers in many parts of Kenya, including peer mediated interventions, HIV/AIDS prevention and control and poverty alleviation strategies (Ngugi et al. 1988; Moses et al. 1991; Luchters et al. 2008). However, male sex workers are

seldom targeted in these projects. This paper aims to enhance understanding of the dynamics of male-to-male sexual activities within the context of commercial sex in Kenya and to guide configuration of targeted HIV prevention services.

Methods

Study setting

Mombasa district, in Kenya's Coast Province, is the site of this study, which took place from October to December 2006. The district has a population of about one million and is a major regional economic centre, with important tourism, port, rail and industrial enterprises. Evidence suggests that the number of men having sex with men in Kenya's coast region is large (Murray and Roscoe 1998; Geibel et al. 2007) and that both Kenyan and foreign tourism are linked with transactional sex in Mombasa and nearby areas (Kiama 1999; Kibicho 2003). This evidence prompted this study, which was done in consultation with the Coast Provincial Medical Office and the Kenya National AIDS Control Council. The study is also a response to the National HIV/AIDS Strategic Plan, which stipulates that men having sex with men be included in behaviour change communication for most-at-risk groups (National AIDS Control Council 2005).

Recruitment and initial contact

The study followed a capture-recapture exercise consisting of a mapping and two enumerations one week apart, which located 65 meeting points and estimated 739 male sex workers selling sex to men in May 2006 in Mombasa and its environs (Geibel et al. 2007). Initial contact was made through 12 peer mobilisers familiar with male sex work in Mombasa. Potential participants were approached in bars, nightclubs, private brothels, beach areas and other community settings. To be eligible for participation, men had to be 16 years or older and active in Mombasa district. For study purposes, a male sex worker was defined as any man who 'recently sold and/or is currently willing to sell sex to other men in exchange for money or goods'.

Phase I

Structured interviews with 425 men provide background demographic and behavioural data for this study, described in detail elsewhere (Geibel et al. 2008). Men were a median 26 years old (IQR = 22–31), almost all were Kenyan citizens (98.4%; 418/425) and the majority had completed primary school or higher levels of education (68.5%; 291/425). A substantial number (41.7%; 177/425) reported sex work as their sole income source and more than half the sample uses their income for supporting their family or friends (56.7%; 241/425). During last anal sex with clients, more men reported insertive sexual roles than receptive ones (57.6%; 242/420 versus 34.8%; 146/420), with only a few combining insertive and receptive roles (7.6%; 32/420). In the past seven days, participants had had a median of two male partners (IQR = 1–3; range = 0–10). Over 80% stated that their last male client was Kenyan. Most respondents (67.1%) had ever had sex with a woman and a quarter (25.4%) reported having sex with a non-paying female partner in the past 30 days. Over 12% had experienced physical abuse in the past year, while 9.9% had been sexually assaulted or raped over the same period (42/425). Only one-third reported consistent condom use in the past month for insertive or receptive anal sex with male

clients (36.0%; 153/425), a figure not surprising given that only 35.3% of those interviewed knew HIV could be transmitted through anal sex.

Phase II

Data presented here describes the experiences of 36 men who reported exchanging sex for money, drawing on three focus group discussions (FGDs) and ten in-depth interviews (IDIs). Study staff identified candidates for either group or individual discussions from among those participating in the Phase I survey. In this process (non-random purposeful selection), staff made a subjective assessment of the likelihood that participants would share their experiences openly.

Men were identified for pre-determined IDI sub-groups (men who have sex with both men and women; men who have sex with men only; men living with a male partner; younger sex workers (16–24 years); men older than 25 years; men who sell sex to Kenyans only; men who sell sex to international tourists; men tested for HIV; men seeking clients in multiple venues; and men in high socio-economic strata). While IDIs sought detailed insights on topics at the individual level, FGDs were conducted to elicit debate or consensus on the same topics from pre-selected subgroups (men who engage in primarily receptive anal sex, men who engage in primarily insertive anal sex and a third group inclusive of both). The age range of participants was 17–45 years, with 8–10 men per focus group. For both the in-depth and focus group discussions, identification and definition of these subgroups was based on formative consultations with male sex workers conducted prior to implementation of this study.

