In Their Own Voices:

Communities in Kenya Speak on the Impact of the Stop-Work Order


How to Handrub?
Sexual Violence is a crime

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Introduction

In early 2025, Kenya's HIV response, once hailed as a model of resilience and community partnership, faced an abrupt and unprecedented disruption. The Stop-Work Order (SWO) issued to implementing partners forced the immediate suspension of community-led HIV services across the country. Within days, Drop-In Centers (DICEs) [1]were shuttered, outreach programs halted, and the lifelines that communities had built over two decades were suddenly cut off.

For more than twenty years, Kenya's progress against HIV had been anchored in collaboration between government, donors, and community-led organizations (CLOs). These organizations had become trusted spaces where people living with HIV (PLHIV), key populations, and vulnerable groups found not only treatment and care but dignity, confidentiality, and solidarity. CLOs were more than just service providers; they were advocates, counsellors, and safe havens, bridging communities to systems that had long marginalized those most at risk.

The SWO disrupted that ecosystem overnight. People living with HIV lost adherence counselling, mentor-mother support, and access to viral load and CD4 testing. Mothers living with HIV faced sudden interruptions in infant prophylaxis and early infant diagnosis (PCR) testing. Women and adolescent girls experienced suspension of cervical and breast cancer screening, while HIV-exposed infants missed prophylaxis and testing schedules. Key populations such as female sex workers (FSWs), men who have sex with men (MSM), and people who inject drugs (PWID) were cut off from prevention commodities, gender-affirming care, and harm-reduction programs. Among young people, access to sexual and reproductive health (SRHR) services including contraception, STI screening, and psychosocial support were abruptly interrupted. Across the country, the closures triggered confusion, fear, and renewed stigma.

The shock came amid broader funding and policy transitions. As Kenya advanced its Universal Health Coverage (UHC) agenda and donors restructured priorities toward system-wide strengthening, programs once delivered by communities were absorbed into county systems often without adequate consultation, transition planning, or safeguards. The result was a storm of exclusion: services were integrated without flexibility, communities felt re-stigmatized in mainstream facilities, and CLOs were left scrambling to survive.

Yet amid the crisis, communities demonstrated extraordinary resilience. Peer educators continued tracing lost peers without pay. Mentor mothers volunteered to guide pregnant and breastfeeding women. County government facilities reallocated local funds to retain community cadres and even relocated DICEs into public hospitals to preserve continuity. Informal community-led monitoring emerged, keeping data flowing and voices alive through grassroots documentation and digital outreach.

This documentation was born from that same spirit of agency. Communities themselves reached out

to UNAIDS, requesting an opportunity to document the lived experiences of the Stop-Work Order and its aftermath. Their appeal was clear: to ensure that this crisis would not be forgotten and to use evidence, stories, and community voices to rebuild a more resilient, rights-based HIV response.

The report that follows therefore presents the reflections, data, and stories shared by communities and county actors across Kenya. It blends analysis with narrative, illustrating not only the magnitude of disruption but the creativity, courage, and solidarity that emerged in response. The lessons are urgent and unmistakable: community-led services are indispensable; integration must protect dignity and choice; and transitions must be inclusive and transparent. Future shocks, whether financial or political, must never again be allowed to silence the very communities that anchor Kenya's HIV progress.

Objectives of the Documentation

The overall objective of this documentation was to assess and report on the impact of the Stop-Work Order (SWO) and the broader funding and policy shifts on community-led HIV services in Kenya, using community narratives and stakeholder engagement to generate evidence for resilience and rights-based advocacy.

Specific objectives were to:

1. Assess the scope and magnitude of service disruptions across affected populations and regions.
2. Examine the social, economic, and health impacts on PLHIV and key populations relying on community-led services.
3. Analyze the organizational impacts on CLOs, including staffing, operations, and service reach.
4. Document community voices, coping mechanisms, and innovations in response to the disruptions.
5. Gather feedback from communities on their experiences with integration into public health

FGD with community representatives in Nyamira County, Kenya

systems.

6. Develop policy and programmatic recommendations to strengthen community systems' resilience and protect essential services during donor transition shocks.

The Documentation Process

The documentation applied a qualitative, participatory approach that combined desk review, key informant interviews (KIIs), focus group discussions (FGDs) and case studies to capture both structural and human dimensions of the disruption. Fieldwork was conducted in four counties of Nairobi, Kisumu, Homa Bay, and Nyamira - selected to represent urban, rural, and high-prevalence contexts. Over 30 in-depth interviews and 37 FGDs were conducted with CLO leaders, peer educators, mentor mothers, county AIDS coordinators, and community members from key and vulnerable populations.

All participants gave informed consent, and discussions were held in safe community spaces facilitated by trained moderators. Communities were engaged not as subjects but as partners, validating findings and co-interpreting results. Data was thematically analyzed, blending lived experiences with policy insight to ensure that evidence reflected both structural realities and community voices.

