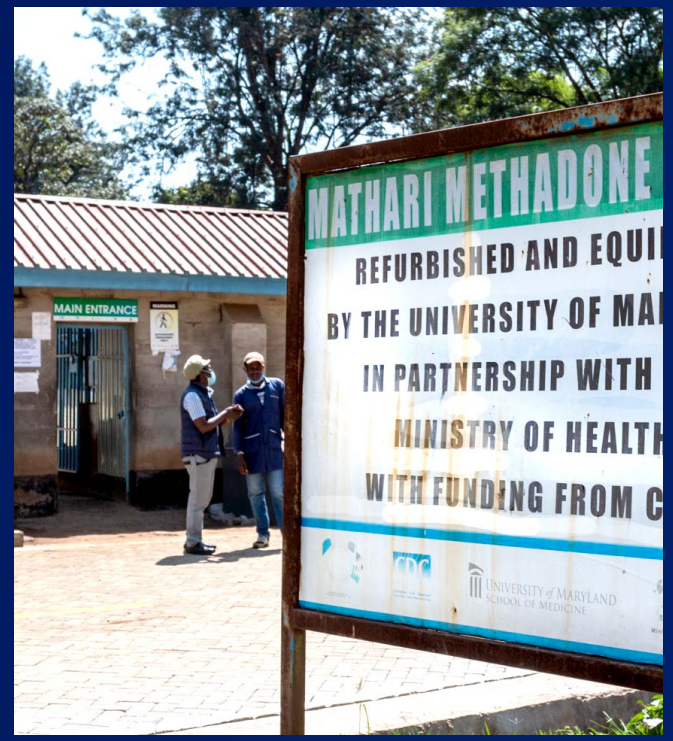
Integrating Key Population Services into Public Health Facilities in Kenya



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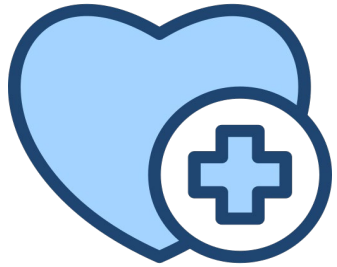
Session 4 | Safeguarding HIV Services for Key Populations: Challenges and Opportunities for Sustainability

Monday, April 20th, 2026

Works in Progress: Transforming the HIV Response in a Time of Change, April 20-22, 2026 | Nairobi, Kenya

Why this matters now

- **The prevention landscape has shifted**: new infections have declined, but 2025 prevention targets were not met**.**
- **Funding shocks are hitting KP programs first**, with reduced outreach, service closures and pressure to move quickly toward more integrated models.
- **At the same time**, community leadership is growing and the prevention toolbox is expanding (e.g., long-acting PrEP, self-testing).
- The operational question for Kenya is no longer whether KP services matter, but **which delivery models can protect reach, quality and trust under tighter financing.**