A standardised interview guide was developed with open-ended questions followed by probes. The guide was customised for both individual and group participants. Interview instruments specifically sought to establish: the context of first sexual experiences; processes of obtaining clients and negotiations (sexual geography); sexual practices and roles; condom use and risk of HIV infection; partner relations; sexual identity; stigma and discrimination; and access to health services.

Trained researchers facilitated the interviews in Kiswahili. The interviews were tape recorded, transcribed verbatim, translated to English and analysed using QSR NVivo 7 Software ©.

Ethical aspects

The Kenyatta National Hospital Ethics and Review Committee in Kenya and the Institutional Review Board of the Population Council, reviewed and approved the study. Written informed consent to interviewing and audio recording of responses was obtained from all interviewees. Participants received 300 Kenya Shillings (US\$ 4.50) for transport reimbursement.

Condom promotion and provision occurred during the quantitative and qualitative phases of the study. Participants also received printed materials on STI, including HIV and referral for HIV testing and counselling. To further promote the health of participants, the interview team was trained to identify respondents who could benefit from free STI treatment or referral and linked participants with such services, where applicable.

Concerns about participant confidentiality and safety made it preferable to have interviews at central venues. For similar reasons participants were asked to provide a nickname during FGDs, which they were encouraged to use when referring to other participants. Pseudonyms are used in presentation of study findings and other participant identifiers are avoided.

Results

Several broad themes were noted in analysis of male sex workers' experiences. These are grouped as follows: first sexual experience; meeting points for obtaining clients; stigma and discrimination; condom use and perceptions of risk for HIV infection.

Context of first sexual encounter and entry into sex work

Respondents' first sexual experience with men occurred in quite varied circumstances. In general, these experiences can be dichotomised as either being clearly consensual or coerced and as occurring either with people well known to them or with complete strangers. Men interpreted their first experiences in terms that included love, sexual exploration, coercion and, predominately, financial incentives. Initial contact with sexual partners was often made in familiar social spaces such as workplaces, schools, public parks, beach areas and other communal settings. In the descriptions of first sex with people well known to them, sexual behaviour often progressed gradually over successive meetings, from physical attraction and appreciative looks to touching, kissing and cuddling, ultimately becoming more intimate and culminating in penetrative anal sex.

For men whose first sexual encounter was at a young age, initiations into homosexual relationships were described as gradual and 'easy' and generally involved people they knew and were comfortable with. In a one-on-one interview, Sam (19 years) explains:

I have always liked men ... we used to touch one another and joke about our sexuality ... then one day at the beach we decided with my friends to try to have sex and see what happens. That was the first time; we then continued to have sex at home and in school toilets.

Men's narratives often mentioned love and affection and were congruent with accounts of romantic attraction to other men or experiencing pleasure and having sex with other men as part of sexual development. In a deeply personal way, John (age 18) told us of his first sexual experience and how he began selling sex:

This began when I was in school in class six [about 11 years] and I was first penetrated by my school mate. I was not doing it for money at that time because I did not know what it was all about. All I know is that I loved him ... after I finished class 8, I began commercial sex. This was due to financial problems we have in the family. My parents could not provide clothing and other things that I wanted, and here was money I could make.

Conversely, some men reported entering into a sexual transaction involving anal sex the same day they met with strangers. These decisions were unplanned and influenced largely by an envisaged immediate financial or material gain. This tended to occur among men at an older age and was strongly linked with livelihood opportunities, even as an easy means of survival as well as of acquiring accessories such as phones, shoes and clothing. Minimal probing showed that unemployment and poverty were the overriding drivers. During an IDI, Ken (28 years) explained the circumstances in which he first had sex with another man, demonstrating the key role of poverty in sex work:

When I first came to Mombasa, I used to visit a local car park. A man came in a car, he called me and talked to me. At first I did not understand. He promised to pay me if I did what he wanted. Since I did not have money I agreed.

