THE IMPACT OF US FUNDING CUTS AND REDUCED FINANCING ON HARM REDUCTION IN KENYA:

A RAPID ASSESSMENT

HARM REDUCTION INTERNATIONAL

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The Impact of US Funding Cuts for Harm Reduction Programmes in Kenya: A Rapid Assessment

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Harm Reduction International is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social, and legal impacts of drug use and drug policy. Through research and advocacy, we promote the rights of people who use drugs and their communities 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 United Nations Economic and Social Council.

Mutuku Stephen Mutinda carried out research and analysis for this report in consultation with Catherine Cook, Gaj Gurung, Ailish Brennan, and Timothy Wafula (KELIN). The report findings were validated by the national stakeholders through a dedicated national stakeholder meeting on 31st March 2026 followed by a review of the report by the same meeting participants, facilitated by KELIN.

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EXECUTIVE SUMMARY

"We lost clients to overdose because there was no administration of naloxone since peer educators could not report or offer [it]. We are scared it might happen again."

– Community Representative, Mombasa

Recent global health funding disruptions, particularly the US government's abrupt 90-day pause (stop work order, 2025) in official development assistance, followed by severe funding cuts affecting the health service provision to diverse communities and the Global Fund's call for grant reprioritisation under Grant Cycle 7 (GC7), have thrown harm reduction programmes in Kenya into crisis. The sudden reduction and uncertainty in donor flows have disrupted essential health services, including opioid agonist therapy (OAT) and antiretroviral treatment (ART), payment of healthcare service providers in Medication assisted treatment (MAT) sites, closure of key drop-in-centres for people who use drugs, and peer education programs, as well as support systems within the community. More people who inject drugs are stopping OAT, and more are overdosing, sometimes fatally. These developments threaten to reverse decades of progress for people who inject drugs in relation to HIV prevention, treatment access, and human rights.

This assessment aimed to document the impact of funding cuts on harm reduction services in Kenya and identify opportunities for advocacy and domestic resource mobilisation to safeguard existing harm reduction achievements amid shifting donor priorities. The research employed a mixed-method approach.

Key findings

"When the funding stopped, the clinic couldn't induct any more. We had to choose between treating new clients or retaining old ones."

– Harm reduction implementing partner, Nairobi

The assessment made **seven key findings** that define the current harm reduction landscape in Kenya:

01 **Service disruptions:** Methadone services have been interrupted due to a loss of human resources and reduced outreach, forcing some people to ration or share medication, and also transfers of MAT services to government facilities, which were affected by low integration.

02 **Notable increase in lost to follow-up clients:** This is largely attributed to service interruptions, stock-outs, and reduced outreach activities due to funding cuts. This is affecting both OAT clients and people supported by harm reduction programmes and follow-ups run by the harm reduction community service organisations.

03 **Workforce attrition:** Funding uncertainty has caused staff layoffs, low morale, weakened supervision, reduced service delivery, and uncertainty on harm reduction programming.

04 **Donor reprioritisation risks:** The Global Fund's reprogramming process under GC7 has reduced the harm reduction allocations by USD 2.4M.

05 **Limited domestic financing:** Despite political commitment from the government, national and county budgets allocate minimal funding for harm reduction, mainly due to legal and policy barriers. However, the government does purchase the methadone used in the Global Fund-supported harm reduction program. The government also supports staff recruitment for some OAT clinics and allocates space for harm reduction facilities within existing public buildings.

06 **Fragmented coordination:** The absence of a solid national harm reduction coordination mechanism across stakeholders has led to duplication, weak accountability, and poor integration of harm reduction into public health systems.

07 **Community resilience:** Networks of people who inject drugs displayed strong self-organisation and advocacy potential, demonstrating the community's readiness to lead responses if adequately supported and resourced, importantly by strengthening domestic funding for communities and civil society through social contracting.

Our analysis revealed a strong correlation between **funding volatility** and **service instability**. Disruptions to OAT are directly linked to people stopping or interrupting both OAT and ART, as clients are not attending or accessing services as they did before.

The funding cuts also had different impacts in different regions. Mombasa and Nairobi experienced the most severe disruptions to harm reduction services. This was due to service providers being forced to close a satellite OAT facility after losing PEPFAR support. In Nairobi, OAT sites were partially supported by PEPFAR, and the funding pause triggered substantial staff losses across harm reduction programmes. Two drop-in centres also closed down in Nairobi. Kisumu reported diminished psychosocial support due to the withdrawal of PEPFAR-supported service providers, and the main drop-in centre in Kisumu closed down. In Lamu, MAT clinics are still operational. The county government was actively sustaining these services by absorbing costs or leveraging alternative funding, as the national government did for the Ngara clinic in Nairobi.

A recurring theme across all data analysed is that **criminalisation and donor dependency make it difficult to sustain harm reduction programmes**, underscoring the urgency of policy and financing reforms.

Advocacy entry points

The assessment identified **six strategic advocacy entry points** to navigate the crisis and rebuild resilience in Kenya's evolving health and fiscal context.

01 **Domestic resource mobilisation:** Advocate for the inclusion of harm reduction programming in national and county recurrent budgets and Social Health Insurance (SHI) to reduce donor dependency and ensure sustainability.

02 **Global Fund and the Country Coordinating Mechanism (CCM) engagement:** Influence the Global Fund Grant Cycle 8 (GC8) funding request to protect harm reduction funding and enhance key population representation in decision-making.

03 **Legal and policy reform:** Advocate for the redrafting and passage of the Harm Reduction Bill and review the Narcotic Drugs and Psychotropic Substances (Control) Act to decriminalise personal drug use, promote a health-based response to drug use and enable government investment in harm reduction.

