

Mental Health, Substance Use, and HIV Prevention Among Gay and Bisexual Men in Kenya

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Gay and bisexual men and other men who have sex with men (GBMSM) are disproportionately impacted by human immunodeficiency virus (HIV) in Kenya, and elsewhere in Sub-Saharan Africa. GBMSM face unique mental health (MH) and substance use barriers that negatively influence their ability to protect themselves from HIV. To examine the relationship between mental health/substance use and their potential influence on HIV prevention among GBMSM we conducted a secondary data analysis of qualitative data from the Uzima Bora research study. This study focused on the integration of mental health/substance use and HIV-related services for GBMSM living in Kisumu Kenya. Respondents shared that mental health and substance use challenges were associated with deprioritizing HIV prevention among GBMSM through four main thematic areas; (a) depression and loneliness, (b) substance use, (c) discriminatory stress, and (d) internalized homonegativity. These themes were identified after a thorough analysis of participants' responses from community charrettes. The findings from this analysis highlight the importance of addressing mental health and substance use challenges when conducting HIV prevention activities. The co-occurrence of mental health and substance use behaviors must be addressed together to improve HIV prevention strategies for GBMSM in Kenya.

Keywords

HIV • Mental Health • Substance Use

Introduction

In Kenya, GBMSM face one of the highest HIV burdens globally, with prevalence rates significantly surpassing those of the general population (Moyo et al., 2023). In a global context, although

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the gay and bisexual community only consists of 1–3% percent of the adult male population in the world, approximately 23% of all newly discovered HIV infections in 2020 were from this population (Mwaniki et al., 2023). One study found that in Sub-Saharan Africa (SSA) the collective HIV prevalence rate was roughly 5% higher among the gay and bisexual community than among other men in the population at large (Hessou et al., 2019). This global pattern is mirrored in Kenya, where GBMSM experience significant health disparities. In Kenya, GBMSM make up an estimated 15% of people living with HIV in the country (Moyer & Igonya, 2018). Despite an estimated HIV prevalence of 4.3% in the general population of Kenya, the prevalence among gay/bisexual men is estimated to be at least four times higher (PEPFAR, 2022).

Studies that have examined mental health and substance use concerns among the male gay/bisexual communities in Kenya have found disproportionately high rates of these health challenges. Prior mental health work in Kisumu Kenya found that more than half (52%) of GBMSM in Western Kenya reported clinically significant post-traumatic stress disorder (PTSD) symptoms and 28% reported clinically significant levels of depressive symptoms (Harper et al., 2021). Similar rates of clinically significant levels of depressive symptoms were reported by gay/bisexual men in the capital city of Nairobi (29.8%), with 39.2% reporting harmful substance use (Doshi et al., 2020). A study conducted on the coastal region of Kenya found that 42% of GBMSM respondents reported moderate to severe symptoms of depression and roughly 60% had some issues with substance abuse (Secor et al., 2015). Finally, another study of 1476 GBMSM in Kisumu, Nairobi, and Coastal Kenya found that overall, 31% of participants reported clinically significant levels of depressive symptoms and 51% reported harmful alcohol use (Korhonen et al., 2018). The lack of mental health and substance use services specifically for GBMSM in Kenya contributes heavily to the burden of these interrelated health issues, making the search for assistance with substance abuse and mental health conditions an even greater struggle.

Elevated rates of both HIV and mental health/substance use challenges have been linked to high levels of pervasive intersectional stigma and discrimination faced by GBMSM in Kenya (Lewis et al., 2023; Harper et al., 2021). This is largely due to anti-GBMSM sentiments in the legal, cultural, and religious institutions. Same-sex relations are criminalized in the Kenyan Penal Code, which can carry up to a 14-year sentence for consensual same-sex sexual behavior (Lewis et al., 2023). Familial rejection is a common manifestation of this cultural sentiment, with participants in a study from Lewis et al. describing being financially cut off, forced into a heterosexual marriage, being cut off from the family entirely, and more (Lewis et al., 2023). Stigma within healthcare is another prominent stress-inducing area, with stigma from providers being a significant barrier to accessing HIV prevention and care (Ndungu et al., 2024).