For his part, Tim (45 years) described how, upon becoming unemployed, he had no other means of providing for his family. One day when he happened to be in a place where sex work negotiations commonly take place, he was offered money for sex. Tim said that he would stop sex work if he found another way to support his wife and children.

In some cases, initial penetrative sex and subsequent acts were the result of sexual exploitation by friends, relatives or other people trusted and well known to the individuals. This is precisely the point made evident in the comment of Musa (21 years) who noted:

My father's friend was very close to me . . . when my father died he took care of me and one of my brothers. He used to have sex with us. My brother was about 12 and I was 14. He paid school fees for both of us for two years before he also died. When he died I had to take care of things and therefore I got into this business [sex work].

Though no informants reported that their first sexual act was physically forced, cases of cross-generation luring and/or financial coercion had occurred. Often, reports suggested that both subtle and overt coercive strategies were employed by older men. For example, Moha, now 35 years old, explained:

I was employed as house help. One day my employer asked me if I wanted to have sex with him. He told me that he would add my salary. I agreed and that is how I started.

In these circumstances, considerable power imbalances between partners meant that safe sex was only feasible if the perpetrator opted for protection, which none of our informants mentioned had occurred. For some men, the practice of unsafe sex with their initial partners appeared to extend to sex with subsequent partners, a pattern common to reports of women who have experienced sexual violence (WHO 2005).

Overall, men's first sexual experiences were often recounted with distinct ambivalence. Regardless of whether initial sexual activity was consensual or coerced, a striking commonality in the narratives is the role played by the promise of material or financial reward. Perhaps no other respondent made this linkage clearer than Kim (age unknown), who explained:

I would say selling sex began with him [first man he had sex with in school] because sometimes after we had sex, he used to ask me what I wanted, and he gave me.

Sexual geography

Examination of solicitation practices provides us with an outline of the different territories where clients are acquired and negotiation of sexual exchanges take place. The discourse around stigma and criminalisation of same-sex relationships overwhelmingly shapes where the pursuit of clients occurs. Meeting points are predominately clandestine, known only to sex workers and their client networks. These locales appear to shift rapidly between day and night for fear of arrest and from the need to evade public hostility.

These meeting locations are diverse and often closely match an individual's socio-economic class and age. The demographics and behaviours of clients (and male sex workers) are thus somewhat specific to a location. Participants in higher social or economic groups reported contacting clients via mobile phones or visiting 'stylish' and secluded locations, such as beach hotels or more exclusive upmarket nightclubs. More experienced and older informants operated from multiple locations outside of Mombasa. Others mentioned having a network of foreign clients and making occasional visits abroad.

Conversely, participants in lower socio-economic groups – more often younger sex workers – mentioned soliciting clients within their local neighbourhood. Favourite meeting spots for this group include community nightclubs, video halls, beach areas, public parks and backstreet or mainstreet locations known to them and offer anonymity and/or secrecy. Once contact has been made, negotiation occurs about the type of sexual activity, price and place. Sex workers based in nightclubs described how these agreements are reached while drinking with a client. Both street- and club-based sex workers noted

that discussion around condom use only forms a minor component of negotiation, if mentioned at all. Additionally, some street-based venues intrinsically hinder safer sex practices as prevention commodities like condoms or lubricants are not readily available.

According to informants in poorer locations, identifying and successfully concluding speedy negotiations with clients is critical, particularly in the potentially dangerous terrain of public meeting points. Securing clients is achieved using well-rehearsed, non-verbal methods. Men thus position themselves to 'assess' and 'signal' to potential sexual partners. Long discussions about safer sex are seemingly out of the question and negotiations mostly cover type of sexual activity. One of the focus group respondents observed:

When I am on the road [streets] at night, I dress differently, I walk and behave differently. A person who is interested will know that you are on the market [selling sex]. Even on the beaches they will know you from your dress and behaviour.

