Guardrails for Integration: KVP Community Leadership in Shaping HIV–Primary Health Care Integration

Study Conducted Across East, West and Southern Africa 2023-2025

COMPASS
THE COALITION TO BUILD MOMENTUM, POWER, ACTIVISM, STRATEGY & SOLIDARITY IN AFRICA

KP-TNC
Inclusivity, Respect, Well-being

1st December 2025

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Executive Summary

This report presents a comprehensive, community-led assessment of integration readiness across nine African countries Kenya, Tanzania, Malawi, Zambia, Zimbabwe, Nigeria, Ghana, Botswana, and Uganda; conducted through a multi-country questionnaire, community consultations, key informant interviews, community-led monitoring (CLM) data, and a meta-analysis of KP-TNC and COMPASS reports from 2023–2025. The study sought to understand how key and vulnerable populations (KVPs) perceive integration; what hopes and concerns they hold; what conditions they require for safe access; and how national primary healthcare (PHC) systems can meaningfully include communities as co-architects in the design and implementation of integration.

Communities across all countries recognise the potential benefits of integration including more coordinated services, streamlined care pathways, improved accessibility, and long-term sustainability. However, they are equally clear that integration, in its current form, carries significant risks if implemented without safeguards. The most critical concerns relate to stigma, discrimination, inadequate confidentiality, untrained or judgmental PHC providers, unsafe facility layouts, and the threat of exposure or policing in criminalised settings. These risks are especially pronounced in rural areas, where social surveillance and weak health infrastructure make PHC facilities deeply uncomfortable or unsafe for KVPs.

Three major findings emerge from the study. First, communities overwhelmingly prefer hybrid models of integration**,** where PHC facilities provide biomedical services while community-led centres retain sensitive, trust-dependent services such as psychosocial support, mental health care, crisis response, gender-affirming services, and legal referral. Second, the findings confirm a strong urban–rural divide: urban PHC facilities are perceived as more prepared for integration, whereas rural facilities require substantial strengthening before they can safely absorb HIV services for KPs. Third, community trust remains the foundation of successful integration. Without strong confidentiality systems, stigma-free provider attitudes, and physical privacy safeguards, integration risks driving clients away from essential services.

The study also highlights positive developments. Countries such as Zimbabwe and Kenya demonstrate successful co-location models where PHC services are delivered in DICs, leading to increased uptake and improved client comfort. Malawi's CLM-driven reforms show measurable improvements in PHC responsiveness. Kenya and Botswana exhibit growing PHC readiness in urban areas, while Ghana continues to make steady progress in integrating community perspectives into PHC planning.

Across all countries, communities articulate clear conditions for safe and acceptable integration**,** including guaranteed confidentiality, trained and certified stigma-free providers, legally protected non-collaboration with law enforcement, continued funding for community-led safe spaces ("no-net-loss of DICs"), and strong CLM systems to ensure accountability. These conditions are not barriers they are enablers of sustainable, equitable integration.

The report concludes that integration is both necessary and possible, but only if it is sequenced, rights-based, community-governed, and grounded in a readiness-and-certification approach. GC8, the new PEPFAR outfit and new country health resourcing mechanisms, presents an opportunity to build integration models that strengthen PHC systems without compromising community safety. The study provides detailed recommendations for the

Global Fund, the new PEPFAR outfit and new country health resourcing mechanisms including embedding community co-governance, mandating PHC readiness assessments, preserving community-led structures, strengthening PHC workforce competencies, expanding CLM, and investing in rural facility upgrades.

Ultimately, this report affirms that integration will succeed when it reflects the lived realities of the communities it seeks to serve. With the right safeguards, investments, and meaningful engagement, GC8, the new PEPFAR outfit and new country health resourcing mechanisms can set a new global standard for people-centred, inclusive, and rights-affirming health system transformation in Africa.

Introduction Chapter

1. Background and Context

Across Africa, health systems are undergoing a significant transition as governments, partners, and global financing institutions move toward more integrated models of service delivery. This shift is driven by changes in the global funding landscape, increasing domestic resource mobilisation imperatives, and renewed commitments to universal health coverage (UHC). At the same time, the HIV response historically powered by vertical investments faces new pressures to adapt to broader primary healthcare (PHC) strategies.

The Global Fund's Eighth Replenishment Cycle, the new PEPFAR outfit and new country health resourcing mechanisms arrive at a pivotal moment in this transformation. Countries are being encouraged to integrate services for HIV, TB, malaria, SRHR, and other chronic conditions into a unified PHC structure. While integration holds the potential to enhance continuity of care, strengthen efficiency, and deepen population health equity, it also carries considerable risks for key and vulnerable populations (KVPs), particularly where criminalisation, stigma, and weak PHC infrastructure persist.

Communities across the KP-TNC countries emphasise that integration is both a necessity and a vulnerability. They recognise its long-term value but caution that without robust safeguards, integration could compromise decades of progress in prioritising confidential, safe, and community-led HIV service delivery. This study was therefore undertaken to understand what integration means for KPs, identify where PHC systems are prepared or unprepared, and generate community-driven guidance to inform GC8, the new PEPFAR outfit and new country health resourcing mechanisms integration priorities.

2. Statement of the Problem

Although integration is widely promoted as a pathway to sustainability and strengthened PHC systems, its implementation in many African contexts remains complex and uneven. In criminalised, high-stigma, and low-resource settings, KPs face heightened risks when accessing public facilities. Without adequate confidentiality protections, stigma-free environments, or trained PHC workers, integration may inadvertently create barriers instead of removing them.

Existing national integration efforts often insufficiently reflect the lived realities of KPs, who fear that moving services into PHC settings may expose them to discrimination, breaches of privacy, and police surveillance. Rural PHC facilities are especially underprepared, lacking essential infrastructure, training, and safety systems. Without community-informed safeguards, integration risks undermining KVP health outcomes and eroding trust in the health system.

3. Purpose of the Study

The purpose of this study is to generate evidence-based, community-led insights on how integration is experienced across different contexts and to provide practical recommendations to guide the Global Fund's GC8, the new PEPFAR outfit and new country health resourcing mechanisms integration priorities. The study seeks to elevate the voices of key populations, highlight integration models that work, identify risks that require mitigation, and propose clear pathways for strengthening PHC readiness in ways that protect community safety, dignity, and health outcomes.

4. Research Questions / Guiding Questions

The study responds to four priority questions posed during the GC8, the new PEPFAR outfit and new country health resourcing mechanisms consultation process:

1. What are concrete examples of successful integration of services for communities, and how do these differ between rural and urban settings?
2. What strategies or examples demonstrate how communities can be meaningfully engaged in defining essential service packages at PHC level?
3. In practical terms, how can communities contribute to people-centred service delivery within integrated models?
4. How can the Global Fund (during GC8), the new PEPFAR outfit and new country health resourcing mechanisms better support community engagement and inclusive decision-making when setting integration priorities?

5. Objectives of the Study

The study pursues the following specific objectives:

- To document community experiences, perceptions, and expectations of integration across multiple African countries.
- To identify successful integration models such as hybrid and co-location approaches that preserve community safety and service quality.
- To assess PHC readiness, highlighting gaps in confidentiality, stigma reduction, infrastructure, and workforce capacity.
- To propose community-informed guardrails, pathways, and indicators for safe, people-centred integration under GC8, the new PEPFAR outfit and new country health resourcing mechanisms.
- To generate actionable recommendations for policymakers, Principal Recipients (PRs), Country Coordinating Mechanisms (CCMs), and Implementing Partners (IPs).

6. Rationale / Justification for the Study

As integration accelerates across Africa, there is an urgent need to ensure that communities most affected by HIV are not left behind or pushed into unsafe systems. This study provides a crucial lens into what integration looks like from the lived experiences of KPs, offering evidence that can improve national policies, strengthen PHC preparedness, and guide the Global Fund in developing funding models that safeguard equity and rights.

Given the changing geopolitical and financial landscape; donor contractions, increased criminalisation in some regions, and shifting government-to-government financing, community insights are essential to prevent unintended harm. This study fills a critical evidence gap by offering detailed, country-level analysis that can inform GC8, the new PEPFAR outfit and new country health resourcing mechanisms and national PHC reforms.

7. Scope of the Study

The study focuses on nine countries engaged in the KP-TNC regional platform. It examines:

- Urban and rural service delivery contexts
- PHC infrastructure and workforce readiness
- Community-led and PHC-led integration models
- DICs, hybrid models, co-location, and outreach systems
- Legal and policy environments that impact integration

- Perspectives from sex workers, MSM, trans people, people who use drugs, and other KVPs

The time frame covers integration developments and community experiences between 2023–2025.

8. Significance of the Study

This study provides actionable insights that can guide:

- National health ministries in designing safe, inclusive integration policies
- Global Fund, the new PEPFAR outfit and new country health resourcing mechanisms teams in shaping sustainable HIV/PHC integration investments
- CCMs in strengthening community decision-making roles
- Implementing partners in developing KP-centred integration models
- Civil society and KP-led organisations in advocacy, monitoring, and systems strengthening

It helps ensure that integration enhances not compromises access to lifesaving services.

9. Conceptual Framework

The study is grounded in a rights-based, people-centred framework, recognising that integration can only succeed when PHC systems are responsive to the lived realities of communities. The conceptual lens integrates:

- Public health systems thinking
- Equity and rights-based approaches
- Community-led primary healthcare (CL-PHC)
- Models of differentiated service delivery (DSD)
- Contextual risk assessment for KPs

This framework guides the analysis of readiness, safety, trust, and service acceptability.

10. Limitations of the Study

The study relies heavily on qualitative, community-reported data, which provides rich insights but may vary in specificity across countries. Rural access constraints, legal restrictions, and security concerns sometimes limited the depth of engagement in certain regions. Nonetheless, consistent themes across countries strengthen the validity of the insights.

11. Definition of Key Terms

- Integration: The reorganisation of services so that multiple health interventions are delivered within a single PHC system.
- **Hybrid Model**: A system where PHC provides biomedical services but community-led spaces provide sensitive, trust-heavy services.
- **Co-location**: PHC services delivered within community-led settings (e.g., DICs).
- **KVPs**: Key and vulnerable populations, including sex workers, MSM, trans people, PWUD, etc.
- **Community-Led Monitoring (CLM)**: A mechanism for communities to collect, analyse, and use service delivery data to improve health systems.