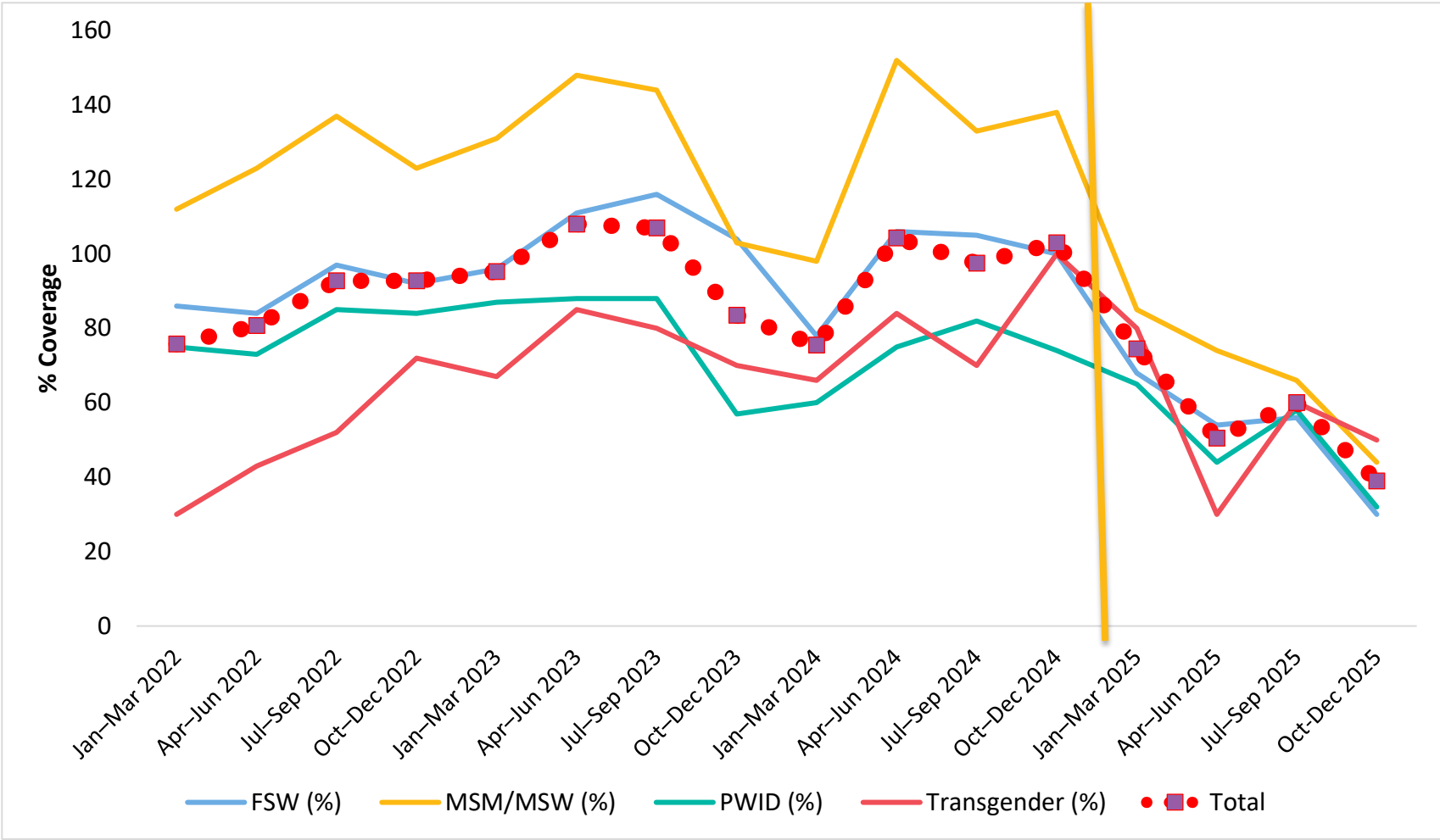
Funding **Coverage** **Quality**

Community trust

Core transition challenges

Need to achieve greater impact with fewer resources—without losing the community-led strengths that make KP programs effective.

What the data are signaling?



