The Nexus of Gender and HIV among Men Who Have Sex with Men in Kenya

SUMMARY PAGE

Gender norms and inequalities increase gay men and other men who have sex with men's (MSM's)[i] experiences of violence and HIV risk while limiting their service uptake. Specific gender-related beliefs (however untrue) are one cause of stigma and discrimination against MSM and a reason that HIV programs do not reach all MSM. Acknowledging and working to transform the gender norms most harmful to the MSM community can further strengthen HIV-focused programs for and by MSM.

Harmful gender-related beliefs most relevant to men who have sex with men

- "Real men" do not seek help, including from health care workers, unless they are very ill.
- Men degrade themselves when they behave in a feminine way.
- Men prove their masculinity by having many sexual partners.
- A man who is the bottom in anal sex is less manly than the partner who is the top.
- Violence against MSM can "cure" them.
- A man should have children to carry on his legacy.

Recommendations

- Continually sensitize staff, even in clinics that are friendly to key populations (KPs), to ensure services free of stigma and discrimination.
- Continue to support the clinics that MSM trust, but recognize that not all MSM will feel comfortable seeking services at an MSM-designated clinic and that some may require access to other competent and stigma-free options.
- Fully integrate violence response services within HIV services for MSM – including intimate partner violence.
- Continue to work directly with perpetrators of violence.
- Explicitly discuss the gender norms and gender-related beliefs that devalue MSM, put them at risk for HIV and violence, and limit their uptake of services.
- Continue to support community-based organizations to implement structural interventions to promote gender equality and reduce stigma, discrimination, and violence against MSM.
- Build on current support groups to provide spaces where MSM with shared experiences can come together for mutual support.
- Ensure that subpopulations of MSM that have been marginalized because of beliefs about value are given equal opportunities to contribute.
- Develop messages targeted to the MSM community that reframe potentially harmful gender-related beliefs to make them positive and conducive to uptake of services.
- Conduct qualitative data collection with male sex workers (MSWs), young MSM,

This brief was developed to encourage and inform gender-integrated HIV prevention, care, and treatment programming for men who have sex with men in Kenya. It can be used by individuals and organizations that deliver services to men who have sex with men; those participating in program design and monitoring and evaluation; and decision makers and funders supporting the programs. It is one in a series of briefs on the _**Nexus of Gender and HIV**_ among key populations most affected by HIV: men who have sex with men, sex workers, transgender people, and people who inject drugs. Information relevant to individuals who are members of multiple key populations (such as male sex workers) can be found across the series.

and MSM who are not "out" or who otherwise prefer to remain hidden, to better understand their unique needs.

[i] The term "gay men and other men who have sex with men" encompasses both men who self-identify as gay, as well as men who do not.

DEFINITIONS

GENDER NORMS: The expectations of what it means to be a man or woman, including social and political roles, responsibilities, rights, entitlements and obligations, and the power relations between men and women [Adapted from *HPP Gender & Sexual Diversity Training*].[4]

GENDER IDENTITY: A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth [*HPP Gender & Sexual Diversity Training*].[4]

GENDER EXPRESSION: The external display of one's gender, through a combination of appearance, disposition, social behavior, and other factors, generally measured on a scale of masculinity and femininity [*HPP Gender & Sexual Diversity Training*].[4]

GENDER INTEGRATION: Strategies applied in programmatic design, implementation, monitoring, and evaluation to take gender considerations into account and compensate for gender-based inequalities [Adapted from *IGWG training materials*].[5]

GENDER-BASED VIOLENCE: Any form of violence that is directed at an individual based on biological sex, gender identity (e.g., transgender), or behaviors that are not in line with social expectations of what it means to be a man or woman, or a boy or girl (e.g., men who have sex with men, female sex workers). It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life [*PEPFAR Gender Strategy*].[6]

BACKGROUND

MSM make up 15 percent of new HIV infections in Kenya.[1] In Nairobi, MSM have an HIV prevalence of 18 percent[2] with higher prevalences — 26 to 40 percent—among MSWs.[3] To inform HIV programming for MSM in Kenya, including MSWs, the USAID- and PEPFAR-supported LINKAGES project conducted a gender analysis to examine how gender norms and inequalities affect MSM's HIV risk and uptake of services across the HIV prevention, care, and treatment cascade.

Why focus on gender in HIV programs for men who have sex with men?