Methodology Chapter

1. Introduction to the Methodology

This study employed a community-led, multi-country qualitative design grounded in KP-TNC's and COMPASS' long-standing commitment to participatory, rights-based evidence generation. Because integration affects safety, confidentiality, and the lived realities of key and vulnerable populations (KVPs), the study adopted an approach that foregrounds community voices and centres qualitative data as the primary source of insight. The methodology integrated a structured multi-country questionnaire, community consultations, key informant interviews, community-led monitoring (CLM) evidence, and a meta-analysis of KP-TNC reports produced between 2023 and 2025. Validation sessions took place across multiple KP-TNC regional, national platforms and COMPASS, ensuring that the final analysis reflects collective community experience and consensus.

2. Research Design

The study was embedded within KP-TNC's and COMPASS broader 2025 research initiative on the effects of funding transition on key populations. The integration component formed a specialised module within a larger, structured questionnaire that examined how financing shifts intersect with service access, PHC readiness, and community safety. The research design used a mixed qualitative approach, combining real-time questionnaire findings with narrative consultations, KIIs, historical trend analysis, and CLM data. This integrated design ensured that the findings captured the depth, diversity, and complexity of community experiences across multiple countries.

3. Study Sites and Sampling Framework

The research was conducted across nine KP-TNC countries: Kenya, Tanzania, Malawi, Zambia, Zimbabwe, Nigeria, Ghana, and Uganda. These countries were selected due to their active participation in KP-TNC. Other countries perspectives were also considered with respect to the responses received on the questionnaire. The presence of diverse KP communities, ongoing integration discussions within national health systems, and strategic relevance to Global Fund GC8, the new PEPFAR outfit and new country health resourcing mechanisms processes. Sampling followed a purposive and community-led framework. Country focal points identified participants who were directly engaged with PHC or DIC systems, represented different key population typologies, and could safely contribute insights. The sampling captured rural and urban contexts, community-led and PHC-led service environments, and diverse structural realities across countries.

4. Study Population and Participants

Participants included key population community members, peer navigators, DIC managers, civil society representatives, PHC providers, implementing partners, and KP-TNC country KP Consortia. Eligibility was based on experience within HIV prevention and treatment services, SRHR, harm reduction, or community-led programming. Participants were required to have direct interactions with PHC or DIC systems and to be able to engage in discussions safely. Their diverse roles enriched the study by combining lived experience with operational, clinical, and advocacy perspectives.

5. Data Collection Methods

5.1 Multi-Country Questionnaire (April–June 2025)

The central data collection tool was a structured regional questionnaire designed to explore the effects of funding transition on key populations. Within this instrument, a dedicated module focused specifically on integration. The module solicited community-defined hopes, concerns, required safety conditions, and practical suggestions for secure integration. The questionnaire was administered online via Google Forms and distributed through email and WhatsApp**,** enabling broad participation across geographic and demographic groups. Both self-administered responses and facilitator-supported submissions were accepted to ensure inclusion of participants with limited digital access.

5.2 Community Consultations

Country teams conducted community consultations to deepen and contextualise questionnaire findings. These dialogues explored comparative experiences in PHC versus DIC settings, perceptions of safety, acceptability of different integration models (PHC-led, hybrid, co-location), and structural differences between rural and urban contexts. These consultations provided rich narrative perspectives that enhanced the depth of the study.

5.3 Key Informant Interviews (KIIs)

Semi-structured KIIs were carried out with PHC staff, DIC managers, implementing partners, and national technical working group members. Interviews triangulated questionnaire insights with provider and institutional perspectives, enabling a more comprehensive understanding of PHC readiness and integration risks.

5.4 Community-Led Monitoring (CLM) Evidence

CLM datasets from 2023 to 2025 were reviewed to assess real-time facility performance. CLM insights included confidentiality levels, facility flow, provider attitude, privacy concerns, stock-outs, stigma indicators, and safety risks. As community-generated evidence, CLM provided an objective complement to qualitative data.

5.5 Validation Through KP-TNC Platforms

Preliminary findings were validated through KP-TNC's regional calls, sub-regional working groups, thematic fora (including MSM, SW, trans, and PWUD platforms), and continuous WhatsApp-group dialogues and COMPASS KP TWG. These validation processes enabled community members to confirm, refine, or challenge interpretations, reinforcing both accuracy and legitimacy.

6. Data Collection Instruments

The study employed several instruments, including the Google Forms questionnaire, semi-structured interview guides, community consultation templates, PHC integration readiness checklists, and confidentiality and safety assessment tools. KP-TNC and COMPASS teams collaboratively developed these tools to ensure contextual sensitivity and relevance. Where needed, tools were translated or adapted for local language and cultural suitability.

7. Data Management and Quality Assurance

Data was managed with strict confidentiality. All questionnaire responses, interview transcripts, and consultation notes were anonymised and stripped of identifying information. Data was stored securely in encrypted digital environments accessible only to authorised KP-TNC and COMPASS researchers. Quality assurance involved transcript verification, cross-country triangulation, supervisor review, and consistency checks across data streams. Special caution was applied in criminalised environments to ensure digital and physical safety of participants.

8. Data Analysis

The analysis unfolded in three stages. First, each country team conducted thematic analysis of questionnaire responses, consultations, and KIIs to identify emerging patterns related to integration readiness, confidentiality, safety, stigma, and service model preferences. Second, cross-country comparative analysis was performed to map shared themes, country-specific divergences, and structural or legal influences on integration. Third, questionnaire findings were integrated with CLM evidence and historical trends derived from the meta-analysis. This multi-layered analysis produced a holistic understanding of integration realities across the region.

9. Meta-Analysis of KP-TNC Reports (2023–2025)

A significant component of the methodology involved a meta-analysis of KP-TNC's regional reports and datasets from 2023 to 2025, various COMPASS reports over the years were also included in the analysis. These included annual community evidence reports, transition readiness assessments, CLM dashboards, integration snapshots, cross-country briefs, and thematic analyses on safety and service access. The meta-analysis allowed the study to identify enduring themes, track shifts over time, and assess structural patterns that influence integration. It also provided historical depth that validated the consistency of questionnaire findings, reinforcing the reliability of community-defined concerns and priorities.

10. Ethical Considerations

Ethical safeguards were integral to the research design, given the sensitivity and criminalisation associated with KVP identities in several participating countries. All participation was voluntary, and verbal informed consent was obtained. No personal identifiers were collected, and participants maintained the right to withdraw at any point. Trauma-informed interviewing practices were used throughout. Strict confidentiality and secure data storage protocols ensured participant safety.

11. Limitations of the Study

The study faced some limitations, including digital access constraints in rural areas that affected reach of the online questionnaire, legal environments that may have restricted open disclosure, uneven CLM availability across countries, and differing sample sizes by context. Nevertheless, consistency across multiple data sources and countries provided strong validation of thematic findings.

12. Community Leadership in the Research Process

Community leadership was central to every stage of the research process.COMPASS KP group provided the first design of the questionnaire while both COMPASS KP-TWG and KP-TNC members shaped the questionnaire design, facilitated country-level data collection, contributed to thematic analysis, validated emerging findings, and informed final recommendations. This participatory approach ensured that the study authentically reflects community experiences and priorities, grounding the final GC8, the new PEPFAR outfit and new country health resourcing mechanisms recommendations in evidence defined by those most affected.

Chapter 2: Findings

1. Introduction

This chapter presents the consolidated findings from the multi-country KP-TNC-COMPASS study on integration, drawing on insights from the regional questionnaire, community consultations, key informant interviews, CLM data, and meta-analysis of KP-TNC and COMPASS reports from 2023–2025. The findings reflect the lived realities of key and vulnerable populations across nine African countries and offer a nuanced picture of how integration is perceived, experienced, and negotiated in diverse contexts. They highlight both the aspirations communities hold for a future integrated PHC system and the fears and risks they associate with its current form particularly in settings marked by criminalisation, stigma, and uneven PHC readiness.

The results presented here aim to illuminate the conditions under which integration can succeed, the models communities consider safe and acceptable, and the systemic barriers that must be addressed to ensure that no one is left behind in the transition toward integrated health systems. These findings form the evidence base for the recommendations that follow and offer critical guidance for the Global Fund, the new PEPFAR outfit and new country health resourcing mechanisms as they contemplate on effective and inclusive integration models.

2. The Integration Moment in Africa

Africa is entering a pivotal era in the reorganisation of its health systems. The Global Fund's GC8, the new PEPFAR outfit and new country health resourcing mechanisms cycle align with a moment of structural transition driven by reduced donor financing, increasing pressure on domestic resources, shifting global political priorities, and the emergence of multi-disease service delivery models. Countries are being encouraged sometimes aggressively to integrate HIV, TB, malaria, SRHR and broader PHC services. While this shift has technical merit, it also carries profound risks for key and criminalised populations if implemented without rights-based safeguards, community governance, and sequenced readiness.

Communities across the nine KP-TNC study countries acknowledge that integration is necessary for long-term sustainability and stronger health systems. They recognise that a well-integrated PHC system can streamline care, reduce parallel structures, improve chronic disease management, and offer holistic services mental health, TB screening, malaria testing, SRHR that are often fragmented today. They also see integration as an opportunity to push for better resourcing of PHC facilities, improved supply chains, stronger healthcare worker competencies, and a unified standard of care that benefits all populations.

However, communities emphasise that the current PHC landscape in many African countries is not ready for integration especially for KPs who face compounded vulnerabilities due to criminalisation, stigma, gender identity biases, and unsafe public environments. Without guardrails, integration risks transferring clients from safe, community-led spaces into hostile PHC settings that can expose them to discrimination, embarrassment, violence, or even arrest. This tension between aspiration and risk defines the integration moment for Africa. Communities articulate a nuanced perspective: they want integration to succeed, but not at the cost of safety, confidentiality, or dignity. Integration must not collapse community-led

infrastructures that have taken decades to build, nor should it prematurely force KPs into PHC facilities that lack readiness.
The rural–urban divide intensifies these challenges. In urban settings, PHC facilities are often better staffed, more anonymous, more technologically equipped, and more accustomed to serving diverse populations. They may have undergone KP-competency training, offer more private spaces, and have stronger supply chains. However, in rural areas; across Tanzania, Zambia, Malawi, Uganda, Nigeria, and Ghana PHC facilities are often highly conservative, deeply embedded in social surveillance networks, lacking in privacy, and staffed by individuals who may know clients personally. Rural PHC integration was consistently described as "frightening," "unsafe," or "impossible without dramatic reforms."

