HARM REDUCTION FINANCING LANDSCAPE ANALYSIS IN KENYA

HARM REDUCTION INTERNATIONAL

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Harm Reduction International (HRI) is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

Research and analysis for this report was carried out by Wambui Karanja, in consultation with Catherine Cook and Gaj Gurung.

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LIST OF ABBREVIATIONS

ACHPR	Africa Charter on Human and People's Rights
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment/Therapy
ARV	Anti-Retroviral Drugs
AUPA	African Union Plan of Action
BPS	Budget Policy Statement
BROP	Budget Review and Outlook Paper
CASPs	County AIDS Strategic Plans
CBO	Community-Based Organisation
CBROP	County Budget Review and Outlook Paper
CFSP	County Fiscal Strategy Paper
CLOs	Community-Led Organisation
CSOs	Civil Society Organisations
DICs	Drop-In Centres
EAC	East Africa Community
FY	Financial Year
GFAN	Global Fund Advocates Network
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
KASF	Kenya AIDS Strategic Framework
KHSSP	Kenya Health Sector Strategic Plan
KP	Key Populations
LMIC	Low- and Middle- Income Countries
MAT	Methadone Assisted Therapy
MMT	Methadone Maintenance Treatment
MOH	Ministry of Health
NACADA	National Authority for the Campaign Against Alcohol and Drug Abuse
NACC	National AIDS Control Council
NASCOP	National AIDS & STI Control Program
OAG	Office of the Auditor General
OAT	Opioid Agonist Therapy

ODA	Official Development Assistance
OIs	Opportunistic Infections
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PEPFAR	The US President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SN	Serial Number
STIs	Sexually Transmitted Infections
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USG	United States of America Government

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EXECUTIVE SUMMARY

This study envisioned the conducting of operational, financial, and stakeholder landscape analysis on harm reduction financing in Kenya, in consultation with community and civil society partners, to produce advocacy strategies aimed at increasing domestic public financing for harm reduction in the country.

Operational landscape

Analysis of the legal and policy environment in Kenya revealed we have adequate laws that advocate for the right to the highest standard of health, and sufficient guidelines to enhance service provision. However, some of the laws criminalise drug use, meaning that people who use drugs therefore continue to face significant barriers to accessing harm reduction services. Furthermore, on registration of civil society organisation (CSOs), while the process is documented, some of the organisations claimed it was tedious and expensive.

Financial landscape

With Kenya transitioning from a lower middle-income country to a low and middle-income country, donor support towards healthcare and HIV programming is decreasing. That said, the Kenyan government has been making strides in increasing budgetary allocations to the health sector, but more needs to be done on advocacy and oversight to ensure more funds are allocated, and that those apportioned are efficiently used. Meanwhile, harm reduction programmes remain underfunded and donor dependent.

Mapping targets/opportunities

This study's aim is to map out key opportunities to engage in a mid-term national strategic plan evaluation that will influence harm reduction financing in Kenya, and to map out key stakeholders with whom joint advocacy for policy reform and increases in domestic funding for harm reduction in Kenya can be achieved.

Recommendations

Long-term

1. Policy change and advocacy to remove legal barriers and punitive laws currently in place in order to create an empathetic environment for people who use drugs. Budgets often follow the law, therefore, recognition of harm reduction and a budget set aside for this very initiative in law will task the government with the provision of harm reduction services.
2. Removal of social barriers, stigmatising, and discriminatory attitudes among the general public, as well as internalised stigma among affected community members.

Medium-term

1. Capacity-strengthening: Develop CSO budget expertise which they can then share with other CSOs through training. CSOs working with public officials (or international organisations) and building their capacity to participate in budget processes. This will result in stronger interventions and better oversight.

2. Improving accountability: When you start demanding data and information, you enforce public accountability. On the one hand, public services may start to feel pressured; on the other hand, they may change their practices in response to this pressure (e.g., start collecting the data that interests civil society).
3. Pursue protective laws and policies by drafting, advocating for, and implementing laws that recognise and protect the full rights of people who use drugs and ensure healthcare access with specialised and efficient formal training and sensitisation is given to key staff in the institutions that provide harm reduction services.
4. Conduct community-led research on the impact (successes/shortcomings/possible improvements) of harm reduction strategies in Kenya. This would maintain "N othing About Us Without Us" and enable the community champions to reinforce their rights, as well as to be educated about them.
5. Support budget authorities (ministries, legislative bodies, etc.) through different stages of the budget cycle to integrate policy, programme, and funding/financing changes. In this case, CSOs act as experts and provide help with drafting a piece of legislation or regulatory documents, designing a programme, developing costing tools, or other implementation instruments, etc.
6. Analytical work: As CSOs develop alternative approaches to budget analysis, they are capable of analysing budget data from a different perspective and uncovering important policy issues. For example, when you try to analyse data in order to advocate for increased prevention and care services for people who use drugs, you can easily take the data on the number of individuals in prison for drug-related offenses, then identify the public expenditures on those prisoners and argue that redirecting funds from repression to care (such as harm reduction) can prevent the overpopulation of prisons for drug related offenses, positively impact the quality of life of people who use drugs, and save public money.

Short-term

1. Build partnerships with stakeholders, i.e., leaders, policy makers, law enforcement officers, prosecutors, judiciary, media, and policy implementers.
2. Collect and share best practices: Every issue has its own specific characteristics, but work done by one group can influence and motivate the work of others.

SECTION 1: INTRODUCTION

In most communities, people who use drugs are denied basic health services.[1] They have no access to non-judgmental primary care, mental health and drug treatment services, and the support they need to maintain stable, healthy lives. Harm reduction has been proven time and again to be extremely effective in reducing morbidity and mortality in affected populations.[2] In recent years, harm reduction has been successfully applied in low- and middle-income country (LMIC) programmes in an attempt to reduce the harmful consequences of alcohol and drug use. However, domestic investment into such programmes remains low.[3] There is therefore an urgent need to mobilise domestic investment into harm reduction programming, particularly in countries where international donor funding is being reduced.

In response to the growing burden of HIV among people who inject drugs in Kenya, a comprehensive package of evidence-based interventions to reduce harms associated with injecting drug use in Kenya was developed and endorsed by the MOH, the United Nations, the Global Fund (GF), and PEPFAR in 2013.[4] The comprehensive harm reduction package includes:

1. Needle and syringe programme (NSP);
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment;
3. HIV testing and counselling;
4. Antiretroviral therapy;
5. Prevention and treatment of STIs;
6. 1.1 Condom programmes for people who inject drugs and their sexual partners;
7. Targeted information, education, and communication to people who inject drugs and their sexual partners;
8. Prevention, vaccination, diagnosis, and treatment for viral hepatitis;
9. Prevention, diagnosis, and treatment of TB.