04 **Integration into universal health coverage (UHC) and primary healthcare:** Position harm reduction as a core part of Kenya's UHC agenda and integrate into primary healthcare points.

05 **Improve coordination across sectors:** Establish a national harm reduction coordination platform to align donor, government, community, and civil society efforts.

06 **Empower communities:** Strengthen the advocacy capacity of networks of people who use and inject drugs so community members can better influence budgets, policies, and accountability processes.

CONTENTS

1. BACKGROUND

Recent US funding cuts to global health programmes have precipitated a profound crisis, with extensive implications for harm reduction and HIV responses in Kenya and globally. The abrupt '90-day funding pause.'[1] announced by the US government, followed by severe cuts, disrupted the financial lifeline that supports critical public health interventions in many countries, including HIV prevention, opioid agonist therapy (OAT), and overdose management. In Kenya, this pause immediately translated into interruptions in the provision of OAT, reduced access to antiretroviral treatment (ART), and increased overdoses among people who inject drugs in coastal and urban regions.[2] These disruptions have exposed the structural fragility of harm reduction programming in Kenya, which remains heavily dependent on international donor support.

The crisis caused by the US funding cut occurred at a time when the Global Fund's Grant Cycle 7 (GC7) has directed countries to reprioritise existing grant allocations, compelling national programmes to make difficult trade-offs between HIV prevention and treatment. While this reprioritisation seeks to ensure programmatic efficiency and sustainability, it risks de-emphasising harm reduction interventions, which are already marginalised within national HIV responses.

At the same time, global shifts in donor priorities – including the growing focus on domestic resource mobilisation, integration into universal health coverage (UHC) frameworks and outcome-based financing – are reshaping how health programmes are funded and managed.[3] Kenya's harm reduction sector now faces a dual challenge: sustaining service delivery amid shrinking donor commitments and aligning with evolving global and national financing models, which increasingly expect domestic co-financing.

In Kenya, several government bodies – notably the Ministry of Health's National AIDS and STI Control Program (NASCOP), the National Syndemic Diseases Control Council (NSDCC) formerly National AIDS Control Council (NACC), and the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) – have committed to filling the emerging funding gaps. However, the limited fiscal space, competing health priorities and entrenched stigma toward people who inject drugs have constrained the government's capacity to allocate resources for harm reduction. As a result, HIV treatment services are at risk of being prioritised at the expense of HIV prevention and harm reduction, undermining Kenya's ability to sustain control of the HIV epidemic and protect the human rights of key populations, including people who inject drugs.

This crisis also highlights the broader connections between HIV, drug use, mental health and social exclusion. Interruptions in OAT and harm reduction services not only endanger individuals' health, but they also worsen health vulnerabilities, such as poverty, incarceration and exposure to violence. Without sustained investment, these intersecting challenges could erode years of progress made by Kenya's national HIV response, reversing gains in community trust, service coverage, and health outcomes.

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1 The American Presidency Project, (20 January 2025), Executive Order 14169—Re-evaluating and realigning United States foreign aid. University of California, Santa Barbara. Available from www.presidency.ucsb.edu/documents/executive-order-14169-reevaluating-and-realigning-united-states-foreign-aid.

2 UNAIDS, (1 May 2025), Impact of US funding cuts on the global HIV response. Joint United Nations Programme on HIV/AIDS. Available from https://www.unaids.org/en/impact-US-funding-cuts.

3 Proceedings of The National High-Level Dialogue on Domestic Resource Mobilization for Sustainable Health Financing Towards UHC in Kenya, (June 26-28 2023), Summary Report, Safari Park Hotel, Nairobi, Ministry of Health, Government of Kenya.

Recognising these risks, Harm Reduction International (HRI), with financial support from the Elton John AIDS Foundation (EJAF), commissioned this rapid assessment to generate robust evidence on the impacts of the current funding crisis in Kenya. KELIN Kenya, HRI's national partner, will utilise these findings to develop a strategic, evidence-driven advocacy and resource mobilisation roadmap to safeguard the achievements already made on harm reduction.

1.1 Objectives of the rapid assessment

01	Document the impact of US funding cuts and reduced global health financing on harm reduction services in Kenya.
02	Identify opportunities for strategic advocacy and domestic investment to sustain harm reduction programmes.
03	Safeguard existing harm reduction gains by generating evidence-based recommendations for sustainability.

2. METHODOLOGY

The rapid assessment employed a qualitative, participatory, multi-stakeholder methodology designed to generate timely, context-specific insights on the implications of global health funding disruptions for harm reduction programming in Kenya. The approach ensured inclusivity, accuracy, and relevance by gathering perspectives from government institutions, donors, implementing partners, and communities of people who inject drugs.

Key information interviews (KIIs) were conducted with 43 respondents drawn from national and sub-national levels. Six focus group discussions (FGDs) were conducted in Nairobi, Mombasa, and Kisumu counties. In total, 25 representatives from networks of people who inject drugs, peer educators, and community-based organisations took part.

The methodology details can be found in Annex 1.

3. KEY FINDINGS

3.1 Service disruptions and reduced access to lifesaving support

Significant service disruptions have undermined the continuity and quality of harm reduction programming in Kenya. A sharp decline in client inductions was reported, largely due to weak community linkages and outreach mechanisms.[4] This has caused the number of people joining OAT programmes to fall. Between January and March 2025, out of 30,641 potential OAT clients, only 19,009 (62%) were reached. In April to June 2025, this declined further to 15,454 (50%).[5]

The withdrawal of key implementing partners, due to funding cuts, further weakened support for people on OAT by reducing the availability of peer educators and case managers, both of whom play a critical role in tracking clients, providing adherence counselling, and helping people who have left treatment to re-engage. Induction levels at OAT clinics have also dipped. Between January and March 2025, 103 people began OAT, compared with 174 between October and December 2024.[6] All Mobile OAT services in the form of mobile vans and satellite sites also ceased operating after the USG funding cuts.

