Kenya:

Key Populations' Strategic Priorities

Introduction

Until the end of 2024, Kenya's key population (KP) HIV response was widely regarded as a leading model for community-led service delivery in sub-Saharan Africa. Donor investment—particularly from PEPFAR and the Global Fund—supported the scale-up of KP-led organisations and strengthened the national KP programme. This partnership enabled KP representation in decision-making spaces and expanded the delivery of community-based HIV prevention and treatment services.

By the end of 2024, Kenya had established a comprehensive KP service delivery framework, including more than 14 KP-led drop-in centres and safe spaces offering integrated services such as condom and lubricant distribution, HIV testing, pre-exposure prophylaxis (PrEP), anti-retroviral therapy (ART), sexually transmitted infection (STI) and tuberculosis (TB) screening, harm reduction, and structural interventions, including violence response and legal advocacy. Service coverage was strengthened by improved KP size estimates, informing planning and resource allocation across the 555 KP-friendly health facilities and Drop-In Centres (DICs) in 45 of 47 counties.

Programmatically, over the years interventions for men who have sex with men (MSM) and sex workers have been more established and comprehensive. Services targeting people who use drugs have been expanding, while programming for transgender populations remains in its infancy.

In the first half of 2025, Kenya experienced significant disruptions to KP programming due to US funding cuts, including stop-work orders, termination of services, the suspension of key advocacy platforms, degradation of KP programme reporting systems, limited access to programmatic data, termination of KP-led CLM contracts, halting of the development of the key and vulnerable populations programme guidance document and the closure of some community-led programs. These disruptions have directly affected service delivery continuity and coverage. The cumulative impact of recent disruptions has placed progress in these areas at risk and warrants continued monitoring and engagement. These losses threaten to reverse years of progress in building comprehensive, community-led KP responses.

Concurrently, the enforcement of laws related to homosexuality, sex work, drug use, "impersonation," and public morality—including statutes on public indecency, nuisance, vagrancy, and loitering—have reportedly been used by law enforcement and, in some cases, health workers to harass members of KP communities. Reports indicate that laws criminalising drug use have been disproportionately applied to people who use drugs rather than to those engaged in drug distribution. Transgender individuals have faced enforcement actions under legal provisions prohibiting "posing as a woman," "cross-dressing," or "cross-dressing for immoral purposes."

What does the data say about HIV prevalence among KPs in Kenya?

Key populations (KPs) continue to be disproportionately at high risk of acquiring and transmitting HIV due to various social, biological and legal determinants. Preliminary findings reported in the July to September Quarterly Programme Review (QPR) show that HIV prevalence among FSWs at 27.5%, MSM at 19.1%, PWID at 9.1% and transgender people at 22% which is much higher than HIV prevalence among the general population; 3.3%[1].

[1] Preliminary findings of the IBBS 2024
[2] Kenya HIV Epidemic Status - Quarterly Performance Review - July/September 2024.

HIV prevalence and Viral load suppression in 9 survey counties[2]

Key Population	HIV Prevalence, % (95% CI)[1]	Viral Suppression, % <200 copies/ml (95% CI)[1]	Population Size Estimate (95% CI)[2,3]
FSW	27.5 (25.1-30)	80.1 (76.7-83.4)	100,903 (83,867-119,812)
MSM	19.1 (17.1-21.1)	76.1 (72.3-79.1)	34,980 (29,687-40,745)
PWID	9.1 (6-12.2)	84.5 (76.8-92.3)	14,290 (11,660-17,180)
TG	22.0 (18.6-25.4)	82.5 (76.6-88.3)	4,058 (3,313-4,887)

[1] CI : 95% Confidence Interval

[2] CI: 95% Credible Interval

[3] Viral suppression is among all individuals who are HIV positive regardless of knowledge of HIV status or use of ART

Where was Kenya on the 95/95/95 track[3]?

