HARM REDUCTION FINANCING IN KENYA

Advocacy for Local Resource Allocation

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TABLE OF CONTENTS

GLOSSARY/ACRONYMS

1. CSO Civil Society Organisation
2. CCM Country Coordination Mechanism
3. CDC Center for Disease Control and Prevention
4. CSW Commercial Sex Worker
5. CCC Comprehensive Care Clinic
6. HIV Human Immunodeficiency Virus
7. PWID People who Inject Drugs
8. MSM Men Who Have Sex with Men
9. NGO Non - Governmental Organization
10. OOP Out of pocket expenditure
11. PLHIV People Living with HIV
12. GF Global Fund
13. HEPC Hepatitis C
14. STI Sexually Transmitted Infections
15. UNAIDS United Nations Program on HIV/AIDS
16. MAT Medically assisted therapy
17. NSP Needle and syringe programs
18. MDM Medicins du Monde
19. MOH Ministry of Health
20. NACADA National Authority for the Campaign Against Drug Abuse
21. GOK Government of Kenya
22. UNODC United Nations office on Drugs and Crime
23. NASCOP National AIDS and STI control Program
24. NACC National AIDS Control Commission
25. OAT Opioid Agonistic Therapy
26. USG United States Government

1.0 Introduction: An overview of Kenya's health-care financing

Kenya is transitioning from a low-income country to a low middle-income country (LMIC); which has meant that donor support towards healthcare and HIV programming is decreasing at an alarming rate. The transition has already seen dwindling resources available for HIV programming as resources were not increased, though the country adopted the global 90-90-90 targets. Between 2014-15 and 2017-18 HIV programming expenditures subsequently increased from KES 59.37 billion to KES 96.52 billion, and although the government's contribution to HIV financing increased from 24% in 2014-15 to 28% in 2016-17, HIV programming still has a resource gap estimated at USD 173 million in 2016-17 and only has a coverage of 51% in 2018.

Healthcare in Kenya is provided through public, private-for-profit and private not-for-profit facilities. Healthcare services are arranged in tiers running from level 1 (dispensary, the lowest level of care) to level 6 (referral hospitals, the highest level of care). Public health facilities are found in the lower levels of care while private-for-profit facilities are concentrated in the higher levels of care. Currently, health care in Kenya is financed from three main sources: out of pocket expenditure (households), government expenditure and donors.

Kenya introduced needle and syringe programmes in 2012 delivered through civil society organizations (CSOs) as part of targeted interventions among people who inject drugs. The needle and syringe programme is a huge complement to existing HIV prevention and care efforts, and also provided an opportunity for a specific focus on people who inject drugs. Over a period of nine years, Kenya has managed to provide healthcare services to over 21,000 injecting drug users who access needles and syringes and over 9,500 opioid agonist therapy (OAT) clients in 8 healthcare facilities. The centres struggle to provide 50% of the complete set of World Health Organization (WHO) recommended interventions which include: 1. needle and syringe programs 2. opioid agonist therapy 3. HIV testing services 4. antiretroviral therapy 5. prevention and treatment of sexually transmitted infections 6. condom programmes for people who inject drugs and their sexual partners 7. targeted information, education and communication 8. prevention, vaccination, diagnosis and treatment of viral hepatitis B and C 9. prevention, diagnosis and treatment of tuberculosis and 10. community distribution of naloxone. Some of the interventions like community distribution of naloxone, and vaccination of viral hepatitis are still not implemented.

This report analyses harm reduction funding and expenditure in Kenya, specifically HIV and harm reduction for the period 2015-2018. It outlines all the CSOs implementing harm reduction in Kenya, where they get their funding and what services they offer. The report analyses the progress and gaps domestically since 2013, donor inputs, different donors, and their area of priority. Finally, it presents a discussion on what the future looks like for harm reduction in Kenya, and the challenges encountered during the COVID-19 pandemic.

1.1 HIV and Harm reduction Financing

In 2014, Kenya had a population of over 1.6 million people living with HIV (KASF 2014). Around the same time, it was estimated that 18.3 % of people who inject drugs were living with HIV.