Socioeconomic barriers, including transport costs, unemployment, stigma, and discrimination, were also cited as factors that deter people from making regular clinic visits. In addition, the lack of flexible dosing models, such as take-home options for stable clients, and absence of mobile OAT delivery, has made retention particularly difficult for people balancing treatment with work or family obligations.

One research participant explained:

For Mombasa, the programme was supported by USAID. The major challenge was the HRH [human resources for health], whereby the staff supporting OAT clinics were paused, leading to strained county staff and delayed service delivery. The donor also supported the renewal of the methadone measure license, which was not renewed, hence forcing the programme to shift to manual delivery of methadone, which was cumbersome. [In] Mombasa, reflecting the coastal region, it was also stated that a satellite facility in Kilifi County was temporarily shut down due to staff shortage, leading to clients missing doses and/or traveling long distances to access the services. There was also a lack of documentation and reporting on the national platform service. Notably, for needle and syringe supply, the programme is supported by Global Fund and hence no interruption so far.

4 National Syndemic Diseases Control Council. Rapid Results Initiative (June 19 2025), Rapid Results Initiative (RRI) preliminary report, Rapid Results Initiative.

5 Kenya Demographic and Health Survey 2025, Key and Vulnerable Population Technical Working Group.

6 Kenya Demographic and Health Survey 2025, Key and Vulnerable Population Technical Working Group.

3.2 Increase in loss to follow-up

An increased loss to follow-up of OAT clients was observed between October 2024 and June 2025. Current clients dropped from 3,808 in October-December 2024 to 3,671 in January-March 2025 and further dropped to 3,584 in April-June 2025.[7] The rise in default rates reflects the compounded effects of recent funding cuts, service disruptions, and weaknesses within the harm reduction delivery chain. Many clients reported challenges in maintaining consistent attendance at methadone clinics due to a decline in staff capacity and reduced outreach follow-up.

This increase in loss to follow-up poses a serious threat to programme effectiveness and public health outcomes as it heightens the risk of unsafe injecting practices, overdose, and HIV transmission. There is an urgent need for client-centred retention strategies, including re-engagement campaigns, strengthened community follow-up mechanisms, and the institutionalisation of peer-led adherence support to help people who inject drugs stay on treatment and improve their health and socioeconomic outcomes.

3.3 Data reporting and management

Most data management personnel were donor-funded, and their departure following recent funding cuts has left a significant gap in programme reporting and information systems. This has resulted in inconsistent data entry, delayed report submissions, and reduced monitoring of key performance indicators across implementing sites.

This has also weakened data quality assurance mechanisms, including verification, analysis, and feedback processes, which are essential for informed decision-making and programme improvement. Consequently, the OAT programme is now struggling to generate timely, accurate, and comprehensive reports for national and county-level stakeholders. This gap not only affects routine monitoring; it undermines strategic advocacy efforts as the lack of reliable evidence limits the ability to demonstrate programme impact, justify funding needs, and inform policy dialogue.

There is a pressing need to institutionalise data management functions within government structures, strengthen staff capacity through continuous mentorship, and integrate OAT indicators into national health information systems such as the Kenya Health Information System (KHIS). Doing so will enhance data ownership, sustainability, and accountability, and ensure that harm reduction programming remains evidence-driven and aligned with Kenya's broader health information priorities.

7 This is data extracted from the National Health Information Platform and shared to a national technical working group on 29 September 2025.

3.4 Increase in overdoses

"In the last two months alone, we lost three clients to overdose; before that, it was rare." - Service provider, Kisumu

Respondents consistently reported an increase in the number of people overdosing, both fatally and non-fatally, during the funding pause. The interruption of OAT and the limited availability of overdose prevention services, such as naloxone, exacerbated this risk, especially among people who began to inject drugs again due to treatment gaps.

Withdrawal symptoms and anxiety over treatment interruptions pushed some clients back to unsafe injecting practices. Focus group participants expressed fear that 'temporary funding pauses' could have long-term behavioural consequences, reversing progress made in reducing HIV transmission and overdose deaths.

3.5 Workforce attrition and programme continuity challenges

"Our peer educators haven't been paid in months; outreach has nearly stopped." - Implementing partner, Nairobi

Harm reduction staff have been affected by 'stop work' orders, salary delays, and uncertainty following the exit of US funding, which previously supported HRH capacity, methadone dispensing technology (methadone measure license)[8], breathalyser operations and mobile outreach van services. PEPFAR supported at least 11 of the 15 OAT clinics, mainly with HRH (positions included MAT Lead, Clinician, Nurses, Pharmacists, Counsellor, Laboratory Technologist, Medical Social Worker, Data Clerk/Health Records Officer, Outreach Workers, Peer Educators, and support staff). The study could not get clear data on the cost of the human resources for the OAT programmes; however, in the Kenya National AIDS Spending Assessment, at least USD 445,509 was spent on methadone and related costs in 2020.[9]

Implementing partners reported losing experienced staff due to the uncertainty created by the funding pause. Peer educators, social workers, and programme coordinators faced salary delays or contract terminations. This led to loss of institutional memory, reduced supervision of operations, and weakened the effectiveness of harm reduction service delivery. The resulting staff demotivation and burnout compromised client follow-up, data reporting, and service quality, particularly in community-based programmes. Several partners warned that retaining skilled harm reduction personnel would become increasingly difficult without predictable funding.

8 This is in reference to the metha-measure License, which was being supported by PEPFAR, especially in Nairobi and the Coast Region. MethaMeasure is a specialised, computerised dispensing system designed for pharmacies and clinics to accurately measure and dispense liquid methadone and other controlled drugs.