There are many effective HIV prevention strategies for GBMSM including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and condoms with lubricants that have been shown to significantly reduce the risk of HIV transmission (Centers for Disease Control and Prevention, 2022). Prior studies have demonstrated that Kenyan GBMSM have not always been able to access HIV prevention services when they are needed, and there are barriers and challenges to using them consistently and correctly (Manguro et al., 2022; Musyoki et al., 2021; Ogunbajo et al., 2019). Avoidance of HIV prevention services can also occur due to fears of revealing one's sexual orientation to both clients and providers in clinics, or anxiety that receiving HIV prevention services will trigger a personal acceptance of one's sexuality (Harper et al., 2015). Others may have had prior negative experiences of discrimination or violence by healthcare providers when it was revealed that they are gay or bisexual during an exam (Aggarwal et al., 2024).

Due to the interlocking systems of oppression that GBMSM in Kenya face, and the subsequent mental health and substance use challenges coupled with HIV prevention challenges, it is important to understand from GBMSM themselves how poor mental health and substance use negatively influence the use of condoms, PrEP and PEP to prevent HIV. This information will help to develop public health interventions that address both mental health and substance use challenges to decrease critical barriers to HIV prevention practices. In this paper, we attempt to understand the mechanisms behind how substance use and mental health challenges can serve as obstacles to HIV prevention for GBMSM in Kenya. We conducted a primary data analysis of existing qualitative data collected from GBMSM living in Kisumu Kenya as part of a larger study exploring ways to integrate HIV and mental health services.

Methods

Participants

This analysis utilizes a sub-sample of existing qualitative data from a larger mixed-methods research study, the Uzima Bora project, which was conducted in 2022 in Kisumu, Kenya. The 58 participants consisted of men who identified as young GBMSM, many of whom were affiliated in some way with at least one GBMSM-focused community-based organization (CBO). “Young” was defined as ages 18–34 in the sampling since this is the legal definition of “youth” in Kenya with at least 50% of participants having some experience with HIV services in the area. However, we did allow a few GBMSM elders who were above the age of 34 to participate given their knowledge of the community. Participants, aged 18–43 (mean age 28), represented 15 CBOs and held various positions, including peer educators, paralegals, and outreach workers.

Data Collection Method

Data were collected using community charrettes. Charrettes, a collaborative planning process where stakeholders share expertise, were used to engage GBMSM in discussions on mental health and HIV prevention challenges (Lennertz & Lutzenhiser, 2006). Charrettes are incredibly effective as they gather integral information about a community’s needs and desires relatively quickly, creating a holistic approach to complex and intricate issues described by participants (Lennertz & Lutzenhiser, 2006; Dunbar-Morris, 2023).

Purposive sampling was used to recruit key stakeholders who were fully aware of the lived experiences of GBMSM, both through their personal experiences and their work in GBMSM organizations. Participants in the community charrettes engaged in directed conversations regarding key research questions in small groups of five. Responses from each group were written on separate pieces of poster paper which became the primary data sources. After these discussions, the participants discussed each group’s comments, and additional information was added to the poster paper.

The poster papers from the community charrette were scanned and then transcribed verbatim for analyses. A thematic analysis was then conducted on the responses and notes that were recorded on the poster papers to identify common themes and trends in responses. Data for the current paper come from one specific research question that participants were asked to explore: How do you think mental health challenges affect how well young GBMSM protect themselves from HIV?

Results

The data from the community charrettes highlighted that GBMSM face a variety of adverse and detrimental mental health and substance use challenges that likely contribute to increased HIV-related risk behaviors and decreased HIV preventive behaviors. There were four thematic areas that we view as potential ways that mental health and substance use factors influence GBMSM's ability to prevent themselves from acquiring HIV, including (a) depression and loneliness, (b) problematic substance use, (c) discriminatory stress, and (d) internalized homonegativity. For each of these mental health and substance use factors, we also categorized the specific HIV-related behaviors that were impacted by each thematic area, thus contributing to potentially higher levels of HIV. These included the following: (a) increased HIV-related risk behaviors (e.g., unprotected sexual activity, multiple partners without protection, injection drug use), (b) decreased HIV-protective behaviors (e.g., condom use, PrEP use, PEP use), (c) avoidance of HIV prevention services (e.g., facilities that provide HIV/STI testing and prevention services), (d) poor adherence to PrEP, and e) cessation of PrEP.