Major donors for HIV and harm reduction programmes include the Global Fund to Fight AIDS, Tuberculosis and Malaria, Open Society Foundations, USAID, United States President's Emergency Plan for AIDS Relief (PEPFAR), United States Centers for Disease Control (CDC), ICAP, University of Maryland, Frontline Aids, Medicins Du Monde (MDM), Mainline, as well as faith based organizations and individuals. The government of Kenya through the Ministry of Health (MOH) and the National Authority for the Campaign Against Drug Abuse (NACADA) supports rehabilitation centres countrywide.

Table 1 : List of donors in harm reduction and their priority areas (2012-2020)

DONOR	PRIORITY	REGION
Government of Kenya (through MOH and NASCOP and NACADA)	Government hospital personnel, infrastructure, electricity, technical support, administration, medical commodities, non-medical commodities, security, mortuary services, maternity, tax relief, rehabilitation centers	Mombasa, Kisumu, Kilifi, Kwale, Nairobi
US Government (CDC, USAID, PEPFAR, FHI, ICAP, Jhpiego, University of Maryland, University of Manitoba	Methadone, research, medical and non-medical commodities	Nairobi, Mombasa, Kisumu, Kwale, Kilifi
The Global Fund to Fight AIDS, Tuberculosis and Malaria	Needle and syringe programme, antiretrovirals (ARVs), personnel, medical and non-medical commodities, audit, advocacy, community networks of people who use drugs	Mombasa, Nairobi, Kisumu, Kilifi, Kwale
Open Society Foundations	Community initiatives, advocacy, personnel, livelihoods, capacity building, training, non-medical commodities, research, audit and legal support	Mombasa, Kisumu, Kilifi, Kwale, Nairobi
Frontline AIDS	Community initiatives, policy, advocacy and legal support	
Mainline	Psycho-social support, non-médical commodités, ambulance support, nutrition support	Mombasa
United Nations Office on Drugs and Crime	Technical support	Mombasa, Kwale and Kilifi
Medicins Du Monde	Psychosocial support, hepatitis treatment, nutritional support, legal support	Nairobi
Muslim community in Mombasa	Nutritional support	Mombasa

1.2 Financing for HIV Commodities (ARVs, labs, and HTC)

The total requirement for HIV commodities for FY 2015-16 was US$ 200 million and was expected to rise to US$ 344 million by financial year (FY) 2018-19, while available funding was constant at US$ 174 million through FY 2018-19. This created a funding gap of US$ 26 million in FY 2015-16, which was expected to increase to US$ 200 million by 2018-19. The main driver of this increase was the rise in total costs of ARVs, driven by an increase of over 45% in the number of patients on treatment (871,000 in FY 2014-15 to 1.4 million in FY 2018-19). By FY 2018-19, available funding covered only 51% of the need for key HIV commodities. (MOH 2016, KASF 2015-2019).

Table 2: Projected funding budget for HIV in Kenya 2015-2019 in millions (Kenya HIV county profiles 2018)

	2015-2016	2016-2017	2017-2018	2018-2019
Projected funds	200	274	310	344
Available funds	174	174	174	174
gap	26	100	116	200
People on ART	596228	897,644	1.2 million	-
%coverage	51%	51%	51%	52%

Table 3: Government expenditure vs donor contributions in billions of Kenyan shillings (NACC 2018)

YEAR	2013-2014	2014-2015	2015-2016	2016-2017
GOK EXPENDITURE	59.38	73.32	73.09	121.33
GOVERNMENT OF KENYA ALLOCATION	10.09	18.33	21.196	37.6123
DONOR CONTRIBUTION	49.29	54.76	51.89	83.71

1.3 HIV and harm reduction services expenditure

Kenya introduced needle and syringe programmes as part of targeted interventions among people who inject drugs in 2012. The needle and syringe programme is a huge complement to existing HIV prevention and care efforts, and has provided an opportunity for a specific focus on people who inject drugs as a key population.