However, needle and syringe programming (NSP) was introduced in 2012 in Mombasa where the programme was piloted, following a decision by the government in 2012 to address injecting drug use as a public health issue.[5] Opioid substitution therapy (OST) with methadone[6] was also introduced in 2014 with financial support from PEPFAR through the CDC, USAID, and

1 Harm Reduction International (2014) The Global State of Harm Reduction. https://www.hri.global/files/2015/02/16/GSHR2014.pdf
2 Canadian Pediatric Society. (2008) Harm Reduction: An approach to reducing risky health behaviours in adolescents. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2528824/
3 Cook C & Davies C (2018) The Lost decade. HRI https://www.hri.global/files/2018/09/25/lost-decade-harm-reduction-funding-2018.PDF
4 NASCOP: Kenya National Guidelines for comprehensive Management of the Health Risks and Consequences of Drug Use. 2013
5 Office of the Coordination of Humanitarian Affairs (2012). Needles to be distributed to injecting drug users https://reliefweb.int/report/kenya/needles-be-distributed-injecting-drug-users
6 Ayon S, Jeneby F, Hamid F, Badhrus A, Abdulrahman T and Mburu G (2019)Developing integrated community-based HIV prevention, harm reduction, and sexual and reproductive health services for women who inject drugs. Springer Nature. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6538559/#CR9

implementation support from the University of Maryland and UNODC. The number of OST clinics has since expanded and there are now more than ten public methadone maintenance treatment (MMT) clinics in Kenya, and over 35 drop-in centres (DICs) distributing NSP. In addition to NSP and OST, the range of harm reduction services offered has also increased to include naloxone in communities, PrEP, and self-testing for HIV. There are also community-based programmes specifically geared towards women who inject drugs.

1.1 Problem statement

This paper envisioned conducting operational, financial, and stakeholder landscape analysis in Kenya, in consultation with community and civil society partners, to produce advocacy strategies aimed at increasing domestic public financing for harm reduction in the country.

1.2 Objectives

Conduct a landscape analysis on international and domestic financing for harm reduction in Kenya and conduct a community, civil society, and stakeholder consultation on international and domestic financing for harm reduction.

1.3 Methodology

To carry out this research, a mixed-method analysis approach was incorporated. This approach included desk-based review of programme documents from secondary sources of information in the public domain, including the official websites of the Ministry of Health, NASCOP, NACC, NACADA, Ministry of Finance, Parliament and Presidents; community and civil society websites; donor websites; and academic literature searches. It also incorporated remote interviews via questionnaires sent by email and follow-up calls with key informants from CSOs that implement harm reduction services, CBOs and community members that carry out advocacy work and fight for the rights of people who use drugs, and other government and civil society representatives. It was somewhat challenging to access up to date documents pertaining to current harm reduction funding and how they were used, and some government institutions were not too receptive to the interview. However, the information gathered from the websites of these institutions assisted in some areas.

SECTION 2: OPERATIONAL LANDSCAPE OF HARM REDUCTION IN KENYA

2.1 Legal and policy environment for organisations

The Kenyan Constitution encapsulates the Bill of Rights which provides the right to register civil society groupings, contained in Sections 78 to 81[7]:

- Freedom of assembly and association with others;
- Freedom of thought, conscience, and religion; and
- Freedom to hold opinions and expression without interference and receive and impart information and ideas.

However, these rights are subject to various constitutional limitations including, for example, in the interest of defence, public safety, public order, public morality, or public health; or reasonably required for the purpose of protecting the rights or freedoms of other persons. Such limitations are reasonably justifiable in a democratic society. There are also adequate regulations at both the national and country levels that offer guidelines to facilitate the meaningful participation and involvement of community-led organisations (CLOs), community-based organisations (CBOs), and CSOs in health-related planning and decision-making platforms.

During the study, most respondents suggested that registering CSOs is not easy, especially when they work on human rights issues. There is a lot of scrutiny that such organisations are subjected to and, as such, networks of people who use drugs may prove harder and more costly to process. One NGO stated that it took one year to be registered after filing. Others indicated that they did not have an issue during registration, but noted that in case of a change, the process would be long. One CBO stated that they had a challenge during registration because the process was tedious and needed a lot of paperwork, including letters from the chief to explain what work they would be doing. Naming the organisation was also an issue, since it cannot be named anything that could be taken to mean the organisation supported drug use. An application fee of Kes. 5,000/- (USD $41) was requested, which the representatives highlighted was very high. Another CBO stated that they did not find the process hard or expensive. Most CBOs stated that they were faced with a lot of stigma from the Registrar's office.

All CBOs agreed that the environment is not friendly to organisations advocating for drug-related issues due to the fact that the laws still criminalise and punish people who use drugs. Service providers stated that while the guidelines are big on service provision, the laws remain punitive. There have been numerous instances where they have been arrested for distributing needles and syringes by the police, detained, and have needed to request assistance from partner advocacy organisations to bail them out. At times, the service providers' "commodities" were confiscated. Annexed is the Registration and Regulating process for Civil Society Organisations in Kenya.

7 The constitution of Kenya (2010) Kenya Law Reports. http://kenyalaw.org/kl/index.php?id=398

2.2 Policy framework and mechanisms for social contracting in Kenya

Social contracting in Kenya is done via public procurement. Article 227 of the Constitution of Kenya provides for a procurement and asset disposal system that is fair, equitable, transparent, competitive, and cost-effective. It also sets requirements for the Kenyan Parliament to pass procurement regulations that would provide for preferential allotment of contracts and protection for disadvantaged groups. To give effect to this article, the Public Procurement and Asset Disposal Act, 2015, was enacted with the aim of providing procedures for efficient public procurement and assets disposal by public entities, and other connected purposes. The Public Procurement and Asset Disposal Act of 2015 has been revised twice – in 2016 and 2022. The Act covers the public procurement and asset disposal cycle; establishment of institutions with clear mandates; decentralisation of procurement giving procuring entities full autonomy to act within the law; and recognition of procurement as a strategic function in public entities. The procurement cycle typically involves a planning and preparation stage, advertisement, evaluation, award, and post-contracting evaluation. There is opportunity for public participation throughout the entire procurement cycle; therefore, citizens can get involved at any stage of the process. However, even with this in place, social contracting with regards to harm reduction in Kenya is not currently in practice.

