

BRIDGING THE GAPS

Health and rights for key populations

REACHING KEY POPULATIONS AND IMPROVING THEIR ACCESS TO HIV SERVICES IN KENYA



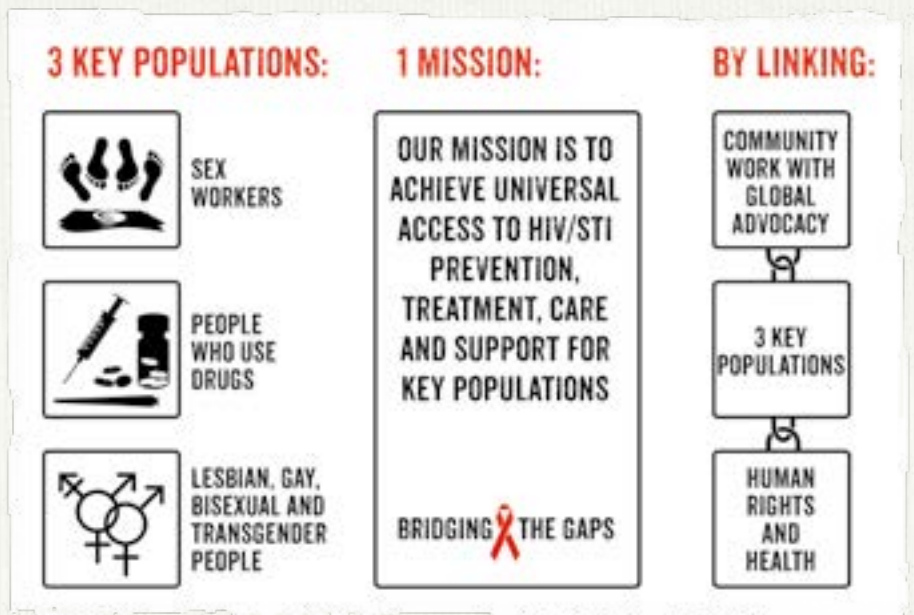
RESEARCH REPORT

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The Bridging the Gaps programme addresses the human rights violations and challenges faced by sex workers, people who use drugs, and lesbian, gay, bisexual, and transgender (LGBT) people, in accessing HIV and other essential health services. The Bridging the Gaps programme works with more than 90 local partner organisations which collaborate with four Dutch non-governmental organisations: Aids Fonds, AIDS Foundation East-West (AFEW), COC Netherlands, and Mainline, and with five global networks: the Global Network of People Living with HIV (GNP+), the International Network of People who Use Drugs (INPUD), the International Treatment Preparedness Coalition (ITPC), the Global Forum of MSM and HIV (MSMGF), and the Global Network of Sex Work Projects (NSWP).



COLLABORATING INSTITUTIONS

Reachout Centre Trust
 Muslim Education & Welfare Association (MEWA)
 The Omari Project
 North Star Alliance
 Ishtar
 Persons Marginalized and Aggrieved (PEMA Kenya)

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ABBREVIATIONS AND ACRONYMS

AHF	AIDS Healthcare Foundation
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CSO	Civil society organisation
HTC	HIV testing and counselling
HIV	Human immunodeficiency virus
LGBT	Lesbian, gay, bisexual and transgender
MEWA	Muslim Education & Welfare Association
PEMA	Kenya Persons Marginalized and Aggrieved
MSM	Men who have sex with men
NACC	National AIDS Control Council
NASCOP	National AIDS/STI Control Programme
PEP	Post exposure prophylaxis
PWID	People who inject drugs
PWUD	People who use drugs
SW	Sex worker(s)
STI	Sexually transmitted infection
TB	Tuberculosis

EXECUTIVE SUMMARY

Background

In Kenya, around one third of all new HIV infections occur among key populations: sex workers (SW), people who use drugs (PWUD), and lesbian, gay, bisexual and transgender (LGBT) people, including men who have sex with men (MSM). To stop the AIDS epidemic and reduce the HIV prevalence in Kenya, which currently stands at 5.6%, it is crucial to upscale effective HIV/STI prevention, treatment, care and support targeting key populations. Since 2011, the Bridging the Gaps programme promotes health and rights for key populations in 16 countries. In Kenya, operational research was conducted in 2015 to gain insight into how the programme reaches key populations and how to increase their access to services. The operational research conducted between October 2014 and August 2015 targeted six local Bridging the Gaps programme partners in Kenya:

- Reachout Centre Trust, Muslim Education Welfare Association (MEWA), and The Omari Project for PWUD;
- Persons Marginalized and Aggrieved (PEMA Kenya) and Ishtar for lesbian, gay, bisexual and transgender (LGBT) people;
- North Star Alliance for sex workers (SW).

These Bridging the Gaps country partners were involved in a variety of ways, from the formulation of operational research to the validation of findings.

Methods

The study was based on a participatory assessment to prioritise research questions. Informants consisted of key populations stakeholders from five organisations in three regions. In-depth interviews were conducted with 21 male and 22 female members of key populations, four female and six male outreach workers, and eight focus group discussions (with in total 24 female and 27 male members of key populations). Key informant interviews were held with six programme managers, 12 service providers and three community representatives.

Results

Good practices to reach key populations identified by the study include peer outreach, drop in centres/safe spaces, clinics run by non-judgmental professionals or peers, mobile testing, rehabilitation, and active social platforms (including radio), to increase awareness of available services. The majority of informants from key populations reported stigma and discrimination when visiting public health facilities.

Conclusions

Bridging the Gaps has made a significant contribution in reaching out to key populations in a variety of ways. The findings indicated that further efforts are needed to reach those currently not accessing or utilising services by improving outreach and the provision of health care services. Sensitising and training health care providers are essential steps toward decreasing stigma and discrimination against key populations. Outreach can be further improved by building trust with communities of key populations, and by better utilising social networks. The uptake of referral services can be strengthened by continuing to actively supporting clients after they have been referred to public facilities. Finally, it is advised to capitalise on the potential of various media to spread critical information on health and available HIV services. Regular mapping of target groups and locations is crucial in order to better understand the population, and to be better equipped to serve those currently not being reached with HIV/STI prevention, treatment, care and support.

1. INTRODUCTION

HIV is a health, socio-economic and human rights challenge that especially confronts men who have sex with men (MSM), sex workers (SW) and people who use drugs (PWUD) (hereafter, the key populations).

High HIV prevalence and incidences have been reported amongst MSM, SW and PWUD worldwide from the early years of the HIV epidemic to the present (Baral et al., 2012, 2015; Lindenburg, 2006; Hagan & Des Jarlais, 2000; Hagan et al., 2001; Hagan, Thiede & Des Jarlais, 2004; Wolf et al. 2013). Stigmatisation due to a HIV-positive status and/or sexuality has been noted as a barrier in seeking health care services (Sharma et al., 2008). Similarly, stigma and discrimination from the general community towards SW (Infante, Sosa-Rubi & Cuadra, 2009) and people who use drugs (PWUD) has been documented (Lloyd, 2010). There have been a variety of responses initiated to reduce and prevent HIV infection in these communities over the years. The developed world initiated a response, while the least developed and developing countries lagged behind. In recent years there has been a growing recognition of the need for interventions for key populations in the least developed and developing countries.

Despite studies since 2007 indicating vulnerability and high HIV incidences and prevalence among MSM, male and female SW (Geibel et al., 2008; Okal et al., 2009; Sanders et al., 2007), for a long time Kenya classified HIV in the national context as a generalized epidemic. This resulted in a failure to meet its responsibility to reach out to LGBT people, SW and PWUD. The 2009 Kenya Analysis of HIV Prevention and Response Modes of Transmission Study (National AIDS Control Council, 2009a) showing high HIV prevalence among key populations – MSM (15.2 per cent), SW (14.1 per cent) and PWUD (3.8 per cent) – was a turning point in Kenya's HIV response trajectory.

Studies have since shown that HIV prevalence amongst key populations is higher than the national average in Kenya.

Pooled HIV prevalence data suggest that three decades into the HIV response, nearly half (45.1% - range 44.0 to 46.2) of SW in Kenya is HIV-positive (Baral et al., 2012), compared to 6.9 per cent of the general female population aged 15-64 years. In 2011, IBBS (NACC, 2014) estimated that 29.3 per cent of female sex workers live with HIV in Kenya. NACC (2009) estimated HIV incidences among SW to be in the region of 50-80% in 2006.

The National AIDS Control Council 2014 report revealed that nearly one in five (18.2%) of MSM in Kenya are estimated to be living with HIV. Other studies estimated

HIV prevalence among MSM at 38 per cent (Geibel et al., 2008) and 43 per cent among men who reported sex with men exclusively (MSM) and 12.3% among men who reported sex with both men and women (Sanders et al., 2007).

The most at risk population study by the National AIDS STI Control Programme (NAS COP) (2013) estimated HIV prevalence among PWUD in Nairobi to be 18.7 per cent. National AIDS Control Council (NACC) estimated HIV prevalence among PWUD in Kenya at 18.9 per cent. The United Nations Office on Drugs and Crime (UNODC), (2011) study conducted at Coast and Nairobi, Kenya, estimated 18.3 per cent HIV prevalence among PWUD. 'The implementing Integrated Bio-Behavioral Surveys among key populations at higher risk of HIV exposure with emphasis in respondent driven sampling' (IBBS, 2012) estimated 18.3 per cent of PWUD were living with HIV.

Besides HIV, key populations are susceptible to many health challenges including sexually transmitted infections in MSM and SW, and hepatitis B and C, abscess, STIs and malnutrition in PWUD.

In these populations, social and legal obstacles prevent access to health services. Perhaps one of the biggest dilemmas Kenya has to contend with is how to include key populations – who are generally criminalised¹ and socially discredited – in HIV interventions. Socially, they face layered stigmas as LGBT people, SW and PWUD. In spite of the shortcomings, from a public health perspective there has been progress in addressing the needs of key populations in Kenya. The Kenyan government had implemented extraordinary measures to manage the HIV epidemic, which has resulted in the inclusion of key populations in HIV programming.