9 Ministry of Health. (March 2023). Kenya National AIDS Spending Assessment FY 2016/17-2019/20. National Syndemic Diseases Control Council, Nairobi, Kenya.

3.6 Donor reprioritisation and the shifting funding landscape

"We understand the need to sustain ART, but prevention programmes are being sacrificed." - Donor representative

Government and donor agency representatives acknowledged that the Global Fund's call for grant reprioritisation under GC7 presents significant risks to HIV prevention programming. Before the stop work order, at least USD 2.7M of the US funding investment was spent on the harm reduction programme in Kenya (around USD 762,000 on methadone and at least USD 1.9M on outreaches and service delivery) through the Global Fund. Notably, most of the products for harm reduction were financed through the HIV programme. The US grant resumption has not yet occurred, as the Kenyan government is currently in discussions with the US government to agree upon a framework for resumption.[10,11] With limited resources, many countries, including Kenya, are under pressure to prioritise HIV treatment over harm reduction.

To accommodate the PEPRAR funding gaps, the Global Fund announced a reduction in Kenya's total allocation for HIV, tuberculosis, and malaria, from USD 407.9M to approximately USD 354.3M in July 2025.[12] Kenya was allocated 12.35M for the prevention package for people who inject drugs and their partners before GC7 re-prioritisation. This amount has dropped to USD 10m post-re-prioritisation, losing around USD 2.4M,[13] with further 18.2% reduction in HIV component for in GC8.[14] This has created a funding gap and prompted the need to re-evaluate and prioritise key interventions. The Ministry of Health, through the Kenya Country Mechanism and its partners, is actively engaged in collaborative efforts to navigate these changes and ensure continuity of care. This reprioritisation underscores Kenya's vulnerability to essential – often lifesaving – services being disrupted due to the country's heavy dependency on donors to finance harm reduction.

Donor representatives emphasised that while HIV treatment continuity is crucial, "prevention cannot be sacrificed without long-term consequences". Community organisations expressed concern that harm reduction interventions might be "deemed non-essential" in the reprogramming process, leading to further erosion of funding.

10 Kenyans.co.ke, (26 November 2025), 'U.S. Announces Ksh19 Billion Medical Funding Targeting Five Countries, Including Kenya' [online article, accessed November 2025], Nairobi. Available from www.kenyans.co.ke/news/118366-us-announces-ksh19-billion-medical-funding-targeting-five-countries-including-kenya.

11 Health Policy Watch, (17 November 2025), 'Former DOGE Official Driving US Bilateral Health Agreements With African Countries' [online article, accessed November 2025], Geneva. Available from https://healthpolicy-watch.news/us-steams-ahead-with-extractive-health-aid-agreements-with-african-countries.

12 The Standard, (no date given), 'Global Fund slashes Kenya's health allocation by Sh7 billion amid foreign aid cuts - The Standard [online article, accessed November 2025]. Available from www.standardmedia.co.ke/business/health-science/article/2001523817/global-fund-slashes-kenyas-health-allocation-by-sh7-billion-amid-foreign-aid-cuts.

13 See Global Fund data explorer, available at https://data.theglobalfund.org/financial-insights.

14 See https://www.dataetc.org/projects/allocation-letters/?country=kenya

3.7 Limited domestic financing and policy barriers

"We can support harm reduction under the health budget if the policy allows it." – County Health Officer

Although government agencies expressed willingness to explore domestic resource allocation for harm reduction, no formal budgetary commitments have been made to those entities National Syndemic Disease Control Council (NSDCC), National AIDS and STI Control Program (NASCOP) working on HIV prevention. However, the county government did absorb some staff who had been affected while working for the harm reduction programmes. Key informants cited competing health priorities and limited fiscal space as major barriers.

Additionally, legal and policy frameworks continue to impede domestic financing for harm reduction. The criminalisation of drug use discourages government investment and limits inclusion of OAT and needle-syringe programmes (NSPs) in national and county health budgets.

The lack of a coherent financing framework also constrains coordination between national and county governments and makes harm reduction programmes heavily reliant on external funding.

3.8 Fragmented coordination and weak public health integration

Harm reduction programmes operate through fragmented coordination structures and have limited integration into mainstream public health systems. While the National Syndemic Disease Control Council (NSDCC) and National AIDS and STI Control Program (NASCOP) provide oversight, implementation is largely donor-driven and NGO-led. This fragmentation limits resource pooling and policy coherence.

Respondents highlighted the need for a national harm reduction coordination platform to align donor, government, and civil society efforts. The current siloed approach has led to harm reduction services in urban areas being duplicated and having limited reach in areas with emerging needs.

3.9 Community resilience and emerging advocacy momentum

"We can't wait for donors; we must speak for ourselves." – People who inject drugs community representative, Nairobi

Despite the funding crisis, communities of people who inject drugs have demonstrated remarkable resilience and growing advocacy capacity. Through peer networks and community-based organisations, community-led groups arranged mutual support systems, organised community awareness drives, and held local and national-level dialogues with policymakers. Organisations led by people who inject drugs have

also held outreaches in the regions, mostly to provide peer education and overdose management. Through the Caucus on Harm Reduction and Drug Policy Reform,[15] communities of people who inject drugs have engaged in the development of the Harm Reduction Bill.

These grassroots movements are an important advocacy asset and show the potential for sustained community-led mobilisation. However, community leaders emphasised the need for technical and financial support to strengthen their engagement in national policy and budgeting processes.