2.3 Integration of harm reduction in national planning processes

The National Guidelines for HIV/STI programming with Key Populations (2014) are the guidelines that introduced harm reduction in Kenya. To address key populations, the National AIDS and STIs Control Programme (NASCOP) and partners on behalf of the MOH developed integrated National Guidelines for HIV/STI Services for key populations. These guidelines provide a framework for all implementing partners and their donors working with key populations at national and county levels to create an enabling environment, and support key populations to reduce their own risk of HIV and STI acquisition and/or transmission. The guidelines detail how to implement the behavioural, biomedical, and structural interventions. These guidelines were premised on the Kenya vision 2030 and NASCOP; the donors, key populations community and representatives, and the technical support units led and finalised these guidelines. Other national guidelines include the Kenya National Guidelines for the Comprehensive Management of the Health Risks and Consequences of Drug Use[8], Standard Operating Procedures (SOP) for Needle and Syringe Exchange Programmes (NSEP) for People Who Inject Drugs,[9] and Standard Operating Procedures for Medically Assisted Therapy for people who use drugs.[10]

In 2018, Kenya began piloting universal health coverage (UHC). Although the essential service package offered under the pilot mentions HIV, by 2018 it had still not been included within the National Hospital Insurance Scheme. The reasons were due to high annual and lifetime cost liability of antiretroviral therapy and the main source of funding being off-budget donor

8 NASCOP- Comprehensive Management of the Health Risks & Consequences of Drug Use. https://www.nascop.or.ke/key-populations-downloads/

9 NASCOP- Standard Operating Procedure on Needle And Syringe Exchange Program https://www.nascop.or.ke/key-populations-downloads/

10 NASCOP- Standard Operating Procedure on Medical Assisted Therapy for people who inject drugs. https://www.nascop.or.ke/key-populations-downloads/

support.[11] In the UHC pilot, everyone is registered as general population and because of this, it is not clear what kind of services key populations can expect. It is not clear how community services will be sustainable in the context of UHC and with the exit of external donors.[12] Despite this, there are organisations that are advocating for HIV to be added to UHC, NACC being one of them. There are also NGOs such as Partnership to Inspire, Connect and Transform the HIV response (PITCH) who have been fundamental in increasing awareness about UHC among people most affected by HIV.[13] In a policy brief in 2018, NACC stated that it is essential to:

1. Include HIV interventions in the essential benefits package for UHC as a means of reaching universal health coverage for all Kenyans and achieving MOH UHC targets;
2. Have a mechanism for channelling HIV treatment-related funds towards increasing the resource pool of health insurance available to cover persons living with HIV sustainably; and
3. Extend the successful HIV primary prevention model and infrastructure to prevention of non-communicable diseases, as a key strategy in reducing future treatment liabilities from NCDs and thus securing the risk-pool and sustainability of the UHC scheme.

2.4 Community and civil society perspectives on participation and involvement in planning and decision-making platforms at national and county levels

The Kenya National AIDS Strategic Plan (KNASP III) identified an enabling policy and legal environment as a facilitating factor in programming for key populations. In order to create this enabling environment and operationalise key population engagement, the National AIDS and STI Control Programmes Key Population Technical Working Group (NASCOP KP TWG) was established in 2009, and NACC established a National Steering Committee (NSC) to provide clear policy direction to respond to epidemics. There are also other technical working groups such as KCM through the GF and engagements through PEPFAR. At least three CSOs agreed that the community engagements by NASCOP are fruitful and bear results, particularly in instances where the service providers discuss lack of commodities. NASCOP created a committee of experts called the Community Technical Review Committee, comprised of five representatives (a NASCOP representative, LVCT representative, GF Implementer, Kenya Red Cross representative, and a community member). CSOs and CBOs also averred that budget decisions have no community input either due to lack of capacity building, or lack of consideration due to discrimination. Harm reduction service provision platforms are not CSO or community-led. The priority remains HIV, TB, and hepatitis C, and not harm reduction on its own. Funding only comes via treatment and prevention of HIV.

Regarding UHC, in June 2018, the Kenyan Ministry of Health announced that the Health NGOs Network (HENNET) would sit on the UHC Benefits Package Advisory Panel. PITCH representatives called for a more meaningful engagement with CSOs that include populations

11 National AIDS Control Council (2108) Leveraging HIV response to drive Universal Health Care in Kenya. https://nacc.or.ke/wp-content/uploads/2018/09/LEVERAGING-THE-HIV-RESPONSE-TO-DRIVE-UNIVERSAL-HEALTH-CARE-IN-KENYA-2ND.pdf

12 Aidsfonds (2019. Why Kenyas UHC pilot cannot ignore HIV. https://aidsfonds.org/story/why-kenyas-uhc-pilot-cannot-afford-to-ignore-hiv

13 Ibid. 12

at risk of being left behind. There were suggestions such as Kenya having a Multi-Stakeholders' Forum under the Ministry of Health to ensure that health CSOs are meaningfully engaged at all decision-making levels, stating that this would be more impactful.[14] On 26 November 2019, KELIN, in partnership with PITCH, conducted a one-day multi-stakeholder dialogue between members of the Mombasa County Health Management team and key populations. During this dialogue, they deliberated on the health needs of key populations under UHC, and the opportunities and risks of incorporating HIV into UHC. The forum brought together 26 participants including representatives from the County Health Management Team (CHMT) and key population leadership from the county. The meeting was premised on declining international funding for HIV with the Kenya government expected to significantly boost its efforts to fund its own HIV response and achieve UHC.[15]

Below is a table of the facilities that offer Harm Reduction Services, their location, the donor that funds them as well as the services delivered at these centers.