1 Section 153 and 154 of the penal code criminalises sex work as it states:(1) Every male person who -
(a) knowingly lives wholly or in part on the earnings of prostitution; or(b) in any public place persistently solicits or importunes for immoral purposes is guilty of a felony.
(2) Where a male person is proved to live with or to be habitually in the company of a prostitute or is proved to have exercised control, direction or influence over the movements of a prostitute in such a manner as to show that he is aiding, abetting or compelling her prostitution with any other person, or generally, he shall unless he satisfies the court to the contrary be deemed to be knowingly living on the earnings of prostitution.
154. Every woman who knowingly lives wholly or in part on the earnings of prostitution, or who is proved to have, for the purpose of gain, exercised control, direction or influence over the movements of a prostitute in such a manner as to show that she is aiding, abetting or compelling her prostitution with any person, or generally, is guilty of a felony.

1.1. KEY POPULATION INTERVENTIONS IN KENYA

From a public health perspective, the government is responsive in addressing HIV among key populations. Key populations in Kenya – MSM, PWUD and SW – are visible as a key focus in HIV prevention in the third Kenya AIDS Strategic Plan 2009/10-2012/3 (National AIDS Control Council, 2009b). Despite the continued criminalisation and an unsympathetic social environment, a supportive policy environment has led to the inclusion work with key populations within the Kenya National Strategic Plan 2009/10-2012/2013 (National AIDS Control Council, 2009b). Recognition of programmes targeting these communities has created a structurally enabling policy environment. This has made it possible for programmes involving these communities to be initiated. The government of Kenya, through the Ministry of Health, NACC, NASCOP and other stakeholders (among them key populations' representatives), has set the road map for HIV prevention and care programmes for key populations. In 2010, a National Aids Policy was adopted that includes key populations. The strategic plan was accompanied by guidelines, training curriculums for health care workers and programmes for key populations². The HIV/STI Package of Services for key populations in Kenya has three components: i) behavioural components; ii) biomedical components; and iii) structural components, as summarised in table 1 below.

The efforts are aimed at ensuring that the HIV/STI package of services for key populations, as outlined above, are implemented in Kenya by public health facilities and by civil society organisations (CSOs).

Supported by international development partners, a number of primarily key population-led and non-key population-led CSOs in Kenya carry out activities to increase access to and utilisation of HIV related services. The main area of interest is to increase the availability of services through the CSOs and the general public health system. As services are being made available, civil societies work to make services accessible, affordable and acceptable to key populations. Strategies employed to increase services include community-based outreach services, integration of services, improving service delivery, peer education, respondent-driven sampling, and referrals and linkages to services.. These strategies are not new and have been implemented in some sub-Saharan African countries, resulting in significant achievements (Baral et al., 2015; Mulongo et al., 2015).

While CSO-led interventions are underway in different parts of Kenya, non-supportive legal and socio-cultural environments are still challenges to address (National AIDS Control Council, 2009b; Sharma et al., 2008). More needs to be done to scale-up and accelerate access to services by key populations.

Table 1. Summary of the prevention programmes for key populations in Kenya*

Behavioural components	Biomedical components	Structural components
<ul style="list-style-type: none"> Peer Education and Outreach Risk Assessment Risk Reduction Counselling and Skills Building Screening and Treatment for Drug and Alcohol Abuse 	<ul style="list-style-type: none"> HTC, STI Screening and Treatment TB Screening and Referral to Treatment HIV Care and Treatment. Promotion, Demonstration and Distribution of Male and Female Condoms and Water-Based Lubricants Family Planning, Sexual and Reproductive Health Services Post-Abortion Care Services Cervical Cancer Screening Emergency Contraception Post-Exposure Prophylaxis Post rape care Screening and management of hepatitis B Opiates substitution Therapy Needle exchange programme Male Circumcision 	<ul style="list-style-type: none"> Ensuring 100% Condom Use Mitigating and managing sexual violence Mitigating violation of human rights Expanding choices beyond sex work Providing psychosocial support, family and social services, and access to micro credit and other financial products

² National training curriculum for health workers addressing LGBT people and SW. Ministry of Health adopted Guidelines for Needle Exchange and Methadone Programmes.

* Source: National AIDS and STI Control Programme. (2012). Most-at risk- populations report: Unveiling new evidence for accelerated programming. Nairobi: National AIDS and STI Control Programme.

1.2. BACKGROUND BRIDGING THE GAPS

The Bridging the Gaps programme addresses the human rights violations and challenges faced by sex workers, people who use drugs, and lesbian, gay, bisexual, and transgender (LGBT) people, in accessing HIV and other essential health services. The Bridging the Gaps programme works with more than 90 local partner organisations which collaborate with four Dutch non-governmental organisations: Aids Fonds, AIDS Foundation East-West (AFEW), COC Netherlands, and Mainline, and with five global networks: the Global Network of People Living with HIV (GNP+), the International Network of People who Use Drugs (INPUD), the International Treatment Preparedness Coalition (ITPC), the Global Forum of MSM and HIV (MSMGF), and the Global Network of Sex Work Projects (NSWP). The five programme objectives of Bridging the Gaps are:

1. Improve the quality of and access to HIV prevention, treatment, care, support and other services for key populations;
2. Improve the human rights of key populations;
- 3.. Integrate specific services for key populations within the general health system;
4. Strengthen the capacity of CSOs that work on HIV and key populations;
5. Develop and strengthen a comprehensive and concerted approach on HIV and key populations by the alliance partners.

In Kenya, Bridging the Gaps focuses on availability and provision of services (through civil society actors and the general public health care system) and on sensitising key populations and the larger communities. This is done through a combination of services including conducting advocacy at policy and community level for the health and human rights of key populations, and implementing community-based outreach programmes. Such programmes include sensitisation and educating of communities, peer education, mobile medical services and HIV testing and counselling (HTC).

Whereas country partners have multiple donors supporting various activities to accelerate access to services among key populations, the focus of the Bridging the Gaps programme has been on increasing access to and uptake of HIV prevention, treatment and care and related programmes, though human rights and policy advocacy, service delivery, capacity building and integration of services in the general health care system. For close to four and half years, the Bridging the Gaps programme supported six country partners in Kenya to increase access to, and uptake of HIV and health related services

by key populations – LGBT people, SW and PWUD – in Nairobi, along the north corridor and Mombasa. The country partners supported were The Omari Project in Malindi, Reachout Centre Trust, Muslim Education Welfare Association (MEWA), Persons Marginalised and Aggrieved (PEMA Kenya), Ishtar, Liverpool VCT Health (LVCT) and North Star Alliance. Other organisations, including HAPA Kenya, UKWELL and Tamba Pwani, are indirectly supported under Bridging the Gaps.

To increase access to HIV/STI prevention, treatment, care and support in Kenya populations, country partners have implemented strategic interventions to provide an enabling environment and to improve access to services and human rights. These include advocacy, specialised clinics, integration of services, community-based outreach and peer education model, harm reduction (amongst PWUD), and referral and linkage to services.

The midterm evaluation of the Bridging the Gaps programme showed that progress had been made in the delivery of services to key populations (Van der Meer, 2013). “Reaching the hard to reach” was identified as a priority focus area in the midterm evaluation, particularly increasing understanding of how best to reach under-served key populations and to increase access to and uptake of HIV prevention, treatment, care and support. Therefore, operational research was planned to (re)examine existing strategies, exploring what works and which barriers exist in existing interventions. The aim of this study was to identify effective strategies in reaching out to key populations and to further improve interventions and outcomes.

1.3. OPERATIONAL RESEARCH

Although there are many definitions of operational research (World Health Organization and The Global Fund, 2008), there is general agreement that operational research concerns improvements in organizational performance or service-delivery, and finding solutions to increase outcomes. The Global Fund and World Health Organization (2007) define operational research as the use of systematic research techniques for programme decision-making to achieve a specific outcome. Operational research provides policy-makers and managers with evidence that they can use to improve programme quality, efficiency and effectiveness, or to determine which alternative service delivery strategy would yield the best outcomes.

Through a consultative process with key population-led organisations, key research aim was defined as “To examine and understand how to increase access to HIV/

STI prevention, treatment, care and support among hard to reach populations”.

By examining the on-going strategies and activities, the research aimed to understand how best to reach key populations with HIV, and to ensure their increased access to services. Specifically, it examined what is working and not working and why, and what obstacles are faced by organisations. The operational research sought to answer the following research questions:

- What factors influence the ability to reach key populations and their ability to access HIV/STI prevention, treatment, care and support?
- What strategies influence the ability to reach key populations with services?
- What are barriers to accessing services by each key population and the barriers in reaching each key population?
- What are the best practices and key lessons for reaching different key populations?

The 2012 Kenya AIDS Indicator Survey estimated Kenya’s HIV prevalence at 5.6 per cent in the general population aged 15-64 years (National AIDS STI Control Programme, 2013). However, the epidemic varies by demographic group and geographic area within this age group. HIV prevalence is higher among women (6.9%) than men (4.4%). The highest HIV prevalence rates in the country are in Nyanza region (15.1%), followed by Nairobi (4.9%), Western (4.7%) and Coastal (4.3%) regions. Urban areas in the country have also been found to have a higher HIV prevalence (6.5%) than rural areas (5.1%). Due to sampling constraints, general population-based surveys, such as KAIS, may not provide accurate data on HIV prevalence among key populations even as previous studies found prevalence in such populations higher than national average.

The study sites were located in Nairobi, the Coast region and along the Northern Corridor of Kenya, where six Bridging the Gaps programme country partners are located (see Table 2.).

Nairobi, Mombasa, Malindi and the Northern Corridor have the highest concentration of key populations and various programmes run by the CSOs, and were therefore selected for the study.

Nairobi is the capital and commercial city of Kenya, is the most populous of the 47 counties of Kenya. It has the highest urban HIV prevalence (9%), and is in the top 10 highest nationally. Nairobi has the highest number of health facilities in Kenya, and these include public, private for-profit, and faith-based for-profit health facilities. It also hosts many non-governmental organisations carrying out various interventions or providing services to key populations.