HIV programmers working with the general population are accustomed to thinking about gender norms and inequalities as negatively affecting women and girls in particular (see definitions to the left). Men, when targeted by gender-integrated programming, are often engaged so that they can play a positive role in their female partners' health as much as their own.[7] This approach, also called constructive male engagement, has flourished — and with good reason. Gender integration, including through male engagement, has been shown to improve and sustain HIV programming outcomes.[7-9]

Systematic gender integration has not been as widely employed in KP programming.[10] However, this approach is vital because gender norms and inequalities negatively affect KPs, and their effects are often amplified because they occur not only when KPs and those around them conform to gender norms but also when KPs are perceived to be non-conforming. A gender analysis is the first step in the process of gender integration and an important tool for achieving ambitious 90-90-90 targets.

Research on issues affecting MSM in Kenya is extensive,[11] **and MSM programming is well-established in Nairobi**. In this context, a gender analysis can build upon existing research — in which MSM and others have explored the impacts of stigma, discrimination, and violence on HIV risk and service uptake — and explore the gender norms and inequalities that underlie the findings. It can also be used to identify new ways to approach these long-standing problems by addressing their gender-related root causes.

METHODS

The gender analysis with MSM was part of a larger gender analysis conducted in Nairobi with the four KPs that are the focus of the LINKAGES Project. The MSM portion of the analysis consisted of a desk review of relevant literature and policies, a scan of MSM programming in Nairobi, and 18 qualitative interviews with representatives from MSM-led organizations (REP_MSM), government officials (GOV), program managers and funders (PROG_MSM), and health care workers (HCW_MSM) in Nairobi. A task force of government officials and KP representatives provided guidance and helped identify relevant programs and literature. Furthermore, research assistants who identified as gay or MSM, helped design the questionnaires, conducted the interviews, and assisted with the interpretation of the findings. The desk and program reviews and interview guides were designed to cover the five gender analysis domains proposed by USAID: laws, policies, and institutional practices; cultural norms and beliefs; gender roles, responsibilities, and time used; access to and control over resources; and patterns of power and decision making.[12]

Interview guides included a list of gender-related beliefs potentially relevant to MSM in Kenya (see **Box 1** for the interview prompt about gender-related beliefs). Respondents identified the most common gender-related beliefs and described each belief's impacts on MSM's HIV risk and HIV service uptake; violence was also discussed in detail because of its impact on each of these outcomes (see **Box 2**). Additionally, respondents recommended activities to counter harmful beliefs and ideas for tailoring programs to meet the needs of MSM.

One weakness of our approach is that, for purposes of easy replicability and in line with most gender analyses' methodology,[13, 14] we did not interview individual MSM about their personal experiences. As a result, our findings contain most information about MSM who are "out" (identifying openly as a gay man), as this was the group of MSM that respondents were most familiar with. Relatively little was known by health care workers and other stakeholders about MSWs and MSM who are not "out" or who otherwise prefer to remain hidden, and more work is required to ensure they are supported in MSM programming. More detailed information on the needs of MSWs can be found in *The Nexus of Gender and HIV among Sex Workers in Kenya*.

FINDINGS

Gender norms and inequalities are at the root of much of the increased vulnerability to violence and HIV risk that MSM experience, as well as at the root of many of the barriers they face to HIV service uptake. This is demonstrated clearly by the differences in experiences of MSM, depending on their gender expression; hence, we make efforts in this brief to talk about MSM not as a monolithic group but as individuals with diverse experiences. According to respondents, a man's gender expression is seen either as more masculine or as feminine, with masculine gender expression being perceived as superior: *"A man is supposed to be masculine and brave. When a man behaves in a feminine way* [is] *seen as shaming and degrading manhood"* (PROG_MSM_O1).

Respondents noted that MSM are treated differently based on their gender expression for two reasons. First, because feminine gender expression is often conflated with sexual orientation, the general public believes that men perceived as feminine are gay while men perceived as masculine are straight, or that to *"behave in a feminine way* [is] *to suggest they are gay"* (PROG_MSM_O1).[ii] Second, and including within the MSM community, gender norms for men and women in heterosexual relationships are also applied to intimate partnerships between men: *"One partner is considered to be*

the macho strong man while the other is considered to be the female, sissy, girly one"* (HCW_MSM_Pre). In many cases, the man with more feminine gender expression is assumed to be the "bottom" or the primarily receptive sexual partner and is expected to take on gender roles traditionally prescribed to women in intimate relationships.[iii] *"People perceive tops to be masculine, while bottoms are perceived to be feminine. The same as in heterosexual relationships women are expected to be submissive so as it is in MSM relationships, bottoms take the role of a woman while tops take roles of a husband"* (REP_MSM_O2).

