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IDPC Briefing Paper

HIV, harm reduction and drug policy in Kenya

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Introduction

Kenya – like most countries – has a long tradition of punitive drug policy responses that seek to eradicate drug use and trade. This is in keeping with the prohibitionist approach that has been dominant across the world for more than 100 years, despite overwhelming evidence that this approach contributes to high levels of HIV transmission among people who inject drugs, as well as many other harms.[4]

In recent years, civil society organisations in Kenya have started to adopt programmes and practices that focus more on public health and human rights – supported mainly with funding from international donors and technical assistance from international non-governmental organisations. As part of this effort, the Kenyan Ministry of Health has recently introduced guidelines and strategies for targeted and evidence-based harm reduction interventions for people who use drugs (see Box 1), as part of its HIV response.

This briefing paper aims to review the recent developments in the response to HIV and illicit drug use in Kenya, and highlights some key recommendations to address the remaining challenges and issues.

Box 1. The meaning of harm reduction

The term harm reduction refers to policies, programmes and practices that aim primarily to reduce the adverse consequences of drug use without necessarily reducing drug consumption itself.[5] The United Nations (UN) has produced evidence-based guidance for countries, and promote a list of nine interventions for HIV prevention, treatment and care for people who inject drugs:[6]

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for IDUs and their sexual partners
7. Targeted information, education and communication
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

However, as many civil society groups have noted, these nine interventions should be complemented by other interventions such as psychosocial support, primary health care services, overdose prevention and management, services in prisons and detention settings, advocacy for legal reform, access to legal services, and socio-economic development.[7]

The HIV epidemic in Kenya

The HIV epidemic in Kenya is reported to have declined from an overall adult prevalence of more than 14 per cent in the 1990s.[8,9,10] The Kenya Demographic and Health Survey (KDHS) 2008/2009 estimated the national HIV prevalence to be 6.3 per cent among adults aged 15-49 years.[11] Preliminary findings of the Kenya AIDS Indicator Survey (KAIS) in 2012 showed an adult HIV prevalence of 5.6 per cent (compared to 7.2 per cent as measured in KAIS 2007).[12] The country has a "mixed" HIV epidemic, with both a generalised epidemic (i.e. greater than 1 per cent HIV prevalence among the general population), as well as a concentrated epidemic among most-at-risk populations.[13,14] Levels of HIV prevalence also vary across gender, age and geographical location. The Kenya Modes of Transmission Study in 2008 indicated that 64.4 per cent of new HIV infections in the country were among heterosexual couples, 14.1 per cent among sex workers and their clients, 15.2 per cent among men who have sex with men, and 3.8 per cent among people who inject drugs (see Figure 1).[15]

A 2012 rapid assessment study conducted by the United Nations Office on Drugs and Crime (UNODC) and Kenya's National AIDS and STIs Control Programme (NASCOP) estimated that there were 20,000 people who inject drugs in Nairobi and Mombasa.[16] In 2013, the Kenya MARPS Size Estimates Consensus Report estimated that there were 18,300 people who inject drugs in Kenya (see Table 1).[17]

In Nairobi and Mombasa, there is a significantly higher HIV prevalence among people who inject drugs than in the general population. In Nairobi, for example, HIV prevalence among people who inject drugs is as high as 18.7 per cent, compared to 8.8 per cent in the general population.[18] Based on experiences from around the world since the 1980s, it is clear that epidemics among people who inject drugs will continue to grow unless adequate HIV prevention measures are available at a sufficient scale. This has therefore prompted donors, civil society organisations and the Kenyan Government to consider harm reduction approaches.

