Experiences and challenges in sexual health service access among men who have sex with men in Kenya

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ABSTRACT

Men who have sex with men (MSM) in Kenya bear a heavy burden of HIV/STIs and are a priority population in the national HIV/AIDS response, yet remain criminalised and stigmatised within society. HIV pre-exposure prophylaxis (PrEP) offers an opportunity to significantly impact the HIV epidemic, as does the concept of U=U, whereby those who are living with HIV and on treatment are uninfectious when when their viral load has been suppressed so as to be undetectable. However, the value of such innovations will not be realised without sufficient understanding of, and respect for, the sexual health service provision needs of MSM. This paper describes findings from 30 in-depth interviews with MSM living in Nairobi that explored engagement with sexual health service providers, barriers to access and perceived opportunities to improve service design and delivery. Findings indicate concern relating to the professionalism of some staff working within public hospitals as well as feelings that many sexual health services were not considered safe spaces for the discussion of MSM-specific sexual behaviour. Diverse views were expressed relating to comfort in public, community and private sexual health services as well as how these are and should be organised.

Keywords: MSM, Kenya, sexual health services, stigma, discrimination

INTRODUCTION

Men who have sex with men (MSM) in Sub-Saharan Africa carry a significantly higher burden of HIV infection than adults in the general population (Beyrer et al., 2013; Smith, Tapsoba, Peshu, Sanders, & Jaffe, 2009). MSM routinely report high rates of HIV acquisition risk practices, for example, condomless anal sex, high partner counts and sex work (Sanders et al., 2013; Vu et al., 2013; Wade et al., 2005), but sometimes demonstrate relatively low understanding of personal HIV risk attributable to same sex behaviours (Geibel et al., 2008). These high rates of HIV are replicated in Kenya where the most recently published estimates indicate a prevalence of HIV among MSM in Nairobi of 18.2% (Muraguri et al., 2015) and 19.8% in the coastal town of Malindi (Singh et al., 2012). Male sex workers in Nairobi (Muraguri et al., 2015) were also found to have a higher HIV prevalence (26.3%) compared to other MSM (12.2%). By comparison, the prevalence of HIV amongst all men in urban settings in Kenya was 5.1% in 2012 (Program, 2014). This starkly higher prevalence among MSM is likely the consequence of complex and interrelating personal, community, cultural and structural level factors (Arreola et al., 2015; Muraguri et al., 2015).

These high HIV prevalence figures noted above were the basis for the inclusion of MSM as a key population within the Kenyan AIDS Strategic Framework 2014/2015-2018/2019 (National AIDS Control Council, 2014). The strategy prioritises development of 'key population friendly' HIV care and treatment services, including peer-based services, and removal of barriers to MSM accessing public and private health services. The strategy seeks to align with World Health Organisation published guidelines on the standards of prevention and treatment of HIV and other sexually transmitted infections among MSM and transgender people (World Health Organisation, 2011). These guidelines cite the need to address inclusivity of services for MSM, which should comprise condom provision, accessible individual and community HIV testing and counselling, individual, community, venue and internet-based behavioural and education interventions, as well as equitable access to adult HIV treatment and care.

However, there is evidence that inclusive and equitable service provision has yet to be achieved for MSM, either in Kenya or elsewhere in East Africa. In 2012, a qualitative study exploring the experience of sexual risk taking and sexual health seeking among MSM in Malindi documented expressed and perceived stigma and discrimination in healthcare facilities (van der Elst et al., 2013). A consequent intervention providing training for healthcare staff working at antiretroviral therapy-providing facilities in Kenya was evaluated and found that specific and accurate knowledge relevant to the management of behavioural and clinical risks for MSM clients prior to training was poor (van der Elst et al., 2013). A study of MSM in the western region of Kenya (Okall et al., 2014) found that nearly two thirds of MSM respondents to a community survey were not comfortable seeking sexual health services from a public hospital. Also in Western Kenya, those who did not feel comfortable in public sexual health services were less likely to report recent testing for HIV (Shangani et al., 2017) while qualitative enquiry identified a belief among many MSM that public healthcare workers do not have sufficient knowledge, or acceptance, of issues affecting them (Shangani, Naanyu, Operario, & Genberg, 2018).

