Common challenges across integrated programmes for key populations highlight the need to follow good practice principles for programming for these communities.

Background

While policy and implementation support for HIV/SRHR integration is increasing, significant questions and uncertainties remain about what such programming means in practice. This is particularly the case in concentrated epidemics, where little is known about what integration should look like for key populations. While integration may be desirable in the long-run, concerns remain about how joining programmes and systems that are not ready could compromise quality of and access to services for these groups that already face difficulty in obtaining appropriate services for both HIV and SRH needs.

Methods

A global review of over 160 resources focusing on HIV/SRHR integration for key populations and available on websites of selected national and international organisations was undertaken. The objective of the review was to assess how HIV/SRHR integration is effective and/or possible, by taking an analytical approach to understand what type of HIV/SRHR integration is effective and/or possible and what the major barriers to its implementation are.

Results

1. Inappropriate design of HIV/SRHR integration
2. Lack of strong referrals systems for HIV/SRHR integration
3. Low understanding of key populations’ specific and diverse HIV/SRHR needs
4. Low attention to gender inequality in HIV/SRHR integration
5. Missed chances opportunities for HIV/SRHR integration
6. Low demand for HIV/SRHR integrated services by key populations
7. Low political, legislative and funding context of HIV/SRHR integration for key populations
8. Presumptions or lack of expertise among service providers
9. Inappropriate design of HIV/SRHR integration
10. Stigma and discrimination related to HIV and key populations
11. Low demand for HIV/SRHR integrated services by key populations
12. Lack of rights-based approach to HIV/SRHR integration
13. Lack of a strong referrals systems for HIV/SRHR integration
14. Proactive address stigma and discrimination as a fundamental barrier
15. Use a rights-based approach that recognises key populations’ individual rights
16. Ensure the principle of the greater involvement of communities at all stages
17. Create demand and build services
18. Address how key populations’ different types and levels of vulnerability inter-relate
19. Use comprehensive definitions of HIV and SRHR that go beyond the ‘usual suspects’ for integration
20. Address the political, legislative and funding context of HIV/SRHR integration for key populations
21. Address the complexity of key populations, but those around them
22. Promote HIV/SRHR integration at all levels, including building an enabling internal and external environment
23. Build a multi-level approach to HIV/SRHR integration for key populations that includes, but goes beyond, the provision of joint services
24. Ensure that training and support to support integrated programming for key populations are appropriately targeted, comprehensive and high quality
25. Recognise peer education as a critical strategy in HIV/SRHR for key populations
26. Recognise the centrality of community organisations and systems
27. Ensure the principle of the greater involvement of communities at all stages
28. Use a situational analysis to understand what type of HIV/SRHR integration is effective and/or possible
29. Identify, understand and respond to the diversity of HIV/SRHR needs within key populations
30. Recognise expertise and knowledge from key populations and their networks
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Conclusions

Integration is a vital strategy to respond to the unmet HIV and SRHR needs of key populations. However, integration that is premature, overly rapid or too large-scale risks compromising rather than enhancing access to high-quality HIV and SRHR services. In the short-term, full HIV/SRHR integration is not required. Community systems and organisations (particularly those that are by and for key populations themselves) are critical to making integration happen.

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