When the Doors Closed: The Human Ripple of the Stop-Work Order

When the Stop-Work Order came into force, its shock rippled across clinics, beaches, villages, and informal settlements. The silence that followed was not only about padlocked DICEs, empty counselling rooms and closed safe spaces, it was about lives abruptly interrupted.

Mothers feared for their babies. Young people whispered anxiously about whether their drugs would run out. Peer educators folded their registers, uncertain if they would ever be called again.

The next section brings together these experiences, told in the words of the communities themselves, to reveal both the scale of disruption and the quiet resilience that followed.

A Youth advocate in Nairobi reflecting on the Impact of Stop Work Order in Nairobi

Mary Nyanchera, A mentor mother during a session in Nyamira County

Lives on Hold — People Living with HIV (PLHIV, Including Adolescents and Young People) Speak

Before the SWO, a sturdy web of community-based care kept thousands of Kenyans living with HIV healthy and hopeful. At every link of that web were human faces: mentor mothers who helped newly diagnosed mothers in clinics; adherence counsellors who reminded clients of pill times; peer educators who provided health education sessions; and youth-friendly corner volunteers who turned fear into friendship. Their work sustained viral-suppression rates and restored dignity.

Then came the Stop-Work Order and panic.
Jerop, a youth leader in Nairobi, recalled the moment word spread through WhatsApp groups and community pages:

> *"The first thing that happened was panic. I myself was panicking. All of us were panicking. The first question that we had was what will happen to our drugs? Where will we get our drugs from? Is that the end of the HIV response that we know; that we have known for decades"*

Youth friendly centers for adolescents and young persons were closed or converted into different units discouraging the young people who used the centers for adherence counselling and provision of youth friendly services.

A young person from Kisumu had the following to say about the youth friendly center

> *"We had a youth friendly center that we used for our weekly and monthly support group sessions. It provided young people with a private place to meet and support each other. The school going adolescents would study in the center as they waited for their turn to see the doctor. Ater the Stop Work order, the center was converted into doctors' offices and all HIV services taken to OPD. Now we have nowhere to meet"*

The Children and young people also had their Operation Tripple Zero (OTZ[3]) Sessions and Clinics shifted from weekends to weekdays as integration did not provide for a healthcare worker over the weekend thus inconveniencing school going children.

An adolescent champion from Nyamira explained that :

> *"The OTZ1 meetings were shifted from weekends to weekdays. The crowds*

1 Operation Tripple Zero(OTZ) is a program that empowers adolescents and young people (10-24 years) living with HIV to achieve three key treatment goals: zero missed appointments, zero missed drugs, and zero viral load. It fosters self management and peer support within a youth-friendly, stigma-free environment through peer support groups that provide health education, psychosocial counseling, and mentorship from trained healthcare workers and peer champions to build intrinsic motivation.

experienced on the weekdays makes it difficult for the children living with HIV to be free. School going children also have to choose between attending the OTZ sessions and attending classes in school"

Mothers living with HIV were among the first to feel the impact. Infant prophylaxis supplies disappeared from facility shelves in the initial days of the Stop Work Order. Some women stopped breastfeeding abruptly, terrified of infecting their babies or being blamed for shortages.

"I cried when they said there was no medicine for my baby. I felt I had failed as a mother. We were forced to stop exclusive breastfeeding for fear of infecting our babies. With the high cost of formula, our babies risked malnutrition" Mentor mother, Nairobi.

Resource centres, youth corners and safe spaces where PLHIV shared experiences were dismantled. Peer educators were laid off, and recipients of care absorbed into general outpatient departments where stigma lurked behind every stare. For adolescents and young people, integration meant invisibility. They feared being recognized at the hospital queue, their confidentiality hanging by a thread.

County AIDS officials later admitted that the rollout had been chaotic since it all happened very fast.

A County official reflected candidly:

"When the circular was going out, I think we did not involve representatives of the beneficiaries to actually also just tell them because we were acting in that panic mode. So the representatives felt that we left them out at that point. But now we've had great engagements in terms of ensuring and also getting feedback."

The disruptions exposed gaps in preparedness, yet they also triggered moments of reconnection.

"Some of the people who had disappeared came back," the same CASCO noted. *"Those lost to follow-up returned when we started community tracing."*

The story of PLHIV during the SWO is one of contrasts: fear and resilience, loss and rediscovery. It reminded Kenya that community structures are not accessories—they are lifelines.

When the Night Clinics Closed — Female Sex Workers (FSWs) Perspectives

For female sex workers, the SWO struck like an unannounced curfew. Before it, DICEs had offered everything under one roof: PrEP, condoms, lubricants, family planning, post-rape care, counselling, and even savings-group meetings that doubled as sisterhood circles. The Clinics opened late at night or on weekends to match their schedules.