At the present time dedicated sexual health services for MSM in Nairobi are primarily delivered by a range of community organisations supported by NGO or international development funding, some of which establish partnerships with the public hospital system for referrals or complex care (Bourne, Fearon, & Nutland, 2016). MSM may also elect to seek sexual health care from private providers offering dedicated MSM services, or instead from local public hospitals and clinics. This variety of services may reduce barriers to service access or engagement, yet it remains unclear to what extent they complement existing healthcare facilities in the provision of holistic care for the population as a whole.

Both positive and negatives experiences of sexual health service engagement are particularly crucial to examine in the context of new biomedical HIV prevention and treatment therapies. A person living with diagnosed HIV who is adherent to antiretroviral treatment can achieve an undetectable viral load, which we now recognise precludes any possibility of onward transmission (Rodger et al., 2019). This has been termed U=U (undetectable = untransmissible). Similarly, Pre-exposure prophylaxis (PrEP) has been proven efficacious in preventing acquisition of the virus among HIV negative men (McCormack et al., 2016; Molina et al., 2015; Grant et al., 2010). The provision of PrEP to MSM has been recommended by WHO since 2016 (World Health Organisation, 2016) and was subsequently licensed for use in Kenya, with a demonstration project among sex workers (male and female) having recently concluded (Karuga et al., 2016; Kimani et al., 2019). Both the Test and Treat approach to antiretroviral initiation and PrEP provision to HIV negative key populations (including MSM) were formally adopted as national policy in Kenya in 2016 (Ministry of Health & National AIDS & STI Control Programme, 2016).

Biomedical technologies such as PrEP, and the notion of U=U, have the potential to curb and perhaps reverse HIV epidemics among MSM (Grulich et al., 2018), however they depend upon facilitating access to and ongoing engagement with sexual health service providers. Timely initiation of PrEP or antiretroviral treatment relies upon ready access to HIV testing and evaluation of eligibility for PrEP or testing with a partner may depend upon clients' comfort in disclosing same sex behaviour and relationships. Effective antiretroviral-based prevention and therapy requires periodic clinical monitoring, laboratory testing and dispensing that relies upon enduring provider-client relationships (Centers for Disease Control, 2017), and potentially the integration of additional clinical, diagnostic and support services to meet wider needs, for example adherence support and STI testing (Graham et al., 2013). Such engagement necessitates services that at the point of receipt are cognisant of, and attentive to, the culture, needs and expectations of MSM. While there has been expansion and development of these services in recent years, in line with policy directions and

strategic planning on the part of the Kenyan Government and international donors, there has been limited examination of the sexual health service experience from the perspective of the user. Such research is required to enable an understanding of how things may (or may not) have improved and what further development or reorientation is required to ensure they can operate as sites for PrEP and TasP scale-up (alongside routine sexual health care).

In this context, our paper examines current engagement with sexual health services, including HIV/STI testing and treatment among MSM in Kenya. This includes, but is not limited to, the experience of those living with HIV accessing routine clinical care. Specifically, it sought to examine (1) men's experiences of accessing appropriate clinical care within sexual health services and the extent to which this operates in line with national and international guidance and, (2) factors that would enhance access to and engagement with sexual health services. Such findings are relevant to those who seek to commission, design or deliver sexual health services to men with the aim of realising the promise of biomedical HIV prevention and care.

METHODS

The study reported on here was part of the TRANSFORM project, conducted between October 2016 and December 2018 (Smith et al, 2021; Fearon et al, 2020). The parent study aimed to assess HIV prevalence and engagement in care as well as HIV prevention and sexual health need among MSM in urban settings in Nairobi, Kenya, and to assess what existing and emerging HIV prevention and care interventions are feasible, acceptable and needed by MSM.

The qualitative phase of the study in Kenya was conducted in Nairobi from February to July 2017. Thirty MSM were purposively sampled through personal invitation through existing community outreach activities, community organisations and sexual health clinics. Criteria for inclusion in the in-depth interviews were current male gender identity or assigned male gender at birth; 18 years of

age or older; resident of/within 50km of Nairobi County; and reporting consensual oral or anal intercourse with a man at least once in the last 12 months. Men currently enrolled in existing research trials or cohort studies were ineligible to participate.