Mombasa is the administrative capital of Mombasa County and lies along the coastal region of Kenya, and a high (7.4 %) HIV prevalence (National AIDS Control Council, 2014) Like Nairobi, it has a high concentration of SW, MSM and PWUD (Beckerleg et al. 2005). It has a number of health facilities: public, private for-profit, faith-based organisations, and facilities operated by non-governmental organisations. There are a number of such organisations providing services to key populations in Mombasa, such as ICRH (male and female SW), PEMA-Kenya, Bomu, HAPA Kenya, and Family Health Options Kenya (FHOK). A number of SW groups also exist.

Malindi town, located between Mombasa and Lamu towns, is in Kilifi County along the coastal region. As a transit point for drug trafficking, there has been a growing local population of PWUD (United Nations Office on

Table 2. An overview of the study sites and participating partners.

Key Population Focus	Country Partners	Location
PWUD	The Omari Project Reachout Centre Trust MEWA	Malindi Mombasa Mombasa
LGBT	PEMA Ishtar	Mombasa Nairobi
SW	North Star Alliance	Northern Corridor (Salgaa in Rift Valley, Emali in Eastern, and Mlolongo in Kajiado



Drug and Crime, 2004; Arnold, 2005; Beckerleg et al. 2005 and SW (Arnold, 2005; Kibicho, 2002). Malindi town has a limited number of organisations implementing activities for key populations. The Omari Project focuses on PWUD, and Ananda Marga Universal Relief Team (AMURT), a NGO, provides services to SW and MSM and referrals for PWUD. Overall, Malindi had limited number of health facilities. The Wellcome Trust and Kenya Medical Research Institute (KEMRI) programmes operates in Mtwapa, also located in Kilifi County.

The Northern corridor is the highway from Mombasa to Rwanda. On this highway truck drivers who transport goods, mainly from port of Mombasa, have numerous stops that developed into small towns. These towns attract SW.

2. METHODS

This study used a case study design as the three key populations being examined – LGBT people (including MSM), SW and PWUD – involve different scenarios, contexts and practices. Qualitative methods were applied to allow for an in-depth examination and analysis of each key population. The operational research was implemented between October 2014 and August 2015 (see Figure 1 for the timeline).

The study design involved three phases. The first phase – the **preliminary phase** – concerned the proposal development and approval, and involved a participatory approach between Bridging the Gaps partners (country and international), key populations stakeholders in Kenya and research team. The researchers, Aids Fonds and Mainline Foundation, conducted consultative meetings on proposal development which included methodology and research tools. Country partners, as the consumers of operational research outcomes, were joined by other key population-led organisations in setting the operational research agenda. A one-day local key population stakeholders' meeting was held, bringing together 25 local key population-led organizations' representatives. The purpose of the meeting was to identify priority area of focus and to formulate research questions. There was consensus on investigating access, uptake, and utilisation of HIV/STI prevention, treatment, care and support by key populations. Also in this phase, the country partners identified community liaison persons who played a key role in informing communities of the operational research activities.

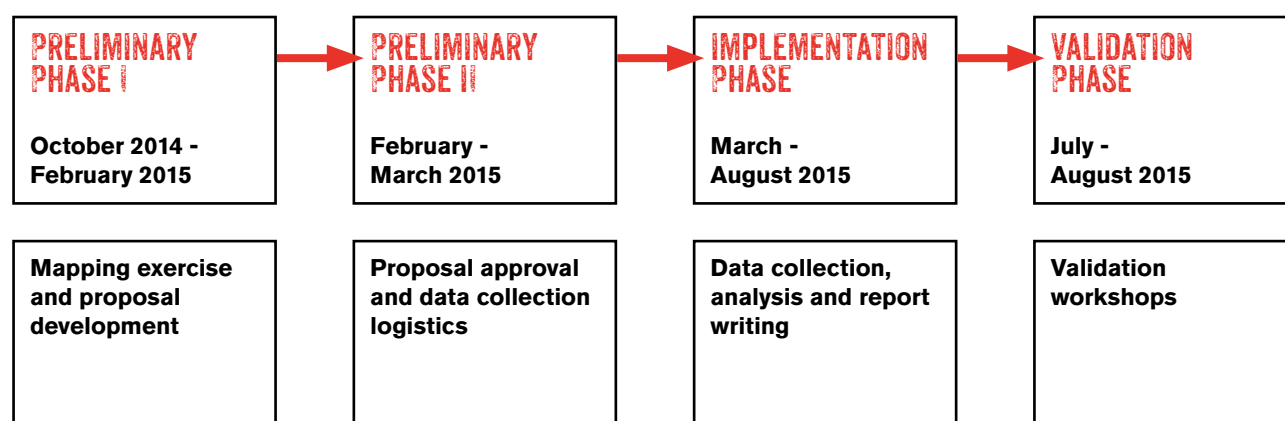
The second phase – the **implementation phase** – was concerned with data collection and data analysis. This phase began with the selection and one-day training on data collection for the research assistants and the community liaison persons. Country partners were also consulted on the dates of data collection. Data collection was conducted between March 2015 and August 2015.

The third phase of the operational research – the **validation phase** – was devoted to feedback, validation of the findings, discussions on and selection of key recommendations. This was completed at four validation workshops organised for each key population organisation: North Star Alliance (SW) in Nairobi; Ishtar (MSM) in Nairobi, PEMA- Kenya (LGBT) in Mombasa; and Reachout Centre Trust, MEWA and The Omari Project (PWUD) in Mombasa. Participants included the directors, senior staff, clinicians and outreach workers/peer educators from each organisation. The workshops were conducted between July 30, 2015 and August 12, 2015.

2.1. SAMPLE

Sources of information were triangulated, to examine the topics from different perspectives (Langdridge, 2004). Participants in the study included beneficiaries³ of the Bridging the Gaps programme drawn from the three key populations, key population programme managers and service providers (outreach workers, peer educators,

Figure 1. Operational research timeline



³ Individuals who receive HIV and related services from key population interventions.

counsellors, NASCOP (project staff and nurses), healthcare professionals (nurses, doctors, laboratory technician), community representatives (religious leaders and civil society organisation director) and key population members who do not access HIV/STI prevention, treatment, care and support provided by Bridging the Gaps country partners. See Table 2 for an overview of all respondents.

In order to draw in-depth insights into the projects non-probability sampling of a small sample of different target populations was used. Purposeful sampling strategy allowed the researchers to achieve the research objectives (Hardon et al., 2001; Mugenda, 2008).

Purposeful and convenience sampling was used in the selection of beneficiaries, frontline health providers and community representatives.

Purposeful and snowball sampling – a convenient chain of referral sampling strategy – were used obtain data on the key populations who did not access HIV related services, or who are not beneficiaries of country partners.

While we planned to recruit group discussion participants from the community, the first focus group discussions with

female PWUD proved challenging, with most community-recruited participants arriving intoxicated and sleepy. As a result, the rest of the PWUD group discussion members were drawn from rehabilitation centres, and all participants were required to have resided in the study site for at least six months.

Inclusion criteria

- Bridging the Gaps programme country partners' beneficiaries who are at least 18 years of age, and living or working in a Bridging the Gaps programme area;
- Key populations not reached by Bridging the Gaps interventions who are at least 18 years of age, and living or working in a Bridging the Gaps programme area;
- Health workers and staff from the key population organizations who had been working on the Bridging the Gaps programme for more than three months;
- Community representatives who had resided in the area for over six months.
- Respondents who provided written consent to participate in the study.

Table 3. Respondents overview

Data collection method	Participant Category	MSM ⁴	SW	PWUD	Total
Key informant interview	Managers/directors	2 (M)	1 (M)	3 (M)	6
Interview	Frontline service providers	2* (M)	3 (2 M 1F)	7 (5M 2F)	12
Interview	Frontline services providers referral				3** (F)
Interview	Outreach workers	3 (M)	3 (F)	4 (M)	10
Key informant Interview	Community representative		1 (M)		3 (2***)
In depth Interview	Beneficiaries	9 (M ⁵)	13 (F)	5 (4M 1F)	27
Group discussion	Beneficiaries	2 (14M)	3 (18F)	3 (13M 6F)	8 Group discussions 51 participants
In depth interview	Not reached with services	5 (M)	8 (F)	4 (M)	17

*Key informant interviewee from PEMA-Kenya was also a frontline health provider.

**Drawn from public health facilities in Mombasa.

4 The operational research found there is no clear engagement with LBT people, apart from sharing similar legal and social concerns of sexual orientation. Funding was limited to MSM. In this section, therefore, the findings focus on MSM.

5 All MSM beneficiaries in Mombasa who participated in the study were sex workers. Those who had not been reached with services were MSM.

The study involved 95 (49 men and 46 women) individuals of key populations (see Table 2.). Of these, 29.9 per cent were PWUD, 29.9 per cent MSM and 40.2 per cent female sex workers. 24.1 per cent of the PWUD individuals were women.

A number of MSM (including MSM who sell sex in Mombasa) posted high education levels compared to PWUD. Outreach workers posted low education levels compared to counsellors. Frontline health providers in public health facilities had higher education compared to some counsellors in Bridging the Gaps country partners. However, country partners' staff had more training on key populations than health providers from public health facilities. All key populations represented a diversity of ethnic groups and systems of beliefs, and had lived in the study area for over a year.

2.3. RESEARCH TOOLS

Semi-structured interview guides were used, including:

- 1. Interview guide for key informants** to assess knowledge on availability of services, on access to services, on programming and service delivery, and on strategies employed in increasing access or reaching out to those not reached with services;
- 2. Interview guide for peer educators/outreach workers** to assess their knowledge of services and their understanding of their work and outreach interventions. Their knowledge on strategies to reach key population and the barriers to accessing services was also assessed;
- 3. Interview guide for health care providers** to assess their knowledge on issues relating to access to services, service delivery practices, and challenges;
- 4. In-depth interview guide for beneficiaries** to assess their knowledge on the availability of services, and to learn from their access trajectory, their (de) motivations, and their experiences with service delivery, social support and challenges or delays in accessing services;
- 5. In-depth interview guide for key population individuals not reached by key population projects** to assess their motivation to access services, their knowledge of the availability of such services, and the barriers they had encountered in accessing such services;
- 6. Interview guide for community leaders** to assess their knowledge on the availability of services and social and legal support, and their experiences of the challenges in accessing HIV related services.
- 7. Focus group discussion guide for beneficiaries** of the programme to learn from their access trajectories, their experiences of barriers to service delivery and challenges in accessing services;

Data collection tools were developed in English and translated into Kiswahili allowing for flexibility in language use per the preferences of the interviewees. Study tools were pre-tested with 13 representatives and revisions were made accordingly. For example, all questions were open ended, to allow for more in-depth answers.