Within days of the order, doors were shut, outreach phones went silent, and the women who once provided life-saving information were themselves left unpaid. A Nairobi CLO head remembered:

> *"We were told in three days to close. People were not even paid. The peer educators, even up to today, have never been paid."*

One of the deepest wounds came from the abrupt termination of an ongoing clinical trial. A focus-group participant recounted painfully:

> *"We felt used like lab rats. Nobody told us anything. They just went quiet on us and closed the trial clinic. Some girls were even left with devices in them. No report, no feedback. We don't know if the intervention worked."*

The shutdown didn't only halt health services; it fractured trust between donors, CLOs, and the communities who had once believed they were partners, not subjects. Integration into public hospitals compounded the loss. Government clinics closed at 5 p.m., just as many female sex workers leave for work. Long distances and transport costs made care inaccessible since the hotspot outreaches were discontinued.

> *"Going to the government hospital for condoms makes me lose time, a client and fare,"* said a peer educator in Kisumu.
> *"At the DICE, I could walk in after midnight or anytime I am free during the night. There was no restriction on time and how many times I take commodities"*

Without the privacy and empathy that DICEs provided, fears of stigma flourished. Yet amid frustration, the FSWs forged solidarity: informal referral chains, table-banking groups, and shared ARV pickups.

> *"We agreed that if one of us goes to the DICE that remained open, she picks drugs for others. We contributed transport for the trip making it cheaper in the long run"* FSW network member, Nairobi.

Silenced Safe Spaces — Men Who Have Sex with Men (MSM) Voices

For years, MSM networks had carved out fragile pockets of safety within a hostile environment. CLOs created safe spaces places where a person could access various services such as PrEP or anal-wart treatment without fear. The SWO erased those spaces overnight.

> *"We had DICES that provided services that other facilities cannot provide. Since the DICES are run by communities, the facilities offer specialized services. For example Anal warts treatment and surgical anal repair services are best handled in MSM led DICES. When the DICES were closed, these services were also erased. It is difficult to talk about anal health in regular health facilities."*

An FGD participant from the MSM community in Nairobi indicated.

The closure of DICEs and paralegal programs left peers vulnerable to both illness and violence including homophobia. The violence response, psychosocial counseling, and support to security agencies. FGD participants described renewed hostility in communities:

> *"The policies that changed really brought out homophobia in the community. People started attacking us, saying, 'now even the donors have stopped supporting you. There was an increase in violence since the support for violence support was stopped. Many people had to go into hiding or move away from the urban areas"*

In government facilities, stigma resurfaced. Without sensitivity training, some health workers laughed or whispered during consultations.

> *"You sit in the queue and feel the eyes on you,"* MSM FGD, Nairobi.

> *"You go to a facility; they diagnose you with an STI and ask you to bring your partner. When you bring your partner, your partner is gay. The healthcare workers have in government facilities have a lot of stigma. You will be scolded and gossiped at in those facilities"* A member of the MSM community in Kisumu reported

Beryl Abade from BHESP following proceedings of an FSW network session

A community member in Kisumu gives their perspective on the impact of SWO in Kisumu

Fear of disclosure led to hoarding of PrEP and ARVs. Others stopped treatment altogether, preferring secrecy to humiliation. Yet, underground resilience persisted. MSM networks created encrypted chats listing "friendly" clinicians. They shared maps of facilities marked code for safe service points.

> *"That's how we stayed alive. We used codes to tell our peers of friendly facilities or healthcare workers. Some people collected drugs from different facilities to survive" said a community paralegal from the MSM community in Kisumu.*

A photo of an FGD session with communities in Kisumu

Despite limited resources, CLOs began to explore formal registration as clinics to qualify for future government health insurance accreditation. There are plans to upgrade DICEs into full-fledged health facilities offering a broad range of services beyond MSM services to attract domestic funding. This act of quiet defiance has signaled hope beyond donor dependency.

Trust on the Edge — People Who Inject Drugs (PWID) Speak Out

The PWID community, already at the edges of society due to criminalization and stigma, felt the SWO like a withdrawal. Before the SWO, harm-reduction programs offered a complete package: methadone induction, needle and syringe exchange, wound care, hepatitis C screening, overdose management, nutrition support, and outreach counselling. These services kept hundreds alive.

When the funding stopped, everything froze.

> *"Peer educators are no longer working because there are no stipends. Some went back to the streets. They relapsed. There are hotspots that remain unmanned. Government facilities only offer prevention, treatment and counselling. But when it comes to needle and syringes exchange program[2], it just stopped..."*
> Explained a leader from the Kenya Network of People who Use Drugs (KENPUD)

Across Nairobi and Mombasa, syringe exchanges halted and new methadone admissions were suspended.

2 Needle & syringes Exchange Program (NSP) is a social initiative designed to reduce sharing of needles among injection drug users (IDUs). It allows IDUs to obtain clean and unused hypodermic needles and associated paraphernalia at little or no cost. The aim is reducing transmission of HIV, Hepatitis C among others.