Semi-structured interviews lasting 60-90 minutes were conducted by three trained interviewers (two female and one male). Interviews were conducted in English, Kiswahili or a mixture of both, depending on the preference of the participant. Topics examined included: engagement with state, private and community based non-government (NGO) sexual health services; barriers and facilitators of quality clinical care; and aspirations for future clinical care. Most questions were broadly framed, allowing for expansion, prompting and probing based on initial responses (e.g. Can you tell me about your most recent experience of attending a sexual health service?; If you wanted to have a sexual health check in the future, what would your ideal service look like?) while others were more focussed on specific aspects of the service interaction (e.g. What location do you feel would be best for providing sexual health services to men who have sex with men and trans people? What are you reasons for this?).For those living with HIV, questions were asked regarding their experience of routine clinical care, such as support received from attending healthcare providers and any experiences that threatened their continued clinical engagement (e.g. being in receipt of hostile attention, language or practice). Participants were offered transport reimbursement of 500 Kenyan shillings (approximately 4 EUR/4.60 USD).

Digital recordings of the interviews were transcribed verbatim and translated to English, where necessary. Debriefing reports were completed after the interview/discussion and circulated to site investigators for assessment of emergent themes and identification of areas vital for adaptation and development of study design. Digital records, transcripts, translations and summaries were retained on an encrypted server in study offices. Anonymised data were uploaded and shared via a secure data sharing platform.

The interview transcripts were subject to a detailed thematic analysis, supported by NVIVO 10. Transcripts were read and re-read by a panel of researchers and interviewers to identify initial codes (relevant or significant features). The meaning and conceptual distinction of these codes was discussed and agreed among the qualitative research team, following which all sections of transcript were coded using this framework. Data within each code was then carefully reviewed and formulated into higher-level themes, crossed referenced against the rest of the coding framework for conceptual clarity. For the purposes of this paper, identification of key themes was undertaken by AB, MC and AS, corroborated by RK, JK and WN.

The study was approved by the Kenya Medical Research Institute Scientific and Ethics Review Unit (KERMI/SERU/CGMR-C/CSC 044/3334), the University of Oxford, Oxford Tropical Research Ethics Committee (OxTREC 47-16) and London School of Hygiene & Tropical Medicine Human Research Ethics Committee (REF: 14144).

RESULTS

Thirty partcipants aged between 19-56 years took part in an in-depth interview, six of whom described themselves as transgender or as having a female gender identity. A summary of their demographic characteristics can be found in Table 1.

[Insert Table 1 here]

All but one had previous experience of visiting a sexual health service. Ten of the interviewees attended community-based sexual health services run by MSM and said that they had accessed testing, treatment, care and counselling, as well as condoms and lubricant. Eight reported having attended a state run or private clinic or hospital for sexual health services in the last 12 months.

Most of those attending MSM led community-based services found out about the service from friends or peer outreach workers. Two mentioned they attended a private hospital because individual staff working there were known to be MSM and thus this was perceived as a safer space. All participants had previously tested for HIV including 5 that had been diagnosed HIV positive (one of whom was diagnosed within the previous 6-12 months, the others more than 5 years ago). Of those whose last test was negative; 16 had tested within the last six months, four within 6-12 months, and four more than a year prior. Seventeen men reported experience of testing for other STIs, of which 11 reported having received treatment.

Professionalism, safety and the standard of clinical care

Much discussion within interviews related to the professionalism of healthcare services, public, private and MSM CBO-led, in their engagement with, and responsiveness to, MSM. While by no means the dominant discourse, a small number of participants described experiences of professional clinical care that was affirming of their sexual orientation and of the fact they have sex with men. In his description of care at a service that runs dedicated clinics for MSM (while also serving other groups), one participant said:

> *Now mostly [the staff] who are there are men. And even when they are men, you don't fear anything. They told when I went now to be tested; they told me everything. 'Even when we test you here even if we find out that you have HIV, nobody will know that you are MSM. 'No that is just our secret'. Even those people, that is they have that welcoming heart for people. You just reach there and you are greeted nicely, you are talked to nicely, there are seats there and you can just sit there and watch TV, yes even you just share stories. Yes even you just like going there.* [Aged 19, HIV negative]

The centrality of confidentiality was notable in many of the account of positive clinical experiences,

as was the experience of being treated in a non-judgemental manner by staff.