Figure 1: Breakdown of new HIV infections in Kenya by risk group or risk behaviour, 2008[19]

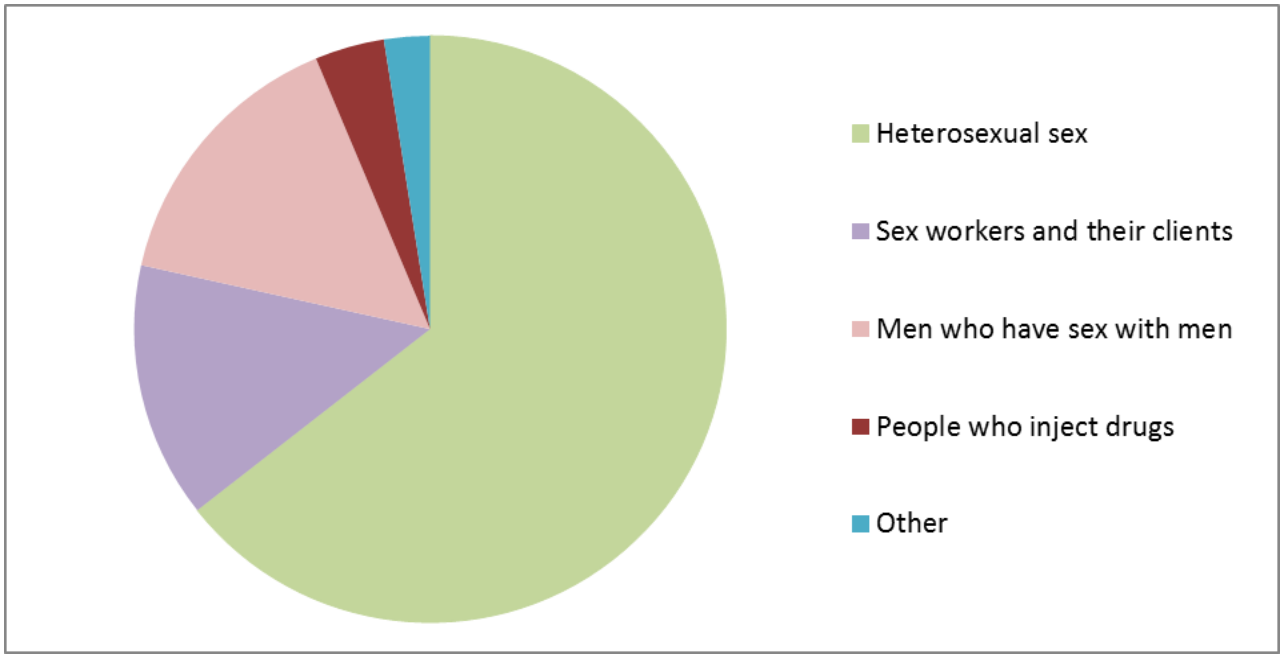

Table 1: Population size estimates of people who inject drugs in Kenya, 2013[20]

Geographical area	Estimated number of people who inject drugs	Percentage of adult population who inject drugs
Central Province	859	0.03%
Coast Province	8,500	0.50%
Eastern Province	898	0.03%
Nairobi Province	6,216	0.30%
North Eastern Province	0	0.00%
Nyanza Province	927	0.04%
Rift Valley Province	195	0.01%
Western Province	732	0.04%
TOTAL	**18,327**	

Current drug laws, policies and guidelines

At the international level, Kenya has ratified the three UN conventions on drug control: the 1961 Single Convention on Narcotic Drugs,[21] the 1971 Convention on Psychotropic Substances,[22] and the 1988 Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances.[23] Together, these form the cornerstone of the international response to drug use and markets – a response that is dominated by law enforcement and supply reduction measures.

At the national level, the National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) is the lead agency for drug control. It focuses on demand and supply reduction, public awareness, drug dependence treatment and rehabilitation, and its mission is to "provide leadership on policy development, education, regulation, management, programme implementation and research coordination on matters pertaining to drug and substance abuse in Kenya".[24]

In 1994, Kenya enacted the Narcotic Drugs and Psychotropic Substances Control Act, with the primary aim of reducing the supply of, and demand for, narcotic drugs.[25] This Act criminalises any person caught in possession of narcotic drugs or psychotropic substance for personal use (with the exception of a person with a licence issued under the Act, a clinician in possession for medical use, or a person in possession for prescribed medical purposes). Illicit possession is punishable by harsh and disproportionate penalties – such as "imprisonment for twenty years and in every other case to a fine of not less than one million shillings [approximately US$ 11,500] or three times the market value of the narcotic drug or psychotropic substance, whichever is the greater, or to imprisonment for life or to both such fine and imprisonment".[26] As for cannabis, possession for personal use is punished by ten years' imprisonment.