The subsequent sections explore and examine the main thematic areas in detail and provide representative examples of GBMSM participants' responses written on the poster paper. This allows for a comprehensive understanding of the mental health and substance use challenges that are likely impacting effective HIV prevention through a community-centered lens.

Depression & Loneliness

Although depression and loneliness refer to unique psychological phenomena that are both associated with negative affect and feelings of sadness, we combined them together for this analysis because participants frequently used them interchangeably during the charrettes. Loneliness is typically a state of mind where a person desires supportive contact with others and can be a symptom of depression which is a more complex mental health condition that has negative effects on how a person thinks, feels, and acts. Depression and Loneliness negatively impacted GBMSM's HIV prevention practices in four areas: a) avoidance of HIV prevention services, b) cessation of PrEP, and c) poor adherence to PrEP, d) increased HIV-risk-related behaviors.

Participants shared that negative feelings and frustrations that accompanied depression led them to feel like they did not have the energy or desire to travel to a facility to access HIV prevention services. One group reported that they felt that depression can also lead to thoughts of suicide, leading to an individual not seeking HIV prevention services because they have "given up" on life already. Depressive negativity also led some young GBMSM to use illicit substances, which then led to even more risk-increasing decisions. Depression was also considered to be a factor that can lead to both poor adherences to PrEP and cessation of PrEP. Concerning isolation, participants talked about how depressive feelings can lead to self-isolation, which in turn may decrease the likelihood that the person will seek out HIV prevention services. In addition, self-isolation was implicated as a factor in increasing HIV-related risk behaviors. Following are responses regarding this potential connection taken from different charrette small groups.

"Depression can make one stop taking PrEP and self-isolation, and create a lack of access to services."

"Suicidal thoughts mean one has already given up and doesn't see the need to protect themselves."

“Depression and frustration can lead to one having poor adherence to PrEP and can also lead to an increased usage of drugs and substances that may lead to uninformed decisions.”

Substance Use

Substance use for GBMSM mainly takes the form of alcohol use, either alcohol that can be purchased in a store or pub, or alcohol that is made in residential homes and public spaces using common ingredients and has a high alcohol content and can be dangerous (i.e., homebrew). Some GBMSM will use marijuana, although it is less common, with a minority using injection drugs or other substances such as cocaine. Substance Use negatively impacted GBMSM's HIV prevention practices in three areas: a) increased HIV-related risk behaviors, b) decreased HIV-related protective behaviors, and b) poor adherence to PrEP.

Participants shared that substance use leads to poor judgment when they are engaged in sexual activity, which typically leads to not using condoms during sex, as well as poorer judgment when using injection drugs, which typically leads to sharing unclean needles. Substance use was also viewed as leading to impaired judgment regarding HIV protective behaviors, and a feeling that one is not able to protect himself from HIV. Participants revealed that when they are high, they cannot make informed decisions on how to take proper measures to protect themselves against HIV. In addition, several groups also expressed concerns that substance use can lead to impaired performance or addiction, both of which were suggested as reasons why other GBMSM may not be able to adhere to PrEP. Following are responses regarding substance use which were taken from different charrette small groups.

“Drug and substance use- when one is high, he can't take the right measures of protection against HIV . . . Intoxication leads to poor judgment hence risky sexual behavior.”

“Drug and substance use = impaired judgment, when you are under drug influence you will not be able to protect yourself.”

“Drug and substance use leads to unsafe sex, withdrawal from drugs, and sharing of injected needles.”