Progress towards 95-95-95 Targets among key populations in the 9 survey counties (Conditional)

Key Population	% Aware of HIV status among individuals who are HIV positive (95% CI)	% On ART, among individuals who are aware of their HIV status (95% CI)	% Viral suppression, among individuals who are on ART (95% CI)
FSW	94.5 (94.2–94.8)	97.7 (97.5–97.9)	86.9 (86.4–87.3)
MSM	93.1 (92.6–93.7)	99.3 (99.2–99.5)	88.7 (88.1–89.4)
PWID	94.7 (93.6–95.9)	99.4 (99–99.8)	88.8 (87.1–90.4)
TG	91.5 (89.6–93.3)	98.7 (98–99.5)	91.8 (90–93.7)

Legend
- >=95%
- 90-94%
- <90%

The data show gaps in the 1st and 3rd 95 targets in the KP programme. These gaps are likely to be further exacerbated by the current PEPFAR funding freeze and the reprioritisation of global Fund GC7.[4]

As of June 2025, Kenya's KP programme continues to face unprecedented disruptions that have significantly impacted the continuity of care, community engagement, and monitoring systems. These disruptions have reversed gains made in coverage, client retention, and structural interventions across multiple KP groups.

[1] Preliminary findings of the IBBS 2024 [2] Kenya HIV Epidemic Status - Quarterly Performance Review - July/September 2024. [3] NASCOP led July - September 2024 Quarterly Programme Review, preliminary findings of the IBBS 2024 [4] Kenya HIV Epidemic Status - Quarterly Performance Review - July/September 2024

Programmatic Disruptions

- **ART Service Losses:** The number of KP clients on ART declined from 27,686 in December 2024 to 19,893 by March 2025—a net loss of 7,793 clients, representing a 28.1% decrease.
- **Community Infrastructure Reduction:** Four of the 14 PEPFAR-funded drop-in centres (DICs) have been terminated, reflecting a 28.5% reduction in ART delivery capacity at the community level.
- **Collapse of Advocacy Infrastructure:** Approximately 80% of KP-led organisations have lost funding to support government engagement, policy dialogue, and stakeholder coordination since the issuance of stop-work orders.
- **Breakdown of Social Support Services:** Over 50% of KP-led organisations previously implementing social support programming have reported a reduction in, or complete cessation of, operations.
- **Termination of Community-Led Monitoring (CLM):** Funding for CLM activities was entirely halted, eliminating routine community feedback mechanisms.Data Systems Degradation: Tools for disaggregated KP data collection are no longer in use, and timely access to KP-specific service data has been discontinued.

While public health facilities continue to serve both general and KP populations, the loss of KP-led infrastructure has created critical gaps in peer navigation, adherence support, and culturally competent services essential for retaining clients in care.

KP Community Core Priorities

1. Antiretroviral Therapy (ART) and Service Continuity

Prior to the PEPFAR cut, Kenya's KP programme had achieved significant ART coverage for KPs. By the end of 2024, Kenya was nearing achievement of the UNAIDS 95-95-95 targets. The national HIV programme had adopted same-day ART initiation for all individuals diagnosed with HIV and ensured access to optimised regimens aimed at achieving rapid viral suppression. For the KP programme[5],

- 97% of HIV-positive female sex workers (FSW) were on treatment,
- 99% of men who have sex with men (MSM) were on treatment,
- 99% of people who inject drugs (PWID) were on treatment, and
- 98% of the estimated transgender people were on treatment.

The harm reduction programme for PWID included over 10 public methadone clinics and more than 35 DICs offering needle and syringe services. However, annual needle distribution per PWID averaged 189, slightly below the WHO recommended global threshold of 200.

KPLHIV Currently on ART	FSW	MSM	PWUD/PWID	TG
October - December 2024	20,934	5,513	880	359
January - March 2025	14,998	4,047	628	220
Total Reduction By March 2025	5,936	1,466	252	139

[5] Preliminary findings of the IBBS 2024

As of December 2024, ART service delivery remained available at all public health facilities serving both general and key populations (KPs). Community-led service delivery platforms—including 14 PEPFAR-funded Drop-In Centres (DICs)—played a critical role in ensuring differentiated care for KPs. In total, 555 facilities reported on KP-specific indicators through the national system, covering 45 of Kenya's 47 counties and reaching over 95% of the national KP population.

However, between January and March 2025, four KP-led DICs were terminated, resulting in a 28% reduction in ART service delivery capacity at the community level. During this period, the number of KP clients on ART declined from 27,686 (December 2024) to 19,893 (March 2025), representing a net loss of 7,793 clients. Service reductions extended across the prevention and treatment cascade, including STI and TB services.