The majority of people who inject drugs are concentrated in specific geographical towns such as Nairobi, Kilifi, Kwale, Mombasa, Lamu and Kisumu. However, areas like Lamu, Busia, Homabay and Migori, Uasin Gishu and Kisii, despite the growth of new injecting drug users, still lack established harm reduction services.

HIV expenditure as a percentage of gross domestic product (GDP) remained relatively constant, at 1.3%. HIV expenditure accounted for 19% in FY 2012-13. 19% of all deaths in Kenya are attributable to HIV. According to NACC 2017, the GOK has been heavily reliant on donor funding for HIV programs. Donor financing towards HIV accounts for 73% of resources, roughly 1.2 times the Ministry of Health's budget. The total five-year cost of the HIV response under the Kenya AIDS Strategic Framework 2014-15 to 2018-19 is estimated to be US$5.5 billion, indicating the need for increased domestic resource mobilization. In the FY 2015-16 budget, the GOK allocated about US$26 million for HIV commodities, showing a commitment to increase domestic funding for HIV.

Comprehensive harm reduction services began in 2014, with the support of PEPFAR, and technical assistance from UNODC

and other key stakeholders. The interventions include:
1. needle and syringe programmes 2. opioid agonist therapy 3. HIV testing services 4. antiretroviral therapy 5. prevention and treatment of sexually transmitted infections 6. condom programmes for people who inject drugs and their sexual partners 7. targeted information, education and communication 8. prevention, vaccination, diagnosis and treatment of viral hepatitis B and C 9. prevention, diagnosis and treatment of tuberculosis and 10. community distribution of naloxone.

The large-scale implementation of such programmes required close collaboration and coordination at all levels. By 2016, all core interventions mentioned above were being offered to clients every day at no cost, over a period of nine years, the centres have grown from 1 centre to 9 centres and from 1600 clients to 30,500 across the country.

The average cost of providing harm reduction services in Kenya per client per day, excluding transport and nutrition, was found to be 149 Kenya shilling (US$ 1.49). Mogaka et al (2021) shows that 86% of total costs are due to personnel costs, while difference in costs between countries can be attributed to the difference in the average dose of methadone used for estimation of cost, and difference in type of methadone used since different types of methadone have varying costs.

1.4 Drop-in Centres (DIC)

Drop-in centres (DIC) are points where people who use drugs access services that are beyond the essential package of HIV assistance available at the healthcare facilities. DICs are available in the country through clinic service points managed by civil society organisations and are run on 100% donor funds. A standard drop-in centre offers needles and syringes, HIV testing and counselling, sexual and reproductive health (SRH) screening, dressing wounds, screening for hepatitis C, overdose management, pregnancy tests, psychosocial support and sometimes nutritional support. DICs are managed by a site coordinator, a medical officer, a pharmacist, a lab technician, and a group of peer educators and outreach workers who participate in community-based activities. Different stakeholders including the police, prison authorities, the judiciary, media, religious leaders, and the private sector are engaged through civil society organisations to create an enabling environment for the promegram and to better address the needs of people who use drugs. For their part, country-wide CSOs include: the Kenya Network of People who Use Drugs (KENPUD), Reach Out Center Trust, Omari Project in Kilifi County, Teens Watch in Kwale County, the Muslim Welfare and Education Trust (MEWA), Support for Addiction Treatment (SAPTA) LVCT Health and VOCAL Kenya. In 2019, there were close to 15 DICs across Kenya, however as of 2020, 4 DICs had closed down due to lack of funding, including the two DICs sponsored by KANCO in Watamu and Kajiado and the two DICs sposnored by MDM in Kawangware, Nairobi.

1.5 OAT clinics

OAT programmes are only found in government healthcare facilities and monitored by government registered doctors, this according to the ministerial guidelines on harm reduction. Kenya began its first OAT clinic in 2015. Since then, Kenya has set up eight public OAT clinics across the country namely, Kisauni in Mombasa County, Malindi in Kilifi county, Kombani in Kwale, Shimo la tewa prison, Mathari in Nairobi, Ngara in Nairobi, Karuri in Kiambu county and Kisumu clinics as part of the national harm reduction strategy for HIV prevention. These programs serve a total of 9,500 people who use drugs across the country. Prior to this, treatment for opioid dependence was usually short-lived detoxification based in private facilities which had limited availability and were costly and associated with high relapse rates and and were not based on a human rights-based approach. A systematic review showed that OAT is cost-effective for treatment of opioid dependence, though the estimated costs of providing methadone varies widely in different regions. As at the time of this publication methadone is the only OAT available in public funded clinics in Kenya.