John Kimani from KENPUD giving a testimony on Impact of SWO in Nairobi

> *"People are reusing needles because the organization that used to deliver those services is gone,"* said one informant in Nairobi.

Relapses multiplied; overdose deaths quietly rose. Yet even without pay, peer educators refused to abandon their networks. They advocated for and began what they called "reverse tracing" which involved finding clients who had dropped out and bringing them back to treatment.

> *"We advocated for funds to look for those who were lost to care. Peer educators and volunteers looked for those who were served in closed DICES and linked them to the ones that remained open "* Outreach volunteer, Nairobi.

Their unpaid commitment underscores a truth that is often overlooked: in harm reduction, trust travels faster than funding.

Dreams Interrupted — Adolescent Girls, Young Women, and Fisherfolk Share Their Journeys

When the DREAMS program went dark, adolescent girls and young women (AGYW) were left adrift. The once-vibrant safe spaces that were filled with laughter, music, and mentorship fell silent.

> *"It disadvantaged the community as a whole. All the interventions stopped. Safe spaces shut down, the services that girls were receiving in the program were no longer there as before"* said an AGYW mentor from Homa Bay.

Without those safe havens, adolescent girls and young women lost access to evidence-based interventions including psychosocial care, dignity

An AGYW mentor from Homabay during a session

kits, and SRHR services. Vulnerability to HIV, gender-based violence, and early pregnancy surged. The mentors, now volunteers, tried to fill the void informally.

> *"Even when the program closed, the girls kept coming. We couldn't chase them away. Unfortunately even the referral pathways were broken"* An AGYW Mentor from Homabay indicated

Along the shores of Lake Victoria, fisherfolk faced a parallel crisis. Outreaches stopped; condom supplies dried up, linkage services were discontinued.

> *"Peer support and condom distribution have gone down. Without outreaches, new arrivals at the beaches are not linked to health services. For a beach with the many people interacting in one small area, this is a big problem"*
> shared a peer educator in Homa Bay.

For transient fishing communities where new faces appear every week, the absence of peer linkage meant heightened exposure to infection. Years of progress in prevention were suddenly fragile. With job losses due to SWO, many residents of the fishing areas ended up in the beaches compounding the vulnerability

"The SWO made many new people come to the beach areas to earn a living because they lost jobs in other areas. This led to so many peers appearing and the beach, yet the Peer educators were not added to take care of the new population. There have been condom shortages because of the high numbers." A peer educator from Homabay shared

The Shock to the System — Organizational and Community-Led System Perspectives

The Stop-Work Order did not only affect clinics, it shook the foundations of community-led organizations (CLOs). CLOs and the community cadres they support were severely affected. Contracts were abruptly cancelled; communication with donors went silent. Some CLOs even closed offices and operations.

> *"This has been the most devastating occurrence. SWO came rapidly. It was so sudden it left no room for transition or reorganization to see how services would reach beneficiaries without creating disruptions. It led to unplanned terminations of contractual obligations with staff, with suppliers. There was massive effect on our staffing, work operations, area of coverage"* A CLO leader in Kisumu reported

Paul Ochieng' a CLO leader provides his perspective on the impact of SWO

Dorothy Onyango, a CLO leader during the documentation process

Peninah Mwanigi, A CLO leader during the SWO documentation process

In Nairobi CLO leader added

> *"We closed two DICES including this one. One was later reopened, but the other is still closed. It's been a very uncertain time for nine months. There has been an increase of people being served here but with no room for increase in investment or staff"*

For community cadres such as peer educators, mentor mothers, and paralegals, the layoffs were more than financial, they felt like betrayal.

> *"We worked for years building trust. Then one message ended it. Communities and Counties no longer trust our abilities to offer services."*
> said a CLO leader in Nairobi.

Yet some county governments stepped up. Some facilities used locally generated Facility Improvement Funds to retain community cadres such as mentor mothers. Counties planned sensitivity training for health workers to adapt to new realities.

These innovations showed that with political will, local systems could absorb community cadres and preserve relationships that money alone cannot buy.

Threads of Resilience — Communities Reflections on What Held Them Together

Across the country, the Stop-Work Order became a stress test for the country's HIV response. It exposed dependence on donor cycles and the fragility of community systems but also revealed extraordinary reserves of resilience.

For PLHIV, loss of infant prophylaxis and safe spaces sparked panic but also mobilized community tracing. For FSWs, the shutdown deepened stigma yet birthed solidarity economies. For MSM, integration unleashed homophobia yet inspired innovation in secure digital networks. For PWID, closure meant relapse, but peer volunteerism prevented worse loss. For AGYW and fisherfolk, dismantled empowerment programs underscored how fragile prevention gains remain. For CLOs, the freeze revealed the danger of donor dependency but also the potential of county-led innovation.