The Act also criminalises "any person who smokes, inhales, sniffs or otherwise uses any narcotic drug", as well as: being in a place where drug use is happening; allowing drug use, preparation or sale on your premises; and possessing pipes or other equipment for use in connection with drugs, including needles and syringes. Anyone found guilty of these offences is liable to "a fine of two hundred and fifty thousand shillings [approximately US$ 3,000] or to imprisonment for a term not exceeding ten years, or both such fine and imprisonment".[27]

There is evidence that law enforcement officials use these clauses to harass and arrest any person in possession of controlled drugs as well as sterile or used needles and syringes.[12,28] Despite the fact that there is no legal restriction on the actual sale of sterile needles and syringes, pharmacists have been reportedly reluctant to sell them to people who inject drugs due to fears that they may be breaching the law. Further evidence from civil society organisations working with people who inject drugs suggest that law enforcement practices and the experience of stigma have fuelled fear among people who inject drugs, deterring them from accessing services.[12,29]

Furthermore, the Narcotic Drugs and Psychotropic Substance Act prohibits the "prescription of any drug containing narcotic drugs or psychotropic

substance".[30] This clause continues to be a barrier to the provision of OST, which is an internationally recognised and proven intervention to reduce HIV transmission and other harms.[31] The Act also proposes the establishment of rehabilitation centres for people dependent on narcotic drugs, although it does not provide guidelines on the quality and operation of these centres.

Nonetheless, there are examples of Kenyan legislation and policy that are more positive. The HIV and AIDS Prevention and Control Act was enacted in 2006 to promote equal access to HIV prevention, treatment and care services for all Kenyans living with, or at risk of, HIV.[32] In addition, the Constitution of Kenya (2010) includes a Bill of Rights which underpins the rights and fundamental freedoms of all Kenyans to attain dignity and the highest standard of health,[33] while Kenya Vision 2030 is the country's long-term development blueprint which aims to create a globally competitive and prosperous country providing a high quality of life for all citizens.[34] Although these documents do not mention people who inject drugs specifically, their broader commitments to health and human rights are useful in the on-going advocacy work in support of this most-at-risk population.

The Kenya National HIV/AIDS Strategic Plan (KNASP) III 2010-2013 proposes targeted HIV prevention and management interventions for most-at-risk populations – including people who inject drugs – in order to promote universal access and contribute to an HIV-free society.[35] This plan has been instrumental in advocating for the inclusion of harm reduction and treatment services for people who use drugs. Work is currently underway to assess the impact of the KNASP III on the HIV epidemic in Kenya, and to identify gaps for further action in a new Plan to be adopted in 2014.

In 2012, NACADA led a consultative process with NASCOP, development partners and civil society organisations to present a technical support document to the Ministry of Health, with the aim of highlighting the need for a policy on HIV prevention, treatment and care among people who use drugs in Kenya.[36] The document presented the wealth of scientific evidence on the vulnerability of people who inject drugs to HIV and other harms, and was aligned to the UN drug conventions, the Constitution of Kenya, Kenya Vision 2030 and the various studies conducted among people who use drugs. Progress on the document has been slowed down because of changes in the new government and the devolution process after political elections in March 2013.

In a similar process, the University of Manitoba and NASCOP are currently reviewing the relevant legal frameworks and policies regarding most-at-risk populations in Kenya to identify priority areas that would need reform or strengthening. This process involves in-depth discussions and interviews with various key stakeholders including policy makers, civil society service providers, people who use drugs, and the general public.[37] The report is expected to be released by the end of 2013.

In addition, a coalition has developed including NASCOP, the Ministry of Health, the National AIDS Control Council (NACC), NACADA, relevant UN agencies, development partners and local civil society organisations representing people who inject drugs. This coalition is working to create a more enabling environment for effective and evidence-based responses to HIV among people who inject drugs, and has resulted in the development of:

- National Guidelines for the Comprehensive Management of the Health Risks and Consequences of Drug Use[38] which were released in 2013 and are based on a combination of approaches that include medical, behavioural and structural components that are gender responsive and protect the dignity and human rights of people who use drugs.