Key Estimates of Reductions on ART (January - March 2025):

Reduction of services among key populations (These number represents the reduction in KP receiving services across all 555 KP serving health facilities and DICs)

Area of impact	Estimated Reduction			
	FSW	MSM	PWUD	TG
Number Reached	63,510	42,012	5,638	2,549
Number Tested HIV Positive	243	-21	5	3
Total Number KPLHIV Currently on ART	5,936	1466	252	139
Number Screened for STI	53,987	23,177	955	901
Number Diagnosed with STI	685	244	-30	69
Number Treated STI	699	346	-21	56
Number Screened for TB	53,661	23,482	20,003	630

Note: Negative values reflect net additions from the previous reporting period.

Non-negotiable Priorities:

- **Scale up access to ART commodities for KPs living with HIV in the DICs.** Ensure uninterrupted access to ART commodities for KPLHIV in DICs to mitigate risks of loss to follow-up and treatment interruption.
- **Scale up support for additional peer cadres to fill the gaps created by the closure of KP-led sites.** Expand deployment of peer educators and lay cadres to address service continuity gaps and re-engage clients lost during the disruption.
- **Restore and fund KP-led service delivery:** Prioritise funding and operational support for KP-led DICs to restore trusted access points and client-centred service models.
- **Train health service providers in KP serving general population ART sites on KP service delivery.** Implement targeted training for healthcare workers in public ART sites to enhance delivery of KP-competent services and reduce stigma-related barriers.

[5] Preliminary findings of the IBBS 2024

- **Scale up KP centres and ensure they have the capacity to be one-stop centres of excellence offering opportunistic infection diagnosis and treatment and TB diagnosis, prevention and treatment.** Equip KP centres to function as one-stop hubs delivering comprehensive care listed in the key population core package of care in appendix 1.
- **Scale up and maintain viral load access by ensuring commodities are available and wait times are shorter.** Ensure sustained availability of viral load testing commodities and reduce result turnaround times to support clinical decision-making and treatment monitoring.

Strategic Element	Current Status	Annual Funding Required	KP Community Impact
ART Commodities	Limited Supply	$3,370,914	The commodities are in limited supply. GoK claims commodities are available at the warehouse; however, there are no resources for distribution.
HIV Test Kits	HIV testing commodities	$125,020	These commodities are generally supplied by the Ministry of health
KP-Friendly public Sites, including community HIV best testing	Available but unsafe	$277,714	The vast majority of KP services are provided at public facilities which are short staffed, and not friendly or professional towards KPs.
Service delivery: HIV treatment in DIC/one-stop-shop/community centre and ART clients lost to follow up	Lost 7,793 clients (27,686 → 19,893)	$269,955	Comprehensive re-engagement strategy including peer outreach, mobile services, and facility-based support
Facility HIV testing, including public facility integration	Maintained but lacking KP-specific support	$157,227	Training and support for KP-competent care in mainstream facilities
Social network testing/EPOA	Need expansion	$295,296	Expand social Network testing beyond urban areas
Service delivery: Index testing-community	Need expansion	$277,714	Expand Index testing in the communities

ART Funding Gap: Approximately **$4,773,840** annually to restore comprehensive, peer-supported ART services for KPs.

What is the cost of inaction? In just 6 months the funding cuts have had drastic effects on the KP ART program with high numbers of KP living with HIV losing access to life saving medications. These numbers will only continue to rise and have a drastic and negative effect on the program and on the lives of key populations.

2. Primary Prevention

Kenya's HIV prevention programming is critical for supporting and protecting KP communities. Outreach activities led by community organisations, supported by peer-led networks to reach key populations with information, make up a significant portion of the success of the KP programme. Kenya's prevention framework included comprehensive PrEP access through over 14 KP-led drop-in centres and safe spaces, complemented by services available at various public health facilities and mainstream-led DICs for KPs. The system provided broad geographic coverage and population-specific services.