Discriminatory Stress

Discriminatory stress for these men included feelings of unease and mental distress caused by interlocking systems of oppression that GBMSM in Kenya face. The majority of the stress emanated from stigma and discrimination that they experienced in a range of settings, including home, school, workplace, community, and healthcare settings. This stress came from various people including peers, family members, co-workers, healthcare providers, teachers, and others who are in positions of power and authority over GBMSM. Discriminatory stress negatively impacted GBMSM's HIV prevention practices in four areas: a) increased HIV-related risk behaviors, b) decreased HIV protective behaviors, c) poor adherence to PrEP, and d) avoidance of HIV prevention services,

Participants articulated that when they were stressed from various forms of discrimination, they forgot to engage in HIV protective behaviors such as using a condom during sex or forgetting to take their daily PrEP pill. Others suggested that when they experienced discriminatory stress they make “unhealthy decisions” such as engaging in increased alcohol use and having an increased desire to have multiple sexual partners. Finally, another group talked about how some GBMSM

experience discrimination from multiple groups when they have used PrEP, including family members, other GBMSM, and healthcare providers. Because of this discrimination, they have reported that some GBMSM will hide the fact that they are taking PrEP, resulting in adherence challenges. Other groups talked about how the fear of experiencing discrimination related to one's sexual orientation leads some to a type of "social phobia" where they avoid HIV prevention services because they are fearful of what they may experience if they seek such services. Following are responses regarding discriminatory stress which were taken from different charrette small groups.

"Discrimination from family members, some members may treat you differently when they see you using PrEP—also discrimination from GBMSM community members and with healthcare providers."

"[Discriminatory] stress can make one make unhealthy decisions such as promiscuity, multiple sex partners, and alcohol use."

"Fear [of discrimination] leading to social phobia and fear of seeking services i.e., HTS [HIV Testing Services], accessing PrEP, STI [sexually transmitted infection] services."

Internalized Homonegativity

Internalized homonegativity can be understood as inherent and internal self-stigma and negative attitudes that affect one's self-esteem or perception of oneself due to their sexual orientation. This occurs due to intersectional anti-GBMSM oppression, which impacts young men in all realms of their lives. Internalized homonegativity impacted GBMSM's HIV prevention practices in two areas: (a) increased HIV-related risk behaviors, and (b) avoidance of HIV prevention services.

Participants expressed that many members of the GBMSM community felt high levels of self-stigmatization (internalized homophobia) due to all the negative societal messages they received, leading them to have no sense of self-worth and low self-esteem. For some, this internalized homophobia manifested itself in fear that others would harass them or discriminate against them if they accessed HIV prevention services. As a result, they avoided accessing such services, and thus often did not have any preventive commodities, such as condoms and lubrication. Some participants even indicated that due to their low self-worth, they feel like they are not worthy of accessing preventive services. For other participants, internalized homophobia led them to engage in a range of HIV-related risk behaviors including having unprotected sexual activity, having sex with multiple partners, and having sex while under the influence of drugs or alcohol. Following are responses regarding homophobia which were taken from different charrette small groups.

"Fear will prevent GBMSM from accessing preventive commodities through self-stigma."

"Sexual orientation may cause someone not to access services because of fear of discrimination."

"Self-stigma can cause one to engage in unsafe sex practices . . . self-stigma leads to low self-esteem due to one's sexual orientation."

Discussion

Intersectional stigma and discrimination faced by GBMSM in Kenya contribute to many public health challenges including mental health and substance use, and HIV infection. Therefore, we sought to understand from GBMSM themselves the ways in which poor mental health and

substance use can negatively influence the use of condoms, PrEP, and PEP to prevent HIV. The unique community charrette data collection approach that we used provided unique insights into GBMSM community members' perceptions of the mechanisms through which mental health and substance use assert their negative influence. This was highlighted by participants sharing their lived experiences, perspectives, and awareness of mental health and substance use barriers that affect their ability to properly protect and prevent themselves from contracting HIV. Participants highlighted that multiple barriers are increasing HIV-related risk behaviors as they relate to HIV prevention such as depression and loneliness, substance use, discriminatory stress, and internalized homonegativity. These barriers are not to be understood as fundamentally isolated, but rather as intersecting and interacting barriers that negatively impact HIV prevention among GBMSM.

This qualitative analysis identifies the types of mental health challenges prominent among the GBMSM community that greatly impact HIV prevention efficacy. These results align with previous literature on mental health concerns for GBMSM concerning HIV prevention (Harper et al., 2021; Korhonen et al., 2018; Lyons et al., 2023). In a study of HIV prevention in the global GBMSM population, participants who were dealing with mental health conditions such as depression were shown to have decreased HIV prevention behaviors falling in line with our findings (Collins et al., 2021). These findings showcase the barriers that must be addressed when working with the GBMSM community in Kenya regarding HIV prevention.