- Standard Operating Procedures for NSPs[39] which offer guidance to service providers on the procedures and minimum quality standards required for the delivery of NSPs in Kenya.

- Standard Operating Procedures for OST[40] which are targeted at policy makers, private clinics currently providing OST, and any private or public entity or civil society organisations planning to offer this intervention in the future.

Harm reduction service delivery

Despite evidence of high-risk sexual and drug use behaviours among people who use drugs, the provision of comprehensive harm reduction services (see Box 1) remains limited.[41] This is mainly a result of the on-going criminalisation of drug use and the lack of legal frameworks to support these interventions. Nonetheless, efforts have been made for government-run public health facilities and civil

society organisations to provide selected harm reduction services: HIV testing and counselling, linkages to ART, prevention and treatment of STIs, condom and lubricant distribution, targeted educational information, tuberculosis services, and psychosocial support. However, despite the availability of these services (predominantly offered free of charge in public facilities), people who use drugs continue to face significant barriers to accessing them – for example, because of stigma and discrimination from service providers or the police. Moreover, the formal training that is given to key staff such as doctors, nurses and security forces, still does not cover basic information related to harm reduction, drug dependence treatment, and the specific needs of people who use drugs.

Needle and syringe programmes

Funding for the roll-out of NSPs in Nairobi and the coastal region of Kenya has been made available through the Community Action on Harm Reduction (CAHR) project (see Box 2), a Round 10 HIV grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria,[42] Médecins du Monde (MdM) and the Open Society Initiative of East Africa (OSIEA). However, the implementation of these programmes was significantly delayed by the lack of an enabling legal environment (including the slow development of Standard Operating Procedures for NSPs), a lack of political will, and resistance from some religious and community leaders. Indeed, the attempted launch of the programme in 2012 was met with strong resistance from religious and cultural groups following high-profile media coverage – ironically as a result of efforts to sensitise journalists and address any questions or concerns that they had. Despite these many challenges, KANCO have worked with community-based organisations – the Omari Project, the Muslim Education Welfare Association (MEWA), the Reach-Out Centre Trust, Teens Watch and the Nairobi Outreach Services Trust – to start distributing safe injection kits in late 2012 in Nairobi and along the Kenyan coast. By August 2013, these partners had already distributed approximately 50,000 safe injection kits to people who inject drugs. Plans are underway for the further scale-up of NSPs through MdM in Nairobi, OSIEA in Malindi, and the Global Fund grant administered by the Kenya Red Cross Society.

Prior to the initiation of these services, civil society organisations took part in various advocacy and training activities – including sensitisation for religious leaders, the police, the media and other key community stakeholders. NASCOP approved standardised safe injection kits that include three needle and syringe sets, sterile water for injection, cotton balls, cotton swabs, cotton filters, a sterile cooking utensil ("spoon"), a plastic stirrer, informational leaflets, condoms and lubricant. In addition, one tourniquet is distributed per person when they first access services. The number of kits issued to a client is not limited, but rather based on his or her individual needs.

The Standard Operating Procedures for NSPs propose the use of fixed-point services (especially community drop-in centres), pharmacies, outreach services, and "secondary exchange" (where people who inject drugs pass on sterile equipment to their peers who are not accessing the services). Current service providers are adopting a mix of these approaches.

Box 2: Kenya and the Community Action on Harm Reduction (CAHR) project[43]

Kenya is one of the five countries in the CAHR project (the other four countries are China, India, Indonesia and Malaysia). This four-year programme is funded by the Dutch Ministry of Foreign Affairs and coordinated by the International HIV/AIDS Alliance. It aims to improve and scale-up HIV and harm reduction services for people who inject drugs and their families – including through capacity building for community-based organisations, the meaningful participation of people who inject drugs, and the creation of enabling policy environments in which services can succeed. In Kenya, the implementing partner for the CAHR programme is the Kenya AIDS NGOs Consortium (KANCO).

The civil society NSP providers conduct quarterly data analysis in order to adapt and improve their services. Their interactions with clients at these NSPs are used to strengthen health education messages and to encourage clients to return any used needles and syringes for safe disposal. In some areas, service providers and their clients organise regular "clean-up" exercises in common injecting sites to visibly demonstrate a service to the local community. However, most people who inject drugs continue to report challenges in returning used needles and syringes, or even in collecting the safe injection kits, for fear of harassment by the police.