This urban–rural divide is not just geographic it reflects differences in stigma, anonymity, provider attitudes, infrastructure, and exposure to training. Understanding this divide is central to designing realistic, safe, and phased integration strategies for GC8, the new PEPFAR outfit and new country health resourcing mechanisms.

Table 1.1: Rural vs Urban Community Perspectives on Integration (Across KP-TNC Countries)

Dimension	Urban PHC Settings	Rural PHC Settings	Implications for GC8, the new PEPFAR outfit and new country health resourcing mechanisms
Confidentiality	Moderate risk; some private rooms; better EMR security.	High risk; open-record systems; community ties; zero anonymity.	Require rural-tailored confidentiality reforms before rollout.
Provider Attitudes	More exposure to KP training; mixed but improving.	Strong moral judgement; less training; higher discrimination.	Mandatory workforce certification before integration in rural sites.
Safety & Policing	Lower visibility; less direct policing.	Higher policing; community surveillance; risk of exposure.	Integration unsafe unless legal and safety protocols are established.
Stigma Levels	Lower due to urban diversity.	Very high; tight-knit conservative communities.	Rural sites require extended transition periods + hybrid models.
Service Availability	Broader HIV, TB, SRHR services available.	Limited; stock-outs more common; fewer specialised services.	Need supply chain strengthening and essential package guarantees.
Facility Infrastructure	Better privacy, more rooms, better staffing.	Constrained infrastructure; crowded; poor privacy.	Facility upgrades required before integration designation.

Dimension	Urban PHC Settings	Rural PHC Settings	Implications for GC8, the new PEPFAR outfit and new country health resourcing mechanisms
Acceptance of Integration	Higher acceptance (70–90%) under hybrid models.	Low acceptance (40–60%) due to safety fears.	GC8, the new PEPFAR outfit and new country health resourcing mechanisms should phase integration and avoid rural rollouts without readiness.
Reliance on DICs	Moderate—DICs needed for psychosocial support.	Very high—DICs essential for safety and survival.	"No net loss" of DICs crucial in rural areas.
Preferred Integration Model	Hybrid or PHC-led (where facilities are prepared).	Hybrid or community-led; PHC-led rejected outright.	Rural integration must remain hybrid/community-led for GC8, the new PEPFAR outfit and new country health resourcing mechanisms.
Risk of Harm if Integration is Premature	Medium	Extremely High	Rural rollouts must follow readiness → certification → launch pathway.

3. Community Perspectives on Integration and Service Preferences

Across all COMPASS and KP-TNC countries, community perspectives on integration reflect a strong willingness to embrace a redesigned health system if and only if safety, confidentiality, dignity, and trust are guaranteed**.** Communities are not resisting integration as a concept; rather, they insist on an approach that centres lived experience, addresses fears rooted in discrimination and criminalisation, and strengthens (not dissolves) community-led safe spaces.

Across nine countries, the vast majority of KPs (ranging from 63% to 92% depending on the country) expressed conditional support for integration, with support strongest in urban areas where PHC facilities are better resourced, more culturally diverse, and more likely to have undergone training in KP-competent care. In contrast, rural PHC sites often deeply embedded in conservative social structures were described as significantly less safe, more discriminatory, and more prone to breaches of confidentiality. This rural-urban disparity was a core determinant of community attitudes toward integration.

A strong pattern emerges in all countries: the hybrid integration model was overwhelmingly preferred. Communities consistently articulated that PHC systems should handle routine biomedical care while specialised, sensitive, trauma-informed, gender-affirming, and crisis support services should remain anchored in community-led centres such as DICs. These safe spaces are more than service points, they are social, emotional, and protective infrastructures.

Communities emphasised the importance of preserving DICs, especially during transitional phases, to prevent forcing KPs into unsafe PHC environments prematurely. Respondents from Nigeria, Zambia, Tanzania, and Malawi were particularly clear that defunding or closing DICs would cause catastrophic disruption to service continuity. Many stressed that they would rather forego treatment altogether than attend PHC sites known for discrimination, profiling, or public exposure.

Integration preferences were deeply shaped by experiences of stigma, discrimination, policing, breaches of confidentiality, and fear of exposure**.** Transgender people, sex workers, people who use drugs, and gay/MSM communities described PHC as an environment that often mirrored societal hostility. In countries where criminalisation is enforced, PHC was described as "too close to danger," especially when police patrols are frequent or when health workers actively collaborate with law enforcement.

Despite these fears, communities expressed optimism that integration could work if GC8, the new PEPFAR outfit and new country health resourcing mechanisms policies enforced strong guardrails, protected safe spaces, mandated confidentiality reforms, strengthened PHC infrastructure, and funded peer-led navigation. They see integration not as a threat, but as a potential opportunity to expand access if implemented correctly.

Table 2.1: Country Perspectives on Integration (% Support, Preferred Model, GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications)

Data synthesised from KP-TNC and COMPASS multi-country qualitative findings and comparative thematic coding.

Country	% Positive Toward Integration (Conditional)	Preferred Integration Model	Key Community Insight	Implications for GC8, the new PEPFAR outfit and new country health resourcing mechanisms
Kenya	9%	Hybrid Model	Urban PHC partially safe; strong reliance on DICs for stigma-free SRHR & mental health services.	Strengthen PHC confidentiality; protect DICs during scale-up; expand peer navigation.
Tanzania	58%	Hybrid or Transitional Model	High fear of exposure in rural PHC; DICs critical for harm reduction & crisis support.	Integration must proceed gradually; PHC certification essential before service shifts.
Malawi	32%	Hybrid Model	PHC stigma remains high; CLM already improving facility responsiveness.	Fund CLM-linked PHC reforms; invest in staff competency certification.
Zambia	22%	Hybrid Model	PHC partially trusted in urban areas; strong preference for community-led	Require infrastructure upgrades; integrate

Country	% Positive Toward Integration (Conditional)	Preferred Integration Model	Key Community Insight	Implications for GC8, the new PEPFAR outfit and new country health resourcing mechanisms
			mental health support.	psychosocial services into PHC.
Zimbabwe	15%	Hybrid + Co-location Model	Co-location successes show PHC uptake increases when delivered in DICs.	Scale co-location; maintain community leadership in PHC integration.
Nigeria	21%	Community-Led or Hybrid	PHC perceived unsafe for criminalised groups; extreme fear of exposure.	Prioritise data confidentiality reforms; protect safe spaces from integration pressure.
Ghana	48%	Hybrid	PHC improving in urban areas but still discriminatory in regions.	Fund stigma reduction; harmonise PHC–community referral pathways.

Interpreting Community Perspectives

The cross-country data reveal a clear and consistent message: communities support integration, but only under the right conditions**.** The overwhelming preference for hybrid models signals that PHC systems are not yet prepared; structurally, legally, or culturally to assume full responsibility for KP-sensitive services. DICs and community-led safe spaces remain essential pillars of continuity, trust, and emotional safety.
Patterns across countries show that:

- Integration acceptance grows when PHC demonstrates readiness.
- Support collapses when confidentiality, safety, and stigma issues remain unaddressed.
- Urban facilities tend to be more prepared than rural ones.
- Criminalisation deeply undermines trust in PHC systems.
- Co-location models significantly improve uptake where tried.
- Communities want integration with them, not to them.

For GC8, the new PEPFAR outfit and new country health resourcing mechanisms, this means integration must not be rushed. It must be sequenced, rights-based, safety-driven, and co-governed with communities. PHC sites should only be designated as “integrated” once they have met readiness and certification criteria that reflect KP realities. This integration is possible but only if it protects, not endangers.

3. Essential Service Package Expectations for Integrated PHC

Communities across KP-TNC and COMPASS countries emphasize that integration cannot be defined merely as the co-location of HIV services within PHC, nor can it be understood as a simple merging of vertical programs into general health systems. True integration requires PHC to deliver an expanded, rights-sensitive, and people-centered package of services that reflects the realities, risks, and lived experiences of key and criminalised populations. Communities insist that integration must bring comprehensiveness, but also safety, confidentiality, continuity, and dignity elements too often missing in PHC environments.

An essential package for integrated PHC must therefore include not just biomedical services but also psychosocial, structural, legal, and human rights components that address the specific vulnerabilities of KPs. For example, while PHC facilities may already offer HIV testing or ART refills, communities highlight that these alone are insufficient. Without stigma-free consultations, private rooms, mental health support, gender-affirming care, and trauma-informed counselling, clients will continue avoiding PHC regardless of service availability.

A central theme that emerges from KP-TNC and COMPASS evidence is the importance of functional integration where services are linked, navigable, and seamless rather than physical integration, which simply consolidates services at a single location. Communities are willing to use PHC when it guarantees respectful, non-judgmental care; ensures safety and confidentiality; and maintains referral linkages to specialised or community-led services. They stress that PHC must be strengthened to provide not only general health services but also KP-sensitive care that meets the complexities of their needs.
Communities also define integration as an opportunity to expand access to underprovided services. Many PHC systems lack gender-affirming services, mental health counselling, harm reduction interventions, crisis response mechanisms, and legal referral pathways; all essential components of the HIV prevention and care continuum for KPs. Integration must fill these gaps rather than dilute or replace specialised services provided by community-led systems.

The essential service package should therefore be multidimensional, linking biomedical, psychosocial, structural, and legal services in a coherent manner. It must ensure that every client accessing PHC receives comprehensive, continuous, person-centred care without fear of exposure, stigma, or harm. For communities, these expectations are not aspirational they are baseline conditions required before PHC facilities can be considered “integration ready.”

Table 3.1: Essential Service Package for HIV–PHC Integration (Community-Defined)

Category	Essential Service Component	Description / Requirements	Rationale for KPs	GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications
Biomedical Services	HIV Testing Services	Provider-initiated and client-initiated testing;	Entry point to care; reduces late diagnosis.	Must ensure confidential triage & private testing rooms.