As shown in **Figure 1**, gender norms influence MSM through two primary pathways, depending in part on their gender expression:

- Pathway 1: MSM are affected by those gender norms to which they and those around them conform. For example, conforming to gender norms around masculinity — such as having multiple partners and not seeking help — may increase HIV risk and decrease service uptake among MSM. Further, because they are often perceived to be straight, MSM with more masculine gender expression may not be acknowledged by service providers.

- Pathway 2: MSM experience stigma and discrimination when they are perceived as

not conforming to gender norms, including to expectations regarding sexual behavior. This keeps some MSM from seeking health services or from disclosing their risk factors to providers. Although this stigma and discrimination affects all MSM, it disproportionately affects MSM with more feminine gender expression and MSM with illnesses that providers believe indicate someone is a man who has sex with men.

The specific gender-related beliefs that reflect either conforming or being perceived as non-conforming are presented in **Figure 1**. These beliefs were identified by respondents as commonly held or important to change

FIGURE 1: The Impact of Gender Norms on Men Who Have Sex with Men's Vulnerability to Violence, HIV Risk, and Service Uptake

INDIVIDUAL MSM AND LARGER COMMUNITY CONFORM TO GENDER NORMS

RESULTING GENDER-RELATED BELIEFS
- "Real men" do not seek help, including from healthcare workers, unless they are very ill.
- Men prove their masculinity by having many sexual partners.
- Only women can experience violence from their partners.
- A man should have children to carry on his legacy.

INDIVIDUAL MSM IS PERCEIVED AS NOT CONFORMING TO GENDER NORMS

RESULTING GENDER-RELATED BELIEFS
- Men degrade themselves when they behave in a feminine way.
- A man who is the bottom in anal sex is less manly than the partner who is the top.
- Violence against MSM can "cure" them.

VIOLENCE

HIV RISK

UPTAKE OF HIV SERVICES

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ii We quote respondents directly when they use the term gay but recognize that gay refers to same-sex sexual orientation.

iii Although some respondents conflated gender expression with one's role within romantic relationships as well as with whether someone would be the primarily receptive or insertive partner, feminine gender expression does not mean that a man is the primarily receptive partner or takes on gender roles prescribed for women. As described by respondent PROG_MSM_O3, *"We have masculine men who are bottoms and effeminate men who are tops."* Further, MSM may or may not be exclusively receptive or insertive partners.

in order to improve the health and well-being of MSM in Kenya. Detailed findings below describe how various beliefs affect experiences of violence, HIV risk, and HIV service uptake.

Violence

Incidence of gender-based violence and other forms of violence against MSM in Kenya is high,[15, 16] with similarly high levels of sexual violence against both MSM and female sex workers.[17] Further, violence against MSM in Kenya is often perpetrated by strangers, suggesting that these acts of violence are "opportunistic aggression."[17] Violence is a human rights violation that increases HIV risk and decreases the uptake of services (see **Box 2**).

MSM's experiences of violence are affected when they, or those around them, conform to gender norms. Because of the gender-related beliefs that **only women can experience violence from their partners** and **"real men" do not seek help including from health care workers unless they are very ill**, many MSM do not report violence or seek support. Fear of exposing their sexual behaviors and the belief that police will not assist them also deter MSM from reporting violence and accessing services. *"Even men get violence but it's only that they do not speak out* [because] *a man is supposed to be strong and not speak out when assaulted and it's bad for gay men because they can't talk about it for fear of stigma and ridicule by society"* (PROG_MSM_O3). The lack of disclosure is a barrier to post-violence clinical care, mental health services, and legal services.

MSM may also experience violence when they are perceived to be rejecting their masculinity. Because of the commonly held belief that **men degrade themselves when they behave in a feminine way** and the conflation of gender expression and sexual orientation, MSM who are perceived as more feminine were reportedly more likely to experience violence from the general public, police, or other security forces (askaris) than MSM who are seen as more masculine. *"MSM who are bottoms behave in a feminine way that's portraying that they are gay so they are more prone to violence"* (REP_MSM_O1). Respondent PROG_MSM_O3 referenced a recent attack against a man with a feminine gender expression: *"Effeminate bottoms are more at risk* [of violence]. *We have had them attacked like the cases on Mombasa where one had his throat slit. Tops, so long as they act straight, do not get violated easily."*

Respondents noted that violence against MSM is often a result of the belief that **violence against MSM can "cure" them** or change their behavior. Respondent PROG_MSM_O1 explained: *"By violence, the public thinks that MSM will learn a lesson and behave normally how a man is supposed to according to our tradition and culture as Africans."* This belief is used to justify violence against MSM, and MSM are expected to conform to masculine gender norms to protect themselves from this violence:

- *"Men try to act straight to avoid bashing and attacks. Feminine men are often told to act like men and hence keep MSM in hiding and hard to reach out with services"* (HCW_MSM_O3).