Coping Mechanisms and Community Resilience

When the Stop-Work Order halted operations across HIV programs, it was the communities themselves who stepped forward to fill the void. Despite closures, layoffs, and fading donor communications, the HIV response did not entirely collapse. Instead, it evolved held together by informal systems, volunteerism, and trust. What emerged was a picture of quiet strength and innovation that reaffirmed one truth: communities are the backbone of resilience.

Rumours, Fear and the Race to Reassure

As panic spread through community networks, mainstream and social media, rumours quickly took root. Communities were told that treatment had stopped, clinics were permanently closed, or their data had been deleted. Community networks responded first. PLHIV leaders, youth advocates, and peer educators mobilized digital campaigns, group chats, and media updates to correct misinformation and reassure clients.

> *"I must admit that there was a lot of misinformation about everything ... In the positive side is that we sort of put a support system together to ensure that any young person, whatever the situation is, then they know they can knock our door and the situation will be sorted ... We were there to really try and ensure they have the correct information they don't just pick up everything that is being said online but also remind them that we won't lack ARVs"* an AYP leader commented

> *"Our role has been to assure recipients of care that treatment is available....We continue to advocate to the government to take that up and to make sure that that is continuing"* PLHIV network leader, Nairobi.

Nelson Otwoma, a PLHIV network leader during the documentation exercise

Youth networks such as Y+ Kenya launched rapid online surveys to track where disruptions occurred and used that data to produce daily updates for their peers and county officials. In doing so, communities reclaimed their role as the most trusted messengers in times of crisis.

The network of People who Use Drugs in Kenya responded to various surveys to provide accurate information on the impact.

> *"There are so many surveys we have done, there are so many discussions we have sat down with people to discuss about the stop-work order" One of the network leaders commented*

Invisible Hands: Informal Referrals and Peer Networks

As official referral systems froze, informal ones blossomed. Peer educators, mentor mothers, and outreach volunteers created WhatsApp groups and neighborhood phone lists to guide clients toward operational facilities. In some counties, one person would collect antiretroviral drugs for several peers, pooling transport costs and sharing commodities.

> *"We pooled resources and sent one of us to collect medicine and commodities on behalf of the rest us,"* said a member of the FSW community in Nairobi.

Mentor mothers maintained direct contact with breastfeeding women

and with other mentor mothers to redistribute infant prophylaxis supplies during the initial phase of the disruptions. MSM and sex worker networks discreetly exchanged facility information while the continuing DICES opened doors for the communities from closed DICES to preserve confidentiality and dignity. Through these quiet acts of coordination, communities recreated the connective tissue of Kenya's HIV response.

When the Pay Stopped, the Work Didn't

Across the counties, volunteerism became the pulse that kept services alive. Peer educators, outreach workers and adherence counsellors who had lost stipends continued tracing clients out of commitment, not contract. Table-banking groups and community savings circles pooled small contributions to cover transport or rent for volunteers.

> *"We knew no one was coming to save us. So, we organized ourselves to ensure our communities are not adversely affected"* FSW community member, Nairobi.

> *"We couldn't watch our people slide back or relapsing, so we kept going, even if we had no support"* said added a PWID peer educator in Kisumu.

In some counties, the County AIDS Offices recognized this unpaid effort, using local Facility Improvement Funds to retain mentor mothers and community cadres. This practical model for institutionalizing volunteer labor into funded public health structures was viewed as a best practice.

The collapse of DREAMS programs hit adolescent girls and young women especially hard. Mentors lost their stipends but not their spirit. They continued gathering girls informally in church compounds, under trees, or in borrowed community spaces to share lessons on health, empowerment, and hope.

A section of FSW community members during an FGD in Roysambu Nairobi

A peer educator in Nairobi during an FGD session in Nairobi

A photo of a fishing boat with Health message in Rusinga Island, Homabay County

> *"We continue to meet and mentor the girls when we can,"* said a DREAMS mentor in Homa Bay. *"Unfortunately, the referral pathways have been altered, but we hope services will resume."*

For fisherfolk, peer networks also kept prevention alive. When formal outreach stopped, peers organized discreet condom distribution during market days or fishing breaks, using whatever commodities they could access.

> *"Even though the programs slowed down, the lake didn't stop. We keep moving,"* said a peer educator from Homa Bay.

The small acts of persistence such as quiet mentoring under trees, late-night reminders at fishing beaches, and peer follow-ups in borrowed community spaces prevented the total collapse of HIV prevention in transient or high-risk populations. They proved that local initiative can sometimes succeed where formal systems fail.

Innovation in Integration: Care Without Walls

Communities also improvised new differentiated service delivery models to maintain adherence. Home-based delivery and community pick-ups

A young person during the documentation exercise in Kisumu

replaced outreach programs; small peer groups met after work hours in community spaces or homes; youth advocates held virtual adherence sessions via WhatsApp.