Category	Essential Service Component	Description / Requirements	Rationale for KPs	GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications
		confidential processes.		
	PrEP & PEP	Initiation, continuation, counselling, and side-effect monitoring.	Core HIV prevention tools.	Fund PHC systems to support initiation + navigation from DICs.
	ART Initiation & Refills	Continuity of ART, differentiated delivery, long-acting injectables readiness.	Prevents treatment interruptions.	Requires supply chain reliability for KP commodities.
	STI Screening & Treatment	Syndromic management + access to drugs often absent in PHC.	High STI burden among KPs.	Must include KP-specific STI medication quantification.
	TB Screening	Symptom screening, sputum referral, linkage to TB treatment.	Prevents missed TB diagnoses.	Integration requires functional TB-HIV-PHC linkage pathways.
	Malaria Testing & Treatment	Particularly needed in high-burden areas.	Common co-infection context.	Integrate malaria services in mobile PHC outreach.
	SRHR Care	Family planning, cervical cancer screening, condoms, lubricants.	KPs face barriers to SRHR access.	Integrate SRHR norms into PHC readiness assessments.
Gender-Affirming & KP-Sensitive Services	Gender-Affirming Services	Hormone therapy referral, safe counselling, STI screening tailored to trans persons.	Trans people avoid PHC due to mistreatment.	Mandatory trans-competency training for PHC staff.

Category	Essential Service Component	Description / Requirements	Rationale for KPs	GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications
	MSM-Competent Services	Lubricants, MSM-tailored STI packages, non-judgmental care.	Prevents stigma blocking care.	Protect KP commodities in PHC supply chains.
	SW-Competent Services	Violence screening, safer-work counseling, condoms, harm reduction.	Sex workers face police harassment in PHC settings.	PHC must separate services from law enforcement units.
Mental Health & Psychosocial Support	Trauma-Informed Care	Training and counselling services for trauma, violence, stigma.	Trauma causes poor retention.	Require PHC trauma competence before certification.
	Mental Health Counselling	Depression, anxiety, substance-use support.	High mental health burden.	Integration must include funded psychosocial positions.
	Crisis Response	Emergency support for violence, evictions, arrest situations.	KPs regularly face crises.	Link PHC with community safe houses & legal networks.
Harm Reduction Services	Needle/Syringe Programs	Where legal frameworks permit.	Essential for PWUD.	Protect harm reduction funding within PHC expansion.
	Overdose Prevention	Naloxone access & training.	Addresses rising overdose risk.	Include in PHC essential medicines lists.
	Safer Consumption Information	Delivered through PHC + DIC referral network.	Prevents harm.	Fund joint PHC–community harm reduction models.

Category	Essential Service Component	Description / Requirements	Rationale for KPs	GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications
Legal, Safety & Rights-Based Supports	GBV Screening & Referral	Confidential, safe, trauma-informed.	High exposure to GBV.	Integrate GBV desks into PHC accreditation.
	Legal Referral	Linkage to legal aid & paralegals.	Criminalisation prevents PHC access.	Fund paralegal partnerships with PHC sites.
	Non-Discrimination & Confidentiality Guarantees	Zero tolerance for breach; role-based access; privacy standards.	Safety prerequisite.	Must be required for PHC certification.
Structural & System Supports	Peer Navigation	Accompaniment into PHC; follow-up; retention.	Key determinant of trust.	Core funded component under GC8, the new PEPFAR outfit and new country health resourcing mechanisms.
	Secure Data Systems	Dual confidentiality, anonymisation.	Prevents exposure.	PHC must adopt data safeguards before integration.
	Community Governance & CLM	TWG participation; integrated CLM systems.	Ensures accountability.	Required for readiness assessments.
	Private & Safe Infrastructure	Private rooms, confidential triage, stigma-free waiting areas.	Protects identity & safety.	Mandatory for integration rollout.

4. Community Roles in Strengthening People-Centred Integrated Care

Communities are indispensable actors in the successful integration of HIV services into primary healthcare (PHC). Across KP-TNC and COMPASS countries, community-led systems have become trusted, accessible and culturally competent platforms that routinely bridge the gap between PHC aspirations and the lived realities of the populations most affected by stigma, criminalisation and exclusion. Integration cannot succeed without their leadership, because the determinants of safety, dignity and continuity of care lie primarily

outside clinical infrastructure and within social and structural environments that communities understand best.

Community organisations, especially KP-led groups, serve as first points of access, providing safe, stigma-free entry to services for people who would otherwise avoid PHC. They build trust, orient clients to the health system, and offer psychosocial support that PHC systems rarely provide. Peer navigators accompany clients through the integrated system helping them understand referral processes, providing emotional reinforcement, ensuring privacy during facility visits, and guiding individuals through complex care pathways. This support reduces drop-offs during integration transitions and assures continuity of treatment, particularly among populations with high levels of fear or past negative experiences with PHC.

Another foundational role is community-led monitoring (CLM). CLM provides a real-time accountability mechanism that identifies structural bottlenecks PHC systems often fail to detect, such as breaches of confidentiality, stock-outs of KP-specific commodities, long waiting times, discriminatory behaviour, and gaps in trauma-informed care. CLM evidence has driven concrete improvements: reorganised service flow in urban clinics, improved triage systems, dedicated consultation rooms, and more responsible commodity management. When PHC sites respond to CLM findings, trust increases, uptake improves, and retention strengthens making CLM an essential component of integration readiness assessments.

Communities also serve as co-trainers and capacity builders for PHC workers. KP-led organisations across Kenya, Malawi, Tanzania, and Nigeria regularly facilitate training on non-discrimination, confidentiality, trauma-informed counselling, harm-reduction principles, and gender-affirming care. These programs build provider competence, reduce stigma, shift attitudes, and support the broader transformation of facility culture. Training delivered by communities is often more impactful than formal health-system training alone, because it brings lived experience directly into capacity building and resets provider assumptions.

Communities play a central role in service design, governance and decision-making. Their participation in technical working groups (TWGs), planning committees, reprogramming forums, district health boards and budgeting platforms ensures that integration is grounded in evidence, community realities, and lived experience. When communities co-govern integration, not merely participate symbolically, they ensure that service packages, facility readiness standards, and data systems are appropriate, safe and acceptable.

Additionally, communities deliver expanded, holistic health support beyond what PHC typically offers. This includes mental health counselling, psychosocial support, crisis intervention, legal assistance, navigation through police harassment, gender-affirming services, and social protection linkages. These elements are crucial for HIV retention but largely missing in PHC systems. Integration that ignores these community-delivered supports risks collapsing entire care pathways.

Communities are also early warning systems, detecting emerging risks long before they appear in national data such as sudden police crackdowns, harmful facility practices, rising levels of stigma, or dangerous stock-outs. Their proximity to lived realities allows them to anticipate and prevent harms that PHC systems often fail to identify.

In all these ways, communities do not simply support integration; they make integration possible. Their roles are structural, not peripheral, and must be recognised, funded and

institutionalised under GC8, the new PEPFAR outfit and new country health resourcing mechanisms for integration to become truly people-centred, equitable and effective.

Table 4.1: Community Roles in Strengthening People-Centred Integrated Care

Community Function	**Description of Role**	**Integration Contribution / Outcomes**	**GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications**
Safe Entry Points	DICs and community sites provide accessible, stigma-free environments.	Increased uptake, trust-building, continuity of care.	Must be preserved ("No Net Loss") within hybrid integration models.
Peer Navigation	Peers accompany clients into PHC, assist with referrals, privacy and follow-up.	Reduced defaulting, improved linkage and retention.	Fund peer navigation as a core integration cost, not optional support.
Community-Led Monitoring (CLM)	Real-time evidence collection on quality, safety, stigma and supply chains.	Facility improvements, stigma reduction, improved confidentiality and efficiency.	Make CLM a mandatory requirement tied to facility certification.
Co-Training of PHC Providers	KP-led training on confidentiality, stigma-free care, trauma-informed practice, gender identity.	Transformative change in provider attitudes and culture.	GC8, the new PEPFAR outfit and new country health resourcing mechanisms should embed community-delivered training in national integration plans.
Governance & Decision-Making	Participation in TWGs, district health boards, integration committees, budget spaces.	Co-governed integration ensures safety, relevance and acceptability.	Require funded, non-tokenistic community seats in integration governance.
Psychosocial & Holistic Support	Mental health care, legal referral, crisis response, gender-affirming services.	Enhances ART adherence, reduces mental distress, stabilises care pathways.	Fund community-based psychosocial support as part of essential PHC packages.
Service Design & Package Definition	Communities define acceptable, safe essential service packages.	Ensures services match lived needs and realities.	Community-led definition of service packages should guide GC8, the new PEPFAR outfit and new country health

Community Function	Description of Role	Integration Contribution / Outcomes	GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications
			resourcing mechanisms grant-making.
Accountability & Redress	Communities identify abuses and unsafe practices; advocate for remedies.	Improved client safety, reduced violations, better retention.	Integrate community redress mechanisms into PHC accreditation standards.
Early Warning & Risk Detection	Communities detect policing risks, stigma trends and vulnerabilities early.	Prevents harm, protects clients, ensures continuity.	Fund early-warning community systems under GC8, the new PEPFAR outfit and new country health resourcing mechanisms resilience measures.
Continuity & Follow-Up	Case management, adherence support, crisis follow-up beyond PHC capacity.	Prevents loss to follow-up and maintains long-term retention.	Include case management in integration budgets and staffing norms.

5. Integration Risks Without Safeguards

While integration offers immense promise, communities emphasise that integration undertaken without safeguards poses serious risks that could reverse progress in HIV prevention and treatment. A recurring theme across all KP-TNC and COMPASS countries is that PHC spaces, as they exist today, are often characterised by judgement, stigma and mistrust. Many respondents described experiences where PHC providers openly questioned their identities or behaviours, refused services, or discussed confidential information in public spaces. Such experiences create a pervasive fear of PHC facilities, and without deliberate reforms, integration could amplify rather than alleviate existing inequities.

Confidentiality breaches emerge as the most serious and widespread risk. In settings where homosexuality, sex work or drug use are criminalised, disclosure whether accidental or intentional, can lead to violence, arrest, extortion, eviction or social rejection. Communities fear that integration into PHC systems with weak data protection practices will expose them to these harms. For example, PHC registers that list client names and services accessed can be easily viewed by others, and electronic systems lacking role-based access controls risk revealing sensitive information.

Another serious risk is the potential loss of community-led safe spaces. In some countries, policymakers have suggested that DICs and peer-led facilities should be phased out as integration progresses. Communities strongly reject this notion, arguing that safe spaces are indispensable for trust-building, mental health support, crisis response and navigation. Without them, many individuals would have no safe entry point into PHC systems. Integration also risks diluting specialised KP services if peer navigators or specialised case managers are replaced by general PHC staff who lack the competencies needed to serve criminalised populations.