- *"You get attacked for acting gay. It has made most people live a lie and in hiding or pretending to be straight"* (REP_MSM_O3).

As illustrated in the quotes above, violence directly affects whether MSM can be reached with services. This is discussed further on the next page.

HIV Risk

MSM also face increased HIV risk when they conform to gender norms. Across respondents, the belief that **men prove their masculinity by having many sexual partners** was identified as commonly held and important to change because it leads to MSM having multiple sexual partners (including girlfriends and wives), resulting in a higher likelihood of HIV and transmission of sexually transmitted infections. Respondent GOV_O1 elaborated on the connection between this belief and HIV risk: *"In our society it's a masculine thing to have many female sexual partners…so when in a program one tries to talk about reducing partners and risky practices, the men cannot see the point because they wonder 'How can I reduce my partners and I am a man?'"*

HIV risk also increases when MSM are perceived as not conforming to the traditional and superior roles assigned to men. Based on the commonly held belief that **a man who is the bottom is less manly than the partner who is the top,** MSM who take on the more feminine gender role in intimate relationships — including but not limited to being the receptive partner — were seen as being weaker and more dependent on the more masculine partner. *"Most of the time bottoms depend on tops as wives depend on their husbands. This reason makes bottoms less manly because a true African man is supposed to be*

responsible and independent" (REP_MSM_O2). Further, some respondents noted that MSM with more feminine gender expression have limited access to economic empowerment and employment opportunities. Respondents suggested this may reduce their ability to negotiate safe sex, increase the potential for intimate partner violence, and in some cases lead to engagement in sex work. The literature further notes that engaging in sex work is fairly common among MSM, with 56 to 77 percent of MSM in Kenya reporting receiving money or goods in exchange for sexual services.[15]

Service Uptake

In conforming to gender norms, some MSM delay or neglect to seek care. Respondents identified **"real men" do not seek help including from health care workers unless they are very ill** as a commonly held. This belief is important to change because it keeps MSM from seeking both HIV- and violence-related care to avoid being seen as weak. Respondent REP_MSM_O3 explained: *"A man would rather die than seek help. If you cry you are seen as weak. 'Be a man' is what everyone says. Is it harmful to MSM? Yes, because most suffer in silence."*

A man should have children to carry on his legacy was also identified as limiting service uptake. Many MSM "live a lie," "live a double life," or "hide" to be seen as conforming, including by having sexual relationships with women. Respondent PROG_MSM_O1 explained: *"It is one of our traditions and beliefs...[It] forces MSM to have children, resulting in living a double life to fit in the society."* MSM who are not "out," and particularly those who also have relationships with women, are less likely to visit MSM-serving clinics for fear of being "outed" if seen. Respondents reported that having a female partner is more likely for some MSM: *"Tops are the ones that are normally married and are husbands out there in my opinion. These are the ones we really need to focus on to get into our programs"* (GOV_O1).

All respondent groups reported that the quality of clinical services available to MSM is affected by stigma and discrimination stemming from the perception that MSM do not conform to gender norms. Men who fear poor treatment at facilities put off service seeking, especially in cases of illness that were seen as "outing" the client as a man who has sex with men. *"Anal gonorrhea or sexual things are difficult to explain. It harms MSM because of fear of being outed or known. It is harmful to MSM because they will not access the services — they wait until they are very*

ill" (PROG_MSM_O2). Although most stigma and discrimination occurs in other public facilities, some incidents do occur even in MSM-friendly clinics if staff are new or have not yet been properly sensitized. "MSM-friendly" refers to government-supported hospitals that are KP-friendly and clinics run by the MSM community.