3.10 Regional disparities

The magnitude of disruption caused by the funding pause varied by region.

a. Mombasa County

Mombasa experienced the most severe disruptions to harm reduction services following the stop-work order. The county reported stock-outs of MAT (medication-assisted treatment) clinic commodities, such as naloxone, and the expiry of the methadone measure license. This destabilised the delivery of essential services, including naloxone, while the expiry of the methadone measure license disrupted services. This interruption significantly increased people's risk of unsafe injecting practices, increased HIV, viral hepatitis, and overdosing.

Mombasa also recorded an increase in overdoses. This was attributed to erratic access to OAT and increased reliance on street opioids of unknown potency. The absence of adequate overdose prevention support, including naloxone distribution, further heightened the crisis. As a regional hub with a high number of people who use and inject drugs, these service gaps had a disproportionate impact on overall public health outcomes in the county.

b. Nairobi County

In Nairobi, the stop-work order triggered substantial staff losses across harm reduction programmes. Many outreach workers, peer educators, and clinical personnel left due to salary interruptions and operational uncertainty. This loss of experienced staff weakened programme continuity and client trust.

This loss of personnel directly contributed to reduced outreach activities, including fewer community visits, limited client follow-up, and diminished services in high-need areas. The decline in outreach reduced people's access to sterile injecting equipment, risk-reduction information, health referrals and linkage to care. Two drop-in centres eventually had to cease operating by the end of 2025. Nairobi's already large population of people at heightened risk of HIV, including people who inject drugs, experienced significantly reduced HIV prevention and support services. This increased many people's vulnerability to HIV transmission, unsafe injection practices and violence.

15 The Caucus on Harm Reduction and Drug Policy Reforms is a national platform in Kenya composed of civil society organisations, harm reduction networks, community-led organisations, legal and health professionals, researchers, and human rights advocates. Its mission is to promote evidence-based drug policy reforms and advocate for health, dignity, and human rights in the context of drug use and harm reduction.

c. Kisumu County

Kisumu managed to maintain stability in ART access for people who inject drugs, largely due to strong integration with mainstream HIV treatment structures and county-supported supply chains. However, the county reported a notable decline in psychosocial support services, which are central to harm reduction's holistic approach. Reduced counselling sessions, peer support activities, and other mental health support weakened client retention and treatment adherence for both HIV and OAT clients.

Kisumu also experienced reduced NSP coverage due to limited operations, reduced distribution shifts, and fewer community outreach events. While clients could still access ART, the weakening of psychosocial and harm reduction outreach services created gaps which increased people's risk behaviours. The main drop-in-centre ceased operating by the end of 2025. This reduced the overall effectiveness of the combined harm reduction services available.

4. ADVOCACY ENTRY POINTS AND OPPORTUNITIES

The rapid assessment identified several advocacy entries points to safeguard and sustain harm reduction programming in Kenya amid shifting donor priorities and funding disruptions. These entry points cut across policy, financing, coordination and community empowerment and provide KELIN, partners and civil society coalitions with targeted pathways for strategic engagement.

4.1 Strengthening domestic resource mobilisation for harm reduction

TIME FRAME: IMMEDIATE ACTION TO LONGER-TERM ADVOCACY PLAN

Advocacy focus: Promote the inclusion of harm reduction services, particularly OAT, NSP and overdose prevention, within national and county health budgets as part of essential health services.

Justification: Kenya's harm reduction programmes are almost entirely donor-funded[16], which leaves them vulnerable to global shocks like the US cuts and the Global Fund reprioritisation. While some government bodies in Kenya have expressed willingness to bridge gaps, there are currently no formal budgetary commitments for doing so. Embedding harm reduction into the national and county health financing frameworks would ensure predictable domestic funding and signal government ownership. This can be done by engaging with the Program-Based Budgeting process and County Integrated Development Plans.

Advocacy opportunities:

- Engage the National Treasury, Ministry of Health and county health departments to institutionalise harm reduction under UHC.
- Advocate for public finance management reforms to allow flexible resource allocation toward harm reduction services.
- Support evidence-driven budget advocacy through cost-effectiveness analyses, demonstrating savings from reduced HIV infections and overdose deaths.

16 "Under harm reduction, donor-funded support accounts for approximately 98% of total funding (with the Global Fund alone reducing allocations by USD 2.4M under GC7), while government-funded work accounts for roughly 2%, limited primarily to purchasing methadone, securing staff for select OAT clinics, and providing space within public facilities."

4.2 Influencing Global Fund Grant Cycle 8 and Country Coordinating Mechanism processes

TIMEFRAME: IMMEDIATE ADVOCACY PLAN

Advocacy focus: Ensure that harm reduction and other HIV prevention interventions remain prioritised in the Global Fund reprogramming process, and that there is strong representation of Key Populations and community voices in decision-making spaces.

Justification: The Global Fund grant reprioritisation under GC7 has reduced allocations for harm reduction, and GC8 will reduce country allocations. This requires consistent advocacy with the CCM which will require strategic interventions for engagement to be generated.

Advocacy opportunities:

- Meaningful engagement of communities of people who inject drugs and their organisations in the country dialogue process.
- Ensure community-friendly and context-oriented service integration protocols
- Strengthen the participation of representatives from communities of people who inject drugs and civil society actors in CCM deliberations and Government to Government (G2G) conversations.
- Advocate for the inclusion of harm reduction indicators and budget lines in the grants.
- Advocate for Harm Reduction to be considered a life-saving service
- Use data from this assessment to demonstrate the public health and human rights impact of maintaining harm reduction investments.
- Develop policy briefs and data dashboards to succinctly communicate evidence to decision-makers.
- Build alliances with donor partners that support prevention-oriented programming (e.g., EJAF, UNODC, UNAIDS).

4.3 Legal and policy reform to enable harm reduction financing

TIMEFRAME: LONG-TERM ADVOCACY PLAN

Advocacy focus: Promote the decriminalisation of personal drug use, and policy alignment that recognises harm reduction as a legitimate health and human rights intervention within Kenya's legal framework.