By and large, success of male sex work is dependent on level of experience, a network of contacts and knowledge of where clients can be obtained. Usually, contact between clients and sex workers occurs without sex-work intermediaries like pimps. However, some informants reported a degree of reliance on informants, friends or newly-acquired clients of friends. Bar waiters and other staff in drinking and entertainment venues are especially useful links. Kelly had this view:

If one of my colleagues has got one [client] already and I have not yet 'fished' one I will have to wait or use the client my friend has got to link me with other clients and sometimes we use waiters. We usually give them a tip ... there is a lot of co-ordination you know ... waiters play a very big role.

Several men described the use of alcohol and drugs, especially miraa (*cartha edulis*) as a common pastime. Jim, a middle-aged married man who leads two lives – as a husband and father during the day and as a sex worker at night in the backstreets of Mombasa – says he often chews miraa or 'depending on money in [his] pocket' drinks alcohol in his favourite location while awaiting clients.

Most sexual encounters involve selling receptive or insertive anal sex, or occasionally both, but masturbation and oral sex are also practised. When asked, none of the men in the group or individual discussions reported ever having had group sex. Some sexual transactions may occur over a period of hours in lodges or private homes, but some sexual activity also takes place 'quickly' in public parks, beach areas, unused buildings or similar places.

In summary, the criminalisation and stigmatisation of male-to-male sex, limited negotiation processes, power imbalances in safer sex negotiation and alcohol or drug use portend risky sexual acts for men. Moreover, as Bloor et al. (1993) observe, communication during transactional sex is replete with ambiguity, which includes whether or not safer sex will be practised.

Stigma, discrimination and violence

We aimed to thoroughly explore the types and sources of stigma and discrimination faced by our participants. Several respondents cited instances of police harassment, arbitrary arrests for loitering and extortion for money or sexual services. Clients were also reported to inflict abuse upon the men through verbal or physical harassment by not paying after sex or by abandoning them in remote locations. Often, the general public were reported to verbally or physically abuse the street-based sex workers. Many

accepted this violence as 'normal' or as 'part of the job'. For some, feminine appearance, behaviour or clothing invited ridicule. To attest to these experiences, a respondent mentioned being called *dume jike* ('man-woman') because of his effeminate looks. Others reported being ostracised by close family members or friends. Another focus group participant reiterated this point:

I have been discriminated against, where people feel that I am a person of no value. My sisters feel I am useless. They ask why I ... do things that a woman should do.

It was clear that many sex workers live with secrecy and fear. Men living with their parents or having formal employment mentioned the 'high cost' of being exposed. For them this would signal a loss of vital proximal and distal networks of family and friends and employment. During a one-on-one interview, Jami, aged 18, very aptly demonstrated this view:

My parents don't like it, they hate it [sex with other men] they suspect I am doing it and I pretend I don't, so I normally hide my male partner relations or else I can't get anything from them [parents].

Evictions by landlords are commonly reported by African men who have sex with men in other settings (Niang et al. 2003; Onyango-Ouma 2005) and this was also reported by the Mombasa sex workers. In-depth interview participant Joe (age 45) described how suspicion by neighbours led to his eviction from a rented house:

According to me it is highly secret [anal sex], but people can detect ... when people [neighbours] came to know that I do this, I was told to vacate a house I was renting. I had to move before getting another house. My belongings were thrown out and in the course of this, I lost some of my belongings.

After the incident he said:

These days I don't stay in one place for more than six months, I keep on moving from one place to another.