Table 1: Harm reduction service delivery, Kenya

Facility/Organisation	Location	Donors	Services Delivered
MATHARI MENTAL HOSPITAL	Nairobi	MOH, USG	ART, inpatient, mental health care, OAT, SRH, maternity, CCC
NGARA CLINIC	Nairobi	MOH, USG, County Government of Mombasa	ART, inpatient, mental health care, OAT, SRH, maternity, CCC
KARURI CLINIC	Kiambu	MOH, USG, County Government of Kiambu, MSF, GF	ART, inpatient, mental health care, OAT, SRH maternity, CCC
MALINDI LEVEL 5 HOSPITAL	Kilifi	MOH, USG, County Government of Kilifi, GF, UNODC, OSIEA	ART, inpatient, mental health care, OAT, SRH maternity, CCC
KISAUNI MEDICAL CLINIC	Mombasa	MOH, GF, UNODC, OSIEA,	ART, inpatient, mental health care, OAT, SRH, maternity, CCC
KOMBANI CLINIC		MOH, USG, UNODC	ART, OAT, Psychosocial Support, SRH, Overdose management,
JARAMOGI -KISUMU	Kisumu	MOH, GF, USG	ART, inpatient, mental health care, OAT, SRH, maternity, CCC

14 Ibid. 12

15 KELIN Kenya (2019) Key Population leverage the Mombasa County KP Working Groups. https://www.kelinkenya.org/tag/pitch-kenya/

MIRITINI	Mombasa	MOH (NACADA), USG, UNODC	ART, OAT, Psychosocial Support, SRH, Overdose management,
LAMU CLINIC	Lamu	MOH, UNODC, County Government of Lamu in partnership with MEWA	ART, OAT, Psychosocial Support, SRH, Overdose management
SHIMO LA TEWA PRISON	Mombasa	PEPFAR USG, UNODC, County Govt of Mombasa, Kenya Prison Service.	ART, OAT, Psychosocial Support
RUIRU CLINIC	Kiambu	MOH, MSF	ART, OAT, Psychosocial support
NOSET	Nairobi	GF, USG	NSP, out-patient, Psychosocial
SAPTA	Nairobi	GF, Frontline Aids	NSP, HTC, out-patient, psycho-social, overdose management
MEWA	Mombasa, Kilifi	GF, Main Line, Frontline Aids, UNODC	NSP, out-patient, psycho-social, overdose management
OMARI PROJECT	Kilifi	GF, USG, UNODC, OSIEA	NSP, HTC, NSP, out-patient, psycho-social, overdose management
REACH-OUT TRUST	Mombasa, Kwale	GF, USG, UNODC, OSIEA	HTC, NSP, out-patient, psycho-social, overdose management
TEENS-WATCH	Kwale	GF, USG, UNODC, OSIEA	HTC, NSP, out-patient, psycho-social, overdose management
LVCT	Kisumu, Migori	GF, USG, UNODC, OSIEA	HTC, NSP, out-patient, psycho-social, overdose management

2.5 Conclusion

While our laws advocate for the right to the highest standard of health and guidelines that enhance service provision, people who use drugs continue to face significant barriers because of stigma and discrimination from society, service providers, and police due to the fact that the law still criminalises and heavily punishes drug use. In addition, the formal training that is given to key staff such as doctors, nurses, and law enforcement (police, prosecutors, judiciary) still does not cover basic information related to harm reduction, drug dependence treatment, and the specific needs of people who use drugs.

SECTION 3: FINANCIAL LANDSCAPE OF HARM REDUCTION IN KENYA

Kenya is a lower middle-income country with a gross national income (GNI) per capita of USD $1,840.[16]

Public health care delivery is devolved. Healthcare services are arranged in "tiers" running from Level 1 (dispensary, lowest level of care) to Level 6 (referral hospitals, highest level of care). Currently, healthcare in Kenya is financed by three main sources: out of pocket expenditure (households), government expenditure, and donors. This is also the case for harm reduction.

3.1 Current level and sources of funding for the harm reduction response

3.1.1 **Donor funding**

Harm reduction is funded through HIV prevention and treatment for KP groups where we find people who inject drugs. The HIV and AIDS sector remains heavily donor funded at 63.5% in 2021/2022. Out of all financing sources, the U.S President's Emergency Plan for AIDS Relief (PEPFAR) remains the largest donor to HIV programmes, contributing 37% of annual total investments across all HIV programmes.[17] With regard to harm reduction, PEPFAR focuses on HIV testing and PrEP, supporting key populations - including the Kenya Key Population Consortium – and HIV treatment, care, and support. The Global Fund is the main funder for HIV-related human rights programmes. Beyond the GF, Bridging the Gaps have supported human rights programming for sex workers, LGBT communities, and people who use drugs. Bridging the Gaps member Aidsfonds spearheaded work with implementing partners representing sex workers, LGBT communities, and people who use drugs on an array of programming that included legal literacy, monitoring and documentation of human rights violations, and paralegal training. The PITCH programme supported community advocacy in Kenya, via which Frontline AIDS worked through LVCT Health and implementing partners from LGBT organisations, people who use drugs, and across key populations, such as the Kenya Key Population Consortium and KELIN. Both Bridging the Gaps and PITCH funding concluded in December 2020. Other HIV funding sources include UN agencies, led by UNAIDS (which coordinates the provision of UN technical assistance in Kenya for the HIV response), the Clinton Foundation, and the Government of Kenya.

The GFs primary recipients are The National Treasury, Kenya Red Cross Society, and Amref Health Africa, while the MOH implements the grant on behalf of the Treasury.[18] Of the above, GF's HIV grants were specifically given to the National Treasury (Jan 2018 – 2021: USD $190,295,823), and Kenya Red Cross Society (Jan 2018 – June 2021: USD $76,852,690).[19] Donors continue to fund the majority of ARVs (82% in KFY 2022/23), 61% of rapid test kits, and PEPFAR procures 96% of all viral and EID laboratory reagents. In June 2022, PEPFAR

16 World Bank GNI per capita Atlas method (current US$) Kenya 2020 https://data.worldbank.org/indicator/NY.GNP.PCAP.CD?locations=KE

17 Kenya Country Operational Plan 2022 (COP 22) July 18,2022 https://www.state.gov/wp-content/uploads/2022/09/Kenya-COP22-SDS-.pdf

18 The Global Fund (2022) Global Fund Grants in the Republic of Kenya, Audit Report. https://www.theglobalfund.org/media/11839/oig_gf-oig-22-005_report_en.pdf

19 Ibid. 18

approved a budget of USD $345,000,000 as its most recent grant, active from October 2022 to September 2023. PEPFAR's implementing agencies include United State Agency for International Development (USAID), Centers for Diseases Control (CDC), Department of Defense (DOD), Peace Corps, and US Treasury. Of this, funding for HIV services in Kenya was PEPFAR: USD $227,676,146; GF: USD $102,909,394: Government of Kenya: USD $226,923,689; and other funders: $63,642,650. The only amount specified in harm reduction is PEPFAR, funding OST at USD $427,062 (see Table 3). See the list of donors in Harm Reduction in Kenya and their priority areas in Table 2 below.