The relationship between the uptake of preventive behaviors and mental health burdens experienced in the day-to-day lives of the community highlights the need for holistic approaches for impactful interventions. As these burdens can contribute to lower adherence to protective behaviors, interventions with holistic mental health evaluation and resources are necessary to support the sustainable development and maintenance of these behaviors outside of clinical settings. The increased participation in behaviors that place people at risk for HIV further showcases this. The incorporation of community voices and insight in intervention development is vital to best understanding the manifestation and potential ways to mitigate these risk-increasing behaviors. Overall future work to increase HIV prevention services and uptake within the GBMSM community in Kenya requires awareness of the social landscape of the focal communities and support for the existing mental health and substance use burdens for impactful change.

Strengths, Limitations, and Future Research

A significant strength of our study was the use of qualitative and participatory-based methodologies. Through the utilization of community charrettes in this study we were able to gain a layered and nuanced understanding of the mental health and substance use challenges that participants were enduring as it relates to HIV prevention. In addition to the nuanced understanding, we were able to center the lived experiences and voices of the community members at hand. Additionally, another major strength of our study is that by using community charrettes we were able to bring together over 50 GBMSM from the community in one central location for a full day of participatory learning and sharing, and they also likely benefited from these new connections.

One limitation of this analysis is that not all of the analysts for this paper were present when the charrettes were conducted. Although most of the concepts were confirmed by Kenyan members of the team, the lead analyst relied on knowledge of the community learned from colleagues, some of whom are Kenyan GBMSM. Another limitation of our study was that participants were recruited

predominantly from community-based organizations, which lacks representation from GBMSM who may avoid interacting with GBMSM-focused organizations due to concealment of their sexual orientation. Those GBMSM in Kenya who conceal their sexual orientation may have distinctive experiences related to MH challenges that are not accounted for in this analysis.

Future HIV prevention programs should address the range of mental health and substance use challenges that impair the ability of GBMSM to protect themselves, as well as the various resulting risk behaviors. Future research and interventions should address both interpersonal and societal factors that oppress and discriminate against GBMSM, as these have a negative influence on the ability of GBMSM to care for themselves (Harper et al., 2021; Jauregui et al., 2021). This could include both community and societal-level interventions to destigmatize GBMSM and HIV. To address these mental health and substance use barriers there are a variety of potential opportunities to increase positive health outcomes for GBMSM in Kenya. The adoption of sensitization training at CBOs and healthcare settings broadly can be a useful tool for Kenyan healthcare providers to receive educational sessions on how to properly engage with LGBTQ+ Kenyans and their unique identities in healthcare. Additionally, the adoption of social support such as group therapy can serve as a helpful tool for GBMSM to utilize to cope with their mental health challenges, which can positively impact mental health and sexual health outcomes (Jadwin-Camak et al., 2022). Finally, prior studies have demonstrated the resilience and strength of GBMSM in Kenya, so future interventions should incorporate these strength-based strategies and concepts into their work (Harper et al., 2021; Harper et al., 2015). Further HIV prevention care continua services should address the range of mental health and substance use challenges such as depression and loneliness, internalized homonegativity, substance use, and discriminatory stress to promote HIV prevention efficacy among GBMSM.

Conclusion

GBMSM in Kenya deal with distinct experiences of mental health and substance use challenges that negatively influence HIV prevention strategies and consequently increase HIV-related risk behavior. This qualitative analysis of data from 58 GBMSM in Kenya identified multiple mental health barriers that are prevalent among GBMSM which greatly impact their ability to engage in HIV prevention strategies including depression and loneliness, substance use, discriminatory stress, and internalized homonegativity. The identification of these mental health challenges sheds light on the need for future intervention programs that are grounded in decreasing mental health challenges to in turn increase HIV prevention efficiency and decrease HIV-related risk behaviors. The data from this study can be useful to advocate for the destigmatization of GBMSM and HIV and help develop strategies to cultivate mental health and HIV integration facilities. The findings underscore the urgent need for integrated mental health services to support effective HIV prevention efforts among GBMSM.

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