CQUIN 6th Annual Meeting
December 6-9, 2022
Durban, South Africa

Applicability and acceptability of quality differentiated HIV service delivery among men who have sex with men in Kenya

Jennifer Zech[1], Silvano Tabbu[2], Ava Mrima[3], Enzi Pascal[4], Oliver Muindi[5], Lucas Mainya[7], Manas Migotn[8], Jeffrey Walimbwa[9]
1. ICAP at Columbia University, 2. KYDESA, 3. Jinsiangu, 4. Ishtar, 5. HAPA Kenya, 6. Maaygo

BACKGROUND / INTRODUCTION

Men who have sex with men (MSM) are at heightened risk for HIV infection because of biological, behavioral and structural vulnerabilities. In Kenya, HIV prevalence is estimated at 18.2% among MSM (NACC, 2014). Numerous studies have documented substantial barriers and challenges to HIV prevention, care and treatment coverage and access to MSM and other key populations. Despite several interventions targeting MSM populations, a huge gap remains in reaching them to test and linking them to prevention, treatment and adherence services. We designed a cross-sectional study to examine HIV differentiated service delivery for MSM in Kenya. The study objectives include: (1) to understand the current HIV service delivery models for MSM in Kenya, (2) to explore MSM the experiences with HIV services access and uptake within MSM facilities in Kenya, and (3) to assess opportunities and barriers for HIV differentiated services delivery among MSM in Kenya.

METHODS

The 2019-20 Differentiated Study was conducted in three counties in Kenya namely: Kisumu, Nairobi and Mombasa. These counties were purposively selected as they have the highest HIV burden among key populations in Kenya.

Data collection included a total of 49 in-depth interviews (IDIs):

- 15 IDIs with MSM service users registered for ART
- 15 IDIs with MSM service users registered for PrEP
- 8 IDIs with healthcare providers (counsellors and clinicians- nurse, clinical officer, medical doctor)
- 5 IDIs with programmers including representatives from key populations organizations
- 6 IDIs with county policy makers

IDI recordings were translated and transcribed. The qualitative data were analyzed using Word and Excel to perform question and preliminary thematic coding and content analysis.

RESULTS

MSM reported to receiving positive health care and HIV treatment/prevention services at the MSM facilities. Most all reported that they were comfortable seeking services within community led facilities because the environment was confidential and safe. Most all MSM reported having good relationships with the healthcare providers, who were trained on friendly, key populations service delivery, and did not feel stigmatized or discriminated against. Compared the previous health facilities, healthcare providers at the MSM facilities were knowledgeable of key populations and the specific needs of MSM. Healthcare provider attitudes affected MSM uptake of services.

"First and foremost, where I accessing services, they are friendly, secure, the information I give out is very confidential. So I free very okay and free to air out my issues. I don't see any hindrance when speaking to them. So I don't see any hindrance at all, I feel free and okay as I know my information is safe and confidential, I will not hear it anywhere else." – MSM Client (PrEP)

"The motivation they give us when we come for refill. They will laugh and make sure that we are very comfortable. It is a safe space. It is so cozy where everybody is welcomed to sit down. We always feel like 'I wish tomorrow I can be coming back for my refill'. That is what motivates me, the fact that the staff are so motivating." – MSM Client (ART)

RESULTS, CONTINUED

Policy makers, programmers and healthcare providers echoed the MSM that public facility healthcare providers are often not sensitized to the unique needs of key populations.

"Currently there are gaps that we have majorly in the ministry of health facilities. Most of our healthcare workers within the MOH facilities are not well equipped in terms of management of MSM or rather how to manage key population because they do not have a good understanding of who key population are and therefore this gives us a gap." – County Policy Maker

Many non-client participants also mentioned the need to sensitize the community in order to address stigma.

"Apart from the health care workers, sensitizing the community. Sometimes the community does not understand the MSM. Most of the time they would point fingers not knowing that it's a different lifestyle, they don't have to conform to what you think is right." – Programmer

Despite mostly positive experiences, some MSM reported shortages of communities like test kits, condoms and condom compatible lubricants.