Table 2: List of Donors in Harm Reduction in Kenya and their Priority Areas

Donor	Priority	Region
Government of Kenya (GoK)	Government hospital personnel, infrastructure, electricity, technical support, administration, medical and non-medical commodities, security, mortuary services, maternity, tax relief, rehabilitation centers	Mombasa, Kisumu, Kilifi, Kwale, Nairobi, Kiambu, Lamu
PEPFAR	Methadone Research, medical and non-medical commodities	Mombasa, Kisumu, Kilifi, Kwale, Nairobi, Kiambu, Lamu
Global Fund	Needle and Syringe Program, Antiretrovirals (ARVs), medical and non-medical commodities, audit, advocacy, community networks of People Who Use Drugs.	Mombasa, Kisumu, Kilifi, Kwale, Nairobi, Kiambu, Lamu

3.1.2 Domestic funding for harm reduction

In financial year (FY) 2017/18, Ksh. 75.4 billion (USD $618,742,813) was allocated to the MOH, and Ksh. 105 billion (USD $861,644,500) to county governments, with the total allocation increasing to Ksh. 209.5 billion (USD $1,719,185,932) in FY 2018/19 for both governments. The allocation to the health sector in FY 2019/20 was revised twice to accommodate increased expenditure due to the pandemic, with a final revision of Ksh. 103.4 billion (USD $848,514,680) for the MOH and Ksh. 124 billion (USD $1,017,561,124) for county governments. The health sector was allocated 5.1% of the national budget in FY 2018/19, 4.8% in FY 2019/20, and 6.5% in FY 2020/21. Despite the allocations, health sector ranking did not change for three consecutive years. Presently, Ksh. 146.8 billion (USD $1.27B) has been allocated to the healthcare sector[20] in the FY 2022/23. Total allocation to HIV services including commodities in 2021/2022 was USD $226,923,689 out of a total amount of USD $621,151,878 (See Table 2). The Kenyan Government funded HIV Care and Clinical Services with USD $94,133,656; prevention, which covers OST among other components as shown Table 2, with USD $103,482,471 (this amount is not disaggregated); and above-site programmes with USD $29,307,562. On average, the

20 Wangui P (2022) Budget 2022/23: Health Sector funds allocation. The Star newspaper Kenya. https://www.the-star.co.ke/news/2022-04-07-budget-202223-health-sector-gets-sh1468bn-allocation/

county government increased the proportion of their total budget allocated to health from 13% in FY 2013/14 to about 28% in FY 2021/22, reflecting the extent to which county governments prioritise health investments over other sectors. There are variations between counties.

Table 3: Funding Landscape for HIV Services (GoK, GF, PEPFAR and Other Funders contribution)[21]

COP 22	Total	Sources of fund			
		Domestic Gov't.	Global Fund	PEPFAR	Other donors
Care and Treatment	**$281,113,157**	**$94,133,656**	**$64,842,660**	**$93,418,099**	**$28,718,742**
HIV Care and Clinical Services		$94,133,656		$30,435,277	
Laboratory Services incl. Treatment Monitoring				$5,555,759	
Care and Treatment (not disaggregated)				$57,437,063	
HIV Testing services	**$16,443,341**	**$0**	**$1,980,575**	**$14,462,766**	**$0**
Facility-Based Testing				$3,405,331	$0
Community-Based Testing				-	$0
HIV Testing Services (not disaggregated)				$11,057,435	$0
Prevention	**$179,415,690**	**$103,482,471**	**$20,331,846**	**$24,030,449**	**$31,570,923**
Community mobilisation, behavior and norms change				$4,052,607	$0
Voluntary Medical Male Circumcision				$3,711,503	$0
Pre-Exposure Prophylaxis				$4,496,681	$0
Condom and Lubricant Programming					$0
Opioid Substitution Therapy				$427,062	$0
Primary Prevention of HIV & Sexual Violence					$0
Prevention (not disaggregated)		$103,482,471		$11,342,596	

21 Kenya Country Operational Plan 2022. Strategic Direction Summary 18th July 2022 https://www.state.gov/wp-content/uploads/2022/09/Kenya-COP22-SDS-.pdf

Orphans and Vulnerable Children	**$47,607,898**	**$0**	**$5,536,696**	**$43,071,202**	**$0**
Case Management				$4,836,571	$0
Economic Strengthening				$25,728,035	$0
Education Assistance				$9,179,403	$0
Psychosocial support				-	$0
Legal, Human Rights, and Protection				$846,237	$0
OVC (not disaggregated)				$1,480,956	$0
Above Site Programs	**$53,519,849**	**29,307,562**	**$3,116,962**	**$17,742,341**	**$3,352,984**
Human Resources for Health				$1,210,851	$0
Institutional Prevention				-	$0
Procurement and Supply Chain Management				$104,333	$0
Health Mgmt Info Systems, Surveillance, and Research				$9,870,745	$0
Laboratory Systems Strengthening				$3,658,548	$0
Public Financial Management Strengthening				$357,729	$0
Policy, Planning, Coordination and Management				$2,540,135	$0
Laws, Regulations and Policy Environment				-	$0
Above Site Programs (not disaggregated)		$29,307,562		-	
Program Management	**$43,051,943**	**$0**	**$7,100,654**	**$35,951,289**	$0
Implementation Level					$0
Donor Level					$0
Program Management (not disaggregated)					$0
Total (incl. Commodities)	**$621,151,878**	**$226,923,689**	**$102,909,394**	**$227,676,146**	**$63,642,650**

3.2 Resource gaps, needs, and allocative efficiency

The government's focus on the fight against HIV and AIDS has seen a reduction in HIV prevalence from 4.9% in 2018 to 4.5% in 2020. Pre-exposure prophylaxis (PrEP) for populations at risk of HIV; methadone assisted therapy (MAT) for people who use drugs; and blood screening and laboratory networking of samples for routine monitoring of patient outcomes are routinely offered across health facilities in Kenya. These services are offered free of charge at all health facilities and community settings.[22] However, the emphasis remains heavily on HIV and health, leaving some harm reduction components overlooked, and therefore underfunded. Components such as OST, NSP, naloxone, social reintegration, and psychosocial support are either underfunded or inadequately provided. In key population groupings, people who inject drugs are often the least vocal group, as well as the least funded. CLOs, especially those involved in advocacy for harm reduction, have a difficult time obtaining funding.

3.2.1 Gaps and needs

The total financial gap for all HIV commodities in FY 2019/20 was USD $128,264,036, calculated based on available information from NASCOP and funding agencies/donors.[23] The financial gap for commodities for key populations, such as methadone, buprenorphine, naloxone, hepatitis B and C screening and treatment was USD $29,398,721.6 as at FY 2019/2022.[24] During 2021, there were multiple stockouts of essential HIV commodities, such as ARVs, resulting in limited multi-month prescribing and huge backlogs (see Table 4). This fuelled frustration with the Kenya Medical Supplies Authority (KEMSA), which is the state corporation responsible for the procurement and storage of medicines and health products for Global Fund Programmes, as well as for delivering those products to county governments or directly to health facilities. The Global Fund had recent audits to identify gaps in the procurement and supply chain processes in Kenya. The Office of Inspector general (OIG) audit found that the system was dogged by procurement delays. The HIV commodities that were tracked saw an average gap of 278 days between procurement and delivery.[25] The system also lacked adequate processes for monitoring, tracking, and reporting those items as they entered the health system.