However, the stop-work orders and funding disruptions initiated in early 2025 caused a severe erosion of this infrastructure. PrEP initiation dropped by 52% between December 2024 and March 2025 (13,528 to 7,050), driven by closures of community-led DICs, interruptions in commodity supply chains, the collapse of outreach systems and the waiver issued by PEPFAR limiting PrEP services to pregnant and breastfeeding women. The Ministry of Health, through the National AIDS and STI Control Programme (NASCOP), has since issued a memo advising the continued provision of PrEP services for all populations across various service delivery sites, including KP sites.

Access to condoms and lubricants is a key prevention intervention in the KP programme. Community-led organisations report a 39.7% reduction in access to condoms and a 36% reduction in access to lubricants between January and March 2025. Peer education and harm reduction services, including access to needles and syringes and Medically Assisted Therapy (MAT) have also been negatively impacted by the programme changes since January 2025.

Among PWID, there was a sharp decline in service utilisation: newly inducted MAT clients dropped from 174 to 103, and HIV testing among MAT clients declined by 35% over the same period. A significant increase in loss to follow-up was observed, including 198 MAT clients lost in a single reporting month.

Key Estimates of Reductions on Primary Prevention (January-March 2025):

Reduction of services among Key population (These number represents the reduction in KP receiving services across all 555 KP-serving health facilities and DICs)

Area of impact	Estimated Reduction			
	FSW	MSM	PWUD	TG
Number reached	63510	42012	5638	2549
HIV Testing	17322	17418	-2,297	653
Number receiving condoms	56962	43008	6654	1468
Number receiving needles & syringes	0	-34	3985	0
Number receiving lubricants	6198	18692	-15	792
Number Screened for STI	53987	23177	955	901
Number Screened for TB	53661	23,482	20,003	630

Note: Negative values reflect net additions from the previous reporting period.

Key Estimates of Reductions For PWUD:

Area of impact	OCT-DEC 2024	JAN - MAR 2025
Number Newly inducted on_MAT	174	103
Currently on MAT Methadone	3792	3650
Number of clients LTFU in the Reporting Month	0	198
Number of MAT clients tested for HIV	1584	1029
Number Initiated_PrEP	37	9

Readiness for Injectable PrEP Rollout

Long-acting injectable PrEP represents a significant opportunity to strengthen HIV programming in Kenya. To date, Kenya has not started implementing CAB-LA; however, in 2025, Kenya was selected as one of nine Global Fund priority countries for the first wave roll-out of six-monthly long-acting injectable Lenacapavir (LEN). This designation recognises Kenya's HIV burden among key populations and positions the country to benefit from catalytic investments in new prevention modalities. However, the current breakdown of foundational community led prevention systems risks undermining rollout efforts. Moreover, $2 million is expected to be drawn from the national GC7 allocation for the LEN roll-out, which would reach only an estimated 33,000 people overall – far below the estimated need among KPs and their partners.

To capitalise on this opportunity, the KP Consortium emphasizes the urgent need to restore KP-led prevention services, rebuild commodity supply chains, and invest in outreach infrastructure capable of supporting equitable, stigma-free access to next-generation PrEP tools.

Non-negotiable Priorities:

- **Restore PrEP access:** Re-establish oral and injectable PrEP access points within community-led DICs to reverse coverage declines and meet current demand among KPs.
- **Reinstate KP-led prevention sites:** Prioritise operational support for KP-led prevention service delivery sites to increase PrEP initiation and retention.
- **Train health providers on KP-competent prevention:** Strengthen capacity of public and private sector providers to deliver non-judgmental, evidence-based prevention services tailored to KP needs.
- **Expand condom and lubricant distribution:** Scale up peer-led outreach programmes to ensure consistent availability of condoms and lubricants in high-burden areas.
- **Restore harm reduction programmes:** Resume and expand needle and syringe exchange services in drop-in centres serving PWUD to reduce HIV transmission risks.
- **Scale up Opioid Substitution Therapy (OST):** Increase availability of buprenorphine and methadone at community sites, including provision of take-home dosing, to improve adherence and retention in care.
- **Prepare for LEN rollout:** Restore foundational systems to ensure Kenya is ready to fully implement the Global Fund-supported introduction of injectable Lenacapavir for PrEP among KPs.