Overall KP coverage* fell sharply during 2025

103% → 39%

Overall coverage
Q4 2024 to Q4 2025

172,675 → 91,685

FSW reached
Apr–Jun 2025 to Oct–Dec 2025

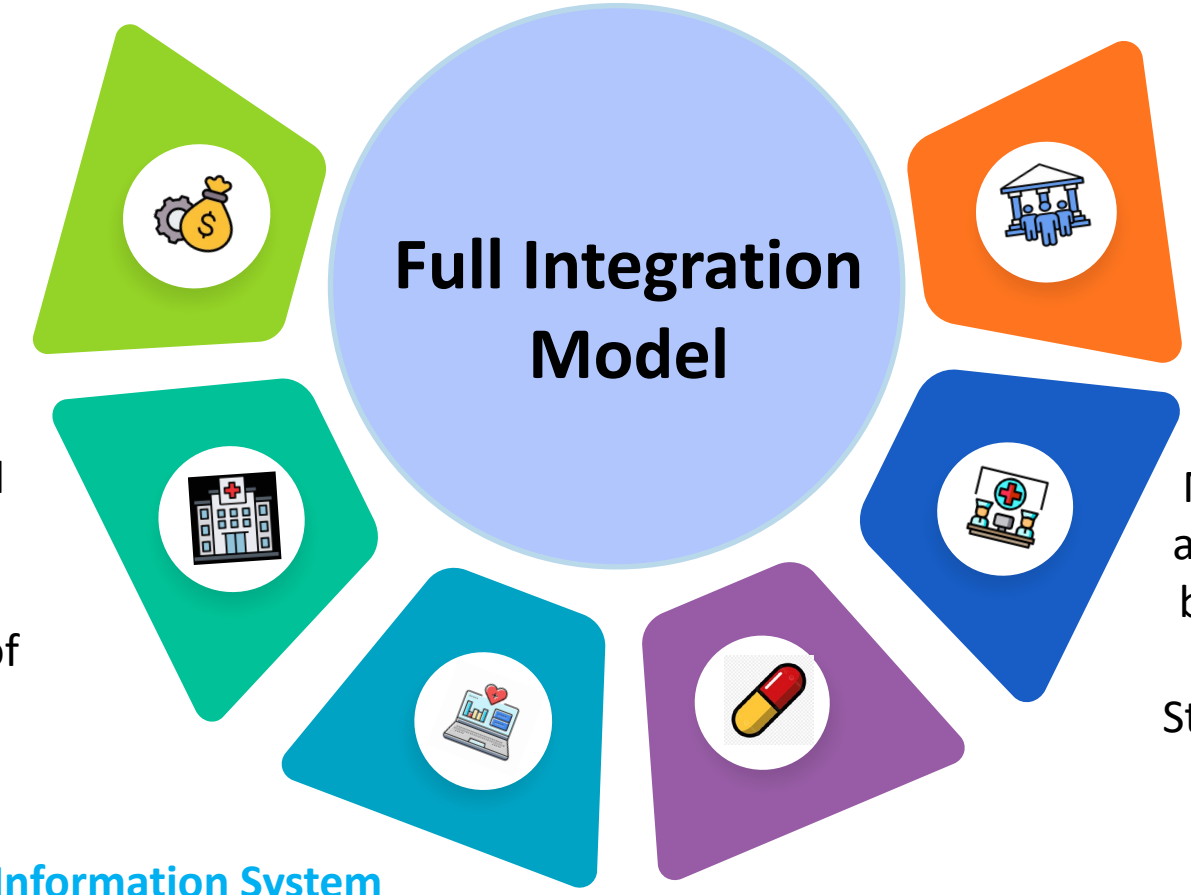
101,340 → 35,791

FSW reached with defined package**
Jun 2025 to Feb 2026

Pattern is consistent with funding disruptions, reduced outreach intensity and reporting/service continuity gaps in several counties.

*Coverage defined as number of KP reached with at least one service vs. target
**At least four biomedical services and one commodity provided.

Example: Integrated Model for KP Services



Financing
Fully funded by county government, facility kitty from SHA (PHC)

Leadership & Governance
County MoH governs and manages the services

Service Delivery
Attended alongside general patients in the OPD.
All biomedical services provided, partial provision of behavioral services.

Human Resources for Health
MoH facility staff provide services and community outreach provided by county-hired peer educators as CHPs (in selected counties).
Staff are trained on stigma-free, KP-friendly services using standard curriculum.

Health Information System
Data is integrated with facility data, generated centrally at facility level and uploaded to KHIS monthly.

Health Products & Technologies
Pharmacy and lab are centralized at the facility. Main facility supplies are integrated in the LMIS for reporting and restocking.

SHA = Social Health Authority
KHIS = Kenya Health Information System
CHP = Community Health Promotors

Kenya is moving to a mixed model landscape

Rather than a single endpoint, Kenya is operating across a spectrum of delivery models, each with different implications for reach, quality, cost and domestic financing.

Full integration

MoH-led within OPD

County + SHA

Best for domestic embedding

MAT clinics

PWID-specific facility pathway

County + SHA

Strong biomedical continuity

Partial integration

CCC or co-located unit

Mixed county + partner

Transitional model

Stand-alone

IP/CSO-run facility

Donor-funded

Protects trust and full package

Integrated stand-alone

CSO facility + non-HIV services

Mixed donor, self & GoK funds

Most preferred by many KPs

More integration / stronger public-system anchoring → **Less integration / more partner dependence**

SHA = Social Health Authority
MAT = Medication-Assisted Treatment (methadone)
CCC = Comprehensive Care Clinics (HIV clinics)
GoK = Government of Kenya

What each model solves—and what it risks

Model	What it protects	Main risk / constraint	Transition implication
Full integration	Domestic ownership; facility workflows; commodity and data integration	KP visibility can dilute; no dedicated KP provider; stigma risk	Requires strong training, supervision and referral discipline
MAT clinics	PWID continuity; clear clinical pathway; facility-based dispensing	Outreach and NSP remain harder to sustain in fully integrated settings	Best where harm reduction remains protected alongside clinical care
Partial integration	Pragmatic bridge model; retains some partner capacity while using facility platforms	Can create fragmented accountability and unclear client flow	Useful as a managed transition model, not necessarily the end state
Stand-alone	Trust, confidentiality and full essential package	Most exposed to donor contraction and parallel systems	Need financing strategy or phased linkage to public system functions
Integrated stand-alone	High client preference; one-stop model including non-HIV services	Dependent on mixed financing and strong CSO capability	Potential anchor for hybrid models if SHA and county mechanisms mature

SHA = Social Health Authority
MAT = Medication-Assisted Treatment (methadone)
NSP = Needle and syringe program

Immediate priorities for sustainable transition

1. **Protect the package**
   Keep the nationally approved KP package visible even where services are integrated.

2. **Fund the platform**
   Advance SHA/SHIF inclusion, enroll KP clients and eligible stand-alone facilities, and clarify service classification.

3. **Protect community roles**
   Integrate peer educators as special CHPs while preserving their outreach and trust-building functions.

4. **Standardize quality**
   Invest in stigma-free training, joint quality assessment, and streamlined data + commodity management across models.

Bottom line

Integration is a means to sustain KP services—not a substitute for community trust, quality and differentiated access.

The next phase should be deliberate, evidence-led and co-designed with KP communities.

SHA = Social Health Authority
SHIF = Social Health Insurance Fund
CHP = Community Health Promotors

Open Questions for Shared Learning

Coverage

Which models sustain reach across FSW, MSM, PWID and trans populations?

Retention

Which models keep clients engaged in prevention and treatment over time?

Cost

What is the comparative cost-effectiveness under tighter and more domestic financing?

Scale

Which models are scalable under county systems, SHA and mixed financing?

Discussion prompt

How do we transition toward sustainability without losing the differentiated, trusted service features that KP communities rely on?

Sustaining reach
Protecting trust
Building public-system ownership

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Thank You!

Discussion and shared learning welcome

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