Finally, communities warn that integration without safeguards could inadvertently increase policing and surveillance. In settings where law enforcement is present near PHC facilities, individuals fear being identified or followed. This is especially dangerous in countries with punitive legal environments. Without explicit measures to protect safety, confidentiality and anonymity, integration risks producing a more hostile environment than the fragmented system it seeks to replace.

Table 5: Integration Risks Without Safeguards

Risk Category	**Description of the Risk**	**Underlying Drivers**	**Potential Consequences for KPs**	**Implications for GC8, the new PEPFAR outfit and new country health resourcing mechanisms**
Confidentiality Breaches	Personal information disclosed verbally, through open registers, or insecure EMR systems.	Lack of private rooms, poor record-handling, shared logbooks, unprotected EMRs.	Outing, arrest, blackmail, sexual/gender-based violence, loss of livelihood.	GC8, the new PEPFAR outfit and new country health resourcing mechanisms must require dual-confidentiality systems and role-based data access before integration rollout.
Provider Stigma & Discrimination	Moral judgement, refusal of services, profiling of clients.	Insufficient KP competency training, religious/moral bias, lack of accountability mechanisms.	Avoidance of PHC, delayed diagnosis, treatment interruption, mental distress.	Certification of PHC staff in KP-competent care before service absorption.
Loss of Safe Spaces (DIC Closure or Defunding)	Integration used to justify shifting all services to PHC, leading to closure of	Misinterpretation of "efficiency," budget rationalisation, weak community governance.	Loss of trusted entry points, decreased uptake, weaker crisis/mental health support.	GC8, the new PEPFAR outfit and new country health resourcing mechanisms must apply a **"No Net Loss" rule** for

Risk Category	Description of the Risk	Underlying Drivers	Potential Consequences for KPs	Implications for GC8, the new PEPFAR outfit and new country health resourcing mechanisms
	community-led centres.			KP-led services during integration.
Increased Exposure to Law Enforcement	Clients encounter police near health facilities or are profiled through PHC data.	Criminalisation of KPs, weak legal protections, PHC–police proximity.	Arrest, harassment, violence, extortion, forced outing.	Integration plans in criminalised settings must include explicit non-collaboration safeguards.
Erosion of KP-Specific Services	Specialized services (psychosocial care, harm reduction, gender-affirming care) not delivered in PHC.	PHC not prepared or mandated to provide KP-specific services.	Reduced service quality, unmet needs, worsened vulnerabilities.	KP-specific services must remain protected within hybrid models.
Stock-Outs of KP Commodities	Condom, lubricant, PrEP, STI drugs disappear within PHC supply chain.	Integrated procurement without KP prioritisation; weak quantification.	Reduced prevention, increased STI/HIV burden.	Supply-chain indicators must track KP commodity availability.
Lack of Structural Privacy	Overcrowded clinics, open waiting areas, lack of safe triage systems.	PHC infrastructure not designed for confidentiality.	Clients avoid care or experience humiliation.	PHC must meet privacy standards before serving KPs.
Weak Complaint & Redress Systems	Clients have no safe way to report stigma or abuse.	No anonymous reporting, fear of retaliation, no disciplinary follow-up.	Persistent abuse, institutional mistrust, reduced retention.	GC8, the new PEPFAR outfit and new country health resourcing mechanisms must enforce mandatory anonymous reporting + follow-up mechanisms.
Tokenistic Community Engagement	Communities are consulted but not empowered to	Weak CCM representation, lack of funded participation.	Integration design overlooks KP realities, increasing risks.	Community co-governance must be mandatory in integration decisions.

Risk Category	Description of the Risk	Underlying Drivers	Potential Consequences for KPs	Implications for GC8, the new PEPFAR outfit and new country health resourcing mechanisms
	shape decisions.			
Premature Integration Rollout	PHC sites begin serving KPs before readiness.	Political pressure, donor timelines, inadequate readiness checks.	Spike in confidentiality breaches, drop-offs in retention, increased harm.	GC8, the new PEPFAR outfit and new country health resourcing mechanisms must require **readiness → certification → launch** sequencing.

6. Human Rights, Safety and Legal Preconditions for Integration

For communities living under criminalisation or social hostility, the ability to access healthcare safely is inseparable from the legal, social and human rights environment in which services are delivered. Many respondents across KP-TNC and COMPASS countries described PHC spaces as extensions of broader societal prejudice, where provider attitudes mirror the discrimination communities experience in daily life. In these contexts, successful integration requires far more than reorganised service delivery workflows; it requires a fundamental transformation of the rights and safety landscape in which PHC is delivered.

First, PHC facilities must institutionalise strict confidentiality protocols, non-discrimination norms, informed consent processes and zero-tolerance disciplinary mechanisms for violations. Communities emphasise that confidentiality procedures cannot be optional or based on individual provider goodwill; they must be embedded in national guidelines and enforced through routine supervision, performance review systems and facility accreditation standards.

Second, safety must be guaranteed through structural improvements within PHC facilities, including private consultation rooms, patient-flow designs that minimise exposure, secure data systems and physical environments that protect anonymity. In many contexts, communities call for dual confidentiality systems; one general PHC record-keeping system and one protected system for KP-specific information to prevent accidental or intentional data breaches. Anonymous reporting mechanisms for stigma, abuse or discrimination are critical to enabling clients to seek redress without placing themselves at risk.

Third, integration must reflect the broader legal and policy environment. In countries where homosexuality, sex work or drug use are criminalised, integration must be implemented cautiously and deliberately. Communities insist that integration should not proceed unless PHC facilities and health authorities commit explicitly to non-discrimination, confidentiality, and non-collaboration with law enforcement in ways that place individuals at risk. Where punitive laws directly impede access, integration must be accompanied by sustained

advocacy for law reform, non-enforcement protections or harm-reduction policies that safeguard client rights.

Human rights and dignity are not ancillary to integration; they constitute its foundation. Without structural protections; legal, procedural and environmental, integration risks becoming a pathway to harm rather than a pathway to health.

Table 6.1: Human Rights, Safety and Legal Preconditions for HIV–PHC Integration

Precondition Category	Specific Requirement	Purpose and Rationale
Legal Environment	Explicit national commitments to non-discrimination; clear separation of PHC from law enforcement activities.	Prevents arrest, harassment or extortion during care-seeking.
Confidentiality Protocols	Mandatory privacy guidelines; dual confidentiality systems; role-based EMR access.	Protects clients from exposure, outing or criminalisation.
Facility Layout & Infrastructure	Private consultation rooms, confidential waiting areas, safe redress mechanisms.	Ensures anonymity and reduces stigma within PHC sites.
Rights-Based Workforce Norms	Training on KP rights, stigma-free care, trauma-informed counselling and gender-affirming practices.	Builds provider competencies and shifts discriminatory attitudes.
Redress & Enforcement Mechanisms	Anonymous reporting, disciplinary action pathways, independent oversight.	Ensures accountability when rights violations occur.
Harm Reduction & Protection Policies	GBV response, legal referral pathways, safety protocols for criminalised populations.	Supports safe access for high-risk or criminalised groups.

7. Integration Models for HIV–PHC

Communities across the region recognise that integration is not a singular event but a structural redesign of how countries deliver care. Because contexts vary widely from criminalisation and stigma, to relatively more progressive urban environments integration cannot be approached through a one-model-fits-all blueprint. The lived realities facing criminalised and stigmatised populations require flexible, adaptive models that allow different systems to work together while respecting the unique strengths and limitations of each. KP-TNC and COMPASS findings consistently demonstrate that integration is not simply a matter of moving services from one building to another; it is about designing systems that protect confidentiality, enable choice, preserve trust, and ensure continuity of care.

Among the models being implemented across Africa, the hybrid integration model stands out as the most effective and most widely supported by communities. In this model, PHC facilities take responsibility for delivering routine and clinical services such as HIV testing, basic STI screening, ART refills, TB and malaria screening, chronic disease management and SRH services. Meanwhile, DICs and community-led centres deliver the sensitive, specialised

and trust-dependent services such as PrEP initiation, STI treatment, psychosocial counselling, peer navigation, crisis response, legal referral, harm reduction and gender-affirming care. This model recognises that PHC alone cannot adequately meet the needs of populations that fear stigma, criminalisation or police surveillance. The hybrid model therefore balances the strength of PHC systems (wide coverage, infrastructure, medical personnel) with the irreplaceable trust and confidentiality offered by community-led systems.

In countries where PHC systems are more advanced and providers have undergone extensive KP-competency training, a PHC-led model can be effective. In this model, PHC facilities become the primary delivery point for most HIV and SRHR services, with community-led systems playing more supportive roles such as navigation, follow-up, CLM, or community mobilisation. However, KP-TNC and COMPASS data shows clearly that PHC-led models carry significant risks when not matched with strong confidentiality, legal protections, safe reporting mechanisms, trauma-informed care and stigma-free workforce norms. Without these conditions, PHC-led models may produce increased avoidance, emotional harm or even exposure to punitive systems.

The community-led integration model remains dominant in contexts where legal or social hostility make PHC unsafe including areas with criminalisation of homosexuality, sex work or drug use. In these settings, community-led organisations become the primary service providers for HIV prevention, testing, PrEP initiation, ART initiation, STI management, counselling and mental health care, while PHC facilities provide only highly specialised or technical services such as laboratory diagnostics, imaging, tuberculosis evaluation, obstetrics or chronic disease management. This model demonstrates remarkable outcomes in trust, linkage, adherence and retention, but relies on sufficient community funding and organisational capacity to sustain comprehensive services.

Finally, many countries are operating under a transitional integration model, an approach that recognises that PHC readiness is not instantaneous. In this model, DICs and community-led centres remain the primary access points during the transition period, while PHC facilities undergo capacity-building, stigma reduction training, infrastructure upgrades, data protection improvements and system redesign. Only once PHC sites can guarantee safety, confidentiality and non-discriminatory care do services begin to shift. Communities strongly favour this model in environments undergoing health reforms, because it prevents premature exposure to unsafe PHC systems and reduces the risk of losing the trust that has been built over decades.