> *What I can say because even the doctors or the nurses they know about you and they have all the information [but] you won't hear them discussing this somewhere else. You are most welcomed because they know you came for treatment or for some protection and also they like you when you go there so they are very friendly and you are free to express yourself and any need you have that you need addressed.* [Aged 30, HIV negative]

While nearly all participants raised a concern for confidentiality to some extent, these were more pronounced among those diagnosed and living with HIV who frequently emphasised the need for privacy and the ability to talk openly with clinical staff in a safe environment.

> *The provider is the same gender as me. Like when you start from the receptionist to the nurse to the director. They are all MSMs. So you feel comfortable you feel at home, yes is good. The information you share with the people […] they are confidential*. [Aged 28, living with diagnosed HIV]

Experiences of affirming and professional care were more common among those frequenting private hospitals, MSM CBOs, or MSM-oriented NGO programs. No such positive experiences were reported by those who identified as transgender or who described their appearance and manner as effeminate (or used similar local terms). More common were experiences of, or pronounced fears regarding, stigma and discrimination while accessing healthcare services. In several instances discriminatory experiences were overt, direct and deeply problematic. One participant reported an instance of taking his male partner to a public clinic for treatment of anal warts and being harassed and chased out of the clinic.

> *They came in just to look at us and they yelled at us as we moved out. 'Hey, those are*

homosexuals, those are partners.' It was that bad and I think that was the worst experience have ever had and from that day I said I will never go to any clinic that is not friendly. [aged 27, HIV negative].

Other participants relayed experiences where they felt humiliated by public hospital healthcare staff when discussing their sexual practice with men, including one participant who described a hostile reaction at the point they disclosed their sexual experience with other men.

The nurse asked me if I was with a girlfriend. And she was a lady [the nurse] so I told her I slept with a certain boy. She started shouting at me, asking me why we are getting involved in such bad behaviour. 'Do you want to be put on diapers?' I left that place annoyed and said I will never step in a clinic in a public hospital again. [aged 29, living with diagnosed HIV]

The experiences of trans participants were, in most respects, considerably more challenging, ranging from a lack of understanding or acceptance of the notion of trans identities to overt, hostile and extremely confrontational situations where they were made to feel unsafe. The following participant recounts an experience of attending a local public hospital when they were unwell.

I was sick and then they asked me, 'Are you pregnant?' […]They wanted to put things in there [gestures to genital region] and at that point I decided to tell them that am not a woman am a transgender and the doctor asked me, 'What!' You are a transgender? What is a transgender?' And I say a transgender is a man who wants to become a woman or a woman who wants to become a man. And now the doctor went outside and called other doctors. 'Come and see. There is a patient in my office, is a man, I don't know whether is a man or is a woman but is telling me she doesn't have a vagina'. I told them let me go to the toilet and I didn't come back […] I was feeling embarrassed and so many questions. [Aged 28, HIV negative]

Numerous participants, both cisgender and trans, described feelings of embarrassment or shame when subject to whispers, inappropriate questions or 'looks' from healthcare workers, or described how healthcare workers would routinely make assumptions as to their sexual orientation (as being heterosexual), an act that itself challenged their ability to disclose their sex with men. Such experiences were shared and discussed with other MSM or trans people in their community, contributing to a broader sense of anxiety or concern about accessing healthcare services, especially those in the public sector. This fear of stigma or discrimination was pervasive and shaped much of our participants' engagement with healthcare workers, facilitating a range of what might be considered maladaptive practices.

In their most extreme form, such responses included avoidance of all public sexual health services due to a fear of how they might be treated, or the attempted self-management of STI related symptoms, such as by taking over-the-counter medications without prescriptions. Such avoidance or self-management challenges not only routine STI diagnosis and effective treatment, but also the provision of PrEP to those HIV negative or support for ART treatment adherence for those who are HIV positive. Alternatively, some participants described how they fabricated information about their sexual practice to avoid having to disclose their sexual engagement with other men.

