WHAT INTERGRATION MEANS TO KEY POPULATIONS: OPPORTUNITES AND CHALLENGES

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BACKGROUND / INTRODUCTION

Key populations (KPs), such as men who have sex with men (MSM), sex workers, people who inject and use drugs (PWI/UDs), and transgender people, experience higher HIV prevalence due to stigma, discrimination, violence, and criminalization. To address this, drop-in centres (DICEs) and peer-led programs have offered tailored HIV and sexually transmitted infections (STI) services. DICEs and outreach programs provide HIV testing, care, and treatment, along with other services like STI screening, pre-exposure prophylaxis education and prescriptions, mental health support, substance use counselling, community engagement, and condom distribution.

However, integrating these services into the broader services available at public facilities has faced challenges, including incomplete referrals, which have resulted in gaps in care, such as missed TB treatments. With these structural barriers, the peer-led model remains vital in delivering accessible care to KPs and ensuring continuity of service delivery in difficult circumstances. Strengthening referral systems, expanding capacity, and addressing stigma are crucial to improving the overall effectiveness of these interventions. Together with the Key Populations Consortium in Kenya we developed a survey to understand KP perspectives on integration and what would make integration work for them.

METHODS

A SurveyMonkey questionnaire was conducted to explore KP communities' understanding and perspectives on integration in Kenya. The survey included both quantitative and open-ended questions, asking 1) What integration means to them; 2) What model of integration works best for their community; 3) What are some concerns/fears of integration; and 4) If integration would help in improving health outcomes.

The survey was administered to clinicians, directors, and program personnel from KP-led community organizations providing HIV services from May to June 2024. A total of 24 respondents from 24 different organizations participated. These organizations represented various key populations, with 8 respondents from female sex worker (FSW) organizations, 9 from MSM organizations, and 5 from PWI/UD organizations. The roles of the respondents included 11 directors, 5 burses, and 8 program coordinators.

RESULTS

The majority of respondents did not think integration would improve health outcomes and preferred integration of services into DICE (Figure 1 and 2). Several facilitators and barriers to integration were identified (Figure 3). Definitions of integration and barriers were further explored in the qualitative data (Table 1).

Figure 1. Do you think integration would improve health outcomes? N=22

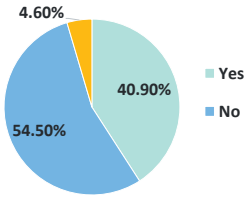

Figure 2. What model of integration works best for your community? N=22

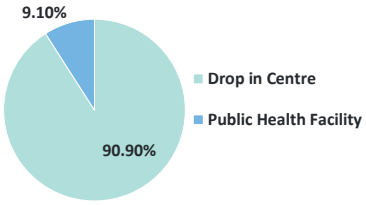

Figure 3. ***Perceived facilitators and barriers to integration among Key Populations***

Table 1. ***How Key Populations define integration and barriers***

Community-based definition
"It means that all the activities and services being done and provided at the DICE, being taken to a public facility whereby the providers who will be providing services, will be part of the MoH staff being paid by the county and the peer educators also being used as mobilisers of peers to receive service at the public facility and being paid directly from the facility level. Some of the staff at the DIC will have to be dropped and MoH staff to provide service".
Barriers for integration
"Cultural competency is another critical area; health service providers must be trained to understand and respect cultural differences to ensure that services are accessible and effective for all. Managing patient data with utmost privacy and security is essential but challenging, as failures in this area can breach trust and deter individuals from seeking necessary care. Lastly, the long-term sustainability of integrated health services is a complex issue, influenced by political climates and fluctuating funding, requiring ongoing commitment and flexible strategies to ensure enduring success."

DISCUSSION

The integration of health services for KPs presents a range of complex challenges that must be tackled in order to ensure effective, inclusive, and equitable healthcare. Stigma and discrimination within the healthcare system further complicate efforts. Healthcare providers often lack the necessary training and sensitivity to meet the unique needs of KPs. This gap in cultural competence results in care that is inadequate and sometimes dismissive, which reinforces feelings of marginalization and creates a barrier to care. As a result, KPs may avoid seeking help, fearing mistreatment or lack of understanding, thus perpetuating their exclusion from essential health services. Tailoring services to meet the distinct needs and unique barriers faced by KP typologies ensures that they can access the care and support they require, ultimately fostering greater health equity and inclusion.

CONCLUSION

Integration should be understood through the lens of KPs. Due to structural barriers that limit access to essential services for these groups, community-led drop-in centers were established as a means to address these challenges. The lack of adequate consultation and representation of KPs during the planning and implementation of integrated health services is a challenge. Without the active involvement of KPs in decision-making processes, the resulting services often fail to address their specific needs, leading to ineffective or even harmful interventions. This exclusion not only undermines the goals of integration but also exacerbates the existing health disparities KPs face