Justification: The criminalisation of people who use drugs is a major barrier to domestic health financing and the integration of harm reduction in public health systems. The current legal framework disincentivises government investment and perpetuates stigma and discrimination against people who use drugs. Policy

reform would create an enabling environment for sustainable programming, consistent with Kenya's obligations under international human rights and public health treaties.

Advocacy opportunities:

- Engage parliamentary health, justice and finance committees to support policy dialogue on harm reduction.
- Consider proposals from community led partners and the leadership of the Caucus of Harm Reduction and Drug Policy Reform in Kenya, which has provided a memorandum on the Harm Reduction Bill to the member of parliament proposing it. This should be done before the bill goes to public consultation.
- Collaborate with the NSDCC and NASCOP to position harm reduction within Kenya's HIV and syndemic disease strategies, including completion of the stalled National Harm Reduction Policy
- Advocate for the review of the Narcotic Drugs and Psychotropic Substances (Control) Act 1994 to support a public health–based approach to drug use.
- Host media briefings and high-level dialogues to reframe harm reduction as a public health and development issue.
- Refine national level substance-use policies to include comprehensive harm reduction, defining harm reduction services necessary for Kenya in reference to global guidelines, and other specific contextual needs and determinants of harm reduction success that are often overlooked.
- Strengthen advocacy for county-level harm reduction laws- such work already exists in Mombasa and Nairobi- to influence county budgeting coverage
- Enhance advocacy efforts for decriminalisation of petty drug offences and alternatives to incarceration for people who use drugs

4.4 Integrating harm reduction into universal health coverage and primary healthcare

TIMEFRAME: LONGER-TERM ADVOCACY PLAN

Advocacy focus: Advocate for the integration of harm reduction services into Kenya's UHC framework and community health strategy, ensuring that people who use drugs can access comprehensive health services through existing systems. Utilise the Global Fund GC8 platform to strengthen the integration advocacy.

Justification: Currently, harm reduction services operate in parallel to mainstream health systems, often limited to donor-supported clinics. Integrating them into primary healthcare and UHC delivery models would expand their reach, enhance sustainability, and normalise harm reduction as an essential health service. The Global Fund GC8 prioritises integration in its approach, and harm reduction integration should be prioritised with caution to ensure that current legal and structural barriers do not impede the access of people who inject drugs to the essential services.

Advocacy opportunities:

- Generate strategic evidence and find allies for harm reduction integration in the Global Fund GC8 application process.
- Collaborate with the Division of Primary Health Care and the Kenya Health Benefits Package[17] Taskforce to include OAT, NSP, and overdose prevention in the benefits package.
- Lobby and dialogue with the Social Health Insurance Fund to integrate the harm reduction services package into their benefit package.
- Use data from this assessment to demonstrate how integration can reduce health inequities and improve HIV and overdose outcomes.
- Build partnerships with county health management teams to pilot integration within select facilities in counties with large populations of people who inject drugs, such as Mombasa, Nairobi, and Kisumu.
- Prioritise community-led anti-stigma initiatives and partnerships to enable successful primary health care integration of harm reduction services

4.5 Strengthening multi-sectoral coordination and governance mechanisms

TIMEFRAME: LONGER-TERM ADVOCACY PLAN

Advocacy focus: Establish or revitalise a national harm reduction coordination platform to align efforts among government institutions, implementing partners, donors, and communities.

Justification: There is fragmented coordination between harm reduction actors, leading to duplication, inefficiencies, and policy inconsistencies. A structured coordination platform would promote synergy, accountability, and joint resource mobilisation while ensuring that harm reduction remains a national priority.

Advocacy opportunities:

- Advocate for the institutionalisation of a multi-sectoral technical working group on harm reduction at the national level, inclusive, accountable, and mandated to lead harm reduction advocacy responses
- Support the development of a national harm reduction roadmap or strategy, harmonised with Kenya's Syndemic Disease Strategic Plan.
- Facilitate structured donor-government dialogues to align funding priorities and avoid service duplication.
- Advocate for the collaboration of health and finance committees within national and county assemblies for effective harm reduction institutionalisation

17 The cost of providing people who inject drugs with essential services is USD 227.55 per person per year and USD 344.78 per person per year for comprehensive services. An estimated 9,618 clients are on methadone, which cumulatively costs at least USD 2,188,095 for essential services and USD 3,316,094 for a comprehensive package per year. Notably, the estimated cost of methadone treatment per person is approximately USD 47.7 or KShs 4,771 per month (per day this equates to KShs 159 or USD 1.6).

- Advocate for structured and transparent collaboration of NASCOP and NSDCC in the national harm reduction response
- Collaborative engagement between the Ministries of Health and the Ministry of Security/Interior
- Consolidate substance use agendas at the county and national levels to include all drugs and substances to form a national outlook

4.6 Community empowerment and advocacy leadership

TIMEFRAME: IMMEDIATE ADVOCACY PLAN

Advocacy focus: Invest in strengthening the capacities of people who inject drugs and their community networks to lead policy dialogue, advocacy, and accountability initiatives at national and county levels.

Justification: The resilience and organising capacity of communities of people who inject drugs was one of the strongest assets in the response to the funding crisis. But most of these community groups lack the technical and financial support they need to sustain advocacy or effectively engage in decision-making spaces. Empowering these communities will strengthen grassroots ownership of both harm reduction services and policy influence.

Advocacy opportunities:

- Support community networks to collect and use evidence for advocacy, including documentation of rights violations and service gaps.
- Support community networks to lead innovative data collection, e.g., through structured community-level advocacy for anti-stigma, reaching not just the pockets but the hearts and minds of policymakers to make the case for the need for harm reduction services.
- Facilitate training on budget advocacy, policy analysis, and media engagement to enhance advocacy effectiveness.
- Build alliances between organisations led by people who inject drugs and national civil society coalitions.

