

**COMMUNITY ACTION
ON HARM REDUCTION**



Alliance
for Public Health

REGIONAL TECHNICAL SUPPORT HUB FOR EASTERN EUROPE AND CENTRAL ASIA

Achievements and challenges in introducing a harm reduction programme in Kenya

A case study

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Acronyms

ART – antiretroviral therapy
CAB – Community Advisory Board
CAHR – Community Action on Harm Reduction
CSO – civil society organisation
IHRA – International Harm Reduction Association
GF – Global Fund to fight AIDS, TB and Malaria
HCT – HIV counselling and testing
KANCO – Kenyan AIDS NGOs Consortium
KENPUD – Kenya Network of People who use Drugs
KP – key population
MARPs – most at risk populations
MAT – medically assisted therapy
MdM – Medecins du Monde
MEWA – Muslim Education and Welfare Association
MSM –men who have sex with men
NACC – National AIDS Control Council
NASCOP – National AIDS and STI Control Program
NGO – non-government organisation
NOSET – Nairobi Outreach Services Trust
NSP – needle and syringe exchange
PEPFAR – The United States President’s Emergency Plan for AIDS Relief
PWID – people who inject drugs
PWUD – people who use drugs

SOP – standard operating procedures
SRH – sexual and reproductive health
SW – sex worker
UNODC – United Nations Office on Drugs and Crime
WHO – World Health Organisation

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Executive summary

Since 2011–2012 Kenya has successfully introduced and implemented a comprehensive harm reduction programme to tackle a sub-epidemic of HIV among people who inject drugs (PWID).

People who use drugs are highly stigmatised in Kenya. Cultural, religious and social norms were against harm reduction, which was widely perceived as encouraging drug use.

To overcome this, advocacy work was done to place harm reduction within a public health context and emphasise the benefits for all society. On a government level, the Kenyan Ministry of Health established a policy framework for a national HIV and harm reduction response targeting PWID. The National AIDS and STI Control Program (NAS COP) developed standard operating guidelines for initiating harm reduction.

At the same time the Kenyan AIDS NGOs Consortium (KANCO) and implementing organisations worked closely with communities, identifying leaders who could advocate for change, and directly addressing concerns and fears. Community Advisory Boards provided a vital link between projects and the places they work in.

Currently harm reduction projects supported by several donors are working in seven towns/cities in Kenya. Services include: distribution of clean injecting equipment; sexual and reproductive health information and services; drop in centres; HIV and TB counselling and testing, and medically assisted therapy (MAT) with methadone.

Since 2012 almost 10,000 PWID out of an estimated 18,000 population have been reached by information, healthcare, and needle and syringe exchange services. Use of condoms and clean injecting equipment, access to sexual health services, and knowledge of HIV have all increased. Communities have seen concrete improvements for all after harm reduction projects started, such as fewer used needles on the streets.

Periodic state crackdowns on the drug trade continue to target PWID, with an adverse effect on harm reduction programmes in communities. Interventions such as MAT are increasingly allowing PWID to achieve more stability in their lives, but more support and strategies for reintegration into wider society are needed.

KANCO is leading development of an east African harm reduction response, supported by the Global Fund to fight HIV, TB and Malaria, across eight countries of the region. Kenya's experience of rapid introduction and scale-up of harm reduction, leading to decreased risk practices and improved access to health and social care, presents a highly positive model that may be adapted and applied to other countries.

1. Background

Harm reduction in Kenya; key information about drug use (2011–2015)

Kenya has made great strides in tackling its HIV epidemic: by 2014 prevalence among the general population was approximately 5.6% (an estimated 1.6 million people living with HIV in 2012), down from a peak of 13.4% in 2000¹. At the same time, a sub-epidemic has emerged among people who inject drugs (PWID), constituting 3.8% of all new HIV cases². Though the share is relatively small, prevalence within the group is high: 18.3 % for men and 44.5 % for women³.

There are an estimated 18,327 PWID in Kenya concentrated mainly in urban areas of the capital, Nairobi, and the largest east coast cities. Evidence indicates increasing numbers of PWID in the lake city of Kisumu, Migori on the Tanzanian border and the highland towns of Thika and Nyeri⁴.

“Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.”