When MSM do receive health services at facilities that serve the general public, respondents noted that many don't disclose that they have sex with men: *"Men live in hiding and don't want to discuss issues of sexuality for fear of stigma and discrimination"* (PROG_MSM_O3). This limits their access to appropriate services, as health care workers and counselors generally do not ask about same-sex sexual behavior, and thus do not offer appropriate HIV prevention messages.[28] MSM with masculine gender expressions are very unlikely to be asked about sex with other men. If sexual behaviors are disclosed, respondents reported that health care workers may not feel obligated to provide services or may lecture MSM clients on their sexual behaviors. Furthermore, providers in these facilities may lack the skills to serve MSM. As illustrated by respondent GOV_O1, *"In our training, we are taught the male genital and the female genitalia. It's unlikely that the anal area will be examined."* This training gap was also supported by the literature.[29]

OPPORTUNITIES

Although there are important issues to address, there is a strong foundation of policies and programming to build upon in reaching MSM with adequate HIV response. Kenya's Ministry of Health, through the National AIDS and STI Control Programme (NASCOP) and the National AIDS Control Council (NACC), has shown leadership in setting policy and programs for MSM. The country has several policy documents such as *The Prevention Revolution Roadmap,[30] the National AIDS Strategic Framework,[1] and National Guidelines for STI and HIV Programming with Key Population,[31]* that guide the response. The national guidelines commit a combination prevention approach that focuses on biomedical, behavioral, and structural interventions with MSM. Funding for MSM programs in Kenya, the focus of which is primarily biomedical interventions, is available from PEPFAR, the Global Fund, and others. In Nairobi, MSM-friendly clinics provide holistic clinical services as per national guidelines. Efforts to address violence, including paralegal support and rights training,

BOX 3. MULTIPLE VULNERABILITIES

In addition to the inequalities caused by the gender norms that exist in society, vulnerabilities related to age, HIV status, and criminalization of behaviors were also raised by gender analysis respondents.

MSM who are not "out" or otherwise prefer to remain hidden — particularly **young MSM** who fear being "outed" because they still live with and are dependent on their families — are rarely reached by MSM-specific research and programming efforts. This gap in reach was supported by the literature[11] and indicates that this subpopulation of MSM are not provided with the information and commodities they need to understand and reduce their HIV risks.

MSM living with HIV, according to KP representatives and program respondents, are at a higher risk of violence and are openly maltreated and discriminated against both by the general public for being MSM and by other MSM for being HIV-positive. This was illustrated by respondent REP_MSM_O3: *"It is one thing to be gay and it's the other to be gay and positive... They often get stigmatized with the MSM community and the general public. Already society deems gay men as a curse and an abomination. When one is sick they have caught the gay man's disease and get pushed out by society."* Respondents noted that the perceived link between HIV and sexual orientation may also result in MSM fearing to disclose their HIV status because they think the general public will suspect they are gay. Within the sex worker community, MSWs living with HIV also face stigma and may be "outed" as living with HIV because of competition for clients.

Criminalization of homosexuality in Kenya also limits access to quality services, both through MSM hiding that they have sex with men because they fear they will be arrested and through health care workers denying services to MSM because they view them as criminals. Respondent REP_MSM_O2 elaborated: *"It [criminalization] has hindered MSM from accessing health services in the fear that they will be stigmatized by health care providers and general public...It has heavily contributed to random arrests by police and city Askaris."*

are ongoing in some programming for MSM. Additionally, NASCOP supports police training to prevent violence against MSM as well as improve violence response services for MSM and has begun training health care providers in both violence screening and response. Further, peer-led support groups and post-test clubs for MSM successfully encourage testing through sharing information and building self-confidence. Social media was also identified by gender analysis respondents as a successful channel for programs to use to connect and share information about HIV with MSM. MSW-friendly clinics were also identified in the sex worker program review, although respondents' comments suggest that additional work should be done to publicize these more broadly.

Of vital importance, a strong network of MSM organizations is involved in all of these efforts. According to gender analysis respondents, MSM — including MSWs — are involved in shaping policies and programs, including in the Country Coordinating Mechanism of the Global Fund and in the NASCOP Key Population Technical Working Group. Although MSW programming is newer, MSM have led advocacy, community mobilization, and programming efforts in Kenya for many years to ensure that programs meet their needs. This has resulted in clinical and other services that take their realities (such as when and where services should be offered) into account.

Although gender norms and the harms they cause are not explicitly discussed in MSM programming, respondents noted these issues are implicitly addressed in programming related to health, rights, and violence.

NEXT STEPS FOR GENDER-INTEGRATED PROGRAMS FOR MEN WHO HAVE SEX WITH MEN

Knowledge of the ways that gender norms and inequalities affect MSM's vulnerability to violence, HIV risk, and HIV service uptake can inform current and future gender accommodating or gender transformative programming for MSM in Kenya. As defined in the USAID Interagency Gender Working Group (IGWG) *Gender Equality Continuum Tool* (see **Figure 2**), **gender accommodating** programs acknowledge, but work around, gender differences and inequalities to achieve project objectives. **Gender transformative** programs aim to promote gender equality and achieve program objectives by 1) fostering critical examination of inequalities and gender roles, norms, and dynamics; 2) recognizing and strengthening positive gender-related beliefs that support equality and an enabling environment; and 3) promoting the relative position of marginalized groups and transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities.