Table 7.1: HIV–PHC Integration Models and Their Characteristics

Model	Description	Strengths	Limitations
Hybrid Model	PHC provides routine care; DICs deliver specialised, safe services.	Balances access and safety; community-preferred.	Requires dual financing and coordination.
PHC-Led Model	PHC delivers most services; community plays support role.	Supports UHC goals.	High risk if PHC is unsafe or unprepared.
Community-Led Model	Community delivers most care; PHC supports labs and chronic care.	High trust; ideal for criminalised settings.	Requires strong community capacity.

Model	Description	Strengths	Limitations
Transitional Model	Integration proceeds gradually as PHC readiness improves.	Prevents premature exposure.	Requires strong commitment and funding.

8. Integration Pathways

Integration does not occur through policy commitments alone; it becomes real through the practical mechanisms that connect community-led systems to PHC. These mechanisms or integration pathways, determine whether individuals experience care that is safe, confidential, welcoming and continuous, or whether they encounter stigma, fear and fragmentation. KP-TNC and COMPASS evidence demonstrates that these pathways matter as much as the model chosen; even the strongest model will fail without secure pathways that ensure smooth movement between systems.

The first and most fundamental pathway is the service referral pathway, a structured, bi-directional referral system that ensures clients can move between DICs and PHC without interruption, humiliation or loss to follow-up. Referrals are successful when they include written slips, shared registers, appointment coordination, case conferencing and post-visit follow-up. In Kenya, this pathway has significantly strengthened retention, as clients trust that peer navigators will accompany them through referral processes.

The co-location pathway brings PHC services directly into community spaces. This includes PHC clinicians providing HIV testing, TB screening, SRH services, mental health consultations or chronic disease management inside DICs or during DIC-led outreach events. This pathway is widely accepted by communities because it preserves the safety of trusted spaces while expanding service availability. Zimbabwe's experience demonstrates that co-location both reduces stigma and increases uptake.

The mobile outreach pathway is indispensable for rural and peri-urban settings or contexts where PHC facilities remain hostile or inaccessible. Integrated outreach teams composed of PHC providers and peer educators deliver HIV testing, TB screening, malaria testing, PrEP, ART refills and SRH services in community hotspots, fishing communities, border regions or remote villages. Tanzania's integrated outreach model has improved early diagnosis and bridged geographic and trust barriers that PHC alone cannot overcome.

The workforce pathway reflects the reality that integration cannot succeed without transforming PHC provider attitudes and skills. Workforce pathways include co-training, mentorship, stigma-reduction programmes, trauma-informed counselling, harm-reduction competencies, gender-affirming care skills and the establishment of dedicated KP focal persons within PHC facilities. These pathways are crucial for shifting facility culture from judgmental to welcoming. PHC systems that invest in KP-competent workforce transformation show measurable improvements in service quality and confidentiality.

Finally, the data and confidentiality pathway is perhaps the most critical. Communities repeatedly identify secure data systems as the foundation of safe integration. Confidentiality

pathways include dual record systems, role-based access controls, secure EMRs, anonymised reporting platforms, confidential triage systems, and mechanisms that prevent law enforcement from accessing medical information. Without secure data pathways, integration exposes individuals to risk of arrest, discrimination, blackmail or violence. The case in some of the studied countries illustrates that unless data safety is guaranteed, clients will avoid PHC regardless of service availability.

Together, these pathways define the operational infrastructure of integration. They determine whether integration advances dignity and equity, or whether it replicates and intensifies existing harms.

Table 8.1: Core Integration Pathways Linking Community Systems to PHC

Pathway	Definition	Purpose	Example
Referral Pathway	Structured bi-directional referral between DICs and PHC.	Ensures continuity of care.	Kenya improves retention through referral slips and case reviews.
Co-Location Pathway	PHC services delivered inside DICs or community spaces.	Reduces fear and stigma.	Zimbabwe shows uptake increases when PHC staff operate in DICs.
Mobile Outreach Pathway	Integrated PHC + peer outreach teams delivering services in hotspots or rural areas.	Reaches underserved and high-stigma areas.	Tanzania's integrated HIV–TB–malaria outreach improves early diagnosis.
Workforce Pathway	PHC training, mentorship and certification in KP competencies.	Builds stigma-free and rights-based care.	Malawi reduces breaches through CLM-led provider training.
Data & Confidentiality Pathway	Secure systems, dual confidentiality, anonymous reporting and role-based access.	Prevents harm from disclosure, outing or criminalisation.	Nigeria demonstrates the necessity of data safety for integration trust.

9. KVP HIV–PHC Integration Indicators

Monitoring the integration of HIV services into PHC requires precise, rights-sensitive indicators that capture not only whether services exist, but whether they are delivered safely, confidentially and with dignity. For key and criminalised populations, integration success is measured by whether PHC becomes more trustworthy, more protective and more effective over time. Integrating timelines into the indicator framework allows countries to track progress in a phased and predictable manner, preventing premature scaling of unsafe PHC sites and creating accountability for readiness milestones.

KP-TNC and COMPASS findings show that integration must unfold through time-bound benchmarks rather than open-ended intentions. Communities emphasise that PHC facilities should not be classified as "integrated" until they have completed workforce certification,

met minimum confidentiality and infrastructure standards, and demonstrated measurable improvements in safety, stigma reduction and continuity of care.

A KVP-Competent Facility Certification Timeline therefore becomes an essential component of GC8, the new PEPFAR outfit and new country health resourcing mechanisms integration. Certification ensures that PHC facilities undergo structured preparation including KP-competency training, trauma-informed care, confidentiality system upgrades, infrastructure improvements and adherence to rights-based service norms before they begin serving KPs at scale. Facilities progress through three stages over time: Readiness, Certification, and Performance Maintenance. Each phase is assessed with indicators, and integration is scaled only when certification milestones are achieved.

The timeline reinforces that integration is *sequenced*, not instantaneous. It also prevents the premature defunding or closure of DICs until PHC facilities demonstrate genuine readiness. Time-bound indicators ensure accountability at facility, district and national levels.

Below is the expanded indicator table now incorporating timelines, certification, performance thresholds and KP-centered accountability requirements.

Table 9.1 HIV–PHC Integration Indicators for Key Populations

Indicator Domain	**Specific Indicator**	**Definition / Explanation**	**Timeline / Certification Benchmark**	**Purpose for GC8, the new PEPFAR outfit and new country health resourcing mechanisms**
Service Uptake & Coverage	Proportion of KPs accessing HIV testing, PrEP, ART refills, STI treatment at PHC	Measures whether PHC is becoming a trusted access point for KPs.	Increase by 20–40% within 12–24 months **after facility certification**.	Tracks true integration uptake rather than availability.
Linkage & Continuity	Percentage of KPs completing referral from DICs to PHC	Measures efficiency and safety of referral pathways.	80% referral completion within 6–12 months of certification.	Ensures continuity and reduces loss to follow-up.
Retention & Adherence	Retention at 3, 6, 12 months for KPs receiving ART/PrEP in PHC	Measures sustainability of integrated care.	Retention ≥80% within 12 months of integration rollout.	Detects risks of attrition in unsafe PHC settings.
Safety & Confidentiality	Number and type of confidentiality breaches in PHC	Tracks verbal disclosure, improper record handling or exposure.	**Zero breaches** tolerated for certification. Monitoring quarterly.	Determines PHC readiness and protects criminalised clients.

Indicator Domain	Specific Indicator	Definition / Explanation	Timeline / Certification Benchmark	Purpose for GC8, the new PEPFAR outfit and new country health resourcing mechanisms
Rights Protection & Non-Discrimination	Stigma/discrimination incidents in PHC facilities	Captures denial of service, profiling, verbal abuse, moral judgement.	Incidents must reduce by **50% within 12 months** post-certification.	Identifies unsafe sites needing corrective action.
Structural Readiness	Availability of private rooms, confidential triage, EMR access controls	Measures physical and systems readiness for KP integration.	Must meet **100% of structural standards** before certification.	Ensures infrastructure safety *before* integration occurs.
Workforce Competency	% of PHC staff trained and **certified** in KP-competent, trauma-informed care	Certification includes exams, simulation, periodic review.	**90% certification** required before integration launch. Re-certification every 18–24 months.	Ensures cultural and skill transformation in PHC.
KP-Centred Facility Certification Status	Facility readiness validated through community & PHC joint audit	Evaluates facility safety, confidentiality, stigma-free norms.	Certification awarded for **24 months**, then renewed.	Prevents unsafe facilities from prematurely integrating.
Supply Chain Reliability	Availability of PrEP, lubricants, STI meds, HIVST kits, condoms and PEP	Availability of KP commodities in PHC facilities.	Stock-out rate <5% within 6–12 months of integration.	Prevents erosion of KP-specific supplies under PHC.
Community Engagement & Governance	Frequency and quality of KP participation in PHC TWGs and integration task teams	Measures co-governance rather than consultation.	Monthly or quarterly participation required; recorded in minutes.	Ensures meaningful community leadership in integration.
CLM Integration & Responsiveness	PHC facilities with formal CLM response plans and documented improvements	Reflects PHC accountability to community evidence.	100% of certified sites must respond to CLM findings within 60 days.	Drives continuous PHC quality improvement.

Indicator Domain	Specific Indicator	Definition / Explanation	Timeline / Certification Benchmark	Purpose for GC8, the new PEPFAR outfit and new country health resourcing mechanisms
Client Experience & Satisfaction	KP reports of respectful, safe, confidential PHC services	Measures trust, dignity and acceptability.	Satisfaction baseline followed by **20% improvement** in 12 months.	Human-centered assessment of integration quality.
Legal & Safety Environment	Number of safety incidents linked to policing or criminalisation	Measures external harms faced during care seeking.	Safety incidents must be monitored quarterly and reduce over 12 months.	Ensures integration does not increase exposure to harm.
Integration Progress Timeline	Readiness → Certification → Integration Launch → 12-Month Review	Tracks implementation sequence.	Full cycle per facility: 12–24 months.	Ensures that integration is phased, not rushed.

Narrative Explanation of the Timelines and Certification Framework

The inclusion of explicit timelines within the indicator framework ensures that integration unfolds in a controlled, safe and evidence-driven sequence. Facilities move through a readiness phase during which they upgrade infrastructure, undergo workforce training, strengthen confidentiality systems and establish community governance mechanisms. Only after achieving the defined readiness benchmarks can a facility be certified to serve KPs under an integrated model.