Opioid substitution therapy

Although Standard Operating Procedures for OST in Kenya have been released, OST is currently limited to only a few private health facilities and remains very costly. Advocacy efforts have been made by civil society organisations to ensure that drug dependence treatment is on the political agenda as a key public health issue, and capacity building has been conducted among both private and public health workers. The Standard Operating Procedures propose three different delivery models – community drop-in centres, day care or outpatient sites, and residential sites. The document goes as far as specifying opening hours, staffing, training needs, location, infrastructure, complementary services, eligibility criteria and duration of treatment – even the number of rooms required in the building. Furthermore, methadone (the most common substance used for OST) has been included in Kenya's list of essential medicines.

With funding from the United States Agency for International Development (USAID), the Ministry of Health plans to roll-out free OST before the end of 2013. Assessments are in progress to identify potential sites (mainly hospitals and clinics) along the Coast and in Nairobi. There are also plans to train health workers on the screening of potential OST clients and the implementation of pharmacotherapies. The main OST service delivery model proposed by the Ministry of Health is a low-threshold programme that combines pharmacological and psychosocial interventions in inpatient and outpatient clinics, while additional plans have been established for the delivery of OST through community drop-in centres.

At the same time, civil society organisations (including networks of people who use drugs) have continued to advocate for OST and raise awareness on the benefits of this approach. Advocacy and sensitisation efforts are targeting key political, religious and community leaders – conducted jointly by the Ministry of Health and civil society organisations. These partners are also pushing for greater funding through a wide range of community engagements.

Other drug dependence treatment programmes

Additional drug dependence treatment services are provided in public and community-based centres, including both inpatient and outpatient services (e.g. social and medical detoxification, psychotherapy, pharmacotherapy, 12-step meetings, and family therapy) – usually alongside rehabilitation and follow-up. However, many of these services lack standardisation, quality control: any implementation guidelines tend to depend on the service provider and donor regulations. Some of these services are provided through hospitalisation, others through community-based drop-in centres or private and public health facilities. NACADA has a mandated role in the supervision and coordination of these treatment centres, and has recently worked with the Ministry of Health to developed draft guidelines for the standardisation of care in rehabilitation centres.[44]

Antiretroviral therapy

The country has witnessed a rapid increase in the coverage of HIV treatment in the general population and across different most-at-risk populations. Evidence shows that adherence to, and outcomes of, ART for people who inject drugs are improved when it is delivered alongside drug dependence treatment (especially OST) and functional social support systems.[45] National guidelines recommend that established structures be put in place to link and integrate ART with OST provision. Community-based organisations working with people who use drugs provide HIV testing and counselling, and link people living with HIV into treatment. Furthermore, Ministry of Health community workers and outreach workers from community-based organisations are rigorously conducting effective referrals to ART sites, and are following-up with their clients to improve their health and social outcomes.

Policing practices, pre-trial detention and imprisonment of people who use drugs

There is much anecdotal evidence and research available concerning the behaviour of the police and other vigilante and community policing groups towards people who use drugs. The CAHR baseline study on access to care for people who inject drugs study reported that many people experienced constant harassment, false accusations and frequent arrests, especially whilst in and around their places of drug use.[46] These particularly include arrests for the possession of small quantities of heroin or marijuana, and for the possession of injecting equipment. As a result, people who inject drugs often refrain from accessing harm reduction services and pharmacies to obtain sterile needles and syringes, and often do not safely return their used equipment for safe disposal. In turn, this is further exacerbating the high rates of HIV transmission and other harms among this population.

The pre-trial detention of people who inject drugs is often reported to be prolonged, especially when there is not enough evidence to bring charges, when a person cannot pay bail, or when bribes for release are not forthcoming. Because of this practice and many other potential abuses during arrest, detention or police custody, many people who use drugs fear detection by the police or attack from local "mob justice" groups. This leads them to stay away from services and revert to unsafe use behaviours.