Looking at the gender-related beliefs that should be considered in such programming (presented in **Figure 1**), it is also possible to make connections back to the gender

norms that underlie these beliefs. The norms most relevant to the gender-related beliefs affecting MSM are:
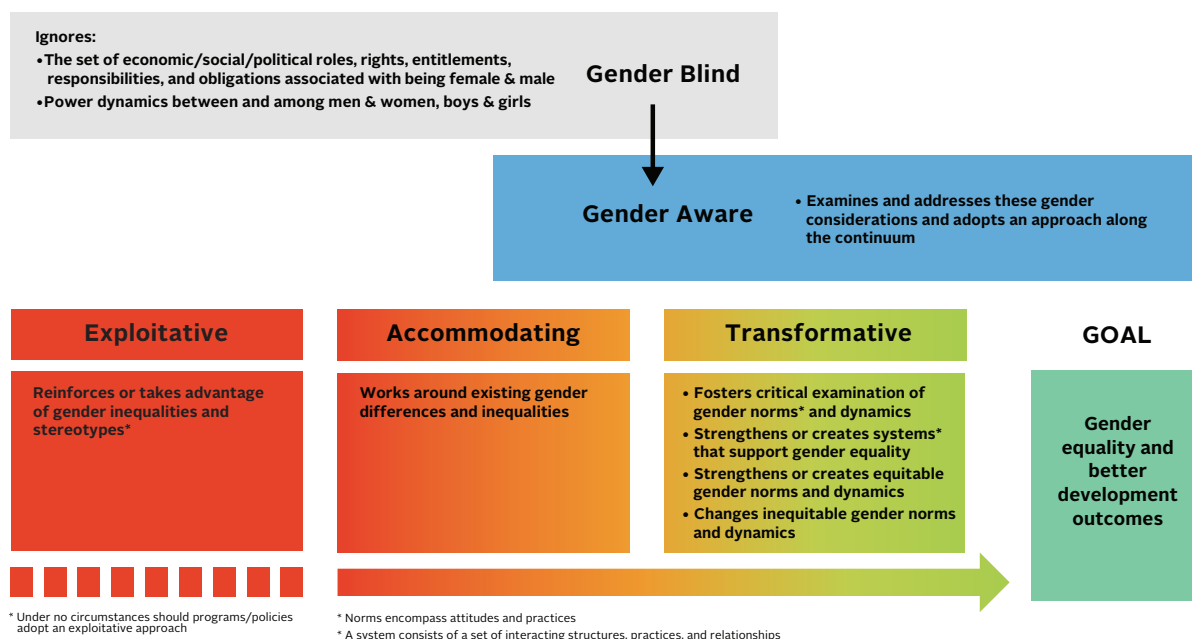
- Men only have sex with women.
- Men are superior to women/masculinity is superior to femininity.
- Men don't ask for help.
- Men are providers.
- Men are physically strong.
- Men are sexually dominant (including by being the insertive partner and having many partners).
- Violence against women is acceptable and normal.

Gender transformative programming in particular should consider how to challenge both the specific harmful belief that is relevant to MSM (e.g., men degrade themselves when they behave in a feminine way) and the underlying gender norm. The following are our recommendations for both gender accommodating and gender transformative programs serving MSM in Kenya. **Figure 3** demonstrates the relevance of the recommendations to achieving the 90-90-90 targets.

Recommendations

- **Continually sensitize staff, even in clinics that are KP-friendly, to ensure services free of stigma and discrimination.** See training materials such as *LINKAGES*

FIGURE 2: IGWG Gender Equality Continuum Tool

Gender Blind	
Ignores: • **The set of economic/social/political roles, rights, entitlements, responsibilities, and obligations associated with being female & male** • **Power dynamics between and among men & women, boys & girls**	

Gender Aware	
	• **Examines and addresses these gender considerations and adopts an approach along the continuum**

Exploitative	Accommodating	Transformative	GOAL
Reinforces or takes advantage of gender inequalities and stereotypes*	**Works around existing gender differences and inequalities**	• **Fosters critical examination of gender norms* and dynamics** • **Strengthens or creates systems* that support gender equality** • **Strengthens or creates equitable gender norms and dynamics** • **Changes inequitable gender norms and dynamics**	**Gender equality and better development outcomes**