> *"We now have community pharmacy where we can pick our drugs from private chemists closer to our homes."* A PLHIV network leader from Kisumu indicated

Counties like Kisumu integrated DICE services into public hospitals but retained the same staff and ethos, ensuring continuity of trust. This flexible adaptation attempted to preserve confidentiality and dignity for key populations and young people alike.

Data as Defiance: Community-Led Monitoring and Advocacy

When traditional data systems froze, community-led monitoring (CLM) kept evidence alive. Peer educators and community monitors logged service gaps, commodity stockouts, and stigma incidents on paper or mobile forms. CLOs and youth networks shared these updates with the leadership county health teams and NASCOP, informing targeted responses.

> *"And what we do currently, we have a version of community-led monitoring where people monitor, volunteers monitor and share with us what is missing,*

> *because that is still important to give feedback to the Ministry of Health"* A PLHIV network leader indicated

The data not only filled accountability gaps but also built communities' confidence as legitimate knowledge producers and partners in policy dialogue.

The informal community-led monitoring (CLM) became the heartbeat of accountability, proving that data need servers to be powerful, it just needs witnesses

Advocacy and Systems Engagement: From Crisis to Influence

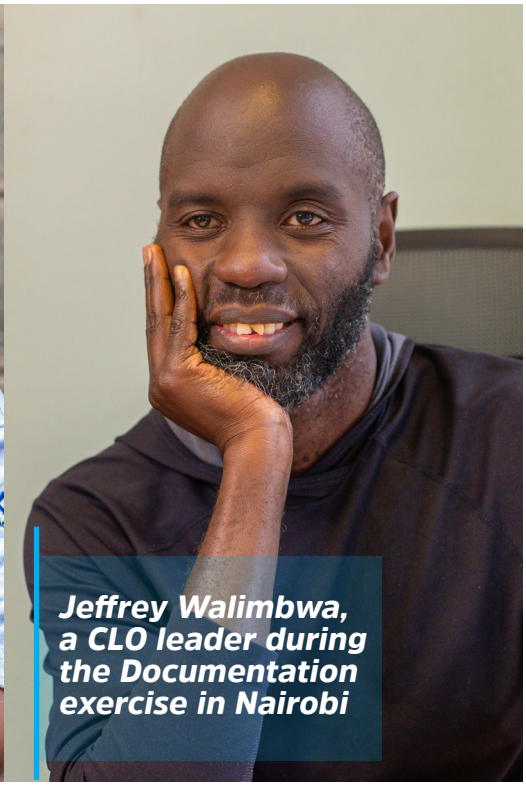
By mid-year, the tone had shifted from survival to strategy. Community-led organizations (CLOs) and networks intensified engagements in policy spaces, turning evidence into advocacy. They petitioned counties to absorb community cadres into payrolls, demanded inclusion in social health insurance schemes, and fed real-time data into donor reprioritization consultations and community dialogues.

> "Our network leaders are advocating for inclusion of HIV services in SHA benefits package," said a community leader in Nairobi indicated.

Some KP led organizations began preparing for the future by upgrading DICES to fully fledged health facilities and applying for Social Health Insurance accreditation. This was not just adaptation, it was evolution.

> *"If donors ever leave again, we'll still be standing. The health facilities will keep*

Jerop Leader, Executive director and young persons leader during the documentation exercise



Jeffrey Walimbwa, a CLO leader during the Documentation exercise in Nairobi

> *offering a wider range of services to our communities beyond what was offered in DICES"* MSM CLO leader indicated

Others launched small-scale income projects to cushion their teams. For many, the disruption had unlocked a deeper realization: resilience requires ownership.

These advocacy efforts signaled a quiet transformation from dependency to determination, from being beneficiaries to becoming builders of systems that listen.

From Survival to Self-Care

As months passed, the emotional toll became evident. Many peer workers faced burnout, financial strain, and grief. In response, communities began reframing resilience around self-care. Mentor mothers began incorporating wellness check-ins into group sessions; youth champions started journaling and peer therapy circles.

> *"We now tell ourselves: take your treatment, take a break, take care of you,"* said a Peer Educator from Homa Bay.

In the words of Nelson Otwoma, a national PLHIV leader:

> *"In the long run, HIV response will only have two people; the one giving care and the one receiving care. Communities must learn to take care of themselves."*

Self-care became both a coping strategy and a political act asserting that community health begins with community wellbeing. Communities were forced to increase self-awareness and self-care since their health was now fully in their hands.

Policy and Programmatic Recommendations

When the Stop-Work Order silenced programs across Kenya, it left behind a question that still echoes in every focus-group circle and community dialogue: *How do we make sure this never happens again?* The answers that emerged were not technical checklists, they were lived principles, drawn from the people who carried the response when systems faltered.