With the country's disproportionately punitive drug laws, arbitrary sentencing for drug offences and large numbers of people in pre-trial detention, Kenyan prisons are overflowing with people convicted for, or suspected of, petty drug offenses. Yet none of these prisons offer harm reduction services or drug dependence treatment, with reports suggesting that those who have been arrested are left to suffer from untreated and protracted drug withdrawal and a total lack of support. The Kenyan prison service headquarters has an AIDS control unit that is responsible for technical support and coordinating HIV activities, with regional units responsible for direct implementation of activities within prison settings.[47] In 2006, the average HIV prevalence in Kenyan prisons was 8.2 per cent (with a rate of 19 per cent among female inmates and 5.5 per cent among male prisoners).[48]

Some civil society organisations, such as the Omari Project in Malindi, MEWA, the Reach-Out Centre Trust, Teens Watch and the Nairobi Outreach Services Trust have initiated advocacy efforts to improve access to justice, provide legal protection for people who use drugs, and support access to drug dependence treatment services in pre-trial detention or prison. These groups have also conducted activities to sensitise law enforcement personnel on the need for drug dependence treatment and harm reduction services, and the importance of upholding the civil and human rights of people who use drugs.

Funding for HIV-related services

Until recently, domestic and international funding for comprehensive harm reduction services was very limited. In the mid-2000s, UNODC was the main donor and supported community outreach services through four civil society organisations in Nairobi and along the Kenya Coast: the Omari Project in Malindi, the Reach-Out Centre Trust and MEWA in Mombasa, and the Nairobi Outreach Service Trust. At the same time, OSIEA and Muslims for Human Rights (MUHURI) were supporting advocacy activities on human rights and access to legal services for people who use drugs.

With increasing scientific evidence on the need for harm reduction services and improved legal environments, additional resources have been allocated in recent years, including from:

- the Dutch Government, through the CAHR programme (see Box 2) and the "Bridging the Gaps" project managed by Mainline
- the Global Fund to Fight AIDS, Tuberculosis and Malaria
- USAID and the President's Emergency Plan for AIDS Relief (PEPFAR)
- UNODC, the World Health Organisation (WHO), and the Joint United Nations Programme on HIV/AIDS (UNAIDS)
- MdM (through their drop-in centre in Nairobi)
- OSIEA

These organisations continue to channel support for comprehensive harm reduction services primarily through public health facilities, private health sectors and local civil society organisations. However, concerns have been raised about possible overlaps, duplication and a lack of co-ordination. As a result,

NASCOP convened a donor coordination meeting in November 2012, which allowed the various agencies involved to discuss shared goals and improve communication.[49]

Crucially, despite the influx of international support, there continues to be inadequate domestic funding to support sustainable, comprehensive harm reduction programming for people who inject drugs in Kenya.[50]

Civil society engagement

As mentioned above, there are several civil society organisations that provide services to, and advocate for, people who use drugs in Kenya. These organisations have attracted funds from the various donors listed above, as well as from the Kenyan Government, to implement HIV prevention, care and support to people who use drugs. Most of these organisations were founded as community abstinence-based groups, and still offer detoxification, outpatient and inpatient rehabilitation, and social re-integration services. However, they have worked hard in recent years to adapt their work to a harm reduction approach.

Representatives from the majority of these organisations (i.e. the Omari Project, MEWA, the Reach-Out Centre Trust, and the Nairobi Outreach Services Trust) have also formed the Kenyan Harm Reduction Network, whose aim is to advocate for supportive environments for comprehensive and evidence-based harm reduction services, increases in funding, and reducing the stigmatisation of people who use drugs in the country.

The Kenyan Network of People who Inject Drugs (KeNPUD) is also a key organisation advocating for the meaningful engagement of people who use drugs in the design, implementation, monitoring and evaluation of HIV and harm reduction services. It was established in 2012 with support from the International Network of People who Use Drugs (INPUD) via the CAHR programme. Since its creation, KeNPUD has been consulted in a number of policy and practice discussions and is increasingly recognised as a key partner in the country.[51] Alongside KANCO, KeNPUD played a major role in the Support. Don't Punish "Global Day of Action" in 2013 (see Box 3).

