Ministry of Health

HIV PREVENTION DELIVERY LANDSCAPE IN KENYA

Exploring channels and platforms for delivering prevention products and services to priority populations

Globally, Kenya has the fifth largest HIV epidemic. Kenya has made tremendous strides in HIV prevention programming

68.5%
reduction of new HIV infections between 2013 and 2021

In 2020, the national HIV prevalence among adults was 4.3%, twice as high among women, at 5.5%, as compared to men at 2.9%[1,2].

In 2014, Kenya committed to prioritize and scale up HIV prevention interventions with the development of the Kenya HIV Prevention Revolution Roadmap 2030[3]. It also set an ambitious target of reducing new HIV incidence by 75% with the development and launch of the Kenya AIDS Strategic Framework 2014/15-2018/19[4]. However, the country was not able to achieve its HIV prevention targets by 2019[1] and has reprioritised reducing new HIV infections as one of the objectives of the Kenya AIDS Strategic Framework II, 2019/20-2024/25.

To prioritise the HIV prevention agenda and accelerate the response, the National AIDS and STI Control Programme (NASCOP) and the National AIDS Control Council (NACC) in partnership with University of Manitoba conducted an HIV prevention landscape assessment during 2020-21.

HIV Prevention Landscape Assessment in Kenya

The assessment specifically aimed to understand the following:

- The geographies, populations and programmes to be prioritized for HIV prevention within Kenya
- The platforms and delivery channels preferred by the priority populations for HIV prevention
- The capacity of the health system to scale up HIV prevention

[1]NACC, Kenya World AIDS Day, Progress report 2013- 2021, December 2021
[2]NACC, Kenya AIDS Strategic Framework II, 2020/21- 2024/25. https://nacc.or.ke/kenya-aids-strategic-framework-kasf/
[3]NACC, Kenya HIV Prevention Revolution Roadmap. 2014. https://nacc.or.ke/wp-content/uploads/2017/12/kenya_hiv_prevention_revolution_road_map.pdf
[4]NACC, Kenya AIDS Strategic Framework,2015/15- 2018/19. http://nacc.or.ke/wp-content/uploads/2015/09/KASF_Final.pdf

This evidence brief presents the study findings on understanding the platforms and delivery channels preferred by priority populations for HIV prevention.

A. Methods

To address the question on the preferred platforms and delivery channels for HIV prevention by priority populations, the study collected primary data through focus group discussions (FGDs), and secondary data through an integrative review of the published literature.

A1. Focus Group Discussions

In collaboration with implementing partners in 7 priority counties (Homabay, Kisumu, Nairobi, Mombasa, Nakuru, Kakamega and Kiambu), the study conducted 20 FGDs with female sex workers (FSWs), men who have sex with men (MSM), people who inject drugs (PWID), adolescent and young people (AYP) and fisher folk. The discussions were conducted in Kiswahili, recorded and transcribed in English. We conducted a thematic analysis of the transcripts.

A2. Integrative Review

The integrative review used PrEP implementation (as an example of an HIV prevention technology) as a case study. A librarian created and executed the search strategy in consultation with the research team. The search included three search concepts: pre-exposure prophylaxis; HIV or AIDS; and Africa. We looked at all delivery-based interventions of PrEP, including evidence from demonstration projects and scaled up programmes among all populations. We extended our search beyond Kenya to include all countries in Africa. All records were imported to EndNote (version X8 and X9, Clarivate Analytics, Philadelphia, Pennsylvania, USA) and duplicates were removed. The review was managed in Rayyan[5], an open source systematic review management tool. The final review explored evidence from 73 manuscripts.

B. Study Findings

B.1. What are the existing and potential channels and platforms to deliver HIV prevention to priority populations?

HIV prevention products and services reached priority populations through private not-for-profit, public sector, and private sector channels.