2.4. DATA COLLECTION

The data collection was conducted by a team that comprised a senior operational researcher, a research coordinator, two research assistants and three community liaison persons. The research assistants and community liaison persons were trained in data collection so they could assist the senior operational researcher and research coordinator. The senior researcher and research coordinator worked with the community liaison persons to identify study participants.

Data collection was conducted between March 2015 and May 2015 among three key populations in four locations – Mombasa, Malindi, Nairobi and three locations on the Northern corridor (Salgaa in Rift Valley, Emali in Eastern, and Mlolongo in Kajiado).

Data was simultaneously collected in all study sites. It was planned to start the data collection by conducting the key informant interviews with project directors or managers, which could serve as an entry point. However, if managers were unavailable, health providers were interviewed. To avoid interfering with the running of the project, interviews with health providers were conducted in their free time. While it was planned to interview beneficiaries third in the hierarchy of interviews, their interviews took place prior to those with the frontline providers and peer educators. Group discussions with beneficiaries depended on their availability.

Due to security reasons, interviews and focus group discussions with MSM in Mombasa were conducted in the evenings, in private discreet establishments.

Conducting focus group discussions with PWUD in the community was challenging as a number of them were intoxicated in the first group discussion. Based on this experience, the decision was made to rely on the rehabilitation centres for recruitment of PWUD participants. Individual participants not reached by services were recruited alongside the recruitment of the beneficiaries. The community leaders were last to be interviewed.



2.5. ANALYSIS

Data collection was conducted in both English and Kiswahili, depending on interview participant preference. With the permission of study participants, almost all interviews were tape recorded and notes were taken. Tape recorded interviews were transcribed verbatim and typed in Microsoft Word. Interviews conducted in Kiswahili language were translated into English. The data was arranged and analyzed according to themes. The findings contained in this report have been shared with and validated by the participating Bridging the Gaps country partners and a section of their beneficiaries.

2.6. ETHICAL CONSIDERATIONS

KEMRI's Scientific Ethical Review Unit (SERU) approved the operational research plan. To participate in the study, study participants read and signed a consent form. For those who could not read, the researcher or the note taker read the consent for them, and only after consenting were their signatures appended.

3. RESULTS

The Bridging the Gaps country partners have identified several strategies being rolled out by organizations to mobilise key populations and increase their access to, and uptake of, services. These include increased access and availability of services, community-based outreach programme activities and peer education, referrals and linkage to services, and integration of services. This section presents the operational research findings.

3.1. AVAILABILITY OF SERVICES

For PWUD, services are available in public health facilities and in Bomu, a civil society hospital in Mombasa. For SW services are available in public health facilities and other civil society facilities along the North Corridor. For MSM, apart from a few selected public health facilities, a number of CSOs offer services to MSM in Nairobi and Mombasa. In Nairobi, these include Health Options for Young Men AIDS and STIs (HOYMAS), Sex Worker Programme (SWOP) and LVCT. In Mombasa they include Hapa Kenya, Bomu hospital, UKWELI, Family Health Options Kenya and KEMRI in Mtwapa.

All Bridging the Gaps country partners offer free but limited HIV services in their clinics and through community-based mobile HIV testing.

North Star Alliance has established seven wellness centers along the Northern Corridor that offer health services to truck drivers, SW and the general community. The centres include Mariakani (Mombasa), Emali, Mlolongo, Mahi Mahi, Salgaa, Namanga and Burnt Forest and are located in trading towns that attract high numbers of truck drivers and SW. While truck drivers and SW are their main clients, the services are extended to the general community living around the wellness centres.

This research focuses on the North Star wellness centres in Emali, Mlolongo and Salgaa. These centres provide the following services:

- HIV testing and counselling
- care and treatment
- STI screening
- HIV post exposure prophylaxis (PEP) and antiretroviral (ARV) refill
- family planning
- condom and lubricants distribution
- tuberculosis (TB) screening and treatment
- treatment for common illnesses
- HTC is offered in communities through community-based outreach model.

There were inconsistencies in the services provided in various centres. Some centres provided HIV PEP, ARV refills, STI treatment and TB screening, while others did not. For instance, ARV refill and PEP were provided in Mlolongo but not in Salgaa and Emali.

Country partners focusing on PWUD provide harm reduction interventions that include HIV related services:

- Needles and syringes
- Condoms
- Referral for vaccinations
- Diagnosis and treatment for viral hepatitis
- Prevention, diagnosis and referral for treatment of TB.
- Opioid substitution therapy and other evidence based drug dependence treatment
- HTC, or a referral to obtain HTC
- Referral for antiretroviral therapy (ART)
- Prevention and referral for treatment of sexually transmitted infections
- Targeted information, education and communication

All PWUD country partners offer HIV testing and counselling as a requirement to all PWUD in rehabilitation centres. Only MEWA outreach workers are trained to detect TB and then refer clients for proper TB testing and treatment.

Reachout Centre Trust and The Omari Project offer HIV testing in their specialised clinics or drop in centres. Occasionally during the harm reduction activities in the community, mobile HTC is taken to the drug dens. At the time of the study, through NASCOP, Reachout Centre Trust provided HIV care (CD4 and viral load counts), in addition to HIV testing and counselling. The HIV care services were limited to the NASCOP's project cycle. In addition to HIV services, Reachout Centre Trust also provided limited treatment for common illnesses such as the common cold, coughs etc.

MEWA, on the other hand, refer or track PWUD to client-preferred public health facilities and occasionally conduct mobile HTC in communities. Treatment for common illnesses was limited due to lack of commodities such as medicines and bandages.

For MSM, PEMA Kenya and Ishtar have clinics providing limited HIV services to MSM. Ishtar operates a clinic that offers HIV testing and counselling, STI screening, condoms and lubricants distribution, and treatment for common illnesses. PEMA Kenya, on the other, hand, only offers HIV HTC.

Due to the restricted services provided by the Bridging the Gaps partners, HIV, STIs and TB care and treatment are made available to key populations in public health facilities and limited civil society health facilities.

Besides the availability of services, a number of motivating or constraining factors were identified:

- Knowledge about the services
- Distance to services
- Service delivery, such as integration strategy, priority in receiving services, friendliness of the services, confidentiality, operating hours, availability of free drugs for common illnesses
- Cost
- Negative community attitudes.

Findings indicate that free drugs and services are significant factors in increasing access and uptake of services among key populations served by the Bridging the Gaps country partners. All Bridging the Gaps country partners offer free but limited HIV services in their specialised clinics and in community settings through community-based mobile HIV testing and testing.

3.2. BEHAVIOURAL DETERMINANTS FOR UTILIZING SERVICES

Behavioural barriers faced by the key populations for utilizing services, include fear of HIV positive status and fear of its disclosure and inaccurate self-evaluation of susceptibility to HIV risk. Specific to MSM are feelings of exclusion or alienation by MSM-led organisations, lack of trust in MSM-led organisations and psychological issues. Specific to PWUD is the prioritisation of accessing drugs over seeking health care.

A general barrier for service up-take is a lack of knowledge of available services.

Sex workers who accessed services from North Star Alliance were knowledgeable about services provided in the wellness centres and public health facilities, and sex workers in Emali knew about services provided by AIDS Healthcare Foundation

While there are a number of health facilities, MSM beneficiaries reported they were not aware of them before they accessed services. MSM knew about HIV related services from their peers/friends (including regular sexual partners), but not from peer educators or outreach activities. In cases where a peer educator was mentioned, it was most likely he was also a friend. Before making contact with organisations focusing on MSM, MSM reported they did not know where to get STI treatment and therefore consulted their peers:

“ I had an STI and I had no treatment (...) I did not have anywhere to go for treatment. Then I explained to some friend who took me to their hospital although there was so much discrimination (...) Some nurses were laughing at me, they were asking how did I get an anal STI, and I never knew how to defend myself since they had a clear evidence that I was a gay, since gayism is not allowed they also called other staffs to come to see me. I felt this was all wrong. I did not even get treated. Someone advised me to go and buy some pills, so I went to the chemist and bought them. ”

– 21 year old MSM PEMA Kenya beneficiary

MSM study participants who had not been reached with services acquired some knowledge of services available for MSM via other communication strategies, such as HIV testing and counselling campaigns, social media platforms and peers who were beneficiaries of MSM interventions:

“ PEMA Kenya has a website that does not offer any information on health. I like very much HOYMAS⁶ website and social media, they are detailed and up date with information of HIV, STI and services they offer or other place where one can seek services. But HOYMAS is in Nairobi. I would like information on where to get counselling but PEMA Kenya are not qualified to give psychological counselling. ”

– 26 year old MSM not reached and not accessing services in Mombasa

Information, education and communication materials were only mentioned in a focus group discussion as one of the ways MSM obtained information on the availability of services. Beneficiaries mainly knew about services from outreach workers/peer educators. While beneficiaries of Ishtar were aware about the times when services were offered, it was difficult to ascertain the operating hours of PEMA Kenya services as they depended on the availability of the health officer.

6 Health Options for Young Men on AIDS and STIs (HOYMAS) is an organisation that focuses on MSM SW organization in Nairobi. HOYMAS maintains a proactive website, Twitter and Facebook pages, mainly focusing on HIV preventions, updates on HIV activities, information on STIs presentation, and availability of treatment.