Strategic Element	Current Status	Annual Funding Required	Key notes
Oral and injectable PrEP service delivery for PrEP Sites and KP Friendly Sites	Services disrupted across KP-led centres	$7,531,678	PrEP Service delivery and restoring oral PrEP access through all 14 drop-in centres with peer support. Restore closed KP PrEP sites with peer support to increase access Scale up KP sensitisation as general health facilities require KP-specific service capacity and training
Oral PrEP Commodities	Supply Chain stalled	$5,528,797	Include supply chain and last-mile delivery
Len PrEP Commodities	New PrEP Commodities	$1,200,960	Include supply chain and last-mile delivery
Prevention Commodities	Supply chains disrupted	$56,080	Condoms, lubricants, and HIV self-testing kits distributed through community networks
MAT sites, Safe Injecting Equipment	Gaps in community-level access and	$321,600	Scale up safe injecting equipment essential for HIV prevention among PWUD in DICs. Outreach workers for prevention education and commodity distribution
MAT Commodities	Supply chain	$92,400	Supply chain
Demand creation and awareness building	Prevention Demand Creation	$112,560	Expand demand creation to include social network based

Primary Prevention Funding Gap: Approximately $14,844,075 annually to restore comprehensive prevention services with peer support networks.

What is the cost of inaction? The Kenya Key Population Programme urgently requires strengthened prevention efforts to effectively reach key populations across the entire cascade. Critical commodities such as condoms, lubricants, testing kits, needles and syringes, among others, serve as entry points to engage with communities that would otherwise be harder to reach, link them to the health system, and ensure they have access to the latest prevention, treatment, and retention options. All of the UNAIDS 95-95-95 targets are at risk of failure without a robust prevention programme.

3. Sexual Transmitted Infections

In Kenya, STI treatment for key populations is managed by NASCOP under the Ministry of Health, guided by the 2018 STI Guidelines and KASF II (2020/21-2024/25). Strategies focus on stigma reduction, integrated HIV/STI care, universal access, harm reduction (e.g., needle exchange), condom/lubricant distribution, and decentralised services. In 2025, efforts include quality improvements, the integration of non-communicable diseases, and health worker training tailored to the specific needs of MSM/TG.

KP-led organisations offer stigma-free clinics with STI prevention, treatment, harm reduction, and empowerment programmes alongside public hospitals, private clinics, and NGOs, who often provide free/subsidised screening/ treatment but face rural access and data gaps.

Compared to Jul-Dec 2024, STI screening dropped significantly. FSW screening dropped from 54,796 to 18,400, MSM dropped from 16,872 to 4,573 while STI positivity rates rose from 1.95% to 2.70% among MSM, 0.74% to 0.94% among PWID, and dropped from 4.99% to 4.14% among TG and 3.66% to 3.02% among FSW. Treatment rates stayed high (>93%), with minor gaps.

Non-negotiable Priorities:

- **Scale up STI screening to 90% and ensure 100% treatment.** Screening KPs for STI and treating those with STI greatly is key and also reduces HIV infection.
- **Boost commodity distribution.** Ensure access to STI screening and treatment is available easily in the community especially among KP led organisation as part of comprehensive services
- **Integrate HIV/violence support to reduce transmission.** Support organisation to respond to violence which can increase transmission of STI due to fears of being screened

There is a significant need to expand and increase STI coverage in Kenya. The non-negotiables and costs are shown in the table below:

Strategic Element	Annual Funding Required	Implementation Notes
Service delivery	**$147,300**	Include management and follow-up
STI Treatment	**$964,800**	Including commodities
STI Lab Monitoring	**$321,600**	Including Lab commodities

Sexual Transmitted Infections Gap: Approximately $1,433,700 annually to restore comprehensive STI screening, prevention and treatment.

4. Community Infrastructure

Kenya has 555 health centres/ DICs that cater to key populations in 45 of the 47 counties, representing a very high coverage of KP service delivery points in the country. Harm reduction programming for PWID alone included over 10 public methadone clinics and more than 35 DICs offering needle and syringe services.

The number of service delivery sites, however, does not automatically mean the KPs are receiving friendly or comprehensive services or that the staff in these facilities are trained to offer services to KPs or that all KPs across the country are reached. Some of the key barriers to service delivery prior to the funding cuts were stigma and discrimination, criminalising laws and a lack of comprehensive service delivery points.