Communities spoke in one voice: the future of Kenya's HIV response must be rooted in justice, trust, and self-reliance. The lessons below are their roadmap, woven from pain but written in hope.

For the Government of Kenya

Across counties, communities of people living with HIV, key population and vulnerable populations repeated the same plea: *recognize us as part of the system, not as visitors in it*.

Peer educators, mentor mothers, adherence counsellors, adolescent mentors, expert patients and community paralegals form the connective tissue of Kenya's HIV response. And yet they are often treated as expendable.

> *"We are the health system's memory. We have lived experience. We have walked the journey. When the system forgets, it is us who remind it who it serves."* said a mentor mother in Nyamira.

Communities are calling for institutionalization of community cadres and inclusion in county health budgets so that the next funding freeze does not erase the very people who sustain care. Kisumu's of relocating DICEs into public hospitals while retaining community staff and equipment offers a glimpse of what genuine partnership looks like.

Integration under Universal Health Coverage, they said, must not dilute care. The new Social Health Benefits Package must formally include HIV prevention, treatment, and community support services such as PrEP and condoms to viral-load testing, harm reduction, psychosocial support, and community follow-up. This inclusion is not a privilege but a right.

> *"We also deserve insurance for our health. We are over 1.2 million people whose health is a responsibility of the government, why should HIV care depend on a donor when we are citizens of this nation?"* said a PLHIV youth advocate.

For many, inclusion in the benefits package represents dignity and a recognition that their health is not charity but citizenship.

> *"If HIV services are included in the benefits package, then Kenya has finally accepted us,"* said a PLHIV network leader in Nairobi

Communities also warned against creeping user fees in integrated clinics.

> *"We were told to bring two hundred shillings for an outpatient card. If you don't have the money it becomes difficult"* said a peer educator

> *"Before you are served you are asked if you have social insurance and if it has been paid. You have to register and pay subscription fees before you are served"* a PLHIV youth leader added

Health services, communities insist, must remain free at the point of need.

At its heart, government responsibility is about respect: flexible clinic hours for night-shift workers, mobile clinics for fisherfolk and PWID, confidentiality for youth. Integration process

should have guidelines to ensure the process is Stigma free and human centered.

> *"We need integration guidance or guideline holistically looking at the integration bit, it needs to be wholesome, it needs to be beneficial, it needs to be without stigma and discrimination and then it actually needs to ensure that both the service provider and the person who is actually accessing care are actually very comfortable to ensure continuous service delivery"* The Key Population community leader indicated

Finally, counties must show leadership not just in rhetoric but in budgets. Facility Improvement Funds and other local funds can sustain mentor mothers; locally driven surveys can track progress; county AIDS units can partner directly with CLOs.

"When our county stepped and included us in the processes and the changes, we felt seen. Counties can protect us if they want to." said a peer educator in Kisumu

For Donors and Development Partners

If the Stop-Work Order taught anything, it is that unpredictability kills trust. Communities were largely affected by the developments especially the element of surprise.

> *"We woke up one morning, and everything we built was gone.*

Solomin Wambua from the KP Consortium during the documentation exercise

Young people in Nairobi during the documentation exercise

There was no warning. Communication channels broke so we didn't know why or even how to proceed" said a CLO coordinator in Nairobi.

Communities recommend partnership with predictability. Donor transitions should be transparent, phased, and participatory. Funding pauses should never translate into service blackouts. There should be Consultation and accountability.

It would have been better if there was some warning signs, a grace period. That maybe within two months or one month, there will be this Stop Work Order. But prior to that, prepare A,B,C,D." A Community leader said

They also urge that even as donors invest in systems, they must preserve community-specific programs such as the DICEs, DREAMS, and harm-reduction initiatives that embody trust.

"You cannot mainstream trust, you must build it where we live. Community programs should be retained even as the shift happens" said a Key Populations leader in Nairobi

During the crisis, community networks gathered data faster than any formal monitoring system. WhatsApp groups, online polls, support group notes, and test messages became tools of survival. Donors are being asked to fund community-led monitoring (CLM) as a core accountability mechanism, not as a pilot project. Evidence gathered from the ground should inform every future funding cycle.

And as CLOs move toward local resource-mobilization and SHA accreditation, they want donors to invest in capacity, not charity.

> *"Help us to fish in our own rivers and to build our own ponds, not to wait at the Harbor for ships that may never come."* said a CLO director

For Community-Led Organizations and Networks

Inside every community office visited, the exhaustion was palpable. Lay workers had given their time, their bicycles, even their savings to keep service delivery. In this fatigue, a new truth emerged that sustainability begins with self-care.

> *"Now people are promoting self-care. Taking HIV treatment as a personal responsibility"* said a PLHIV network leader.

CLOs are beginning to reimagine resilience as wellness. Support groups are now doubling as spaces for reflection and prosperity. Savings circles now include emergency funds for members' medical and sustenance needs.