According to Cáceres, Aggleton and Galea (2008) stigma may lead to self-segregation or forced migrations among vulnerable populations. Jamal (IDI participant, age 28), who engaged in insertive anal sex only, describes how this process of separation can take place:

... these days I don't talk much ... a very close friend of mine used to see me interact with different people [men], one day he asked me why I was talking to people some of whom looked like homosexuals. He later talked ill things against me ... even colleagues at my work came to know about this. I almost lost my job.

Most participants spoke of having to make difficult decisions when they became ill, as they feared prejudice in both public and private health facilities. Few health facilities or staff are responsive to their needs, particularly when seeking treatment for rectal infections. This situation leads many to seek care from unqualified health professionals or even to self-medicate. Ali (age 26) summed this up:

Services in government hospitals are not good. You will be looked down upon, they can even send you away ... or ask you insensitive questions; you see we really need a lot of confidentiality.

Participants in Ali's focus group agreed with these views and expressed a reluctance to visit public health facilities. Another discussant averred:

... when I met the doctor I did not tell him exactly what I was suffering from [rectal infection], I changed what I had to tell him, and only said that I was suffering from a headache.

These participant's narratives powerfully evince the burden of stigma faced from family, friends and society. Like other groups of men in Kenya, most respondents mitigate this by attempting to evade scrutiny; adopting tactics like self-segregation, hiding their sexual identity or seeking social acceptance through marriage or having girlfriends. Most men practicing receptive or insertive roles said that they attempt to pass as heterosexual in the heteronormative society. During an IDI, Kasim (age 34) described the steps he took to conform to social expectations:

... I am expected to marry, so I have a wife with two children. We love each other ... but I would like to tell you that my feelings for men is much stronger than that for women, that's why I have intimate relationships with men.

In all, only a few men like Brown (aged 27), who has a relatively high socio-economic status, felt confident in dealing with stigma. He achieves this by 'carefully selecting' clients he has sex with and staying away from *mtaa* [housing estates] where he is likely to be stigmatised. He states:

... I have not experienced that [stigma] because I don't engage in sex with just anybody. It is also because I go to private hospitals when sick ... there was some stigma in the *mtaa* and I moved to another *mtaa* the moment I felt it ... I select married men because they have families, careers, image etc., which they would not want to risk.

Interestingly, it appears married men formed a common client group for our participants, which has been noted in other studies (Estep, Waldorf, and Marota 1992; Morse et al. 1992).

Condom use and perceptions of HIV risk

Although a 'casual relationship' between homosexuality, unsafe sex and HIV infection has been dominant in HIV and AIDS discourses in the West (Wolitski et al. 2001; CDC 2005) there is limited evidence for this in Kenya. To obtain more detailed information, participants were asked about frequency of condom use and factors that influence this, including perceptions of risk for HIV acquisition.

Of the ten men who participated in IDIs, only two reported insisting on condom use, declining clients unwilling to use a condom. Firstly, Brown reported consistent condom use with clients by choosing men carefully based on criteria of 'career and image'. The other, Karim, provided this explanation:

I insist on condom use because in the long run you can use all the money you get from clients to treat yourself.

Although both men called condoms 'cumbersome' because of the time taken to put them on and as they were seen as reducing pleasure, they considered condoms 'very necessary' to avoid infection with HIV or other STI. Also, men reporting condom use cited unavailability of water-based lubricants as a 'major problem,' opting instead to use oil-based lubricants owing to higher costs.

Respondents rated unprotected anal intercourse as more pleasurable than protected intercourse. In a focus group session, Lucky (age 23) expressed a common sentiment that:

We are all aware that when you use a condom you don't get that maximum pleasure ... so as to get that maximum pleasure we have sex without a condom.

The idea of *not* using condoms with clients seemed normative; some sex workers even maintained that condom use was 'rarely' discussed with partners. Those proposing condoms with clients reported 'facing resistance', citing client desire for optimal sexual pleasure. To avoid using them, some clients offer additional money for unprotected sex,

which highlights the key role of the financial negotiation and transaction process for sex workers. The self-perception of the sex worker as a 'businessman' is reflected in a quote by Kale (age 27) who maintained that:

This [sex work] is like a shop, what is important is to agree on the price. A shopkeeper does not care who comes into the shop.