Amongst those who had not accessed their services, PWUD country partners were more known for providing rehabilitation services. Those benefiting from the HIV related services learned about these services primarily from outreach workers/peer educators. To increase education space, Reachout Centre Trust runs a call-in radio programme on one of the Mombasa local media stations to educate communities on drug use, HIV related services.

At the time of this operational research, two initiatives attracted new people who use drugs to visit the Bridging the Gaps partner Reachout Centre Trust. First, the Mombasa Governor offered them financial support, to provide free rehabilitation services. Additionally, NASCOP recruited PWUD who had not accessed services before, through respondent driven sampling for a study they conducted in the venue of Reachout Centre Trust. Some of their respondents became clients after their participation in the study. Interestingly, some of their respondents indicated that the Reachout Centre Trust was known by some people for rehabilitation services, but not for HIV and related health services:

“ Some people come here knowing they are coming to be facilitated to go to the rehab. When they come in here and I talk to them about HIV testing, they say, I did not know this is what I was coming here for. ”

– NASCOP staff

3.3. DISTANCE TO SERVICES

Proximity to the services was determined to be both a motivator and a constraining factor. The majority of SW preferred North Star Alliance because the centers were close to them, hence eliminating the need to incur transport costs and to spend time seeking services. However, HIV and sex work-related stigma (perceived, self, enacted) challenged access to services for a proportion of SW. Those who do not want to be identified as SW or with HIV would avoid being seen in the vicinity of North Star Alliance wellness centers or any other health centers, for fear that such association would lead to accidental disclosure. Instead they prefer to travel further, and to access services in facilities where they are not known.

For most of the MSM, Ishtar and PEMA Kenya clinics were located far away. While, on one hand, distance to the clinics was an inhibitor to access of services, on the other hand, it provided confidentiality and offered a safe space.

For PWUD seeking services within Mombasa town, distance was a non-issue. Transport cost and the community-based outreach programme facilitated transportation to health facilities, and limited the amount of time spent in public health facilities through fast-tracking case management practice.

3.4. SERVICE DELIVERY

“ (...) it's confidential, they are very respectful, they are very welcoming, and you are given first priority that's why we like here. ”

– SW beneficiary

Exemplified by the quote above, a number of factors form the basis of good practice, such as the availability of staff, the attitudes of staff, and the length of wait-times and queues.

All Bridging the Gaps country partners made efforts to improve services delivery practices, and beneficiaries reported being motivated by the availability of services and staff. With the exception of PEMA Kenya, where availability of staff offering HTC was not guaranteed, all other Bridging the Gaps country partners had staff available to offer the service, and this was seen as a key motivating factor:

“ (...) the doctors are always there. Like I can work till in the evening and when I come late I will always find the doctors here even at 11.00PM. ”

– SW beneficiary

For SW operating hours are essential for ensuring access to services. Because of its main clientele demographic, namely truck drivers and SW, North Star Alliance wellness centres operated between 11.00AM and 11.00PM, a period of time believed to be convenient for SW.

However, in Salgaa site, the wellness centre operating hours limited the access of SW from Nakuru, a neighbouring town. It was noted that sometimes the clinic opened late and closed early, before the SW from Nakuru arrived. In a focus group discussion in Salgaa, participants suggested a 24-hour clinic to cater for those who are denied services due to the current operating system.

For PWUD, country partners operate offices from 8.00AM to 5.00PM, Monday to Saturday, and HTC is available. Community-based outreach programme activities run from Monday to Saturday from 9.00AM to around 1.00PM. This is also the time when PWUD visit maskani mbaya (drug dens) to purchase illicit drugs and exchange needles and syringes.

PEMA Kenya and Ishtar clinics offer services between 8.00AM and 5.00PM and on Saturdays from 8.00AM to 1.00PM. Depending on the availability of one health officer, PEMA Kenya, offers services on Saturdays from 8.00AM to 5.00PM.

Services in the public health facilities are available from Mondays to Fridays between 8.00AM and 5.00PM. According to a health provider, it is typical practice to dedicate the morning hours to seeing patients, while after lunch hours are used for report writing.

“ Here you are so busy (...) you have 50 patients on the queue to see before lunch hour. ”

– Frontline health provider

Beneficiaries were motivated by health providers who are easily approachable, nonjudgmental, empathetic, and who observe confidentiality:

“ (...) what motivates us to come is they don't judge us. When we go to those other facilities we are judged... they disrespect us ... they think we are not human beings, they don't give us priority. North Star Alliance treats us well (and treats us as) human beings. ”

– SW beneficiary, group discussion

Most Bridging the Gaps country partners' staff have received trainings and sensitisation on offering friendly, non-judgmental services. Furthermore, organisations working with MSM and SW engage peer educators to use their networks to mobilise their peers to access services. PWUD country partners, on the other hand, engage former PWUD to mobilise active PWUD and other ex-PWUD to access services.

The Bridging the Gaps health workers are described as having a caring and compassionate attitude in the delivery of services, which has the effect of encouraging

beneficiaries to access health services. Outreach workers are also described as exhibiting non-judgmental caring skills, with one beneficiary noting: “They help us whole-heartedly...while it is their job, they do it straight from (the) heart”.

Besides outreach programme activities, outreach workers – in particular the peer educators – as also act as ‘treatment adherence supporters’ to PWUD who commence HIV treatment:

“ A peer educator used to check whether I was taking the drugs or not. At times it was really difficult to take the medicine because I used to feel so much pain and also suffered from the withdrawal effects of the drugs that I used to abuse. I really thank (the) peer educator for all that he did for me. He really wanted me to get cured. I thank him. ”

– 43 year old female PWUD beneficiary

The beneficiaries reported that the nonjudgmental attitude displayed by the programme staff, especially the outreach workers/peer educators, makes them feel accepted and humanised.

PEMA Kenya and Ishtar's MSM clinics were described by beneficiaries as providing a non-judgmental, confidential and safe place, which motivated the open sharing of health and other related issues.

However, those who sought HIV services from public health facilities reported that the health workers were friendly to them, as long as they presented themselves as heterosexual:

“ I was in Kilifi and went to a hospital called Vipingo (...) I have been there twice for HIV testing. The health providers were welcoming and actually explained everything to me and later they tested me and they were very friendly... I had to lie at some point when they asked me if I had a girlfriend. I said ‘yes’ whereas I did not have one, so that it may not look foolish...I fear if I introduce myself as a gay person, they are going to give me another form of treatment rather than the one I would get if I was a straight guy. ”

– 24 year old MSM non- beneficiary



All beneficiaries indicated that they encountered negative attitudes when accessing public health facilities. Access to public health services is therefore challenged by having an STI that could indicate HIV status.

SW reported negative judgmental attitudes among health care workers in Ronga public health facility, where they experienced difficulties in accessing PEP. During validation meetings, Salgaa clinical officers reported that referral for HIV care and treatment was working better than referral for PEP, because of the many reports of broken condoms. A SW from Salgaa who attended the validation meeting shared her experience of PEP referral:

“ (...) I had a condom burst and was referred to Rongai. I went when I told the nurses, they said, 'These Salgaa prostitutes, we are not giving them PEP. Go to Nakuru'. I left and went to Nakuru. I did not get PEP. I had to move further to another place where I was given PEP. ”

– SW beneficiary, group discussion

Interviews with PWUD, the staff of PWUD organisations, and public health care workers interviewed revealed reports of negative attitudes from health care workers in public health facilities in Mombasa County. Such experiences were likely to occur when PWUD independently sought services from public health facilities.

Findings indicate that confidentiality is another services delivery practice that has an influence on access to services. All Bridging the Gaps country partners promise confidentiality and trust, and all staff were seen maintaining confidentiality.

In addition, North Star Alliance wellness centers extended services to the general population for confidentially purposes. In this setting, SW were given 'silent' priority and fast-tracked to SW express services. However, confidentiality in wellness centers can also be challenged by extending services to the general community. In a focus group discussion, participants observed feeling uncomfortable queuing with women who are not SW, and reported that the women gossiped and pointed them out as “husband snatchers”.

In addition, despite the existence of a consultation room where patients can individually meet with the health providers, it was noted by SW (during both the focus group discussions and in-depth interviews) that the space was not soundproof. As a result, discussions in the private consultation rooms could be heard by those who were outside the consultation rooms, thus negatively impacting confidentiality.

Bridging the Gaps PWUD country partners made efforts to observe confidentiality in two ways: not to divulge HIV status to family members, and not to divulge drug use habits to law enforcement officers.

Country partner staff working with MSM also commit to observing confidentiality with regard to HIV status and sexual orientation. However, it was noted that PWUD and MSM do not keep HIV positive status confidential among themselves. In particular MSM who engage in sex work are likely not to observe the confidentiality of their peers, partners or clients with regard to sexual orientation.

There were also fears among MSM who have not been reached by services and a number of North Star Alliance beneficiaries that confidentiality would not be secured in specialized clinics. Some SW did not want to be associated with anything that could reveal them.

3.5. STRATEGIES USED TO INCREASE ACCESS AND INCREASE ACCESS TO AND UPTAKE OF SERVICES

Beside availability of services and improvement of services delivery practices, the Bridging the Gaps country partners use a combination of strategies to increase access to, and uptake of, HIV services.

3.5.1. Integration of services

Findings indicated two ways to ensure integration of services: (1) incorporating treatment of common illnesses in HIV services, and (2) incorporating key population friendly services in the public health care system and offering community-based outreach services.

The first approach has been adopted by PEMA Kenya and North Star Alliance wellness centres as one of their main strategies in increasing access to services. The strategy aimed to reduce stigmatisation, expand options for providers, and accelerate access to services. Besides offering HIV services, North Star Alliance wellness centres offer treatment for common illnesses, and Ishtar and Reachout Centre Trust also offer treatment for minor illnesses besides HTC. The findings show that this approach of providing other health services beside HIV-related services is a motivator to access services. North Star Alliance for example, extended its services to the larger community as a means of de-stigmatising its HIV-related services. According to SW in a focus group discussion, this integration of services made accessing services more acceptable and easier to access:

“ We shall be discriminated and they will say it is for sick women only who go to get drugs. ”

– SW beneficiary, group discussion

Despite efforts in integrating services, the findings indicate that AIDS is associated with the wellness centres, which was cited as a barrier to visiting the clinic:

“ (...) but you know there are some that fear coming to hospital, because some think that when you come you have come for ARV, so they fear... some even come to my house for the condom, because they fear coming for them here. ”

– SW beneficiary

“ (...) yes, I at first feared people will see me, because people thought that whenever one comes here he or she is coming for ARV. ”

– SW beneficiary

Furthermore, some beneficiaries found that the extension of services to the general community made them feel uneasy in accessing services. In a focus group discussion a participant reported that as a SW she feels ashamed accessing a facility where the larger community sought services, and preferred specialised facilities.