IHRA (2010), IHRA Briefing “What is harm reduction?” Available at: www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf

Drug use is criminalised in Kenya, based on the 1994 psychotropic act⁵, which penalises trafficking and possession of even small quantities for personal use. Possession of injecting paraphernalia is also a criminal offence. The government implements periodical crackdowns, closing ‘maskanis’ or drug dens and incarcerating large numbers of users - the most recent was an August 2015 presidential directive on drug use and terrorism.

¹ Kenya MoH (2012), Kenya AIDS Indicator Survey 2012. Available at: www.nacc.or.ke/images/documents/KAIS-2012.pdf

² The World Bank, UNAIDS (2008), Modes of Transmission Study 2008. Available at: <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/KenyaMOT22March09Final.pdf>

³ National AIDS Control Council of Kenya (2014), Kenya AIDS Response Progress Report 2014, Progress Towards Zero. Nairobi, Government of Kenya 2014.

⁴ UNAIDS (2013), National AIDS/STI Control Program size estimate consensus report. Nairobi, 2013.

⁵ Narcotic Drugs And Psychotropic Substances (Control) Act, No. 4 of 1994, Kenya Law Reports Cap 245

Heroin is almost exclusively the drug used in Kenya, arriving in coastal cities en route to Europe. In the early 2000s supply shifted from 'brown sugar' to 'white crest' heroin, which led to a widespread shift from chasing to injecting⁶.

One Kenyan peculiarity is that many if not most users are seasonal injectors, i.e. when hard-pressed financially or drugs are of lower quality they inject because a single dose goes further or gives a better high, but when their financial situation improves they may switch back to smoking. The change is often linked to the tourist season on the coast and related income for PWID. Issues of peer pressure, pleasure and quality of hit also play a secondary role⁷.

Some social services for drug users – primarily rehabilitation – have been available at community level since the 1990s (the Omari project was founded in 1995) but due to stigma, a perceived association with crime and sex work, and lack of social integration, PWUD often lack access to HIV prevention and to treatment services – including ART – for the general population. Early attempts to introduce harm reduction date from 2004–6, when some experts were trained in needle and syringe exchange (NSP) and opioid substitution therapy (supported by PEPFAR and UNODC). However neither the government nor social opinion supported these strategies at that time.

A 2008 Modes of Transmission study found that a third of all new HIV infections in Kenya were among key populations (PWID, SW, MSM, prisoners – who overall account for just 2 % of the population)⁸. As a result, the 2009–2013 Kenya National HIV/AIDS Strategic Plan for the first time identified both key populations and relevant harm reduction strategies to tackle the spread of HIV in these groups.

A state crackdown on drugs in 2010-11, cutting off heroin supplies but failing to provide detoxification or rehabilitation services, created an opportunity for practical introduction of strategies, as did donor funding earmarked specifically for harm reduction. The first community-based peer led NSP programme began in 2012 supported by CAHR.

The National AIDS and STI Control Program (NAS COP) developed Standard Operating Procedures defining the standard package of services for PWID including medically assisted therapy (MAT) with methadone. There are currently over 9000 PWID reached with clean injecting commodities, and 545 receiving MAT at three sites with two more in development on the coast. MAT and NSP among evidence-based interventions, and human rights protection and stigma reduction for KPs as part of enabling environment

⁶ Guise A, Dimova M, Ndimbii J, Clark P, Rhodes T. 'A qualitative analysis of transitions to heroin injection in Kenya: implications for HIV prevention and harm reduction'. Harm Reduction Journal, September 2015. <http://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-015-0061-2>

⁷ See note 6

⁸ MoH Kenya (2014), Kenya HIV prevention Revolution Road Map. 2014

creation, are included in the Kenya MoH NACC HIV Prevention Revolution Road Map (2014) which lays out a national strategy until 2030.

Kenya's KANCO supported by the GF is now leading development of an east African harm reduction response (regional advocacy, policy reform, information) across eight countries: Kenya, Uganda, Zanzibar, Tanzania, Seychelles, Mauritius, Ethiopia and Burundi.

2. Introduction

2.1 Harm reduction projects; key implementing organisations

From 2011–2015 Kenya’s national harm reduction response was supported primarily by the Dutch Government-funded Community Action on Harm Reduction (CAHR) project of the International HIV/AIDS Alliance, implemented in-country by the Alliance linking organization Kenyan AIDS NGOs Consortium (KANCO).