> *… because you see our community out there we are not being accepted even to some health providers so when you say you are having sex with a fellow man some other questions will start coming like, 'Why, why are you doing this?' So, I needed to avoid this [and say I have sex with women]. Because in fact where I come from nobody knows I am an MSM.* [aged 33, HIV negative]

Concern for the reaction of healthcare workers further impacted the willingness of many to disclose symptoms, or request diagnoses, that might identify them as MSM, such as anal warts.

So now when you are going there you don't know whom you are going to meet and how you are going to explain those STIs which are commonly known for MSMs. You cannot lie when you go there … for example you find if it gonorrhoea which is common or syphilis or chlamydia [it is okay] but when it comes to anal warts, when someone sees you with anal warts he knows hundred percent you are MSM. [aged 33, HIV negative]

Finally, concerns relating to the confidentiality of services were held by many, with fears that their engagement in sex with men may be disclosed to (potentially hostile) third parties. Such concerns extended to perceiving public hospitals as extensions of government and, with that, came a concern for how their sexual identity or behaviour may be reported to those in positions of power.

Because like if you talk of the government, the government itself is trying with all its means to fight MSM. Ok to fight homosexuality in the country. So we would rather go to an NGO… according to the Kenyan constitution homosexuality is not legalised. [aged 21, HIV negative]

While the above participant illustrates a common concern about the level of confidentiality in public hospitals, such concerns were not limited to state run and private clinics but were reflected in different ways in community-based and peer-led services. One man attending a community service reported that a staff member had accessed his confidential phone number to contact him inappropriately, while others expressed concern about the lack of soundproof facilities at MSM CBO services, challenging the privilege of clinician-patient discussion.

Comfort and cultural affinity in service provision

In a context of stigma (both felt and enacted) and discrimination in public health services, it is perhaps unsurprising that many participants expressed a preference for services that were run exclusively by MSM. This was especially the case for those who described themselves as more effeminate or identified as transgender, who did not 'pass' as straight and were thus subject to

enhanced hostile attention. Participants overwhelmingly stressed the perceived benefit of having services for MSM only, staffed and run by MSM who could appreciate the sexual health related experiences and needs of this community. In such settings it was, participants expressed, easier to openly talk about and explain what had brought them to the service:

> *… if it is an MSM clinic it's easier to explain what the problem is so it's easier to say … please I have a pain in my dick. You will tell him I have a pain in my dick. Where is this pain coming from?* [aged 30, HIV negative]

This sentiment of being surrounded by other MSM, in all aspects of service engagement, was a particularly valued characteristic of service provision, not simply because of the perceived safer manner in which clinical care could be delivered but also in facilitating a safe space for MSM in the city to congregate and interact. Participants especially valued the opportunity to alleviate loneliness, to socialise with other men outside of bars or hotspots [settings where MSM might congregate] and in an indoor space free from the risk of physical harassment or stigmatisation by members of the broader community.

> *… they have that welcoming heart for people. You just reach there and you are greeted nicely, you are talked to nicely, there are seats there and you can just sit there and watch TV, yes even you just share stories. Yes, even you just like going there*. [aged 19, HIV negative]

While indicating a clear preference for MSM-run services, as sites in which they could largely feel safer (than in public hospitals), several trans participants did still state a need for trans-run services, given that MSM did not always understand the realites of trans experiences.

> *So if me, I want to be served [at a clinic] I will want to go to the transgender somebody who will understand me. We will talk one language we will tell each other what the problem is and so forth […] With MSM they like to ask lots of questions […] Like if a met a trans woman and is the one assisting me I will feel comfortable.* [Aged 28, HIV negative]

A clear preference for MSM-led or MSM-specific services was articulated by participants living with diagnosed HIV who, by viture of their diagnosis and clinical need, were more likely to engage with sexual health services on a regular basis. This not only meant they felt subject to potential harassment more commonly than may be the case for HIV negative participants (such as in a hospital waiting room, surrounded by non-MSM patients) but also that they could be required to repeatedly 'out' themselves, or educate clinical staff. One participant proposed a simple change in clinical practice to help address this concern.