Occasionally, MEWA integrate reproductive health services into mobile HTC in the general community. According to the MEWA director, this has attracted large numbers of clients.

PEMA Kenya focuses on the integration of STI/HIV prevention, treatment, care and support for MSM in the general public health system in Mombasa County. In implementing its integration of services strategy, PEMA-Kenya sensitised two health providers each in of the six selected public health facilities. However, this strategy appeared to stop with the training and not proceed further. There is no clear referral system and a lack of communication to the MSM community on the integration of services. There was also no information provided on who the trained providers were. While there is value in implementing sensitisation to reduce stigmatization, there is a need to expand the sensitisation of health care workers in the public health system, and include training on STIs that are specific to MSM and specific needs of key populations. This was made clear in an interview with a nurse in a public health facility in Mombasa County:

“ Yes I had a client in CCC. He was a new client. I enrolled him, and put him on Septrin. I told him to come after one week we do the CD4 count. He told me, ‘sister I am not only here for CD4 I have another problem’. He said he had a big dirty like a boil around the anus. I knew it as a boil. I didn’t bother to examine, and prescribed antibiotics. He came back three days later, and told me he was using the monthly period pads for women. On checking I was shocked it was a very big wound, it was a sore, it was not even a boil or warts...the whole anal area was oozing of pus, it was ulcerated and looked very painful, and he had to queue like the rest of the patients because our policy is first come first served. He also just looked like an ordinary person. I had no idea he was MSM. To me it was like ulcers and not an STI., so I gave him more antibiotics(...). The following day he came to ask for a transfer letter. That really hit me, why, where did I go wrong? Where have I failed? I think he realised I could not help him...It was until three weeks ago while attending some training on harm reduction sponsored by LVCT, when they mentioned STIs that affect MSM that I realised that client had an STI and I mismanaged him (...) I did not give him the best (care). (...) I feel very guilty. I think he needed more help and time. (...) But how would I have started to ask him such a question. So you see, they see us health providers should provide them with services but we do not have time for them. We also do not have the knowledge. ”

The interview excerpt is an indication of the treatment received by MSM when seeking services from public health facilities. He did not have a written referral form as used in the cases of SW.

3.5.2. Community-based outreach/peer education model

Community-based outreach programmes involve bringing health services to the target audience, commonly referred to as ‘moonlight outreach or services’, ‘mobile HTC’ or ‘medical camps’. PWUD country partners and North Star Alliance wellness centres have initiated such community-based outreach services to increase access and uptake of services.

For North Star Alliance, their strategy has included bringing HTC services to the community, creating awareness and educating communities on HIV, location mapping and site load analysis, peer education and referrals to wellness

centers, and condom distribution. North Star Alliance’s mobile clinic focuses on HTC, providing information on HIV, and condom demonstration and distribution.

For **SW**, ‘camps’ are set up during the night, and therefore referred to as ‘moonlight outreach services’. Those who test positive for HIV are referred to North Star Alliance wellness centers for further services. The strategy is to reach out to those in the community who do not normally access health care facilities. However, this activity is not on a regular or systematic basis and is not well coordinated by the North Star Alliance wellness centers.

Location mapping and peer education are two further examples of community-based strategies implemented to engage with SW:

Location mapping is a community-based activity that takes a census of SW within the transport corridors and catchment locations for the wellness centres. This takes place in locations where key populations frequently work or meet. The exercise provides a quite accurate number of SW within the defined zone. The findings suggest that location mapping is important in understanding the dynamics of sex work locations and SW movements, especially in identifying new members. However, this activity was not frequent enough and lacked uniformity in all sites.

Peer education is a significant component of North Star Alliance’s community-based outreach programme and can include the mobilisation of SW, providing health education or talks, facilitating support and economic empowerment groups, demonstrating and distributing condom and lubricants and providing referrals from the community to North Star Alliance wellness centers. Peer educators provide services in known sex work locations, as well as in the homes of home-based SW, and are also involved in follow up of clients who were referred for services at wellness centres and other health facilities. Peer groups activities were much more pronounced and consistent on particular days in Mlulongo and Emali, but were less visible in Salgaa.

While the peer education strategy is essential for programmes to reach out to SW (including home based SW), findings indicate that peer education can be challenging. Difficulties in motivating peer educators were noted in some sites, and North Star Alliance had experienced issues in incentivizing SW. The payment of lump sums as allowances to peer educators, without providing targets to be achieved, was ineffective. According to staff, some of the peer educators came only for the allowance and then performed poorly in reaching

out to SW. To hold peer educators accountable and committed, the standard monthly allowance of Ksh. 3000 was replaced with a payment of Ksh. 15 per client referred, resulting in peer educators moving to other organisations. Mlolongo and Emali reported a vibrant peer education system. In Mlolongo there were reports of SW running out of condoms, and visiting wellness centres to collect condoms or purchasing from shops.

In its community-based outreach programmes, North Star Alliance collaborates with the owners of guest houses used as sex work locations, to allow condoms to be dispensed in the premises. This also provides a means of engaging the SW in health education forums and empowerment.

Each of the Bridging the Gaps country partners outlined an elaborate and strategically planned community-based outreach model, and all beneficiaries interviewed reported being accessed through this strategy. Community-based outreach work targets drug dens where PWUD congregate to purchase and/or use drugs, popularly known as 'maskani mbaya' (prohibitive spaces by law). Community based-outreach services were conducted from Monday to Saturday by a dedicated team that included outreach workers and supervisors and community mobilisers. This strategy utilises motorbikes provided with financial support from Bridging the Gaps through the Mainline Foundation. The services offered primarily included harm reduction activities and making referrals for further services, thus increasing the demand for such services. Each outreach worker is assigned to reach 40 to 50 PWUD with harm reduction interventions between 9.00AM and 1.00PM. During this time the outreach workers also attend to the other health, legal and social issues faced by PWUD.

“ They (outreach workers/peer educators) will take people from anywhere, and take them to the hospital to ensure they are seen, treated, and take them back to their homes, and they will still do a follow up until the person feels better. ”

– male 39 years PWUD beneficiary

Through the community-based outreach model, HTC services are offered in prisons. Every Tuesday The Omari Project provides health education to prisons in Malindi, and MEWA occasionally takes mobile HTC to Kilifi prison.

“ In fact, like Kilifi prison, we have very good relationship. The in-charge is a good friend. Last month we took our outreach there and went there and 100 inmates took HIV test. ”

– programme manager

Ishtar and PEMA Kenya do not have a community-based outreach programme other than peer education. This was attributed to the hostile social situation, and a lack of funding. Ishtar was funded by MSMGF to conduct community-based outreach services in Nairobi. However, due to limited funding Ishtar could only support two community advocacy and education activities.

It was noted that in Mombasa the unsympathetic community does not allow MSM assemblies, and the focus is limited to mobilisation of MSM to attend education sessions.

“ Stigma is very high for HIV and MSM. The environment does not favour us. The community also attacks us. ”

– PEMA Kenya health staff

A community representative in Mombasa also reported that three weeks before the study commenced, community members had broken into an MSM workshop in a hotel in North Coast and physically assaulted the participants.

It was further observed that locations where MSM gather in Nairobi were too temporal to implement sustainable community-based activities. To mitigate this obstacle, PEMA Kenya and Ishtar have invested in a peer education programme. However, each organization has a limited number of peer educators. The engagement of peer educators is not clearly defined beyond a role in distributing condoms and lubricants, and keeping in touch with peers. During an interview, a peer educator observed that he has nine peers whom he targets with services, and it appeared that he had no intention of sourcing more peers in his circle. It was not surprising therefore that friends/peers are more consulted for information than peer educators.

3.5.3. Referrals and linkages to HIV related services

The findings show that all Bridging the Gaps country partners relied on public health facilities or other civil society organisations to provide the services that they could not provide. Referral and linkage to other service providers is therefore a critical strategy in ensuring access to services.

All North Star Alliance wellness centres referred SW to the general public health system for HIV care and treatment. In Emali, SW could access the general health system and AHF, an NGO clinic. In wellness centres where PEP refill was not available, clients were also referred to the general health system and AHF. Efforts have been made to train one or two contact persons to facilitate quick and confidential referral services to SW.

The findings indicate a lack of synergy across the wellness centres. In sites with well-coordinated referral system like Mlolongo, many clients received referral services. However, in sites with poorly coordinated referral system, such as Salgaa, most clients did not honour the referrals they received. SW in Salgaa reported encountering negative attitudes from health care workers and being denied services, especially access to PEP.