* Under no circumstances should programs/policies adopt an exploitative approach

* Norms encompass attitudes and practices
* A system consists of a set of interacting structures, practices, and relationships

Health Worker Training[iv] and *Promoting the Health of Men who have Sex with Men Worldwide: A Training Curriculum for Providers* for ideas.[32]

- **Continue to support the clinics that MSM trust, but recognize that not all MSM will feel comfortable seeking services at an MSM-designated clinic and that some may require access to other competent and stigma-free options.** Advocate for pre-service training for all health care workers that explores the ways that gender norms may affect how they provide services — for both women and men — in order to help bridge this gap. The training should include content on gender expression versus sexual orientation to prevent future conflation of the two.

- **Fully integrate violence response services within HIV services for MSM – including intimate partner violence.** Train all those working with MSM, including health care workers, to provide first line response to individuals who have experienced violence and refer them to the services they need. Ensure that all referral points - especially those that may be a first point of contact - can share time-sensitive information on HIV services such as post-exposure prophylaxis. Ensure that health care workers are aware

of the ways that gender norms may impact an MSM survivor's feelings of guilt or shame about experiencing violence. Continue to document incidences of violence experienced by MSM and actions taken to address them. See *LINKAGES Violence Screening and Response Training*[iv] for additional guidance.
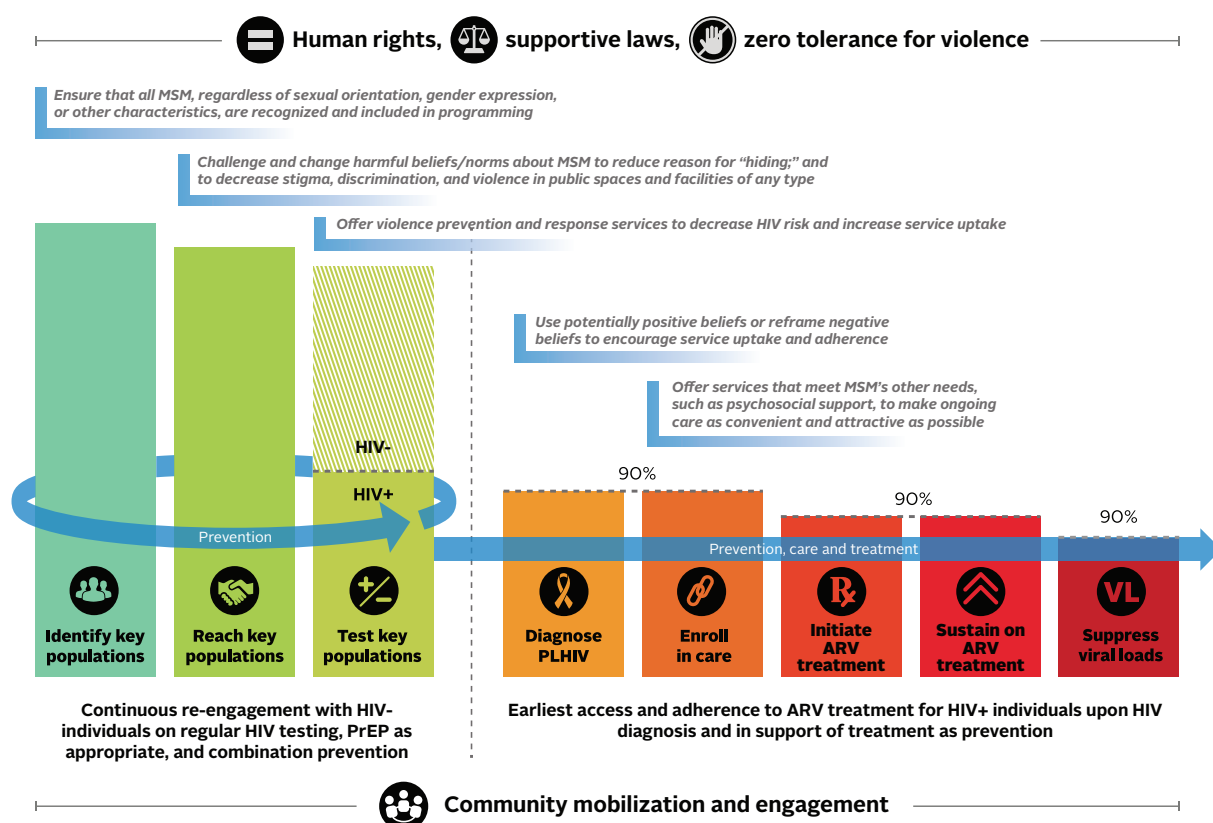
- **Continue to work directly with perpetrators of violence,** such as the police, to discuss the ways that gender-related beliefs specifically condone or encourage violence. See *Responsive Law Enforcement for HIV Prevention: A Manual for Training Trainers to Sensitize Police on Their Role in a Rights-based Approach to HIV Prevention among Key Populations* for a Kenya-specific training resource.[33]