2.0 Research aims and objectives

The overall aim of this study is to document harm reduction funding and funding sources in Kenya between 2015 and 2017.

1. To document the level of financial investment in harm reduction programing and sources of such funding
2. To highlight the interventions that are supported with this investment
3. To discuss the funding gaps and challenges and decision-making on resource allocations for harm reduction at national and local levels.

3.0 Study design and sampling strategy

The survey took a mixed method approach beginning with a literature review to understand the harm reduction funding landscape, and quantitative approach that featured the use of questionnaire and interviews on a purposive sample, and a mixed method approach to generate data from four urban regions in Kenya where drug use is prevalent, and where harm reduction services are present.

Sampling: the research used purposive sampling, targeting implementers of harm reduction, donor office representatives and focal persons involved in harm reduction programming between 2015 and 2017. It also targeted government offices and county offices who are responsible for county budgets and implementation.

4.0 Data collection

4.1 Data collection tools

VOCAL Kenya used two different kinds of tools to collect data from respondents who were managers, coordinators and finance officers in CSO implementing harm reduction programs. County government policy makers, heads of health ministries at the county level, heads of government program under the ministry of health which support harm reduction programmes were also interviewed. Also involved were heads of government run facilities offering OAT and ART, people who use drugs, pharmacists, lab technicians, hospital administrators, programme counselors, hospital human resource officers and matrons. Individual facility data was collected using the unit costing tool while facility data was collected using the tracking tool. Both tools are useful for this exercise as will be seen in the results. The unit costing tool also singled out every service delivered per facility, it helped to identify which regions lack specific service and why.

Tool 1: Harm reduction unit costing tool

VOCAL Kenya used the Harm Reduction International (HRI) costing tools to help the team collect data per drug user. The figures were then calculated and transferred to the harm reduction expenditure tracking per programme per facility per year. The harm reduction unit costing tool estimates in-country unit cost per OAT and NSP client per year. The tool is meant to calculate the unit cost of providing high-quality harm reduction services.

Tool 2: Expenditure tracking tool

This tool was used to generalise the expenditure at facility level. It includes annual costing for medical and non-medical commodities, personnel and capacity building. This tool captured programme annual budgets in general but not cost per unit.

Challenges encountered during data collection

Did the pandemic affect data collection?

Given the constraints during the pandemic, some questionnaires were filled through phone interviews, and others via zoom calls, however most respondents insisted on face-to-face meetings given the sensitivity of the financial documents.

Government officers remained closed most of the time as people worked from home, the few who were around remained suspicious and wanted to remain anonymous for speaking openly about corruption. Many budget documents were also available online.

Obtaining data for organisations, such as MDM, that had stopped services was delayed and challenging, since emails were not being replied to.

Participants expressed that the data tools were too long and took too much time.

Delayed interviews due to government bureaucracies, especially in cases where permission had to be sought from more than one officer.

5.0 Findings

5.1 HIV financing estimates 2015-2017 (NACC 2018) in billions of Kenyan Shillings

Table 4: Government vs donor input in HIV funding between 2015 and 2017 in billions Kenyan Shillings

Funding source	2014-2015	2015-2016	2016-2017
Public Sources (GOK)	128,927,757,490	26,431,834,127	35,388,842,123
Private Sources (private sector)	7,556,193,467	8,536,435,791	9,450,309,497
PEPFAR	46,425,882,882	53,073,270,967	63,601,206,636
The Global Fund to Fight AIDS, Tuberculosis and Malaria	7,576,996,434	7,975,847,595	12,647,045,336
Other bilateral Donors	213,258,639	47,599,296	49,244,828