Table 4: Summary of Unfunded/Underfunded Priorities for the FY 2022/23 (Source Sector Working Group Health Report October 2021)

Program	In Millions			
	Requirement FY 2022/23	Allocation FY 2022/23		Gap
		GoK	Donor	
Procurement of Blood commodities	1,000	619	-	381
Procurement of HIV Commodities	7,498	1,587	1,101	4,810

22 Health Sector MEDIUM TERM EXPENDITURE FRAMEWORK (MTEF) FOR THE PERIOD 2022/23-2024/25 https://www.treasury.go.ke/wp-content/uploads/2021/10/HEALTH-SECTOR-REPORT.pdf

23 National AIDS & STI Control Program, Ministry of Health Kenya. National Quantification report for HIV commodities for FY 2019/20 to 2021/22, October, 2019.

24 Country Operational Plan 2022 Kenya – PEPFAR (July 18, 2022) Strategic Direction Summary – PEPFAR https://www.state.gov/wp-content/uploads/2022/09/Kenya-COP22-SDS-.pdf

25 Green A (29 March 2022) Global Fund called to account for stock shortages in Kenya, https://www.devex.com/news/global-fund-called-to-account-for-stock-shortages-in-kenya-mozambique-102859

Procurement of TB Commodities	3,427	206	727	2,494
Total	**41,105**	**7,702**	**14,179**	**19,224**

It is important to note that as of 2022, Kenya does not have recent survey data on HIV prevalence among KPs. The last integrated bio-behavioural survey (IBBS) conducted in 2011 showed that the HIV prevalence was 18.2% among MSM, 29.3% among FSW, and 18.3% among people who inject drugs.[26]

3.2.2 Allocative efficiency

A key requirement for Kenya to obtain PEPFAR funding in 2022 was the demonstration of a solid supply chain plan. Extensive discussions were held with the MOH and the Global Fund in order to reach an agreed upon basket of essential HIV commodities to prevent the frequent and severe stock outs experienced over the past 12-18 months from being repeated. This included a critical request that the Government of Kenya increase their contribution towards the purchase of essential HIV commodities, over and above their required counterpart contribution within the Global Fund grant. It was accompanied by an understanding that at minimum, quarterly high-level discussions would be held in order to monitor commitments from all parties, review pending deliveries and stock levels, and track actual expenditures.

3.3 Gaps and challenges for accessing domestic funding

Harm reduction CSOs, CLOs and CBOs do not receive domestic funding in Kenya. However, these are the challenges faced during public procurement and should be lessons to learn for the advocacy of domestic funding for harm reduction. Despite the reforms undertaken in public procurement, the public procurement and asset disposal system in Kenya has challenges, including, but not limited to[27]:

- The public procurement and asset disposal system faces ethical challenges occasioned by weak governance that impede competition, accountability, transparency, and integrity principles.
- Records management in procuring entities is characterised by scattered, inaccurate, and incomplete documentation, as well as poor filing that hampers auditing of public procurement and asset disposal processes.
- A large segment of society is economically disadvantaged due to unfair competition or discrimination in government procurement opportunities. Local industries face stiff competition from well-established foreign firms, thereby edging them out of business.
- Poor procurement planning by procuring entities is a major contributory factor to inefficiencies in the delivery of goods, works, and services, resulting in budget overruns and creating pending bills.

26 Kenya Country Operational Plan (July 2022) Strategic Direction Summary. PEPFAR. https://www.state.gov/wp-content/uploads/2022/09/Kenya-COP22-SDS-.pdf

27 The National Public Procurement and Asset Disposal Policy. 2020. Treasury Kenya. https://www.treasury.go.ke/wp-content/uploads/2021/12/NATIONAL-PUBLIC-PROCUREMENT-AND-ASSET-DISPOSAL-POLICY-2020.pdf

- Lack of standardisation of procurement processes leading to unfairness, lack of transparency, and accountability, which hampers competition and compromises value for money. Furthermore, it creates room for corrupt practices and loss of government funds.
- Public procurement and asset disposal systems are faced with numerous risks, including, but not limited to financial, economic, technological, legal, environmental, social, and political risks. The occurrence of these risks often leads to loss of public resources which hinders service delivery.

The aforementioned challenges and the emerging issues in the dynamic business environment necessitate policy interventions on various fronts, including legislative and regulatory framework, institutional framework, capacity development, public procurement operational standards, and governance.[28]

3.4 Conclusion

On one hand, the Kenyan government has been making great strides in increasing budgetary allocation to the health sector, but more needs to be done on oversight to ensure the allocated funds are efficiently used in service delivery. Harm reduction programmes in Kenya are under-funded and donor dependent. While donor support for harm reduction remains in place, it will not be adequate to scale up access to OST to the levels required to impact the HIV epidemic among the community of people who use drugs. Furthermore, the KASF II 2020-2024 target for OST coverage at 40% is just too low to address the epidemic effectively. There has been no evidence of the government of Kenya directly funding CSOs that work in harm reduction. However, CSOs obtain their own funding from international donors when it comes to service provisions. CSOs that offer harm reduction services such as distribution of NSP get authorisation from the government through NASCOP.

28 Ibid. 27

SECTION 4: MAPPING TARGETS AND OPPORTUNITIES

4.1 Mechanisms for prioritisation, efficiency, and resource allocation

The process of allocating budget resources to the respective sectors in Kenya is the same at the national and county levels. The county and national treasuries communicate the budget caps to the various sectors through the Budget Review and Outlook Paper (BROP) or the County Budget Review and Outlook Paper (CBROP), which are normally released in September and must be approved by the Cabinet and the Assembly at each level of government. Although the BROP provides initial indication of the amount the health sector might receive, interventions and advocacy for more health funding should be done before its release. Sector Working Groups guide their respective ministries or departments in preparing three-year rolling budget plans for programmes and activities at both national and county levels. These groups prepare reports that inform the cabinet and county executive committees so they can refine sector caps. Stronger justifications for additional funding may lead to an adjustment of the annual caps, which are published in the Budget Policy Statement (BPS) (National) and County Fiscal Strategy Paper (CFSP) (County). These publications are released in February of each year and determine the final caps approved by Parliament at the national level, and by the County Assemblies at the county level. These publications are accessible online on the Parliament and National Treasury websites.