However, the 14 community-led organisations were changing how services were offered by bringing the services closer to people in the community, and also providing friendly services and covering the gaps that general health facilities struggled to address. By December 2024, KP led organisations also had comprehensive support for structural interventions including advocacy, policy change, violence prevention and response programmes, engagement with government and decision makers at the local and national level, engagement with law enforcement, capacity building and support for duty bearer accountability.

After the funding cuts, however, 80% of KP-led organisations lost their funding to engage the government on policy and stakeholder engagement. 80% of KP led organisations that had the resources and structures to provide food, shelter, psychosocial support including referral and outreach services also lost their funding. There was only one KP-led CLM funded by PEPFAR whose critical work to highlight the quality of service offered to key populations was also stopped. FSW programmes that supported structural interventions also lost their funding limiting structural intervention related support to Global Fund KP sub-recipients.

Drop-in Centres and Safe Spaces

The drop-in centre model provided:

- **Safe spaces:** Spaces where community members feel safe to gather, receive services, seek medical advice, report violence, share knowledge and maintain confidentiality.
- **Direct clinical services:** HIV testing and counselling, ART dispensing, PrEP initiation, and continuation, condoms and lubricants, STI screening and treatment, family planning, TB services, and cervical cancer screening, adherence support, and psychosocial care, community-affirming services, among others.
- **Peer education and support services:** delivery of services by individuals from the community who have lived experience
- **Referral networks:** Linkages to specialised care, legal services, and emergency support

After the funding cuts, 4 out of the 14 KP-led organisations were fully terminated. These organisations offered services for SWs in Busia and Malaba (2 border towns with Uganda) and MSM in Kisumu, and Machakos. The remaining KP-led organisations are only allowed to provide minimal services. The remaining grants excluded any staff support (exclusive of clinical staff), outreaches and peer educators all of which make up the bulk of KP led service delivery.

Key Estimates of Losses (December 2024 - March 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
KP-led drop-in centres	28% capacity reduction	4 out of 14 PEPFAR-funded drop-in centres terminated, significantly reducing safe space availability
Outreaches	100% reduction	All outreaches were terminated reducing ability to find community members
Peer cadres	100% reduction	Peer navigators essential for treatment continuity and adherence support and need to be increased for outreaches
Staff support	Extremely Limited	Only limited to clinical support
Advocacy organisations	80% funding loss	80% of KP-led organisations lost funding for government engagement, policy work, and stakeholder coordination
Social support programmes	50%+ capacity reduction	More than half of organisations providing food, shelter, and psychosocial support negatively impacted
Community-led monitoring	100% elimination	CLM funding completely cut off following stop-work orders

Non-negotiable Priorities:

- **Scale up** the national KP coalition or network with capacity to convene, consult with and mobilise communities.
- **Scale up KP advocacy and accountability** organisations with coverage in all priority geographic areas and for all KP population groups.
- **Restore and scale up violence prevention and response interventions:** Key Populations are often targeted by violence and abuse. Funds must be restored and scaled up to support prevention and response efforts
- **Restore and fund KP-led service delivery:** Prioritise funding and operational support for KP-led DICs to restore trusted access points and client-centred service models.
- **Restore and scale up peer education and outreaches:** Community service delivery is a key component of KP case identification and linkage to services. These interventions must be restored and scaled up.

- **Restore and increase human resources for health:** Health service providers in the HIV response have been significantly reduced since the stop work orders. Resulting in sharp declines in retention, linkage, testing among others.
- **Restore and fund KP-led CLM activities:** We recommend the restoration of funding towards community-led monitoring led by all communities including key populations.