5.2 HIV funding gap (NACC 2016, 2018)

The Kenyan government adopted the 90-90-90 targets; however, current resources will not be able to deliver the services necessary to achieve these targets. Between 2014-15 and 2017-18, HIV programming expenditures increased from KES. 59.37 billion to KES. 96.52 billion. Although, the government's contribution to HIV financing increased from 24% in 2014-15 to 28% in 2016-17, HIV programming still has a resource gap estimated at US$ 200 million in 2016-17. To close this gap between resource needs and resource availability, the Kenya AIDS strategic framework has been promoting innovative and domestic financing of the HIV response through maximizing efficiencies and adopting innovative sustainable financing.

Table 5 HIV Resource Gap (NACC 2018) in Billions Kenya shillings

	2014-2015	2015-2016	2016-2017	2017-2018
Resources needs	0	0	58599	58599
Resources spent	1386	1575	1668	1834
Resource gap	1386	1575	56931	56764

Table 6: showing harm reduction service delivery centres across Kenya 2021

FACILITY/ORG	Location	Donors	Services delivered
Mathari mental hospital	Nairobi	MOH, United states Government	ART, inpatient, mental health care, OAT, SRH, maternity, CCC
Ngara clinic	Nairobi	MOH, County government of Mombasa, USG	ART, inpatient, mental health care, OAT, SRH, maternity, CCC
Karuri clinic	Kiambu	MOH, County Government of Kiambu, United states government, MSF, GF	ART, inpatient, mental health care, OAT, SRH maternity, CCC
Malindi level 5 hospital	Kilifi County	MOH, CGK GF, UNODC, United states Government, OSIEA	ART, inpatient, mental health care, OAT, SRH maternity, CCC
Kisauni medical clinic	Mombasa County	MOH, Global Fund, UNODC, OSIEA,	ART, inpatient, mental health care, OAT, SRH, maternity, CCC
Kombani clinic		MOH, United states government, UNODC,	
Jaramogi -Kisumu	Kisumu	MOH, Global Fund, United states Government	ART, inpatient, mental health care, OAT, SRH, maternity, CCC
Noset	Nairobi	Global Fund, United states government	NSP, out-patient, Psychosocial
Sapta	Nairobi	Global Fund, Frontline Aids	NSP, HTC, NSP, 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, United states Government, UNODC, OSIEA	NSP, HTC, NSP, out-patient, psycho-social, overdose management
Reach-out trust	Mombasa, Kwale	GF, United states government, UNODC, OSIEA	HTC, NSP, out-patient, psycho-social, overdose management

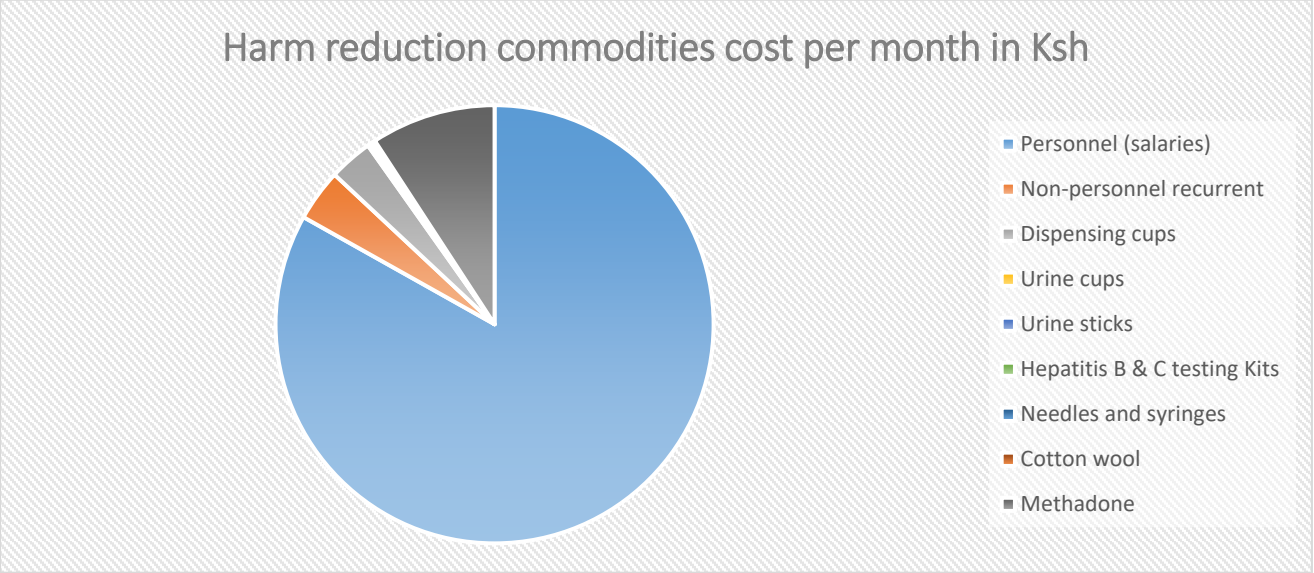
Teens-watch	Kwale	GF, United states government, UNODC, OSIEA	HTC, NSP, out-patient, psycho-social, overdose management
LVCT-Kisumu	Kisumu	GF, United states government, UNODC, OSIEA	HTC, NSP, out-patient, psycho-social, overdose management
KENPUD	Nairobi	Global fund, UNODC, OSIEA	Community capacity building and awareness