5. ANNEX

Annex 1: Methodology

1.1 Methodological approach

The assessment consisted of a desk review, stakeholder engagement, and participatory data collection. This approach was selected due to the urgency of the funding crisis and the need for actionable evidence to inform immediate advocacy and decision-making.

The methodology emphasised:

- **Participation:** Ensuring meaningful involvement of affected communities, particularly people who inject drugs, and local partners.
- **Triangulation:** Cross-validating information from multiple sources for reliability.
- **Evidence-to-action:** Translating data into concrete advocacy and policy recommendations.

1.2 Data collection methods

Multiple data collection tools were used to capture diverse experiences and institutional perspectives.

a. Key informant interviews

Key information interviews (KIIs) were conducted with 43 respondents drawn from national and sub-national levels. Participants included senior officials from the following:

- **Government agencies:** Ministry of Health, NSDCC, NASCOP, NACADA, and selected county health departments
- **Donor agencies and multilateral partners:** PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), UNODC, UNAIDS, WHO, and EJAF
- **Implementing and technical partners:** Civil society organisations and health service implementers, including Mathari MAT (medically-assisted treatment) Clinic, Jaramogi Oginga Odinga Teaching and Referral Hospital MAT Clinic, Kisauni MAT Clinic, Support for Addictions Prevention and Treatment in Africa, Reachout Trust Center, Kenya Network of People Who Use Drugs, and the Muslim Education and Welfare Association

The interviews explored key issues, including funding impacts, programme sustainability, coordination mechanisms, policy frameworks, and emerging advocacy opportunities.

b. Focus group discussions

Six focus group discussions (FGDs) were conducted in Nairobi, Mombasa, and Kisumu counties. In total, 25 representatives from networks of people who inject drugs, peer educators, and community-based organisations took part. The discussions focused on:

- experiences of service interruptions due to the funding pause
- perceived impacts on access to OAT, ART, and psychosocial support
- coping strategies adopted by communities
- perspectives on advocacy and policy engagement.

The FGDs provided rich qualitative insights into the impact funding disruptions are having on people's lives and the resilience of affected communities.

c. Document and policy review

An extensive review of policy documents, strategic plans, donor communications, and national programme reports was conducted to contextualise the findings from the interviews and focus group discussions. Key documents reviewed included:

- Kenya AIDS Strategic Framework (KASF II) 2020–2025
- National Policy for Prevention, Treatment, and Rehabilitation of Drug and Substance Use (2021)
- Global Fund Grant Cycle 7 guidance and reprogramming notes
- Programme data from the Kenya Health Information System (KHIS)
- NASCOP and NSDCC reports on HIV and Key Populations
- Public statements and circulars relating to the US funding pause

d. Validation and stakeholder consultations

A validation session was held with representatives from KELIN, the Ministry of Health, harm reduction partners, PWUD networks, and other PWUD-led groups and donor agencies to review preliminary findings, verify interpretations, and ensure stakeholder ownership.

1.3 Ethical considerations

The assessment adhered to ethical standards for research involving Key Populations. Informed consent was obtained verbally from all participants before they took part in the assessment. Confidentiality was maintained through anonymised reporting of quotes and data. The process was guided by principles of 'do no harm', voluntary participation, and respect for the privacy and dignity of all respondents.

1.4 Data analysis

The analysis aimed to identify emerging themes, patterns, and relationships relating to the impact of funding cuts, system vulnerabilities, and advocacy opportunities for harm reduction sustainability. It combined both deductive (testing pre-determined themes against the data) and inductive (building themes from the data) approaches to ensure systematic interpretation and triangulation of findings from multiple data sources.

a. Data management and coding

All KII and FDG transcripts were recorded, transcribed verbatim, and reviewed for accuracy. The transcripts were then imported into NVivo 12 (qualitative analysis software) for coding and thematic categorisation. Initial coding was guided by pre-identified domains derived from the assessment objectives. These were: the impact of funding cuts, service delivery implications, governance and coordination, the policy and legal environment, and advocacy opportunities.

An inductive coding process was then applied to capture emerging sub-themes, ensuring that community narratives and lived experiences were fully reflected. Coding was conducted independently by two researchers and cross-verified to enhance reliability and minimise bias.

b. Thematic analysis

The analysis yielded several core themes, summarised as follows.

Theme	Description	Illustrative evidence
Service disruption and access barriers	Interruption in OAT and ART availability, staff attrition and supply chain interruptions following funding pauses.	"We were told to halve our methadone doses because they are not certain of the future due to funding cuts." – FGD participant, Mombasa
Human resource and programme continuity challenges	Implementing partners reported staff layoffs and volunteer dependency due to reduced funding certainty.	"Our peer educators have not been absorbed nor considered in any budgetary allocation; outreach has nearly stopped." – Implementing partner, Nairobi
Increased health risks and overdose incidents	Participants linked decreased access to OAT and psychosocial support with a rise in people overdosing and relapsing to illegal drug use.	"In the last two months alone, we lost three clients to overdose; before that, it was rare." – Service provider, Mombasa
Donor dependency and reprioritisation risks	Stakeholders expressed concern that GC7 reprioritisation may divert funds from harm reduction to HIV treatment.	"We understand the need to sustain ART, but prevention programmes are being sacrificed." – Donor representative
Emerging domestic financing opportunities	County governments expressed tentative willingness to co-finance OAT centres if national policy guidance is provided.	"We can support harm reduction under the health budget if the policy allows it." – County Health Officer
Community resilience and advocacy momentum	Networks of people who inject drugs have begun self-organised advocacy to emphasise inclusion in decision-making.	"We can't wait for donors; we must speak for ourselves." – Community representative, Nairobi

c. Triangulation of findings

Findings from KIIs, FGDs, and document reviews were cross-validated to ensure consistency and credibility. Key insights were compared across stakeholder groups (government officials, donors, implementers, and community representatives). This revealed that stakeholder groups shared some perspectives, but differed on others.