Another factor is the means of referral. In some sites referrals are accompanied by telephone calls to ensure that clients are given priority, while in other sites, clients receive a referral form and have to queue like the other clients. In addition, the absence of the contact person named on the referral poses a challenge to the system:

“ (...) sometimes a staff gives a referral to the person, then the sex worker on arrival at the referral site may find the contact person is not in. Sometimes they just come back without getting the services and says the contact person was not in. So they miss the services. They want personalized services and they want to be seen by the contact person. Sometimes they do not want people to know they are SW. So they ask the staff to call and let the contact person know they are going for the services because they only want the contact person who knows about their case to deal with it, and no one else to see them. Sometimes they came back and they say unfortunately you send me to so and so who was away. ”

– programme manager

PWUD local partners, on the other hand, have a strategically planned referral and linkage system, which has reported significant gains on access to and uptake of health services:

“ (...) You see the problem is that PWUD are not easy to go to hospital even when they are unwell... They don't have time. You have to track them. These are people who need to be tracked. And that is why we say that outreach is a very good component ...You need to reach out to them; you need to go where they are. ...Our outreach workers are people in the community, these are people, some of them are recovering and so they know how to get them. It is not easy just to tell someone to go for health services or to take this medicine...they are not like normal people. Their first priority is hard drugs, heroin and not ART because if I don't take heroin, I become very sick. (...) It is not easy and you need to follow up on them. ”

– programme manager

The findings reveal a highly coordinated referral and linkage system, from community-based outreach to referral sites. The process is made easier by engaging service providers (case managers/trackers/social mobilisers/outreach workers/peer educators) who help PWUD to navigate access to services in public health facilities. These service providers are entrusted with the responsibility to help clients navigate the referral system and be fast-tracked for services. This is facilitated by motor bikes provided to peer educators to access communities and health facilities. Once they are linked to a referral site, the case managers are entrusted with the responsibility to ensure continued utilisation of services, by bringing them to their clinic appointments.

This practice was recognised by health care workers in referral sites and PWUD as ensuring access to continued care and treatment, and mitigating stigma or negative attitudes among health care workers:

“ Most of the time they come with an outreach worker who has a badge. In fact they really assist PWUD as well as the health care worker because health care workers fear them because they are aggressive, they demand to be given certain drugs and also that can steal from the health care worker. Also accompanying them ensures continuity of services. ”

– health care worker at public health facility

Only MEWA has an exit strategy in place. After a certain period of tracking and case management, the PWUD on the tracking programme is released to seek health services on their own. Indeed, two PWUD who had been released continued their successful care and treatment. They honoured their clinic appointments for care and collection of ARVs, and one of them travels to Kilifi, which is 60 kilometres from Mombasa, for HIV care and ARVs.

The findings show a weak referral system by country partners targeting MSM. The system began with the identification of referral sites and the training of a few health care workers in the referral sites. But there was no plan on how to link those seeking health care with the referral sites. Those who accessed care were either self-referrals or they had depended on friends for information and referrals. Most self-referring MSM who accessed HIV services from public health facilities indicated that they were heterosexual, due to the challenges in accessing STI treatment in public health facilities, as noted above.

Even though Ishtar and PEMAKenya have trained staff in public health facilities on MSM-friendly services, they lack a clear referral system and follow-up mechanism. Yet, as observed by a peer counsellor: “MSM do not like you to refer them to a health facility then they do not get the services they need, and are referred to another health facility. They do not go”.

An MSM organisation director noted that “most feel uncomfortable being referred and telling their stories over and over again”.

Finally, transfers of health care workers in public health facilities further aggravates the challenges of referral system.

3.6. ENABLING ENVIRONMENT

3.6.1. Community support

All Bridging the Gaps country partners in Kenya indicated to struggle with gaining community support. It was very evident from interviews that all key populations experienced stigmatisation and discrimination in their families, communities and public health facilities.

The findings show a need for community support for the key populations:

“ Families don't want to hear anything about them. In fact we are the family, they drop them to us and we become their mothers, fathers, sisters and brothers. ...There's a PWUD who told me that their worker at home has been told to beat him if he tries to come back to the house. Imagine getting to that point because once he enters that house, something will go missing. It is not that easy, it has to take time. (...), it is not that easy for families to accept them back and help them. ”

– programme manager

Such sentiments were specifically related to the MSM community. Most MSM had not disclosed their sexuality to their families, and the few who did had encountered violence or other forms of abuse. Most SW also receive little support from their families and community. All key populations depend on their peers for social support. North Star Alliance is the only organisation who facilitated peer groups for empowerment activities, such as table banking.

3.6.2 Advocacy

Organisations involved in advocacy work, indicated that non-confrontational advocacy (negotiation by civil society organisations to adapt policies or practices, instead of demonstrating and claiming rights) are more effective at national policy level and in the community. This type of advocacy contributed to allow key populations to access services. However, negative attitudes in the general community and in law enforcement agencies still prevail.

3.6.3 Stigma and discrimination

The findings indicate that stigma and discrimination remain the main barriers in reaching all key populations and ensuring that they can access services:

“ Negative attitudes and perceptions about gays instill fear in them. Negative kinds of attitudes and perceptions are discriminative, and with that kind of thinking that is how stigma comes up, and that is where the violence will arise if one is known to be gay. So they really try to be discreet in the community, and may not access health services in public health, and may not want to register with PEMA Kenya. ”

– peer educator, PEMA Kenya

Insecurity is a barrier for both MSM and PWUD. Like stigma and discrimination, fear of the general community and law enforcement agents drive MSM and PWUD into hiding:

“ Because in case of insecurity most of the gay community will fear to actually go and access the health services in the public facility. Because if the media is already announcing about gay people being arrested, if the media itself is talking about arresting of the gay people, beating them up, which gay person will want to walk out of that house into the community and get into the public facility for health care. They fear that if identified in a public hospital an alarm may be raised and they will get arrested (...) So you see the fear of insecurity (from the larger community) instills the fear in the gay community such that they will open up and visit the health facility that provides such services such as STIs, screening and taking of the ARVs. ”

– 28 year old MSM beneficiary

The research revealed that there are hidden or underserved communities that are likely to be neglected by interventions. These include overlapping communities, such as PWUD who sell sex to fellow male PWUD to finance their drug habits. This group may identify as PWUD, but not as MSM/SW. Also in this category are female PWUD who are SW or female PWUD who do sex work to finance drug use habits but who do not identify themselves as SW.

4. DISCUSSION AND CONCLUSION

This study examines strategies and practices on how best to reach key populations not yet reached with HIV services, and to take steps to improve strategies and increase access to HIV/STI prevention, treatment, care and support. The aim of this report is to examine strategies and practices used by country partners in reaching out to and increasing access to target populations, and also to examine the related barriers.

Good practices include advocacy, establishing specialised clinics, service delivery, referral and linkage to other services providers, integration of services, and a community-based outreach and/or peer education model.

STUDY LIMITATIONS

The main limitations of the operational research were time and funding. The study would have benefitted from a longer time span, to observe implementation of services and interventions within Bridging the Gaps. It is recommended to build in operational research from the start of a new programme.

It turned out very challenging to recruit key populations who have not accessed services for interviews. Mobilising MSM in Mombasa, was especially difficult, due to a public outcry against MSM at the time of the study. Therefore, interviews had to take place at night.

Including three different key populations and different geographical locations and contexts, turned out to be very ambitious to gather in-depth insights for each of the programmes. However, narrowing down to one organisation to represent all key populations would have provided too limited insights into the different contexts and strategies.

ADVOCACY AND SOCIAL MOBILIZATION

While HIV services have been in Kenya for over a decade, key populations nonetheless found it challenging to access them due to the unfavorable social and legal environment. Although advocacy efforts have resulted in acceptability of HIV/STI prevention, treatment, care and support for key populations in Kenya (National AIDS Control Council, 2009b), the unfavorable legal and social conditions have not been eliminated.

Sustaining non-confrontational advocacy with policy makers and law enforcement agents, public health facilities and the civil society is essential and must remain a core component of the HIV and AIDS response as a long-term goal. In the new constitution dispensation, advocacy with policy makers (politicians) should be sustained, and expanded to include County governments. Bridging the Gaps country partners should be proactive participants

in County government's health and security committees, County AIDS/STI Control Programme (CAC) and devolved structures of the NACC. The country partners should persistently lobby for friendly and free services for key populations, including treatment for common or minor illnesses.

Bridging the Gaps country partners should take advantage of the regular medical education sessions in public health facilities to advocate for the rights of key populations. They may also work with some health workers in public health facilities to report on negative attitudes among health workers in public health facilities.

For social mobilisation, the local partners must take stock of public opinion, carefully assess the social context, and explore socially acceptable strategies. Bridging the Gaps country partners should protect their target populations, and identify, sensitise and work with community representatives in defending the rights of key populations.

AVAILABILITY OF SERVICES

Previous studies show that supply factors (cost, equipment, staff attitudes and capacity, waiting times, knowledge on technology, management efficiency) and factors that influence health seeking behavior (cost of services and transport, quality of the services, income, social, household, cultural characteristics, knowledge of health care available and general education on health) are important factors in the access and uptake of services (Ensor & Cooper, 2004).

HIV/STI prevention, treatment, care and support are available in key population-led clinics, operated by civil society, private and public health providers in Kenya. All Bridging the Gaps country partners have clinics that provide limited HIV related services to targeted key populations and navigate with other providers to realise comprehensive HIV services. While availability of services is important, Galanis et al.(2013) have found that attaining comprehensive knowledge on the services and terms of accessibility is an important basis for ensuring access to services. While **SW** beneficiaries were knowledgeable about services provided by wellness centers before they accessed them, knowledge about the services for **MSM** was lacking. **PWUD** knew about the services mainly from outreach services in drug dens. This underlines the necessity of continuously marketing accurate information on the services available through various platforms, such as social media, peer educators or PWUD social networks, health groups, etc.

Good services delivery practices are also essential in ensuring ability to access services. All Bridging the Gaps

country partners have invested in creating favorable service delivery practices through sensitization and training of all staff, which is noted best practice. Additional good practices include friendly services (respectful and non-judgmental attitudes), confidentiality, and the availability of staff. These practices motivate access to services, and must be continued.

While this approach is successful in specialised clinics, negative attitudes by health care workers in public health facilities continue to impede access to services. Sensitising a limited number of health providers in a public health facility challenges sustainably, particularly in the context of perpetual transfers and regular absences. Public health care workers with increased knowledge of good service delivery practice will improve the quality of services for key populations, and is an effective strategy in the long term.

COMMUNITY-BASED OUTREACH SERVICES

The Kenya National AIDS Strategic Plan 2009/10-2012/3 proposes community-based approaches to increase universal access to HIV services, especially among marginalized communities. The strategic plan recommends taking stock of social contexts and best practices to strengthen the capacities of communities to plan and implement priority programmes.