Many participants also expressed the view that using condoms with regular partners was difficult. It appears that levels of condom use decreased with degree of intimacy and stability of a relationship. As commonly reported within heterosexual relationships, suggestion of condom use by a regular partner often signifies 'mistrust' or is a reflection of having been 'unfaithful' or even 'HIV-infected.'

In Kenya, the silence of HIV prevention programmes and lack of media reports on anal sex may reinforce perceptions that anal sex is not a high-risk sexual practice. Some informants held a conviction that they would not acquire HIV, despite having unprotected anal sex with both male and female partners. Some participants believed anal sex was 'safer' than vaginal sex and were more likely to report condom use for vaginal sex. Seif (age 24), a man who has sex with both men and women, expressed this view:

There is AIDS and all these but I have never heard of anybody having a sexually transmitted infection in the anus ... mostly I think these diseases are found in the vagina and mouth, but I still can't understand it well.

Phil, a focus group participant, observed:

I don't believe that most men use condoms because with the information I get illness is in the vagina and not the anus ... I have never heard of anybody getting illness from the anus, even from our teachers.

As mentioned earlier, alcohol is available in many sex work locales. Men seeking clients in nightclubs, beach areas and other community settings frequently mentioned use of alcohol and drugs. Many observed that this often leads to poor decision making, as even those reporting frequent condom use mention lack of such use when intoxicated. Tabu, (age 44) describes the effects of being intoxicated as:

I mostly use condoms to protect myself from STIs including HIV. It is for my safety, but there are times when I am drunk, and then I don't use a condom.

Bright, (age 29), put it this way:

When drunk or high you are unable to think properly. When in this state you can easily get into unprotected sex.

This finding is consistent with findings from studies in other sub-Saharan African contexts where alcohol consumption was associated with unprotected sexual intercourse (Stall 2001; Chersich et al. 2007; Kalichman et al. 2007; Lane et al. 2008; Parry et al. 2008). Similar to what Diaz and Ayala (1999) and Parry et al. (2008) reported, getting drunk or high on drugs was associated with 'relieving stress', 'passing time' or 'instilling courage' prior to selling sex.

It is evident that the practise of unprotected sex is underlined by a dynamic interplay between sex workers and clients. Similar attitudes and condom practises have previously been documented (Colby et al. 2004; Kalichman et al. 2007; Parry et al. 2008). Key factors are: power relations; notions of trust; sexual pleasure; alcohol and drug use; and a belief that male-to-male sex has low risks of HIV transmission. Most importantly perhaps, as noted elsewhere, the practice of unsafe sex occurs where clients are in control of the encounter and sex workers are unable to contest that control (Browne and Minichiello 1995).

Conclusion

In seeking to explore the lives of male sex workers this study documented the dynamics of male-male sexual activity and their implications for vulnerability to HIV and overall wellbeing and health. Reflecting on our findings, we note that alongside individual risk behaviours of participants there exists a range and variation of specific groups, such as low socio-economic strata, younger, aged and incarcerated men, that even further magnifies these risks (Cáceres, Aggleton, and Galea 2008). Also, both phases of the study found that most clients are Kenyan, contrary to occasional public pronouncements that male-to-male sex is a foreign import.

Why then does male sexual activity take place and how do such notions apply in this population? According to Plummer (1995), male-to-male sexual experience is classified within four categories, namely casual homosexuality, situational homosexuality, personalised homosexuality and homosexuality as a way of life. He explains that schoolboy crushes or masturbation, sexual activity in prisons or military camps, secret homosexual desires and open acknowledgment of homosexual preference, respectively, fit these classifications. In Kenya, male-to-male sex of a situational nature has previously been documented where men are in closed settings (Kiama 1999; Mathenge 2008). However, it is difficult to apply Plummer's categorisation to our population in simple terms. For many men in this study, male-to-male sex is motivated largely by financial incentives and not as a way of life *per se*. This, however, is not to say that male-male sex is limited to economic motives alone in this setting. Sex with other men occurred also due to same-sex desire, socio-economic circumstance or a combination thereof.