> **Shared perspective:** All respondents agreed that the 90-day funding pause led to service disruptions and increased uncertainty.
>
> **Differing perspectives:** Donors emphasised temporary financial reprogramming, whereas community groups saw the situation as a longer-term systemic threat.

d. Validation and synthesis

A validation session was conducted with representatives from the Ministry of Health, KELIN, harm reduction networks, and donor agencies. Participants reviewed preliminary findings and provided additional insights to ensure ownership and contextual accuracy. The final report integrated this additional input into the thematic framework, then used this to develop the evidence-based advocacy recommendations presented in Section 5.

e. Data presentation

How frequently a theme was raised was analysed to determine dominant areas of concern. Service disruptions (25%) and donor reprioritisation (20%) emerged as the most cited issues. Respondents in all regions expressed uncertainty about OAT services. But there were also regional variations. There was uncertainty of OAT commodities in Mombasa, descriptions of staff shortages in Nairobi, and reduced psychosocial support in Kisumu. Further analysis revealed communities and implementers felt the greatest urgency but had the least capacity to respond, underscoring the need for stronger advocacy partnerships.

1.5. Overview of research participants

A total of 68 people were engaged through KIIs and FGDs across national and county levels, ensuring a balanced representation of perspectives. This provided a rounded understanding of the funding crisis, capturing both high-level policy and grassroots-level operational realities.

Stakeholder Group	Number of participants	Representation
Government institutions (Ministry of Health, NASCOP, NSDCC, county health departments)	15	Policy, coordination, and financing perspectives
Donors and development partners (PEPFAR, Global Fund, UNODC, WHO)	8	Funding priorities, sustainability, and global policy alignment
Implementing partners and Civil society organisations	20	Programme management, technical implementation, and service delivery
Community representatives (networks of people who inject drugs, peer educators, leaders of community-based organisations)	25	Client experiences, community impact, and advocacy perspectives
Total	**68**	

1.6 Frequency and distribution of key themes: The pressing concerns

Key themes were identified and ranked by frequency across stakeholder responses, providing insight into the most pressing concerns.

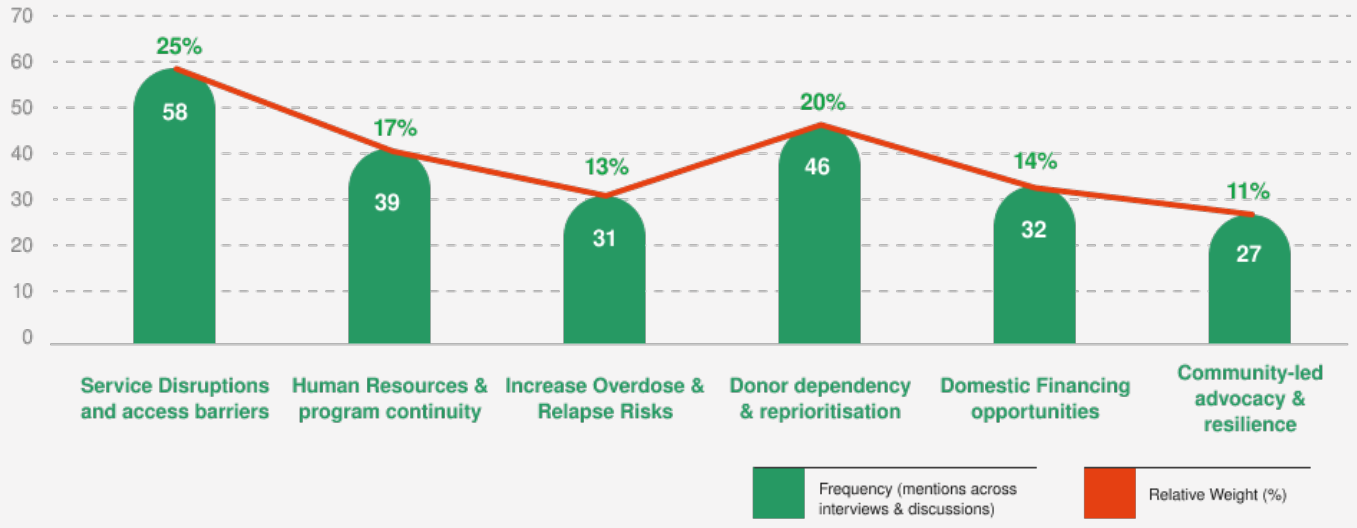

Figure 1: Frequency distribution of key themes raised by respondents (n=233)

Service disruptions (25%) and donor reprioritisation (20%) were the most frequently mentioned issues. This underscores the immediate operational impacts of funding cuts and the systemic risk to harm reduction sustainability.

Annex 2. Stakeholder Mapping Framework (Sample Matrix)

Category	Institution/ Name	Role	Interest in Harm Reduction	Influence Level	Potential Role in Advocacy
Government	Ministry of Health/ Departments of Health	Policy & budget allocation	Medium	High	Potential ally for budget advocacy
Parliament	Health Committee	Oversight & budget approval	Low-Medium	High	Key target for advocacy
Donors	Global Fund	Financing	High	High	Strategic partner for sustainability
Partners	KELIN	Advocacy & legal reform	High	Medium	Partner & advocate
Community	PWUD Network	Service demand & voice	High	Medium	Grassroots mobilization