DICE entrance


DICE with resting room and library

Grafitti art at the Mathare MAT clinic


Community outreach workers conducting health education

[5]Mourad Ouzzani, Hossam Hammady, Zbys Fedorowicz, and Ahmed Elmagarmid. Rayyan — a web and mobile app for systematic reviews. Systematic Reviews (2016) 5:210, DOI: 10.1186/s13643-016-0384-4.

Table 1: Channels and platforms used by priority populations

PRIVATE NOT-FOR-PROFIT	AYP	Fisher Folk	FSW	MSM	PWID
Community Based Organisations (CBO/NGO Clinics) or Drop-In-Centres (DICEs)	●	●	●	●	●
Peer Educators/Outreach Workers (ORW)		●	●	●	●
Mobile Vans			●		
Churches	●				

PUBLIC SECTOR	AYP	Fisher Folk	FSW	MSM	PWID
Public Hospitals	●	●	●	●	●
Community Health Workers/Volunteers (CHW/CHV)	●	●			
Medically Assisted Therapy (MAT) Clinics					●
Condom Dispensers			●		●
Prison Clinics					●
Huduma Centres	●				
Beach Management Units		●			

PRIVATE SECTOR	AYP	Fisher Folk	FSW	MSM	PWID
Private Clinics	●	●	●	●	
Chemists/Pharmacists	●		●	●	
Local Shops		●			
Clubs					●
Schools and Universities	●				

B.2. Why are specific delivery channels and platforms preferred by priority populations?

Across all priority populations, affordability, confidentiality, non-discriminatory service provision, accessibility, and short wait times are factors that influenced the preference for certain delivery channels.

Table 2: Factors affecting usage of a delivery channel or platform to access prevention services among priority populations

FACTORS	AYP	Fisher Folk	FSW	MSM	PWID
Affordability	●	●	●	●	●
Confidentiality	●	●	●	●	●
Non-discriminatory	●	●	●	●	●
Accessibility - distance	●	●	●	●	●
Short waiting times	●	●	●	●	●
Anonymity/discrete services	●	○	●	●	●
Drug availability	○	○	●	●	●
Empathy by service providers	○	○	●	●	●
Safety and protection	○	○	●	○	●
Availability of drug rehabilitation services	○	○	○	○	●
Services for couples	○	●	○	○	○
Flexible timing	●	○	○	○	○
Youth friendly services (Wifi, Music)	●	○	○	○	○

B.2.1. DICE/NGO clinics are the most preferred channels among not-for-profit services among key populations and AYP

Respondents mentioned friendly services, shorter waiting times, discrete service provision, and an absence of experiences of discrimination as reasons for favouring DICEs to receive HIV prevention products and services.

Both FSW and MSM respondents said they preferred places where they are seen faster by service providers so that they could use their time to earn money and pursue other jobs that they have.

> "We get services from DICE as the first option because we know if we go somewhere else we might have to queue for a long time...Maybe it is almost my time to go to work. But when we come here, we are attended to quickly."
>
> **- FGD, FSW Respondents**

FSWs also preferred DICEs as they felt that service providers genuinely cared for them.

> "The doctors here [DICE] are good. They usually follow up. After they give you drugs, they will call and ask you how you are doing...You can call the doctor even past working hours and tell him/her how you are feeling. She/he will also call to follow up on you."
>
> **- FGD, FSW Respondents**

MSM reported familiarity with the facility and direct access and ease of meeting with the service providers at DICEs as advantages of this channel.

> "....If you go to DICE, you just know where the doctor is, you simply walk directly [to him], but you can't get that in other health facilities where you will have to follow some process that is tiresome."
>
> **- FGD, MSM Respondents**

FSW and MSM respondents also preferred DICEs as they were served by sex worker peer educators and advocates. They generally preferred to go to DICEs that are not close to their homes so that they are not seen by family members or neighbours in these spaces.

AYP FGD respondents said they get PrEP at the NGO clinic, can feel at ease, sit there and chat during their visit.