The study also provides insight into the relationship between health and place. Although understandings of solicitation practices are complex (Macintyre, MacIver, and Sooman 1993; Flowers, Marriot, and Hart 2000), this study explains, in part, its nexus with high-risk behaviour. The chances of negotiating or acquiring commodities to make sex safer decreases with the social class of the location and although social class classification has limitations in measuring health (Naidoo and Wills 2000), it does serve as an important indicator of living conditions and access to services. Also, as previously described (de Wit et al. 1997), the number of anal sexual partners and acts vary according to venue in which sex occurs. All this suggests locale-based interventional approaches are required for different sex work settings (Flowers, Marriot, and Hart 2000).

Beyond this, narratives of public prejudice and family ostracism depict the extent of social exclusion experienced by male sex workers. This link has important implications for sexual behaviour, partner relationships and HIV vulnerability. Perceived societal norms bar many men from openly discussing their same-sex experiences or seeking health services. Social structure and beliefs tolerate stigma and violence against these men. Escoffer (1997) and Cáceres, Aggleton and Galea (2008) argue that stigma frequently promotes increased mobility and vulnerability for such marginalised population groups. Additionally, considerations for family honour and social standing are associated with maintaining concurrent heterosexual relationships. This has potential implications for the broader HIV epidemic, given that male-male sexual networks are often integrated with the general population.

To reduce HIV and STI transmission in male sex work settings in Mombasa, results from the quantitative and this qualitative study were analyzed and used to inform the development of health interventions. Firstly, patterns of self-identification, client-seeking and healthcare avoidance described by informants indicated that an outreach strategy driven by the men themselves might be most effective in reaching peers. Thus, to help

facilitate delivery of health information and referrals for STI services, 40 men were recruited as peer educators and trained in basic HIV prevention, harm reduction (hazardous use of alcohol and drugs) and as HIV testing counsellors. Negative experiences at healthcare facilities were described by participants. This showed that local health workers were not trained or familiar with anal STI issues, prevention information specific to male-to-male practices or in the public health importance of sensitivity and confidentiality towards these men. To respond to this concern, 20 health service providers in Mombasa attended a workshop to sensitise them to the health-related needs of male sex workers and on recognising anal STI symptoms and tailoring HIV prevention advice. These are key first steps towards addressing the unmet prevention needs of men having sex with men in Mombasa.

Our study has some limitations. Although selection of participants according to pre-selected categories enabled the study to capture a range of experiences, the sample may not be representative of the sex worker population. Interview subgroups and discussion topics were also selected based on formative discussions conducted prior to survey implementation and may not have included important issues that emerged in the first phase quantitative survey. Some of the reported norms, patterns and behaviours may also be specific to the local sex work context in Mombasa, although there are likely broad commonalities between the experiences of this group and those of other male sex workers in Kenya and other African countries.

Overall, findings from this study show that HIV prevention needs of men having sex with men have been largely overlooked. However, policymakers in Kenya have shown an increased willingness to review the evidence and address the issue. Further acknowledgement by African HIV coordinating bodies, as well as informed public discussion, are important steps forward. Evidence indicates that increased awareness and understanding of same-sex issues helps mitigate HIV vulnerability and results in policy action and improved services (De Graaf et al. 1994; Cáceres et al. 2006; Baral et al. 2007; Saavedra, Antonio Izazola-Licea, and Beyrer 2008). In Africa, comprehensive HIV strategies that include specifically tailored HIV prevention, STI treatment and condom and lubricant provision for men are urgently needed. To facilitate delivery of these services, it is important that healthcare systems be sensitised and equipped to serve these men in confidential and non-judgmental environments. In Mombasa, targeted interventions that consider the diverse motivations, socio-economic backgrounds, solicitation patterns and sexual behaviours of male sex workers are also recommended.