KANCO’s local CSO/NGO partners include the Muslim Education and Welfare Association (MEWA), the Nairobi Outreach Services Trust (NOSET), Reachout Centre Trust, Teens Watch, and the Omari Project.

Key state partners are the Kenyan Ministry of Health, The National AIDS and STI Control Program (NASCOP), National AIDS Control Council (NACC).

CAHR started in 2012 in Nairobi and in Mombasa, Malindi, Kilifi and Ukunda on the coast, before extending services to Central Kenya in Thika and the Nyanza region in Kisumu and Migori Counties in 2015.

Currently harm reduction services available in Kenya include: distribution of clean injecting equipment; sexual and reproductive health information and services; drop in centres providing food and showers, health education and basic medical treatment from an on-site nurse; HIV and TB counselling and testing; referrals to state medical facilities with fees sometimes waived for payable services (TB treatment and ART are free); case management for drug users living with HIV; MAT with methadone since 2014.

The Kenyan Ministry of Health has established a policy framework for a national HIV and harm reduction response targeting PWID. The National AIDS and STI Control Program (NASCOP) developed standard operating guidelines for initiating harm reduction in Kenya and for MAT.

MAT is supported by PEPFAR through its two implementing partners: University of Maryland in Nairobi areas and UNODC in coastal areas. Medecins du Monde together with Kenya NGO SAPTA; Mainline, and Open Society Institute actively support harm reduction projects in Kenya. From 2015 NSPs and outreach services are included in Kenya’s GF programme realised by the Kenyan Red Cross and KANCO, which, along with other donor projects, is reaching over 8000 PWID⁹.

⁹ NASCOP (2015), Technical support unit report for the period ending September 2015

2.2 Changes in services availability

Since the introduction of harm reduction in Kenya in 2012, almost 10,000 PWID have been reached with information, clean needles and syringes, and sexual and reproductive health information and services.

Results of base-line (2012) and end-line (2015) assessments of the CAHR project show a significant impact of harm reduction in Kenya. National data from NASCOP, in two national behavioural outcome studies conducted in 2013–14 and 2015, confirm this impact.

CAHR data show the percentage of PWID reporting using a clean syringe the last time they injected increased to nearly 90%, compared to only 51.6% in 2012. The number of those injecting with used equipment in the past 30 days dropped to 7.4% from 48.4% at baseline. Ninety per cent of PWID reported that they had acquired knowledge on how to prevent HIV through avoiding re-use of needles/syringes, indicating that behaviour change communication interventions are having an effect.^{10 11}

NASCOP 2015 data indicates the same percentage of clean syringe use but shows that non-availability of new needles is still a reality, with 28% periodically experiencing the same (a drop from 36% in 2014). NSP programmes therefore need to improve planning to ensure availability of commodities at all times¹².

Progress has been made in prevention of sexual HIV transmission amongst PWID. CAHR data shows condom use amongst PWID has increased by 11%, and condom use with commercial sexual partners increased by 16%. However, overall condom use remains low especially among female PWID. Access to sexual and reproductive health services

WHO recommends the following services to be included into harm reduction package:

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

WHO (2014), Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Available at:

www.who.int/hiv/pub/guidelines/keypopulations/en/

¹⁰KANCO (2014), End line evaluation report for the community action on harm reduction project in Kenya. Mutuku, A.

¹¹ International HIV/AIDS Alliance (2014), Independent Evaluation: Community Action on Harm Reduction (CAHR). Shaw G.

¹² NASCOP (2015), National Behavioural Outcome study. Nairobi 2015

has improved, with only 5.4% of respondents stating they did not have access to sexual and reproductive health services, compared with 10.7% at baseline. Access to general health services has also improved with access not possible for only 2.7% at the end of the project compared with 10.2% at baseline¹³.

Perceptions of HIV vulnerability have fallen by a third from 58.1% at baseline to 27.7% at the end of the CAHR project. Perceptions of being highly stigmatized are down from 56.2% at baseline to 46% at end of project. However reported cases of arrest for drug related charges had increased by 6%.