According to Mogaka et al, 2021, The sum of the total cost of methadone maintenance treatment in Kenya per year was Ksh. 37,619,300 (US$ 376193) in 2021. The average daily cost of methadone treatment was US$ 1.49 per individual with average personnel cost constituting most of the cost (86.4%) while methadone cost comprised a tenth of the total. The other non-personnel recurrent costs comprised 4% of the direct costs with majority of this cost being from cost of dispensing cups. This is shown in more details in the table below

Table 7: The table below shows an analysis on how much it costs to deliver harm reduction services per person per day in Kenya.

Summary of daily cost of harm reduction treatment based on direct costs		
Item	Cost per month in Ksh	Cost Per Year in Ksh (US$)
Personnel (salaries)	2,710,000	32,520,000
Non-personnel recurrent	124,940	1,499,300
Dispensing cups	105,000	1,260,000
Urine cups	5000	60,000
Urine sticks	5000	60,000
Hepatitis B & C testing Kits	4200	50,400
Needles and syringes	4700	56,400
Cotton wool	1040	12,500
Methadone	300,000	3600000
Total	3,130340 (31,303.40)	37619300 (376,193)
Cost per client	4471 (44.71)	53,742 (537.42)
Average cost per client per day	149 (1.49)	149 (1.49 USD)

(*Adapted from Brenda Mogaka et al, 2021*)



6.0 Discussion

A literature review revealed that between 2015 and 2017, the government of Kenya contributed 31% of the 121 billion spent in HIV programs across the country in the financial year 2014-2015, 29% of the 73.9 billion Kenya shillings in the financial year 2015-2016 and 25% of the 73.3 billion spent in 2016-2017. The research also revealed that around the same time 4% of the resources spent was allocated to HIV prevention in 2014-2015, 8% in 2015-2016 and 8% in 2016-2017, the category where harm reduction falls.

	2014-2015	2015-2016	2016-2017
GoK contribution to HIV funding	31%	29%	25%
Total HIV funding (Govt and partners	121 billion	73.9 billion	73.3 billion
Expenditure in HIV prevention (Harm reduction related commodities)	4%	8%	8%

The data collected shows that it costs 149 Kenya Shillings per day or US$ 1.49 to deliver the biomedical component of harm reduction, this is in addition to transport and nutrition which costs approximately 100.00 Kenya Shillings per person per day and transport to the facilities. In total, funding takes care of 149 ksh per day while out of pocket (OOP) accounts for 200 Kenya Shillings per day in total US$ 3.49. The biggest expenditure for the biomedical component was personnel for both CSO and government, which costed more than 70% of the total annual budget. It is also important to note that human resource in Kenya is fairly expensive consider to other East Africa countries because the cost of living is also one of the highest in Africa.