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Résumé

Les connaissances sur les pratiques sexuelles et sur les expériences de vie des hommes qui ont des rapports avec des hommes au Kenya et dans d'autres pays d'Afrique de l'Est sont limitées. Bien que l'impact de la transmission du VIH par rapports sexuels entre hommes en Afrique soit de plus en plus reconnu, les initiatives en prévention du VIH restent fortement centrées sur la transmission hétérosexuelle et sur la transmission de la mère à l'enfant. En s'appuyant sur les données provenant de dix entretiens en profondeur et de trois groupes cible (36 hommes), cette analyse explore les déterminants sociaux et comportementaux des risques sexuels chez les hommes qui vendent leurs services sexuels à d'autres hommes, à Mombasa, au Kenya. L'analyse révèle une diversité parmi ces hommes, qui fluctue selon l'âge et la classe sociale. Les premières expériences sexuelles avec d'autres hommes ont eu lieu pour des raisons diverses qui incluent l'amour et le plaisir, et constitué des composantes de l'exploration sexuelle, de l'échange économique et de la coercition. L'usage du préservatif est imprévisible et sujet à des contraintes courantes, comme l'interférence sexuelle et les motivations des clients. Un faible niveau de connaissances ouvre la voie à la prise de risques sexuels, avec en toile de fond la croyance répandue selon laquelle le risque de transmission du VIH lié aux rapports sexuels anaux est plus faible que celui qui est lié aux rapports vaginaux. Les valeurs familiales traditionnelles, les stéréotypes de l'anormalité, les normes de genre et les influences culturelles et religieuses sous-tendent une stigmatisation et une discrimination intenses. Ces résultats doivent guider l'élaboration de programmes d'éducation par les pairs et de sensibilisation des prestataires de santé, proposant des réponses aux besoins en prévention jusqu'ici ignorés. De tels changements sont nécessaires dans toute l'Afrique de l'Est.

Resumen

Los conocimientos sobre las prácticas sexuales y experiencias de la vida de hombres que tienen relaciones sexuales con otros hombres en Kenia y en todo el este de África, son limitados. Aunque se reconocen cada vez más las repercusiones de la transmisión del virus del sida entre hombres que participan en relaciones homosexuales, las iniciativas para prevenir el contagio del VIH sigue centrada en gran medida en la transmisión heterosexual y de madre a hijos. Con ayuda de datos de diez entrevistas exhaustivas y tres grupos de trabajo (36 hombres), en este análisis analizamos los determinantes sociales y de conducta en lo referente a los riesgos sexuales entre hombres que venden sexo a hombres en Mombasa, Kenia. Los resultados del análisis mostraron un alcance y variación en cuanto a edades y clases sociales. Las primeras experiencias homosexuales con hombres ocurrían por diversas razones, entre ellas el amor, el placer, como parte de la exploración sexual, el intercambio económico y la coerción. El uso de preservativos es irregular y sujeto a limitaciones comunes, incluyendo las nociones de interferencia y motivaciones sexuales de los clientes. Estos conocimientos limitados conducen a una conducta de riesgo sexual y se cree comúnmente que el riesgo del contagio del VIH mediante sexo anal es mucho menor que el de sexo vaginal. Los valores familiares tradicionales, los estereotipos de anormalidad y las normas de género, así como las

influencias culturales y religiosas, crean un estigma y una discriminación arraigados. Con esta información pretendemos que se desarrollen programas educativos de grupos paritarios y la sensibilización de los proveedores sanitarios de modo que se aborden las necesidades insatisfechas sobre la prevención del VIH. Estos cambios son necesarios en toda la zona del este de África.