The certification phase serves as a safeguard against premature implementation. Facilities must demonstrate that they have met structural standards (such as private consultation rooms), achieved zero confidentiality breaches, and reached at least 90% workforce KP-competency certification. Certification is not a one-time milestone; it lasts 18–24 months and requires renewal to ensure continuous compliance.

Once certified, facilities move into Integration Launch, during which service uptake, safety and retention indicators are tracked at 3, 6 and 12 months. Sites fail certification renewal if they violate confidentiality, record high stigma incidents, or demonstrate declining retention and satisfaction.

Annual integration reviews allow countries and PRs to distinguish between high-performing facilities that can be scaled and sites requiring remediation.

This sequenced, time-bound approach aligns GC8, the new PEPFAR outfit and new country health resourcing mechanisms with the core principle that integration must proceed at the pace of readiness not the pace of budget cycles. It prevents the defunding of community-led

safe spaces before PHC is genuinely prepared and ensures that integration strengthens rather than endangers KP health outcomes.

10. Country Examples, Gaps, Outcomes and GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications

The KP-TNC and COMPASS multi-country analysis shows that while integration pressures are rising across Africa, countries remain deeply unequal in their readiness, infrastructure, and socio-legal conditions for integration. Each country presents a different starting point, influenced by the legal environment, stigma levels, maturity of community systems, robustness of PHC facilities, and the historic strength of HIV vertical investments. The examples below illustrate these differences and highlight where integration can succeed, where it must be phased, and where it risks causing harm without strong safeguards.

Kenya

Kenya demonstrates meaningful progress toward integration, especially in major urban centres where PHC facilities are increasingly engaging with communities and investing in stigma-reduction training. Community-led organisations in Nairobi, Mombasa, and Kisumu have built strong networks peer navigators, DICs, and CLM systems that complement PHC efforts and create a solid foundation for hybrid models. While challenges persist in rural settings where confidentiality and stigma are still concerns, communities are optimistic about Kenya's direction. They emphasise that continuing to reinforce PHC–community collaboration, strengthening provider competencies, and improving privacy infrastructure will make integration safer and more effective nationwide. **For GC8, the new PEPFAR outfit and new country health resourcing mechanisms, Kenya is well-positioned to scale hybrid models and deepen community-PHC partnerships.**

Tanzania

Tanzania is making steady progress in urban areas where PHC engagement with communities has increased, and more providers have begun receiving KP-competency training. These developments show clear commitment to improving the safety and quality of integrated services. At the same time, rural communities express concerns about confidentiality, stigma, and fear of policing, which make PHC access challenging. Stakeholders acknowledge these realities and see them as opportunities for targeted strengthening rather than barriers. **Under GC8, the new PEPFAR outfit and new country health resourcing mechanisms, Tanzania can further consolidate gains by investing in PHC privacy upgrades, safety protocols, and sequenced integration that reflects the differences between rural and urban contexts.**

Malawi

Malawi has demonstrated impressive leadership in community-led monitoring (CLM), which has helped PHC facilities identify gaps and implement meaningful improvements in areas such as patient flow and provider responsiveness. Urban sites are becoming more responsive as CLM insights inform action plans and follow-up. Rural facilities, however, still face challenges related to stigma, limited privacy, and resource constraints all acknowledged areas where further support can make integration safer. Communities strongly appreciate Malawi's openness to CLM feedback and see this as a major strength for future integration. **GC8, the new PEPFAR outfit and new country health resourcing mechanisms can build on this momentum by scaling CLM-driven reforms and reinforcing hybrid models that protect community-led services alongside PHC expansion.**

Zambia

Zambia continues to strengthen its community-led systems, which play a critical role in supporting integration and extending reach to populations with limited access to traditional PHC. Communities recognise these efforts and describe growing collaboration between PHC facilities and KP-led organisations. At the same time, they highlight areas where PHC facilities could benefit from additional support particularly in trauma-informed counselling, gender-affirming services, mental health care, and confidentiality systems. These gaps present opportunities for Zambia to further enhance PHC readiness. **GC8, the new PEPFAR outfit and new country health resourcing mechanisms presents a platform for Zambia to deepen community–PHC collaboration, expand stigma-free service provision, and strengthen integrated psychosocial and legal support systems.**

Zimbabwe

Zimbabwe is widely recognised for pioneering **co-location models**, where PHC services are partially delivered within community-led spaces. These models have shown excellent results: increased uptake, reduced stigma, and stronger continuity of care. Communities appreciate that co-location allows clients to benefit from both PHC services and community-led psychosocial support without fear of discrimination. Some PHC facilities outside major cities still face challenges around privacy and stigma, but these are understood as areas for partnership-based strengthening rather than obstacles. **GC8, the new PEPFAR outfit and new country health resourcing mechanisms offers Zimbabwe an opportunity to scale its successful co-location model nationally and to support knowledge-sharing across the region.**

Nigeria

Nigeria has strong and resilient community-led systems that continue to provide essential services in complex legal and social environments. Communities and civil society acknowledge the efforts of PHC providers who strive to deliver respectful care despite the pressures created by criminalisation and policing. However, fear of exposure, confidentiality breaches, and safety concerns remain significant barriers that require careful, collaborative solutions. These concerns are not framed as criticism but reflect genuine lived realities that integration must take into account. **For GC8, the new PEPFAR outfit and new country health resourcing mechanisms, Nigeria has the opportunity to advance integration through strengthened confidentiality protocols, enhanced facility safety structures, and protected community-led safe spaces.**

Ghana

Ghana has made notable progress in urban PHC facilities, with increasing engagement of civil society in training, advocacy, and service optimisation. Communities describe these urban improvements positively, noting better provider attitudes and more privacy-conscious triage systems. Rural facilities still face challenges related to social surveillance, stigma, and limited infrastructure, which communities identify as opportunities for targeted investment rather than weaknesses. **GC8, the new PEPFAR outfit and new country health resourcing mechanisms can support Ghana in scaling stigma-reduction initiatives, enhancing PHC–community referral pathways, and strengthening hybrid models that respond to regional differences.**

Botswana

Botswana continues to demonstrate strong commitment to health system strengthening, particularly in urban areas where PHC facilities are better resourced and have benefited from multiple rounds of training and mentorship. Communities in these areas describe care as increasingly respectful and safe. Rural districts continue to evolve, with ongoing initiatives to improve provider competencies and reduce structural stigma. Communities encourage continued investment in rural PHC readiness to ensure that integration benefits all. **GC8, the new PEPFAR outfit and new country health resourcing mechanisms provides Botswana with a platform to formalise readiness certification and advance integration district by district in a safe, structured manner.**

Uganda

Uganda has highly engaged community networks that work tirelessly to support safe access to services within a challenging legal environment. Community-led organisations provide essential psychosocial support, legal orientation, and safe referral pathways that PHC systems depend on. Communities acknowledge the efforts of individual PHC providers who strive to offer respectful care but also emphasise that broader structural challenges; particularly confidentiality risks and the legal environment must be addressed collaboratively. These are seen as shared challenges requiring collective action, not blame. **GC8, the new PEPFAR outfit and new country health resourcing mechanisms creates space for Uganda to enhance legal safety, strengthen non-collaboration protocols, and expand hybrid models that protect both clients and providers.**

Summary Across All Countries

Across the region, countries are making steady progress in strengthening PHC systems and expanding collaboration with community-led organisations. While each country faces unique contextual challenges, communities across all settings express willingness to support integration when it is implemented thoughtfully, respects safety concerns, and preserves community-led safe spaces. The diversity in readiness urban vs rural, low stigma vs high stigma, supportive legal frameworks vs criminalised environments reflects opportunities for GC8, the new PEPFAR outfit and new country health resourcing mechanisms to deploy tailored, context-responsive strategies rather than a uniform approach. What communities seek is partnership, not perfection shared responsibility, not blame. With the right investments and safeguards, integration can advance health equity across all these settings.

10.1 Integration Status, Gaps, Outcomes & GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications

Country	Integration Status (Revised, Diplomatic Language)	Key Gaps	Outcomes / Community Experience	GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications
Kenya	Steady progress in urban integration foundations; continued strengthening underway in rural areas.	Stigma, rural confidentiality gaps	Uptake rising in hybrid models	Invest in certification + preserve DICs

Country	Integration Status (Revised, Diplomatic Language)	Key Gaps	Outcomes / Community Experience	GC8, the new PEPFAR outfit and new country health resourcing mechanisms Implications
Tanzania	Integration foundations emerging in urban centres; opportunities for enhancement in rural settings.	Rural hostility; policing	PHC avoided in rural settings	Use sequenced model + infrastructure upgrades
Malawi	Strong momentum through CLM-driven improvements; rural integration readiness evolving.	High rural stigma; privacy gaps	Improved flow; trust rising	Fund CLM-driven reforms + hybrid integration
Zambia	Growing community-led infrastructure supporting integration; PHC capacity strengthening in progress.	Weak psychosocial services; stigma	Reliance on DICs	Strengthen PHC culture + legal protection
Zimbabwe	Notable success with co-location models offering promising pathways for broader integration.	PHC stigma outside cities	Uptake increases in DIC-linked PHC	Scale co-location nationally
Nigeria	Community systems strong; integration feasibility improving with focus on safety and confidentiality.	Criminalisation; unsafe PHC	Extreme fear of PHC	Prioritise safe spaces + legal protection
Ghana	Solid groundwork in urban integration; continued opportunities for improvement in rural PHC.	Rural discrimination	Community reliance on DICs	Focus on stigma reduction + hybrid rollout
Botswana	High readiness in many districts, with rural areas steadily engaging in PHC strengthening.	Rural stigma	Growing acceptance	Certify PHC sites before expansion
Uganda	Strong community engagement underway; integration feasibility increases with enhanced safety safeguards.	Criminalisation; policing	PHC dangerous for KPs	Strict safety frameworks + hybrid only

11. How the GC8, the new PEPFAR outfit and new country health resourcing mechanisms Can Strengthen Community Engagement & Inclusive Decision-Making

GC8, the new PEPFAR outfit and new country health resourcing mechanisms presents a unique opportunity for embedding community leadership into the architecture of integration. Communities across all countries emphasize that meaningful participation is not about invitations to consultative meetings; it involves real power, shared governance, and structured accountability. Successful integration hinges on communities having authority to shape service packages, define readiness criteria, evaluate PHC facilities, and hold implementers accountable for safety and quality.
The Global Fund, new PEPFAR outfits and new country health resourcing mechanisms should adopt a co-governance approach, ensuring that communities participate as equal partners in integration steering committees at national and sub-national levels. This includes representation in CCM integration subcommittees, PHC technical working groups, district health boards, budget formulation platforms, reprogramming sessions, and M&E frameworks. Community engagement must be funded not tokenistic and embedded as a structural requirement in GC8, the new PEPFAR outfit and new country health resourcing mechanisms grant-making.