Strategic Element	Current Status	Annual Funding Required	Key notes
Drop-in centre reopening and continuation	4 of 14 centres terminated (28% reduction)	$1,358,600	Rent, staffing, clinical supplies, and integrated services needed
KP-led drop-in centres	28% capacity reduction	$1,358,600	4 out of 14 PEPFAR-funded drop-in centres terminated, significantly reducing safe space availability to include rent, staffing and integrated services
Outreaches	100% reduction	$252,000	Restore outreaches were terminated to improve KP outcomes
Peer cadres	100% reduction	$500,000	Restore the peer education programme to increase service to KPs
Staff support	Extremely Limited	$700,000	Restore the capacity of KP led organisation staff, including clinical staff
Social support programmes including capacity building and social enterprising	50%+ reduction in capacity	$380,400	Food, shelter, psychosocial support, and emergency assistance programmes
Community-led monitoring	Completely eliminated	$480,400	Restore CLM capacity with training, tools, and coordination mechanisms

Data systems	KP disaggregation eliminated	$126,800	System upgrades and technical assistance for KP-specific indicators
Structural interventions including GBV	Funding terminated	$228,245	Violence prevention, legal aid, and law enforcement engagement programmes
Human rights & legal protection	Restore structural intervention programmes	$180,400	Violence prevention and response, legal aid, law enforcement engagement, and human rights monitoring across priority counties.
KP Consortium	Support and coordinate KP programing	$280,400	Coordination of KP organisation and KP programmes.

Community Infrastructure Funding Gap: $5,845,845 to rebuild essential community systems and protective mechanisms.

What is the cost of inaction? The loss of community-led capacity will be devastating to the KP programme. DICs, outreaches, peer cadres, staff, community-led monitoring and structural interventions determine the success of the programme and will be irreplaceable. A lack of advocacy capacity to engage with government, influence policy, and coordinate with stakeholders will increase the stigma, discrimination, and criminalisation of communities. This represents a fundamental threat to the sustainability and accountability of KP programming in Kenya.

5. Data and Monitoring Systems

Part of the success of KP data has been the ability to reach all KP typologies and to disaggregate data by population group, ensuring that resources are effectively used to reach communities. To enable this, Kenya maintained comprehensive KP-specific data collection through PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators with disaggregated reporting across the national system. However, after the funding cuts, PEPFAR eliminated most KP specific indicators from DATIM, making it difficult to track PEPFAR's KP programme performance. Access to information from PEPFAR quarterly review meetings has also stopped, reducing any ability to review programme progress and make adjustments. The staff who led data tracking, such as monitoring and evaluation staff and peer educators at the community-led organisations were also terminated, greatly affecting the organisations' ability to collect and report on data. The IBBS validation process is also no longer receiving PEPFAR support, delaying access to vital programming information.

Key Estimates of Losses (December 2024- March 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
Data Disaggregation	Complete loss	Data tools no longer disaggregated for KPs; no access to up-to-date KP-specific data from DATIM.
Data collection and entry	Partial loss	Key data collection staff were terminated impacting data collection and reporting efforts

Non-negotiable Priorities:

- **Restore high-quality, disaggregated data** for an effective prevention and treatment programme for key populations.
- **Restore staff who supported data collection.** This includes data clerks, health records and information officers (HRIOs) and M&E officers including peer educators and field officers/outreach workers.

Strategic Element	Current Status	Annual Funding Required	Key notes
Disaggregated data	Not collected	$126,800	Restore high-quality, disaggregated data
Data collection and entry	Terminated	$126,800	Restore data collection staff support

Data and Monitoring Systems Gap: $253,600 annually to rebuild data and monitoring

What is the cost of inaction? The elimination of KP-disaggregated data collection has created critical blind spots in programme monitoring and response. Without access to up-to-date KP-specific data, organisations cannot assess service gaps, track outcomes, or advocate effectively for resource allocation.

Summary of the proposed cost of the Kenya Key Population Plan

In Kenya, the methodology used the national population size estimates from PEPFAR, UNAIDS KP Atlas and the recent NACOP BBS data. Where lacking an estimate for TG, a standard percentage from the region is used. We considered the percentage of KPs that need prevention services (set initially at 90%). We further estimated KP living with HIV using HIV prevalence from PEPFAR or the KP Atlas. Where lacking prevalence data, a standard percentage from the region is used. We had considered % of KP LHIV in need of treatment services (set initially at 100%). To meet the Kenya KP budget, Kenya will focus on 50% of treatment and 70% as indicated below. Prisoners and clients of FSW are not included in the costing exercise. This covers the Kenya Key Populations Strategy Summary below with a programme cost total of $28,688,696, targeting 160,000 KPs. The itemised costing of each intervention is found on this link: Kenya Costed Budget.