> *The idea I have is if the government can sensitize all nurses and all doctors about don't mention 'do you have a girlfriend'. That is the main topic. Yes 'do you have a wife' they will always ask 'do you have a wife do you have a girlfriend'. Why can't they ask 'do you have a sex partner' do they have to use such language? Everytime I have to explain*. [Aged 33, living with diagnosed HIV]

Capacity and accessibility of services

Increased engagement with sexual health services, including enhanced opportunities for PrEP provision or ART support, might be facilitated by greater attendance to the values and preferences of MSM with respect to the package of interventions on offer, including how and where these are delivered. Above and beyond aforementioned concerns pertaining to stigma and discrimination, participants of this study outlined a wide range of influences over their engagement. These related to existing service attributes that could be strengthened (e.g. opening hours and clinic locations) as well as a call for enhanced services to meet complex and intersecting needs. Principally, most participants expressed a desire for enhanced STI testing, diagnosis and treatment in all clinic types, moving away from syndromic screening alone (which is commonplace in MSM CBO clinics), and for point-of-diagnosis treatment, rather than being subject to referral to other sections of a hospital where it was feared staff may be more (or similarly) discriminatory towards MSM.

HIV testing, HTC, STI screening, treatment as well, for STIs for those who are infected and also counselling for those infected or affected by AIDS should be in same place. And also it should be welcoming more or less like it should be ample, should be you feel like you are at home […] If it turns out that they have to go to another clinic they are not supposed to tell them to go to that other clinic or just refer you to another clinic, things will be bad. They are supposed to have all the equipment to treat and to guide the person. [Aged 20, HIV negative]

Considerable diversity of opinion emerged regarding the physical siting of clinics between high traffic, centrally located, and those in more discrete locations. Contrasting concerns were expressed regarding the need for convenience, with a feeling that a central location might facilitate access, versus the need for anonymity, which could better be ensured in locations outside of city centres where the risk of being seen entering a site that may become associated with MSM was perceived to be higher.

It should be centrally placed ... Somewhere like in the CBD [central buisuness district] *… ok in CBDs there is a high number of MSMs*. [aged 21, HIV negative]

I can prefer it to be somewhere there is not many people … to be very private, very secure. [aged 29, HIV positive]

A frequently stated concern was that state-run facilities were under-resourced and could often not provide the services they required. Many participants expressed a desire for a sexual health service that could provide condoms and lubricant (the latter often hard to acquire and which can also indicate anal intercourse), counselling, support groups, drug and alcohol services, legal support and employment services. Others talked about the need for broader healthcare support for a range of other conditions such as malaria and tuberculosis. This was especially the case for trans participants, for whom negative experiences in the past had made many fearful of engaging with public hospitals

and thus were most likely to express a preference for wider clinical services to be offered in MSM (or perhaps ideally trans-run) spaces.

DISCUSSION

Despite the existence of comprehensive guidance from both national and international authorities, many MSM in Kenya continue to receive substandard or unprofessional sexual health care. This paper documents numerous overt experiences of stigma, discrimination and hostility within clinical contexts in public hospitals. Such experience, or indeed the fear of having such an experience (shaped by report from others), significantly impacted the accessibility and effectivnesss of clinical care for many of those we interviewed. It led to avoidance of clinical services that they would otherwise benefit from, as well as the withholding of relevant information that could inform clinical practice. Challenging and hostile experiences were particularly prounced among those identifying as trans, with limited cultural competence and acceptability among healthcare providers evident in the naratives of trans participants. Given their more regular interaction with sexual health services, participants living with diagnosed HIV were especially likely to express concern about the professionalism and capabilities of staff in public facilities, as well as holding concerns about the risk of harassment from other (non-MSM) patients. The situation was markedly different among those accessing MSM-led or MSM-specific services in Nairobi, for whom the presence of other MSM provided comfort, a sense of safety and a greater belief that the information they disclosed would be held confidential. Such services were not, however, perceived as perfect and thoughts were expressed regarding the need for enhanced service provision, HIV and STI treatments and for greater accessibility. While MSM-run clinics were largely favoured by trans participants over public or private hospitals, the value of having trans-led, affirming and knowledgeable clinical care was emphasised. MSM-led services could provide a safer environment, but not necessarily one that catered to all of the unique needs of trans people.