Box 3. The "Global Day of Action" in Kenya

Support. Don't Punish is a global advocacy campaign to raise awareness of the harms being caused by the criminalisation of people who use drugs. It emerged from the CAHR project, and aims to change laws and policies which impede access to harm reduction interventions, and to promote respect for the human rights of people who use drugs.[52] As part of the campaign, a "Global Day of Action" was coordinated across 41 cities around the world on 26 June 2013 – the UN's International Day Against Drug Abuse and Illicit Trafficking.[53]

In Kenya, participation in the global campaign was led by KANCO and KeNPUD, with support from the International Drug Policy Consortium (IDPC) and the International HIV/AIDS Alliance.

Processions were held in Kawangware, Nairobi and in Watamu on the Kenyan coast, with key messages displayed prominently on banners and placards: "Don't stigmatise us: Understand and support us" and "Right to health is respect for human rights". In Nairobi, the procession led into a public event at which civil society partners, government officials, people who use drugs and UN officials addressed the crowd. The events in Kenya helped to attract positive media attention, and provided momentum for the creation of a dedicated policy advocacy forum of more than 20 local civil society organisations whose aim is to further advocate for more political and legal support for people who use drugs.[54]

Conclusions and recommendations

Harm reduction services for people who inject drugs are rapidly expanding in Kenya, driven mainly by support from international donors and civil society groups. The Kenyan Ministry of Health has started to support the delivery of these services, although many challenges remain before these services can reach the required scale. In addition, there are still significant legal and policy challenges to overcome. Following consultations and engagement with various civil society organisations in Kenya, and reflecting on international best practice, IDPC proposes the following recommendations to strengthen Kenya's response to drug use, drug policy and HIV:

- The Kenyan government should urgently and strongly support the introduction and scale-up comprehensive, evidence-based harm reduction interventions – in community-based settings, public and private health facilities, and in prisons. This endorsement should be visible across all government departments, and should be prominently reflected in the new national AIDS plan being drafted for 2014.

- The Kenyan government needs to reform its drug laws that fuel stigma and impede access to HIV prevention, care and support services for people who use drugs. This includes laws that present barriers to the delivery of NSPs and OST. Kenya's drug policies should also promote human rights and avoid imposing criminal sanctions against people for drug use or possession for personal use. At the same time, the Government should work closely with civil society partners to ensure access to justice and legal support for people who use drugs.

- Funding for harm reduction services – both from domestic and international sources – should be further expanded to reach the level of coverage required to minimise HIV transmission and other harms among people who use drugs. Funding needs to be accompanied by commitments to support capacity building, technical assistance and advocacy resources for service providers. The Kenyan government needs to take ownership of the costs of harm reduction in the country, in order to ensure the long-term sustainability of interventions.

- The Ministry of Health should accelerate efforts to integrate harm reduction services (especially OST) with other HIV, tuberculosis, hepatitis and primary care services (especially the provision of ART). This includes the integration of drug policy and harm reduction issues into the training curriculums of health workers, policy makers and law enforcement personnel.

- The Kenyan Government and other stakeholders should ensure the meaningful engagement of people who use drugs and civil society organisations in the design and implementation of harm reduction services and policies – and that these groups are adequately resourced to fulfil this essential role.

- The existing sensitisation trainings and events on human rights for people who use drugs should be continued in order to promote understanding of harm reduction and human rights among policy makers, law enforcement personnel, faith-based organisations, service providers, community leaders, the media, and the wider population. These efforts should also seek to raise awareness of the harmful impacts of drug prohibition and punitive policies.

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Endnotes

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The International Drug Policy Consortium (IDPC) is a global network of NGOs and professional networks that promotes objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harms. IDPC members have a wide range of experience and expertise in the analysis of drug problems and policies, and contribute to national and international policy debates.

Kenya has a long tradition of punitive drug policy responses that seek to eradicate drug use and trade. In recent years, civil society organisations in Kenya have started to adopt programmes and practices that focus more on public health and human rights – supported mainly with funding from international donors and technical assistance from international non-governmental organisations. This briefing paper aims to review the recent developments in the response to HIV and illicit drug use in Kenya, and highlights some key recommendations to address the remaining challenges and issues.

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