In order to improve current service delivery, MSM recommended:

- Conduct additional healthcare provider training on post-counseling services
- Increase in healthcare provider follow-up with clients (i.e., phone calls and reminders)
- Hire more healthcare providers so clients can spend more time with providers and providers are not overworked
- Expand psychosocial support groups
- Introduce online booking
- Provide access to health services for other diseases

Some MSM also explained that nutritional support and transportation incentives would improve their engagement in care and adherence.

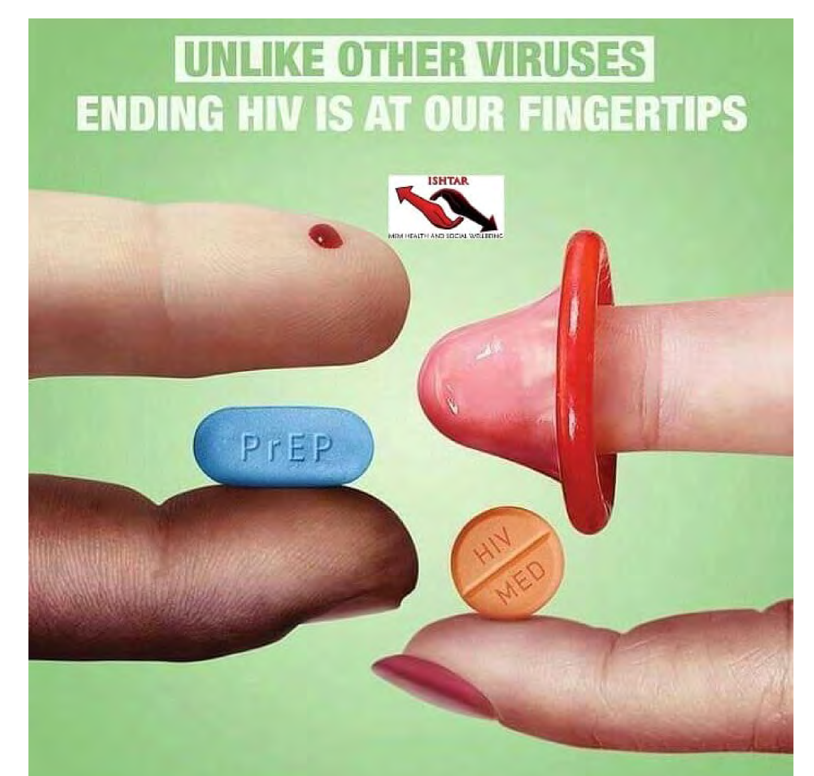
MSM were interested in multiple forms of differentiated service delivery including multi-month dispensing, home delivery and community-based delivery. However, some MSM were not in favor of community-based service delivery due to stigma.

Policy makers, programmers and healthcare provider participants were supportive of decentralizing HIV prevention and care services, which help hard to reach clients access services. Some participants highlighted the need to integrate drop in center services into public facilities to ensure sustainability of these services if/when programs come to an end. The need for community level peer-led support groups and peer champions to support decentralization by empowering and engaging clients was highlighted.

"We should have continuous service provision at the hotspot level with a comprehensive health package." – Healthcare provider

"If we look at decentralizing in terms of sustainability, then it would be so much easier and people know if it is within a certain{25:14 inaudible}, if MSMs know this public facility offers one, two, three or five, then you are able to walk in and get your services without having to feel the fear of being discriminated or stigmatized." – Programmer

"The peers need to be engaged, empowered and given proper information because with knowledge comes power." – Healthcare provider



DISCUSSION

For effective DSD models there is need to train healthcare providers on key populations friendly service delivery. Community led drop in centers need to be well supported with commodities and drugs. Stigma and fear of lack of privacy may be a barrier to uptake of community-based differentiated service delivery models among MSM. We must explore further how to provide services to MSM within the community in a way that is acceptable.

ISHTAR MSM HEALTH AND SOCIAL WELLBEING | JINSIANGU | MAAYGO A Healthy Socially Inclusive Community | ITPC INTERNATIONAL TREATMENT PREPAREDNESS COALITION | HIV Learning Network The CQUIN Project for Differentiated Service Delivery