- **Explicitly discuss the gender norms and gender-related beliefs that devalue MSM, put them at risk for HIV and violence, and limit their uptake of services**. Use peer education, support groups, and social media to talk about where these beliefs come from, how gender-related beliefs affect our individual and collective behavior, and how we can challenge harmful gender norms in our daily lives. At the same time, **address bias within the MSM community against MSM with more feminine gender**

expression and create awareness that the devaluation of men based on their gender expression or on playing the "woman's role" in an intimate relationship are manifestations of the stigma against the entire MSM community. Provide safe spaces where diverse gender expressions are celebrated and incorporate activities to build self-confidence, especially for young MSM. See the *Ishtar Facebook post* for how to begin this conversation via social media.

- **Continue to support community-based organizations to implement structural interventions to promote gender equality and reduce stigma, discrimination, and violence against MSM.** This includes funding community-based organizations and building their capacity to accomplish this work.

- **Build on current support groups to provide spaces where MSM with shared experiences can come together for mutual support,** build each other's confidence and motivation to test for HIV, and encourage collective action. This is particularly important for young MSM.

FIGURE 3: Application of Recommendations to HIV Prevention, Care, and Treatment Cascade

Human rights, supportive laws, zero tolerance for violence

Ensure that all MSM, regardless of sexual orientation, gender expression, or other characteristics, are recognized and included in programming

Challenge and change harmful beliefs/norms about MSM to reduce reason for "hiding;" and to decrease stigma, discrimination, and violence in public spaces and facilities of any type

Offer violence prevention and response services to decrease HIV risk and increase service uptake

Use potentially positive beliefs or reframe negative beliefs to encourage service uptake and adherence

Offer services that meet MSM's other needs, such as psychosocial support, to make ongoing care as convenient and attractive as possible

HIV-

HIV+

Prevention

90%

90%

90%

Prevention, care and treatment

Identify key populations

Reach key populations

Test key populations

Diagnose PLHIV

Enroll in care

Initiate ARV treatment

Sustain on ARV treatment

Suppress viral loads

Continuous re-engagement with HIV- individuals on regular HIV testing, PrEP as appropriate, and combination prevention

Earliest access and adherence to ARV treatment for HIV+ individuals upon HIV diagnosis and in support of treatment as prevention

Community mobilization and engagement

- **Ensure that subpopulations of MSM that have been marginalized because of beliefs about value are given equal opportunities to contribute** to community decisions and play leadership roles in the development and evaluation of HIV and MSM programs. If they are not at the table, their needs will not be met by MSM programming.

- **Develop messages targeted to the MSM community that reframe potentially harmful gender-related beliefs to make them positive and conducive to uptake of services.** For example, use "men care for and respect their bodies" instead of ""real men' do not seek help, including from health care workers, unless they are very ill." Target messages directly to the most hard-to-reach groups, such as young MSM and those who are not "out" or who otherwise prefer to remain hidden. Social media may be one effective way to deliver messages to those who are more difficult to reach.

- **Conduct qualitative data collection with MSWs, young MSM, and MSM who are not "out"** or who otherwise prefer to remain hidden, to better understand their unique needs.

CONCLUSION

Gender analyses have been conducted with the general population for many years. Our research adds to the body of knowledge that demonstrates ways in which harmful gender norms affect HIV-related outcomes — but for KPs in particular. MSM's HIV risk, vulnerability to violence, and service uptake are all affected by both conforming to gender norms and being seen as non-conforming. In the context of HIV in Kenya, this research provides evidence that addressing gender norms and the beliefs that stem from them in HIV prevention and care interventions is essential. Recommendations made here will assist both implementers and the government in using the research findings to enhance programs and policies for MSM.

Finally, our findings make clear that gender transformative MSM programming could also play a role in larger efforts to promote gender equality. Changing harmful gender norms that affect MSM would also benefit women, men, and transgender people of varying gender expressions and sexual orientations by challenging biases that value men and masculinity over women and femininity and that demand strict adherence to rigid gender norms.

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