> "...I think we are more comfortable with these [NGO clinics]. I can go to the NGO, I can sit there and chat, I mean it's home."
>
> **- FGD, AYP Respondents**

AYP also found the opening hours of NGO and CBO-led clinics to be friendly for young people as they are open on the weekends after school hours. They liked having access to wifi in these places because they can stay engaged surfing the web while they wait to get services. AYP respondents also shared that though they have access to free condoms in the county or government hospitals, they risk being spotted or seen picking up condoms by their parents or someone who knows them. Hence they sometimes avoid public hospitals.

B.2.2. CHWs and MAT clinics are the most preferred channels by some priority populations to receive HIV prevention

CHWs were most preferred by fisher folk to receive HIV prevention. They described CHWs as providing non-discriminatory and empathetic support. CHWs are well known to the community and this familiarity instilled confidence, trust and a high degree of comfort among fisher folk.

> "...Yes because I can easily open up to them [CHWs] and tell them this and this is affecting me, if they have the kits with them they can just test me while we are just the two of us, they should be given everything even the drugs, they can make me not have that fear of HIV."
>
> **– FGD, Fisher Folk, Women Respondents**

AYP also found CHWs to be helpful, although they would like to see more younger CHWs.

> "I think the community health workers really help a lot in the community. As for young people, I have never seen a young person who is a community health worker on my side, so I would really like for young people to be on this part of community health worker."
>
> **- FGD, AYP Respondents**

PWIDs preferred MAT clinics which are located within the public health facilities and provide free services beyond just methadone to address other needs that they may have.

> "When I came here [MAT] I was helped. I was not asked for money for a card or anything else. Because it was an attempted rape, I was even given drugs and now I am okay."
>
> **- FGD, PWID Respondents**

B.3. How can the channels and delivery platforms be strengthened and leveraged to reach priority populations?

The study points to the need for multiple delivery channels to reach different populations, with a mix of integrated and targeted approaches. PrEP and new emerging technologies should be seen as part of a differentiated model of HIV prevention and offered alongside and in conjunction with other HIV and SRH service options.

B.3.1. Integrated service delivery, relationship dynamics and support from partners, and dedicated programme staff can strengthen HIV prevention delivery among AYP

Young people, and young women in particular, may benefit from prevention technologies that are integrated with the delivery of current contraceptives (such as long-acting PrEP formulas to match long-acting injectable contraceptives). Youth also benefit from supports that extend beyond HIV prevention, such as peer-based empowerment clubs that address gender-based violence and partner communication. Even with 'female-controlled' technologies, like PrEP, which can be taken privately, relationships still impact whether girls and women feel empowered to take it. Hence, there is a need to address relationship dynamics and engage partners, who can play a role in supporting access to services and adherence to new technologies.

Findings from the literature review point to a need for dedicated human resources focussing on PrEP, or prevention services, to ensure that screening and counselling for new prevention technologies are comprehensive.

B.3.2. A 'couples-focused' approach can strengthen uptake of HIV prevention among serodiscordant couples

Among serodiscordant couples, the literature shows that PrEP is working well among couples tied to delivery channels taking on a "couples-focused approach". Among serodiscordant couples, prevention technologies, such as PrEP, can relive tensions around discordance.

Hence, managing PrEP as a shared priority among couples, where taking ART and PrEP together supports adherence for both partners and is seen as an act of care and a way to demonstrate commitment to the relationship is critical. However, PrEP is often provided as a bridge to ART adherence and viral suppression for the partner living with HIV. PrEP discontinuation can be seen as a loss by participants and as reintroducing HIV risk, so there is an important need for flexible and individual approaches to supporting PrEP continuation for those who stand to continue to benefit from it.

PrEP can also reinstate fertility desires among discordant couples that were disrupted by a positive HIV diagnosis. PrEP can be well incorporated into a differentiated care model of safer conception, alongside ART, circumcision, and timed condomless sex, with the evidence pointing to couples using multiple safer conception options.