Community-based outreach services play an important role in taking services to community settings and create a demand for services. The PWUD country partners and North Star Alliance interventions represent examples of best practices in community-based outreach. The PWUD country partners display elaborate community-based outreach services that use harm reduction interventions as an entry point to other HIV related services. This is a promising strategy that should be expanded or replicated elsewhere.

Community-based services might benefit from increasing the number of outreach workers or exploring new ways to reach out to those not reached. It is worth exploring peer-driven identification (borrowing from the respondent-driven sampling strategy). Peer-driven identification will involve peers (active PWUD) to identify those who have not been reached with services in their social networks and link them to the interventions or outreach workers.

It might also be worth exploring other ways to attract key populations to community-based services. For example:

1. Integrating reproductive health services in community-based HTC might motivate female PWUD. This will de-stigmatize services and provide space for social mobilization.
2. Mobile HTCs that visit communities and locations where PWUD gather to use drugs should integrate the other services offered in wellness centers.
3. North Star Alliance together with its Bridging the Gaps country partners, should scale up and replicate a number of its successful community based activities, such as location mapping.

PEER EDUCATION

Peer education is a promising strategy for reaching key populations. Studies show peer education has been used in interventions for (young) PWUD and SW to increase their knowledge of condom use, HIV, sharing of needles, and STIs in developing countries (Norr et al., 2004; Garfein et al., 2007; Ergene et al., 2005; Agha & van Rossem, 2004; Agha & Van Rossem, 2004; Ergene, Cok, Tumer & Unal, 2005; Garfein et al., 2007; Norr, Norr, McElmurry, Tlou & Moeti, 2004). As reported in Norr et al. (2004), Agha & van Rossem (2004) and Ergene et al. (2005) peer education is effective in increasing knowledge on HIV prevention and transmission, STIs, and condom use. Norr et al (2004) also reported peer education has a positive effect on condom attitudes and confidence in condom use, personal safer sex behaviors, and positive attitudes towards people living with HIV.

North Star Alliance peer education, to a certain extent, exemplifies best practice. This strategy is effective in increasing knowledge of, and access to, services. They also played a significant role in HIV prevention, conducting location mapping (and taking condoms and lubricants to these locations), conducting peer groups and linking the SW community to services.

Yet North Star Alliance's peer education nonetheless suffers from inconsistencies. In Salgaa, for instance, peer education is weak while Mlolongo posts a strong peer education model. Exploring ways of strengthening peer education and synergy across all wellness centers is essential. While peer education is popular due to people's nature to help others, or because there is the reward of a small amount of money (Morisky et al., 2006; Ergene et al., 2005) (Ergene et al., 2005; Morisky, Stein & Chaio, 2006), in order to save the peer education crisis in Salgaa, North Star Alliance must work out the motivation and retention modalities for the sustainability of the model.

In contexts where MSM are struggling with a challenging social context, peer education – the feasibility of which has been demonstrated (Mulongo et. al., 2015) – might be

an avenue to reach out to those who have not been able to access services. MSM peer education is struggling, and country partners focusing on MSM may benefit from North Star Alliance's experiences.

Finally, North Star Alliance and MSM country partners should pay attention to recruitment of peer educators. Careful recruitment of peer educator is important (Morisky, Ang, Coly & Tiglaio, 2004), and attention should be paid to the motivation-levels and social networks of prospective peer educators.

REFERRAL AND LINKAGES TO SERVICES

The fragmentation of services means that referrals and linkages to HIV and related services are essential. All Bridging the Gaps country partners referred and linked key populations for services such as HTC, clinical care and treatment, STI testing and treatment, TB testing and treatment, and HIV clinical care and antiretroviral treatment.

Referral took two forms: (1) from community by peer educators and outreach workers to HIV testing centres (including Bridging the Gaps country partners' specialised clinics testing), and (2) from testing centres (HTC staff) to health facilities that provide follow up services. PWUD country partners exhibited a best practice referral and linkage system that was strategically planned and coordinated. One of the best practices observed in referral and linkage comes from the PWUD country partners. Their approach involves transportation to health facilities by case managers who fast-track those seeking services. This practice ensures prompt access and continued access to services.

However, the risk that this best practice might create dependency is noteworthy. Only MEWA had in place an exit strategy. The fact that some study participants from MEWA go on to access HIV related services independently after a period of being escorted to clinics is a strong indication that members of the PWUD community can be empowered to manage their own care. Building a competent community that can access services independently without overreliance on the PWUD country partners is a pertinent and useful long term strategy. By encouraging PWUD to independently seek services, outreach workers have more time to focus on reaching out for those who have not been reached by services.

North Star Alliance implements a more disjointed referral system, from wellness centres to further services. The referral system that included provision of a referral form/ letter (sometimes accompanied by a telephone call), works well in some sites while other sites struggled. LGBT and MSM country partners' system of verbal or self-referrals seemed the least effective approach. Country partners

serving MSM might benefit from increased sensitisation and trainings of health care workers in public health facilities, and adopting a proactive referral system, which includes communicating referral information to MSM communities (MSM and MSM who sell sex).

INTEGRATION OF SERVICES

In this operational research, the integration of services for target populations to receive all appropriate interventions at one health facility was promoted in two ways:

1. incorporating provision of health services to MSM in the public health facilities; and
2. offering treatment for other illnesses in addition to HTC mobile testing and counselling in key population specialised clinics or community-based outreach interventions.

The provision of treatment for other illnesses in North Star Alliance wellness centers, Ishtar clinic and the occasional MEWA mobile HTC is likely to improve confidentiality and stimulate accessing of services, and therefore it is best practice. In the context of SW, offering services to the larger community has the result of de-stigmatising North Star Alliance wellness centers and improving the confidence that SW have in the centers. Furthermore, silent priority ensures SW are seen promptly. However, offering services to larger community may also be an impediment to access services by SW who are part of the community around wellness centers.

Integration by PEMA Kenya, on the other hand, followed the approach of providing services within public health facilities. This is likely to ensure access to all necessary services and to ensure continuity of services from one health facility. As reported in a study by Pfeiffer et al. (2010) integration of services in public health facilities put patients on ART more quickly and efficiently.

Even though a number of health workers in health facilities have been trained to facilitate integration and offer MSM friendly services, PEMA Kenya's integration of services strategy lacked planning and coordination, and MSM appear to lack information on the integration of services in terms of where, how and when.

MSM country partners should explore lobbying for sensitization and training of all health care workers, and also find ways in strengthening referrals. PEMA Kenya should explore different ways of communicating about the integration of services to MSM communities (MSM and MSM SW). One of the ways that is reported to be effective in reaching MSM is through social media (Green, Girault, Wambugu, Fosua & Adams, 2014).



A range of factors influence reaching out to and increasing access to HIV/STI prevention, treatment, care and support among key populations, and a combination of well planned and executed strategies are required. Based on different contexts and key populations, there is no one single strategy solution that would increase access to services in communities of concern in this study. Bridging the Gaps country partners must consider different ways to reach out to and increase access to needed services.

RECOMMENDATIONS

Reaching people who use drugs

- PWUD country partners often focus their outreach services on drug dens and PWUD currently accessing services, missing opportunities to reach out to those who are not frequenting drug dens. Conduct location mapping to understand the dynamic of PWUD. Invest in PWUD's social networks to identify and reach out to peers who do not access HIV/STI prevention, treatment, care and support.
- Build a competent community that can independently seek services from referral sites. This will free up outreach workers and peer educators to focus on reaching out to PWUD who are not currently being reached.
- Strengthen collaboration with the public health institutions and advocate for free health services to PWUD.

- Continue to advocate with policy makers for a sustainable environment that is 'conductive' to providing services.

Reaching men who have sex with men

- Strengthen referral systems and service integration through better strategic planning, coordination, supervision, and investment.
- Knowledge about available services and systems can be shared through social media (Facebook, Twitter and WhatsApp) and peer education.
- Experiences of stigma underscore the importance of peer education as an avenue for reaching out to MSM. Pay attention to recruitment, networks of peers, and invest in the planning and coordination of peer education.
- Reports on experiences with negative attitudes by health providers in public health facilities underlines the necessity for sensitization and training of health care workers. Proactively participate in health facilities' medical education programmes.
- Improve confidentiality within MSM communities.
- LBT appear to be the harder to reach than MSM. Following discussions from the validation meeting, efforts should be put in place to reach out to LBT communities and increase their access to services. Recruit LBT peer educators to reach out to their peers.

Reaching Sex workers

- Inconsistencies in peer education across all sites indicate the need to strengthen the peer education system. Encourage peer education exchange programmes for peers from different wellness centers to share their experiences. Attention should be paid to the motivation and retention of peer educators.
- Despite streamlining confidentiality issues, the findings indicate the need to further de-stigmatize wellness centers and services. Consider integrating reproductive health services and treatment for common illness in community-based services targeting the general communities. Work with SW on how to improve confidentiality in integrated services and referrals.
- Inconsistencies in referral systems in wellness centres illustrate the need to share lessons and results.

OVERALL CONCLUSION

Although various strategies for reaching out to key populations have made a significant contribution to increasing their access to services, it is essential to increase efforts to reach those who are currently underserved. In general, the findings suggest that this can be done by strengthening the existing strategies and examining other opportunities to enhance efforts. The overall conclusions of this study are:

- Making services available, acceptable, affordable and accessible is important in increasing access to, and continued utilisation of, STI/HIV treatment, care and support. To increase access to HIV services to key populations, specific strategies are needed to build their confidence and uptake of available services.

- Further improve planning, investments and strengthening of the community-based outreach and peer education, referral and linkage to services, and integration of services.
- Capitalise the potential of various media, in order to spread critical information on health and available HIV services. Finally, building supportive communities through increase of knowledge on HIV and social interventions.
- Continue investments in awareness raising or sensitisation and training of health providers in public health facilities is crucial in reducing stigma and discrimination against key populations and improving service delivery practices
- More strategic planning and investments in advocacy at the national, public health facility institutions and general community are needed for policy change and social enabling environments
- Location mapping and site loading analysis is essential for understanding the dynamics of key populations for planning
- Increase collaboration between key population organisations, to ensure increased access for people not identifying as one specific key population.



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