In the words of Nelson Otwoma, a PLHIV Network leader:

> *"In the long run, HIV response will only have two people, the person providing care and the person receiving care. We cannot keep waiting for others to care for us."*

This philosophy of self-care should also expand into Community led organizations through mutual-aid funds, micro-insurance schemes, and pension contributions for community cadres. This will help cushion them during transitions.

CLOs are also strengthening evidence-based advocacy. Through informal Community Led Monitoring and feedback collection, communities kept monitoring services. From handwritten field notes to digital dashboards, they are learning to turn lived experience into policy influence.

> *"We are no longer visitors in planning meetings; we participate actively using information from our community forums"* a youth advocate added

Ultimately, diversification has become a survival strategy. CLOs are launching social enterprises such as health facilities to sustain core activities.

> *"Sustainability is no longer a donor word. It is a survival word. We have to start enterprises to sustain our crucial services to communities"* A CLO leader in Nairobi indicated

Cross-Cutting Priorities

Three truths weave through every story told in this report: flexibility, dignity, and resilience.

Flexibility means services that fit real lives. Clinics that are open when clients can come. Outreach that travels where people live and work. Technology that connects the unreachable.

> *"When you respect the schedule of our work, you respect our lives,"* said an FSW peer educator during an FGD session in Nairobi.

Dignity is the soul of care. Integration without confidentiality re-traumatizes those who have

fought for decades to be seen as human. Safe spaces and stigma-reduction are not luxuries, they should be the definition of the therapies.

The SWO revealed that resilience is no longer an aspiration; it is a necessity. Kenya's HIV response must move from reaction to preparation. Embedding community cadres in policies and payrolls, financing CLM, and creating emergency funds for continuity are acts of foresight, not charity.

As one PLHIV activist summarized: *"We don't want to be heroes anymore. We want a system that does not need heroes or volunteers to survive."*

Conclusion

When the Stop-Work Order was announced, fear spread fast. Yet, amid uncertainty, communities discovered an unshakable truth: *they were the core of the response all along*.

In closed DICEs and shuttered offices, communities built new forms of connection: table-banking circles turned into counselling sessions; WhatsApp groups became treatment trackers; volunteerism became resilience. What many saw as an interruption, communities experienced as revelation.

These stories are not about victimhood; they are about agency. They reveal that health systems draw their real strength not from budgets or buildings but from people, the ones who refuse to let go even when everything else stops.

As Kenya moves toward Universal Health Coverage and the 2030 goal of ending AIDS, this report carries a simple reminder: policy means nothing without proximity. The further a policy drifts from the people it serves, the faster it fails them. Communities have shown what works i.e participation, flexibility, and care that respects their humanity.

The Stop-Work Order was not only a rupture but also a revelation. It revealed the courage of those who refused silence, the creativity of those who rebuilt trust, and the quiet revolution of those who promoted self-care and inclusivity.

And as Nelson Otwoma reiterated in his closing reflection:

> *"Communities will have to take care of themselves. Because we have learned if we don't, no one else will."*

The next chapter of Kenya's HIV response will not be written in policy briefs alone. It will be written in the voices of those who kept showing up: in the footsteps of mentor mothers walking to clinics, in the hands of peer educators carrying hope from house to house, and in the shared belief that resilience is not what happens after collapse, but what prevents it.

Acknowledgements

This documentation exercise was made possible through the contributions of community members, community-led organizations, and county health teams across Kenya. We extend our appreciation to all individuals who generously shared their experiences, ensuring that this report reflects the realities faced during the Stop-Work Order.

We acknowledge the support and participation of the following organizations whose collaboration was central to this process:

1. National Empowerment Network for People Living with HIV/AIDS in Kenya (NEPHAK)
2. KP consortium
3. Bar Hostess Empowerment & Support Programme (BHESP)
4. ISHTAR
5. Kenya Network of People Who Use Drugs (KENPUD)
6. Kisumu Shiners CBO
7. Ambassador for Youth and Adolescent Reproductive Program (AYARHEP)
8. Women Fighting AIDS in Kenya (WOFAK)
9. Nyamira Post Test Network (NYAPOTE)
10. Changu ni Chema Network
11. Nyabende Support Programs
12. Lake Region Community Development Initiative (LARCOD)
13. Movement of Men Against AIDS in Kenya (MMAAK)
14. Rusinga Nile Perch CBO
15. Community DREAMS mentors and adolescent/youth networks
16. Beach Management Units and fisherfolk peer groups

We further appreciate the insights provided by County AIDS and STI Coordinators (CASCOs), facility in-charges, and community health teams who contributed essential policy and system-level perspectives.

We thank UNAIDS Kenya Country Office for responding to community requests and supporting this documentation effort, and the field teams whose work in data collection and analysis made this report possible.

Above all, we acknowledge the resilience and leadership of Kenya's communities, whose voices form the foundation of this report.

Young people at a pier in Homabay County