KENYA	Costs	Total	Cost per target	General costs	GBV	Testing	TX	Biomedical Prev	STI	MAT
Kenya Priorities	Costs	$28,688,696	$178	$820,080	$96,184	$1,271,203	$5,322,126	$18,649,803	$2,225,550	$303,750
	Per cent of total			2.86%	0.34%	4.43%	18.55%	65.01%	7.76%	1.06%
		National Targets								
Targets	KP Treatment	**35,700**								
	KP Primary Prevention	**125,100**								
	Total	**160,800**								

Appendix 1: **What should a good core package for quality key population service delivery include?**

- Outreach services
- Lubricant
- Male condoms
- KP friendly HIV testing and counselling, including HIV self testing
- KP friendly HIV care and treatment
- HIV and PrEP support groups to improve continuity in care
- Psycho-social support
- Pre-Exposure Prophylaxis (PrEP)
- Post-Exposure Prophylaxis (PEP)
- Mental health services
- Linkage to justice services
- Pmtct
- Information package for sexual health services
- KP friendly STI prevention, testing & treatment services
- Gender-based violence services on-site or by referral
- Peer educators/navigators at the facility
- Vaccination, diagnosis, and treatment of viral hepatitis (including HBV, HCV)
- Prevention, diagnosis, and treatment of tuberculosis
- Counselling and risk reduction information
- Anal health services
- Voluntary Medical Male Circumcision (VMMC)
- Prostate cancer screening
- Cervical cancer screening
- Screening and treatment for ano-genital warts
- On-site and referral for other SRHR services

PWUD specific:

- On-site and referral drug dependence initiation and treatment (e.g. methadone)
- On-site and referral drug-dependence counselling and support
- Resources to take up referred services (e.g. taxi fare)
- Wound and abscess care
- Unused needles, syringes, or other injecting equipment
- Overdose management and treatment (e.g. naloxone)
- Drug dependence support group

TG specific:

- Hormone Replacement Therapy (HRT)

Methodology

This rapid strategy and budgeting exercise was designed as a structured assessment process to capture country-level impacts of foreign aid transitions and identify essential services requiring continued investment for key populations. The methodology began with orientation to a standardised Excel worksheet framework designed to systematically capture country coalitions' assessments across three critical domains: ART service delivery, HIV prevention programming, and community infrastructure (including civil society engagement, community-led monitoring, community mobilisation, and advocacy capacity).

The assessment process examined three distinct time periods: baseline status at the end of 2024, immediate impacts following foreign aid transitions that began in January/February 2025, and current conditions as of June 2025. Country coalitions collected quantitative and qualitative data through surveys, key informant interviews, organisational assessments, and coalition consultations to document service disruptions, funding gaps, and programmatic changes across these timeframes.

Following data collection, coalitions engaged in facilitated consensus-building processes to analyze findings, identify priority concerns, and develop collective views on current programming status. Through these discussions, coalitions articulated their "essentials"—critical activities, services, and investments necessary to maintain effective HIV responses for key populations in their contexts. This worksheet was used as the basis for a strategy narrative, developed by the GBGMC support team, that included a summary table of priority interventions requiring funding and attention.

In Kenya, the Convening of the Kenya Key Populations Consortium members in early July kick started the development of the Kenya tool. This was followed by desk reviews of existing data sets, reports and various resources produced by the relevant agencies of the Kenya Ministry of Health (NASCOP, NSDCC). Reports and useful resources produced by UNAIDS, PEPFAR were also reviewed.

Kenya KP representatives convened in Kigali, Rwanda on the sidelines of the IAS Conference on Science for a further review of this report before the final review in early August 2025.

The Team

We thank the many advocates, organisations, and government partners who participated in national consultations and supported the drafting of each plan. Your leadership and lived expertise are at the heart of this work.

Kenya community advocates

Generational Holistic Partnerships Network-Kenya [GHPN-Ke] and the MSM-led member organisations.

Kenya Network of People who Use Drugs [KeNPUD] and the PWUD-led member organisations.

Kenya Sex Workers Alliance [KESWA] and the SW-led member organisations

National Transgender Advocacy Network [NTAN] and the TG-led member organisations

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Funders:

Elton John AIDS Foundation (EJAF)

UHAI-EASHRI

AidsFonds