This survey also noted that not all the money allocated to the MOH is used for the purpose, staff responsible for commodities indicated that there are constant shortages caused by the gaps in procurement. Systemic corruption at the MOH has been viewed as one of the implementation bottlenecks to donor funds. In 2017, the US government suspended aid to Kenya after an audit showed the MOH could not account for 5 billion Kenyan shillings (US $49 million) and funds meant for care had been diverted. Kenyan doctors and nurses have been reported in the press to have said that the corruption denies hospitals basic equipment such as drugs and gloves. Kenyan doctors in public hospitals have in the past protested by going on strike more than three times to push government to improved their working conditions, an issue which has never been resolved.

Programmatic evidence showed that only 30% of people who use drugs in Kenya access harm reduction services. This is due to the fact that harm reduction is only available in 5 counties out of 12 regions in Kenya with growing numbers of people who use drugs. A recent survey funded by Global initiative and conducted by VOCAL-Kenya indicated that by 2020, there was an increase in the number of people who smoke heroin who had transitioned to injecting, an increase in the number of low level heroin and cocaine sellers in the streets of major towns in Kenya and growth in the number of people using methamphetamine. In some towns the number of sellers had doubled, while drugs like methamphetamine and tramadol were fast gaining popularity among Kenyan youth. This is especially true for areas where there are established universities and colleges.

Table 8: HIV Financing Resource Allocation (NACC KAPR REPORT 2018)

Resource Allocation	2014-2015	2015-2016	2016-2017
Treatment and care	86%	76%	79%
prevention	4%	8%	8%
Children and adolescence programs	0	0	0
Community mobilization	0	0	0
Governance	9%	11%%	8%
Blood safety	0	0	0
Universal precautions	1%	0	0
Serology surveillance	1%	0	0

6.1 Challenges during the COVID-19 pandemic

Kenya has faced huge coordination and planning challenges between its different levels of healthcare and the health system during the COVID-19 pandemic. There are also many actors in the health sector, which also made data collection by the research team difficult with some actors opting out.

The COVID-19 Presidential guidelines are implemented by the police which has led to arrests of people who use drugs stressing further the critical need for services for people who use drugs. Researchers who visited the medical facilities were faced with questions on how to support people who use drugs who were missing their daily doses of methadone because they had been arrested.

Harm reduction services have been largely interrupted after government halted plans for the implementation of methadone take-home dose and community distribution. Many people have lost jobs and cannot afford transport costs to and from the facilities daily, making many drug users to skip methadone doses and go back to using heroin.

RECOMMENDATIONS

There has been an increase in the gap in funding in healthcare and harm reduction programmes, the Kenyan government needs to increase its allocation and potentially partner with the private sector to close the gaps. Addressing corruption will also help to reduce wastage of money and procurement of pharmaceutical products at the county facilities, this will help to finance harm reduction and healthcare.

There must be better coordination between government, donors, CSOs and faith-based institutions. This is particularly vital when it comes to budgeting and resource allocation, to ensure there is little chance for duplication, and create a balance so all regions receive support according to the population needs, currently what is happening in Kenya is too much focus in some areas with no focus at all in others, leaving room new HIV infections among people who inject drugs. This will also prevent donor crowding which has led to double reporting and conflict between CSOs operating in one area when competing for numbers to be reported. This has been a problem in harm reduction in Mombasa and Nairobi.

The ministry of health has too many documents with information spread all over, there is need to consolidate for easy access.

There must be investments in more research on how harm reduction is contributing to HIV prevention, saving lives and reducing costs in the criminal justice system. This will help inform policy makers to be able to do more towards policy change.

Finally, despite the fact that people who use drugs require integrated healthcare services, this is not the case in many routine healthcare clinics in Kenya. There many services that are lacking currently due to corruption, reduced funding, lack or awareness, ignorance or lack of oversight by the authorities involved. These include psychosocial support to access antenatal care, deliveries and immunizations for children of women who use drugs. Mitigation actions and planning are urgently needed.

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