The Global Fund, however, requires a country to request technical assistance through Country Coordinating Mechanisms (CCM) and Principal Recipients (PR) in countries with Global Fund grants. The purpose of this is to improve the planning and implementation of Global Fund grants in order to support strong national programmes and disease responses. Support is available within the following general categories:

- National Strategic Plan or investment case support;
- Concept note development;
- Grant management technical assistance for CCMs and PRs;
- Medium- to long-term assistance.

Harm reduction is funded through HIV prevention, treatment, care, and support for KP groups. The emphasis remains on the HIV response, therefore harm reduction services such as NSP, OST, psychosocial Support, re-integration, and education and awareness specifically for people who use drugs are mostly overlooked and subsequently underfunded.

4.2 Opportunities for harm reduction funding

The allocation of health budgets has traditionally been done along budget vote lines, but this may not be sufficient to address the funding required for harm reduction service delivery. There is an urgent need to determine the full cost of harm reduction service delivery and efficiencies in service delivery so that appropriate funding is allocated for domestic resources. The GoK already recognises the need to increase local ownership of the HIV response and has already identified transitioning of donor supported programmes as a flagship project, including HIV commodities and human resources for health (HRH) in the Medium-Term Plan (MTP) IV for

the health sector.[29] At COP22, PEPFAR stated that it will deepen engagements with the GoK towards local ownership of PEPFAR-supported programmes, starting with HIV commodities and HRH. Other opportunities that could encourage sustainability and integration of harm reduction service provision in Kenya may include, but are not limited to:

- Harm reduction financing reforms that promote and advance efficiency in resource mobilisation to harm reduction services and commodities such as the National Harm Reduction Bill, which introduces funding for harm reduction services by the government, advocating for harm reduction to be added to the UHC.
- Leveraging GoK's UHC and National Hospital Insurance Fund (NHIF) expansion to cover harm reduction components and financial risk pooling for improved access to affordable, quality health services for people who use drugs. In 2018, the Cabinet Secretary for Health had stated that the Ministry was working with partners in health for inclusive involvement and targeting of vulnerable and marginalised groups. She disclosed that under the UHC framework, the government will include the integration of harm reduction interventions as part of the primary health care package. An opportunity to implement this by the Ministry of Health would be beneficial.
- Innovative financing, such as engaging with the private sector and incentivising government-led investments in the health sector to expand the uptake of harm reduction services.
- Leveraging the private sector to assist with reintegration into the society for people who use drugs through joining with the government to create jobs for people who use drugs in recovery.

4.3 Community and civil society perspectives on priority actions to overcome harm reduction funding challenges

A number of community members and CSOs were interviewed to share their perspectives on the priority actions to overcome harm reduction funding challenges. Increase in domestic financing for harm reduction is a necessity to reduce donor dependency and sustain the progress already made. The perspectives include:

> *Policy Change and Advocacy by removing legal barriers and punitive laws in place, to create an empathetic environment for people who use drugs. Budgets often follow the law, therefore recognition of harm reduction and a budget set aside for this very initiative in law would task the government with the provision of harm reduction services.*

> *Building partnerships with stakeholders such as legislators, law enforcement officers, prosecutors, judiciary, media, and those implementing policies.*

> *Supporting budget authorities (through different stages of the budget cycle — ministries, legislative bodies, etc.) to integrate policy, programme, and*

29 Kenya Country Operational Plan 2022. (July 2022) Strategic Direction Summary. PEPFAR. https://www.state.gov/wp-content/uploads/2022/09/Kenya-COP22-SDS-.pdf

> *funding/financing changes. In this case, CSOs act as experts and provide help with drafting a piece of legislation or regulatory documents, designing a programme, developing costing tools or other implementation instruments.*

> *Demonstration of a solid funded supply chain plan: Hold extensive discussions with the MOH, KEMSA, and NASCOP in order to reach an agreed upon basket of essential HIV commodities to prevent the frequent and severe stock outs prior experienced being repeated.*

> *Partnership with CSOs, CBOs, and community members to work on a strategic, joint, and coordinated response in programmatic, technical, and fiscal spaces for harm reduction funding to support the government to increase the funding and sustain the growth.*

SECTION 5: MAPPING PARTNERS

5.1 Community and civil society perspectives on upcoming opportunities for harm reduction budget advocacy

The ultimate targets of budget advocacy are the key government representatives (key decision-makers) who influence budgetary allocations, policies, and regulations. This includes different levels of public officials and technical staff who are in charge of implementing public budget allocation decisions.

Some of the steps and strategies needed to achieve the ultimate advocacy goals include: encouraging changes in communities (awareness-raising and mobilisation), campaigning to create public pressure, writing policy briefs, organising public events, having direct meetings with government representatives, and building alliances.

The key partners who should be involved in budget advocacy include, but are not limited to: human rights organisations, faith-based organisations, CSOs and CBOs working with people who use drugs, community members, legislators from both the national and county governments, and health service providers.

The upcoming opportunities are feasible but will require funding of their own. Expectations are positive because, with domestic funding in place, this will mitigate the dwindling funds from the donors. They added that the funds can hopefully be sustainable because the government itself does not fund most of the harm reduction components, as it relies on donor funding. To be able to increase the success rates and provide more services to people who use drugs, the funds need to be sufficient

Public budget is public money, and harm reduction services are the gateway to the health and social well-being of people who use drugs. It is a Kenyan's right and obligation to advocate that the government spend money on harm reduction and do so sustainably.

Drug use exists in all counties in Kenya, and this has led to a lot of harms due to punitive laws and approach, including HIV, STIs, and even death. A positive aspect is that the CSO and CBO registration laws are not stringent, therefore there are a number of CSOs that are already in place with various expertise and would help ease implementation of budget advocacy when funds are available.

There is now a great opportunity to push for budget allocation for harm reduction and its importance. This would go a long way in reducing harms associated with drug use and at the same time reduces reliance on external funding that is never sustainable, while at the same time complementing the other available funding.