B.3.3. Social networks, safe spaces with sensitive providers, and consistent funding are important for uptake of HIV prevention by FSW and MSM

Studies among sex workers show interest in PrEP and new prevention technologies due to experiences of risk in their work environments and responsibility for financially supporting their families.

Social networks and support play an important role in rolling out new technologies. Peer ambassadors and leaders play important roles in dispelling rumours and concerns early on. Studies among MSM showed that community-based programs which have scaled up network-based outreach attract new and more "not so visible" members, pointing towards the importance of both new technologies and peer-based outreach.

Equally important is providing prevention services in clinics, which provide a safe space with non-judgmental staff and free services for accessing care. There is a need to sensitize health care providers to ask men about same-sex partners or anal sex to improve healthcare services and avoid missed opportunities to engage men in care.

Funding challenges, resulting in the engagement of fewer peer educators in sex worker programmes and commodity stock outs, can impact prevention programme success.

B.4. What are the other barriers to effective use of these channels and platforms for HIV prevention?

Structural factors like poverty, violence and exploitation, stigma and discrimination, and cultural and religious beliefs and practices hindered the effective use of various channels and platforms of uptake of HIV prevention by priority populations.

B.4.1. Violence and exploitation aggravate risks to prevention

Violence from various perpetrators like police, clients, and intimate partners prevented the effective use of channels and platforms for prevention. For instance, PWID face frequent violence from the police when they are found in places where drugs are used. They are chased and caught by law enforcement officers, and jailed as a way of getting them off the street. As a result, the HIV prevention programme cannot reach PWID to provide prevention services. Similarly, for FSWs, the uptake of prevention products and services are threatened by violence from their clients, as they have limited ability to negotiate condom use during such instances.

B.4.2. Stigma and discrimination hinders the use of channels by priority populations

Unfriendly healthcare worker attitudes were reported as a disincentive for FSWs and MSM to effectively use healthcare facilities. For instance, FSWs reported facing impatience and frustration from healthcare workers if they repeatedly visited for STI treatment, or asked for the morning after pill, or for post exposure prophylaxis because the condom burst during sex. MSM reported being asked about how they got anal warts and other invasive questions when they visited facilities.

B.4.3. Cultural and religious beliefs and practices impact the use of channels

Most religions practiced in Kenya, such as Christianity or Islam, forbid same sex relationships. This means that using religious institutions as channels for HIV prevention becomes difficult. For instance, condoms could be given out in churches or services could be provided in places of worship. However, expectations that the church does not encourage young people to have sex outside of marriage, and that same sex relationships are unacceptable, work against such an initiative. Often, people engaging in same sex relationships hide their status because of their religious beliefs.

B.4.4. Financial insecurity leads to condomless sex

The need for money to care for dependents, finance livelihoods or buy drugs can lead to condomless sex among priority populations. For instance, among fisher folk, during the off-season, women have insufficient money to buy fish from male traders. As a result, they buy the fish on credit, which they repay with sex if they do not make enough money to pay back to the creditors. FSW also spoke about clients paying more for condomless sex.

CONCLUSION

The study points to the need for multiple delivery channels to reach different populations, with a mix of integrated and targeted approaches. Priority populations preferred DICE/NGO clinics within the not-for-profit sector and CHWs and MAT clinics within the public sector to receive HIV prevention services. However, there needs to be further exploration of engaging with other private channels like pharmacies and private clinics.

The common characteristics of preferred channels included:

- friendly services
- shorter waiting times
- discreet service provision
- absence of experience of discrimination
- accessibility - distance

All channels and platforms utilised for HIV prevention services should aim for these characteristics.