The Global Fund must also strengthen community-led monitoring (CLM) as a mandatory component of integration. CLM provides the most sensitive indicator of whether PHC facilities are safe, respectful, and confidential. GC8, the new PEPFAR outfit and new country health resourcing mechanisms should mandate that all PHC facilities serving KPs have CLM-linked improvement plans, with enforceable timelines and documented accountability actions. Integration cannot be declared "complete" until CLM demonstrates real improvements in dignity, confidentiality, and service acceptability.

Furthermore, the Global Fund, the new PEPFAR outfit and new country health resourcing mechanisms should require the institutionalisation of community-defined essential service packages**,** ensuring that the integrated PHC system incorporates mental health, trauma-informed care, gender-affirming services, legal referral, crisis response, and harm reduction. These services must not be considered secondary. They are central to ensuring that PHC is genuinely people-centred.

Finally, GC8, the new PEPFAR outfit and new country health resourcing mechanisms should support community system strengthening**,** ensuring that DICs and KP-led centres receive sustainable funding. Integration must not weaken the systems that currently guarantee safety and trust. Instead, the Global Fund, the new PEPFAR outfit and new country health resourcing mechanisms should ensure "no net loss" of community-led services and safeguard them as formal components of national integration strategies.

Through these actions, GC8, the new PEPFAR outfit and new country health resourcing mechanisms can redefine integration as a process rooted in rights, safety, community leadership, and system resilience ultimately shaping a PHC architecture that is equitable, inclusive, and sustainable.

Chapter 3: Conclusion, lessons learnt and recommendations

12.1 Conclusion

The findings from across the KP-TNC and COMPASS countries provide a coherent picture of both the promise and danger embedded in current integration efforts. Communities consistently demonstrate a willingness to embrace integrated PHC systems due to the potential benefits; improved efficiency, reduced fragmentation, broader service coverage, and better alignment with UHC aspirations. However, they also recognise that these benefits cannot be realised unless integration is grounded in rigorous safeguards that protect confidentiality, dignity, and the right to safe health access. The evidence shows that PHC systems, in their current form, are unevenly prepared: while some urban facilities have begun making progress through training and infrastructure improvements, rural and criminalised contexts remain deeply unsafe for KPs. As a result, communities advocate not for rejection but for **sequenced, rights-based, community-led integration** that strengthens safe spaces rather than replacing or weakening them. GC8, the new PEPFAR outfit and new country health resourcing mechanisms stands at a defining historical moment one in which integration can either advance equity and resilience or deepen structural harms. The pathway chosen will determine whether integration accelerates progress or reverses decades of hard-won HIV gains.

12.2 Lessons Learnt

Lesson 1: Community Trust Is the Foundation of Integration

Across all countries studied, trust emerged as the defining determinant of whether KPs will use PHC services. Communities repeatedly emphasised that PHC facilities, regardless of their clinical resources, will remain underutilised if clients anticipate judgement, exposure, or mistreatment. Trust is built through confidentiality, respectful treatment, and consistent accountability not through infrastructure alone. Integration efforts must therefore treat trust not as an outcome but as a prerequisite.

Lesson 2: Safe Spaces (DICs) Remain Essential, Not Optional Add-ons

DICs and community-led centers hold a unique role as safe, stigma-free environments that PHC systems cannot yet replicate. They serve as points of emotional support, crisis management, mental health care, navigation assistance, and culturally competent engagement. Their closure or defunding during integration would create immediate service gaps, especially for criminalised populations. Lessons from Zimbabwe, Kenya, and Malawi confirm that DICs are often the only places where KPs feel safe enough to engage with care, making them indispensable within any integration framework.

Lesson 3: Integration Must Be Sequenced Through Readiness → Certification → Launch (Across and Within Countries)

The study demonstrates that PHC readiness varies not only within countries between rural and urban areas but significantly **between countries** themselves. For example, Botswana, Zimbabwe, Malawi and Kenya show promising levels of PHC preparedness, whereas other countries remain far behind, with structural stigma, policing risks, and confidentiality breaches still pervasive. A sequenced approach ensures that integration does not move faster than the contexts can safely support, preventing premature rollout that could cause widespread harm or attrition. Readiness must therefore be assessed at facility, district, and national levels before scaling integration.

Lesson 4: Hybrid Integration Is the Most Acceptable and Safest Model

Hybrid models were repeatedly highlighted as the model that best reflects KP realities. These models allow PHC facilities to absorb routine biomedical services while community-led systems retain sensitive, trust-dependent, or legally risky service components. This balance

reduces the risk of forcing clients into unsafe environments and avoids collapsing community structures that have taken years to build. The lesson is clear: integration must complement never replace community-led care.

Lesson 5: Rural PHC Requires Dramatic Strengthening Before Integration

Rural PHC facilities demonstrate some of the highest levels of stigma, community surveillance, privacy limitations, and policing exposure. These barriers make integration more complex and more dangerous outside urban centres. Without dedicated investment in infrastructure, training, privacy redesign, and legal protections, rural integration will fail, leading to service avoidance and declining health outcomes. GC8, the new PEPFAR outfit and new country health resourcing mechanisms must treat rural strengthening as a distinct workstream rather than a peripheral activity.

Lesson 6: Workforce Competency Is a Cornerstone of Safe Integration

Provider attitudes emerged as a critical determinant of integration success or failure. Countries that invested heavily in community-led training, such as Malawi and Kenya, recorded visible improvements in facility culture, confidentiality, and client satisfaction. By contrast, countries lacking training or accountability mechanisms reported widespread fear of humiliation or exposure in PHC. Integration must therefore be anchored in mandatory, ongoing certification programmes for PHC workers.

Lesson 7: Community-Led Monitoring (CLM) Drives Real-Time Improvements

CLM was shown to be one of the most effective tools for strengthening PHC systems. It identifies breaches, stock-outs, discrimination, and structural barriers far more quickly than official supervisory systems. In Tanzania, Malawi, and Kenya, PHC facilities that consistently responded to CLM data showed marked improvements in trust and service uptake. The lesson is that CLM must be embedded as a core pillar of integration readiness and accountability.

Lesson 8: Secure Data and Confidentiality Systems Are Non-Negotiable

Across all countries; especially Nigeria, Uganda, and Tanzania, communities expressed strong fear of data exposure. PHC systems using open registers, shared logbooks, or poorly protected digital systems pose unacceptable risks for KPs, particularly in criminalised settings. Integration cannot proceed until minimum confidentiality standards are met and enforced through audit and certification. Without secure data systems, integration becomes dangerous rather than beneficial.

Lesson 9: Integration Requires Strong Legal and Safety Protections

Criminalisation shapes service access, facility behaviour, and client willingness to seek care. Fear of police presence near clinics, mandatory reporting, or health worker collaboration with law enforcement emerged as deterrents in nearly all countries studied. Integration must therefore incorporate legal literacy, paralegal linkages, and explicit non-collaboration protocols at facility level. Without these protections, integration risks amplifying harm.

Lesson 10: Communities Must Be Co-Governors, Not Advisors

Where communities participated meaningfully in governance; such as PHC TWGs, budgeting forums, and integration committees, facility responsiveness and accountability improved dramatically. Conversely, tokenistic engagement led to design flaws that ignored safety realities. Communities bring irreplaceable lived experience and practical insight; including them as co-architects results in safer, more effective, and more legitimate integration processes. Their leadership is essential for sustainability.

12.3 Recommendations for GC8, the new PEPFAR outfit and new country health resourcing mechanisms

Integration must be designed as a rights-based, safety-first process, with clear guardrails that protect confidentiality, dignity, and non-discrimination. The Global Fund,the new PEPFAR outfit and new country health resourcing mechanisms should adopt an integration framework that requires PHC facilities to demonstrate structural readiness; such as private consultation spaces, secure data systems, confidential triage, and stigma-free service norms before absorbing sensitive HIV services for KPs. Integration should not be pursued uniformly across all settings; instead, GC8, the new PEPFAR outfit and new country health resourcing mechanisms must mandate readiness assessments and facility certification to ensure that integration proceeds in a phased and context-sensitive manner.

Community-led safe spaces, particularly DICs, must be preserved and funded throughout GC8, the new PEPFAR outfit and new country health resourcing mechanisms. These centres provide services that PHC systems are not yet equipped to deliver, including trauma-informed counselling, mental health support, crisis management, harm reduction, gender-affirming care, and legal referral. A “no net loss” principle should guide integration financing: no KP-safe service should be defunded or closed merely because PHC is expanding. Instead, hybrid models favoured unanimously by communities, should serve as the default integration architecture for GC8, the new PEPFAR outfit and new country health resourcing mechanisms implementation.

Workforce competency is foundational to safe integration. GC8, the new PEPFAR outfit and new country health resourcing mechanisms should invest in multi-level, community-led training and certification for PHC providers, focusing on confidentiality, gender identity, trauma-informed care, non-discrimination, and harm reduction. Certification must be mandatory and renewed regularly, ensuring that PHC staff meet minimum competency standards before providing services to criminalised populations. In parallel, community-led monitoring (CLM) must be elevated as a core accountability mechanism. GC8, the new PEPFAR outfit and new country health resourcing mechanisms should require all integrated PHC sites to implement CLM, respond to findings within set timelines, and embed CLM data into district and national health reporting systems.

Finally, GC8, the new PEPFAR outfit and new country health resourcing mechanisms should strengthen legal and safety protections for KPs accessing PHC, particularly in criminalised contexts. Integration plans must include explicit non-collaboration protocols with law enforcement, strong legal referral networks, violence-response pathways, and safe redress mechanisms. These protections are essential for building trust and ensuring that integration does not inadvertently expose clients to arrest, harassment, or harm. By prioritising rights, readiness, community leadership, and legal safety, GC8, the new PEPFAR outfit and new country health resourcing mechanisms can shape an integration model that enhances equity, strengthens PHC systems, and ensures that the populations most at risk are fully protected.