SECTION 6: ANNEXURES

Table 5: List of community, civil society and stakeholder consultation participants

SN	Name	Title	Organisation/ Individual	Organisation Type (CLO, CBO, CSO)
1	Chris Abuor	Executive Director	VOCAL KENYA	CSO
2	Rita Gatonye	Executive Director	WRADA	CBO
3	Stephen Horace	Executive Director	NOSET	CSO
4	George Odhiambo		LVCT - HOMABAY	CSO
5	Anthony Kimemia	Executive Director	CAIK	CBO
6	Michael Anami	International Working Group Member	YOUTHRISE	CSO
7	Ahmed Said	Executive Director	KWANPUD - KWALE	CBO
8	Solomon Wambua	National Coordinator	KP CONSORTIUM	CSO
9	Showsee Mohammed	Executive Director	NEW LEAF - LAMU	CSO
10	Rachael Wambui Kariuki	Program officer people who inject drugs	LCVT – KIAMBU	CSO
11	Geoffrey Ombogo	Executive Director	KISPUD - KISUMU	CBO
12	Mohamed Awadh Abuod		THE OMARI PROJECT	CBO
13	George Collins Owuor	Executive Director	Transform Empowerment for Action Initiative (TEAM)	
14	Thomas O Abol.	Executive Director	Keeping Alive Societies' Hope (KASH)	
15	George Ayoma	Executive Director	KUZA TRUST	
16	John Kimani	Executive Director	Kenya Network of People Who Use Drugs (KENPUD)	
17	Cosmus Maina	Executive Director	TEENSWATCH CENTRE	

Table 6: Targets for NSP for FY 2017/18- FY 2021/22 (Source: National HIV commodities Quantification Report 2019/20 to 2021/22)

	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
People who inject drugs population	16,561	17,604	18,647	19,691
Number of people who inject drugss targeted with NSP	13,483	15,552	17,621	19,691
Program coverage (%)	81%	88%	94%	100%
Total No. of NSP Service Points	35	35	35	35
Total number of NS required per person per year (76 per person per month)	12,296,496	14,183,424	16,070,352	17,958,192
Number of kits required per person per year (1 NS kit has 3 needles)	4,098,832	4,727,808	5,356,784	5,986,064

Table 7: Targets for Medically Assisted Therapy (MAT) for FY 2018/19- FY 2021/22 (Source: National HIV commodities Quantification Report 2019/20 to 2021/22)

	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Estimated No. of people who inject drugs	16,561	17,604	18,647	19,691
No. of people who inject drugss Targeted - Methadone	4,500	6,000	7,500	9,000
Daily dose-mg	80	80	80	80
Milligrams per person per year (80mg/ person/day) *365	29,200	29,200	29,200	29,200
Total Milligrams for target population per year	131,400,000	175,200,000	219,000,000	262,800,000
Total Kilograms for target population per year	131	175	219	263
Annual quantification in Kilograms	131	175	219	263
Annual quantities required in 1000mls bottles	131,400	175,200	219,000	262,800
Bottles of 1L	26,280	35,040	43,800	52,560
No. of MAT Service Points	15	15	15	15

Legal registration process in Kenya

Non-Governmental Organisations (NGO)

NGOs are registered by the N on-Governmental Organisations Co-ordination Board. The board was constituted by the Non-Governmental Organisations Co-ordination Act Cap 19 of 1990. The board falls under the Ministry of Interior and Co-ordination of National Government. Besides registration, it regulates the NGO sector by coordinating the operations of local and international foundations in the country, issuing policy guidelines, and receiving and analysing annual reports. It is an offence, for any person to operate an NGO in Kenya without registration and a certificate under the NGO Coordination Act. NGOs exempt from registration must apply for exemption. An NGO can be National and International. The registration procedure for NGOs is as follows;

- Name search – This is done by filling form 2, the form involves applying for a reservation of the NGO's name. This process costs Ksh. 1,000/- if the name is approved, it is reserved for the next 60 days (Form 2)
- Submit a formal application request for registration, with information about the NGO's office location and postal address. It shall also state the organisation's goals and its top three authorities. The top 3 officials have to sign this. (form 3 – 2 copies)
- Submit duly filled form containing information about the contact details of the NGO to be founded. (Form 1)
- Payment of Ksh. 400 shall accompany the submission of Forms 1 and 3.
- Submission of 2 colored passport photographs for the officials and 2 other board members.
- Among the top three officials, one of them MUST be a Kenyan as a basic requirement for all foreign or international based NGOs

The documents required are duly filled Form 1, ID/Passport and KRA pin certificates for the 5 proposed officials and board members, a valid police clearance form (certificate of good conduct), Minutes of the NGO's board meeting authorizing the filing of the application. Proposed one year budget, processing fee of Ksh 16,000 for National NGOs and Ksh 30,000/- for international NGOs, a Memorandum of understanding (MOU), if any, between the donors and the organization, A forwarding letter from the proposed NGO to accompany the application. These documents should then be presented to the NGO Coordination Boas and wait for its approval. The process takes about 2 months.

After registering, it is important to notes that if an NGO needed to make some changes, this changes may attract payments, while others are free. i.e. Change of financial year, Change of Name, Change of officials, Change of address, Amendment of constitution. Payment range from 0-12,000/- depending on the change being sought.

Community Based Organisations (CBO)

A CBO is a registered non-governmental, non-profit and non-political organization. This organisations vary in size and structure, CBOs with well-established structures, such as a written constitution and directors are formally registered and incorporated. The smaller and

informal CBOs are registered by the Department of Gender and Social Development.

For a CBO to be registered by the Department of Gender and Social Development, the registration forms requesting the registration of the CBO should be signed by the Chief of the location where the CBO will operate or the Assistant Chief of the sub-location where the CBO will operate. The forms should also be signed by officials of the Department of Gender and Social Services and those of the Division of Social Development Committee.

The Documents required in the registration of a CBO in Kenya include;

- The minutes of the meeting seeking the registration of the CBO. The minutes should also have the names of the individuals fronted as the officials.
- List of the members of the CBO. The list of members should contain the names, the position, the ID number and the signature.
- The rules and the by-laws of the CBO.
- The Memorandum of understanding where applicable.
- The cost of Registration is Ksh. 5,000/-
- The timeline is about 10 days.

These documents are presented to the Department of Gender and Social Services, together with the registration forms and the requisite registration fee. Once a Community Based Organization is registered, it will be required to submit half-year reports to the registering authority as well as allow access to its records by the registering authority. Renewal of CBO certificates is Ksh 500.

Self Help Groups

To register a self-help group, the application is made with the Ministry of Labour and Social Protection. The group has to have at least 10 members, a constitution shall be drafted. The registration process requires;

- Registration form
- Minutes of the meeting seeking registration
- Constitution
- List of members duly signed
- Cost of registration is Ksh. 1,000/-
- The timeline is 10 days.
- Once process is complete group receives a certificate of registration, renewable every year.

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