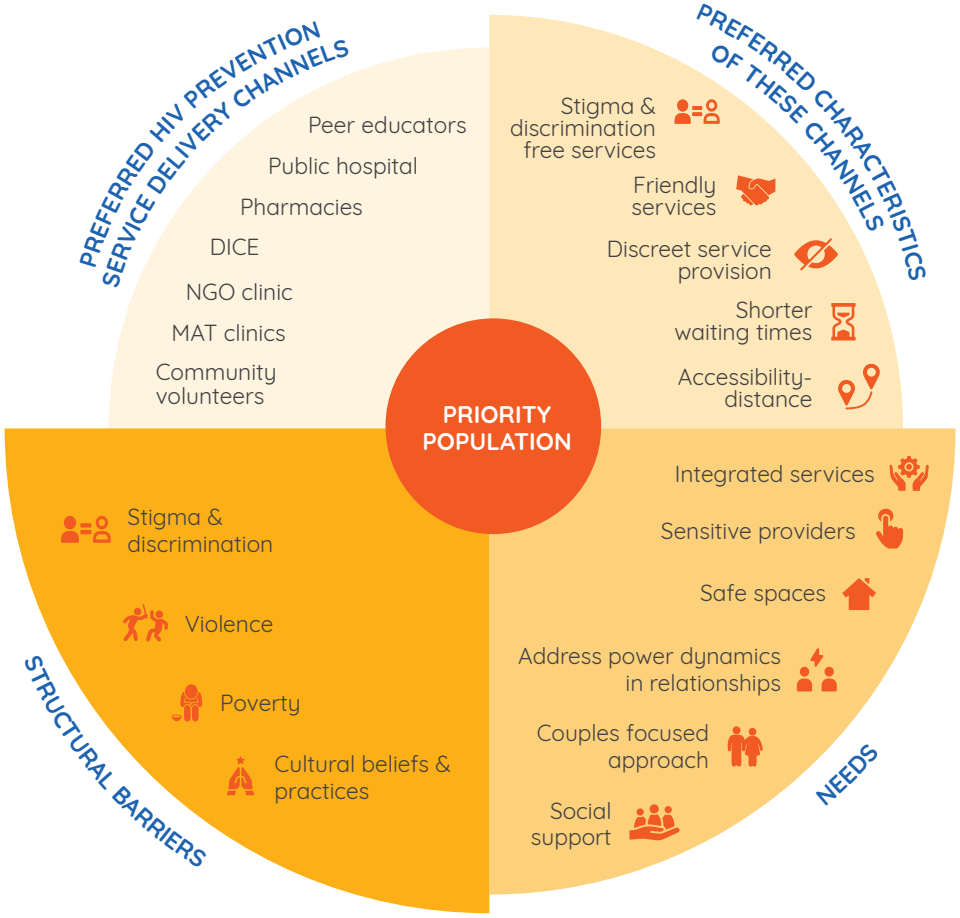
The populations also desired

- the integration of prevention services with other HIV, SRH and non-health services
- the need to address power dynamics in relationships and a couples-focused approach
- consistent funding and human resources
- social support and a network-based approach to support those who are not yet connected to current programmes
- safe spaces with sensitive providers

Structural barriers like

poverty **violence** **stigma & discrimination** **cultural beliefs and practices**

also need to be addressed to facilitate access and utilisation of prevention services.



IMPLICATIONS FOR PROGRAMMING

As Kenya considers scaling up HIV Prevention and introduction of new HIV prevention methods like dapivirine ring, the country should ensure that a mix of delivery channels and platforms are used based on the preference of the priority populations.

The chosen delivery channels should be accessible, stigma-free, and discreet. They should be user-friendly and have shorter waiting times.

The specific needs of different subpopulations should be understood and addressed, such as those of sex workers needing safe spaces or adolescents girls and young women preferring integrated services.

The programmes should address the structural barriers including, violence, stigma, and discrimination, to facilitate access and utilisation of new prevention products.

In moving towards country ownership and sustainability of the HIV response, it becomes imperative for Kenya to ensure that all service delivery platforms, and especially the public health platforms, strengthen the preferred characteristics and incorporate the service needs recommended by priority populations in an integrated way, while also addressing barriers to access and utilisation of these services.

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Data collection team: Memory Melon, Gladys Agwanda, Mariah Mensah, Winfred Nduku, Mercy Nyakowa, Fiona Mutua

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