The pervasive concerns and negative experiences expressed by participants must also be understood within a broader context of commonplace harassment or abuse directed towards MSM in Kenya and neighbouring countries. Homosexuality is illegal in most African countries (including Kenya) and MSM face widespread political and societal discrimination (Zahn et al., 2016), sexual and physical violence (Micheni et al., 2015) and denial of health services (Baral et al., 2009). Such societal attitudes and cultural perspectives on homosexuality likely shape the perceptions of many healthcare staff, whose capacity to engage with MSM in relation to HIV and STIs may be further impacted by insufficient medical training relating to transmission between men (Beyrer et al, 2012).

The last decade has, however, seen a number of interventions aiming to 'sensitise' healthcare workers to the cultures and needs of MSM, including locally evidenced interventions in the public healthcare sector that have been endorsed by the National AIDS and STI Control Program (although the extent to which these are still in operation is unclear). These have seen some success in challenging stigmatising views in the coastal region of Kenya (van der Elst et al., 2013) and numerous similar programmes have been delivered by MSM CBOs, often funded by international donors (Bourne et al., 2016). However, findings from the current study would suggest these have been insufficient in addressing all discriminatory practice and ensuring sufficiently professional service provision. While scale-up of such sensitisation efforts are clearly warranted, even if uniform acceptance and respect for MSM by healthcare workers were acheived, considerable efforts may be required to overcome the residual fears and anxieties that many may hold having experienced previous ill-treatment. This could take the form of enhanced outreach efforts and social media campaigns, in partnership with MSM CBOs, to emphasise culturally competent and safe services to the MSM population. Assurances of confidentiality and of respect for both MSM and trans individuals should be central to such service promotion initiatives.

Given how MSM-run sexual health clinics have become recognised by many as safe spaces, it is perhaps unsurprising that MSM should then wish to see these sites provide them with a much broader range of health, social and legal services. This level of support will likely be challenging for most health clinics to deliver at scale but could be facilitated by co-location of services, or via skills-exchange ventures between adequately trained public services working in partnership with sufficiently resourced MSM CBOs. Examples of such can found in ANOVA Health in South Africa and in 56 Dean Street in London, both of which principally operate sexual health services but facilitate connection to other services, such as mental health, alcohol and other drug support, via a mixture of co-location of services and external capacity building of other health sectors to better meet the needs of gay, bisexual and other MSM.

This paper only reflects the needs and experiences of MSM resident in Nairobi and, given our sampling approach, may have selected MSM who are more engaged with services provided by CBOs. This approach is commonplace in research among MSM in Sub-Saharan Africa (Cange et al., 2015; Sandfort, Knox, Collier, Lane, & Reddy, 2015) and reflects the marginalisation of this community and the challenges in safely recruiting via other means. Efforts were made to reach beyond MSM CBOs for recruitment (such as through community connections of the research team), which did result in a small proportion of participants. Our sample does not include those who had not engaged with any sexual health service but may be fearful of the consequences of doing so. Given the integration of communities and the current absence of trans-specific sexual health services, our study deliberately sought to be inclusive of trans identifying people and those who now affirm their identity as female but we assigned a different sex at birth. However, it does not constitute a comprehensive investigation of the clinical needs of trans people in Kenya, which should be the focus of future research. These limitations notwithstanding, the findings reported here will be of value to those advocating for, commissioning or facilitating a plurality of sexual health services for MSM and trans people in Kenya.

As exciting as PrEP and U=U are as epidemic-changing interventions, their potential will not be realised without addressing prevailing stigma directed towards MSM and without taking steps to earn the trust of those who have grown accustomed to ill-treatment in the healthcare settings upon which deliver of these intervention depend. Biomedical technologies are only as good as the social and personal interactions on which they are based, and these data suggest much ground is still to be made in providing a basic standard of care.

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AUTHOR DISCLOSURE STATEMENTS

All authors declare that they have no competing interests.

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Table 1. Summary of participant demographic characteristics

Demographic characteristic	N	%
HIV testing history		
Diagnosed HIV positive	5	16.7
Last test negative	25	83.3
Place of birth		
Kenya	24	80.0
Different country	6*	20.0
Gender identity of participants		
Male	24	80.0
Trans/transgender	5	16.7
Female	1	3.3
Gender of partners in last 12 months		
Men only	22	73.3
Women only	8	26.7
Age		
Mean	30.35	
Range	19-56	

* other countries include Rwanda (2), Uganda (2), Burundi (1), South Africa (1)