The majority of PWID at the end of the CAHR project reported they had received HIV counselling and testing, and take-up of ART or perception that PWID might need ART, had improved¹⁴. However, access to ART is still only 56% among HIV-positive PWID surveyed by NASCOP in 2015¹⁵.

KANCO and partners have expanded the reach of the programme following the establishment phase in 2012, and started pilot programmes in the Central and Western regions of Kenya in 2015, where a previously unexplored group of drug users with high rates of HIV and in strong need of services was identified. NASCOP 2015 data show that especially Kisumu in western Kenya needs to strengthen interventions¹⁶.

Donor-supported advocacy programmes have advanced the right to health for PWID and increased participation of PWID in decision making, with KENPUD established in 2012, represented on most relevant decision making bodies, and boasting a membership of 5000.

The Kenyan government has committed to financially supporting 1000 MAT patients, with the Global Fund-financed national programme taking on management of the MAT programme and supporting some services (some NSP, peer led outreach programmes) thus sustaining and embedding harm reduction in the national response.

¹³ See notes 10, 11

¹⁴ See notes 10, 11

¹⁵ See note 12

¹⁶ See note 12

3. Shift in the policy environment

On 25 December 2015, Kenyan Member of Parliament Suleiman Ndori Msambweni, whose constituency is the coastal district of Kwale, held a party for some of the district's 750-strong population of drug users.



A few days later, clients and staff from the outreach project Teenswatch in Ukunda were in the drop-in centre watching the event on TV. The same MP had promised to provide the centre with three car-washing machines, so that project clients would have a means of earning a living. It was a very visible indication of how much both public opinion

and government policy has changed in Kenya since the first syringe was given out from the Teenswatch premises as part of a new and controversial harm reduction programme, in November 2012.

"I think we've managed to change social attitudes towards drug users. At first we couldn't announce that we were having a meeting of drug users in our office. Now you can announce a party for drug users on national TV". Allan Ragi, KANCO

3.1 Finding the entry point

"The most important thing was to get people talking about it; start a conversation."
Onesmus Kalama Mlewa, KANCO

A number of factors contributed to a successful introduction of harm reduction in 2011–12 in Kenya:

- A strong knowledge and evidence base of the scale of risky drug use and its impact on the HIV epidemic in Kenya
- Evidence base of harm reduction as an effective response
- Support within state health and social policy structures for a prevention strategy targeting key populations

- Growing experience, expertise and voice within communities of, or working with, drug users
- Willingness by KANCO and other organisations to take risks and introduce a controversial strategy
- Focused donor support (CAHR entered Kenya specifically to introduce NSP)

A 'window' for harm reduction was opened by the government's crackdown on drugs in 2011.

“What happened was chaos, the users had nowhere to go.” Faizal Sulliman, UNODC

“The government did this and then realised it had to cope with the consequences... It was a wake-up call.” Caleb Agirra, NOSET

Community and international organisations, state medical services, donors, community, and PWUD themselves joined to lobby for a change of strategy. At the same time CAHR came in offering extensive technical support and experience from countries like the Netherlands and Ukraine that had successfully implemented harm reduction programmes. Studies on the impact of the crackdown, and on frequency of injecting and sharing equipment among PWID, provided an evidence base to put before stakeholders.

As well as working with authorities, pioneers worked within communities where drug use was taking place, with PWUD and their relatives to establish if services would be accepted, and what needs were.

An early test of advocacy skills had an apparently negative result: a press conference on harm reduction in 2012 produced a deluge of media coverage and a backlash within communities who believed NSP would encourage drug use and lead to more used needles on the streets. KANCO understood that the programme should be introduced on a small scale, through established CSOs with their long-term clients. The strategy worked, gradually scaling up to new clients and eventually to new geographical areas and organisations.

“It's important to start small with international funding. The Dutch government was ideal because it understood harm reduction, the challenges, and was quite flexible. Start small and make sure it works and you can show the results... It's important that local organisations do it with local leadership, but it's also important to have international support which is ready to respond with advice, training.” Tanya Deshko, Alliance for Public Health

3.2 National strategic plan and standard operating procedures

“Most services are in conflict with the law and the law has still not changed, it’s still illegal to use drugs or be a sex worker or an MSM. We had to use a public health approach to reach these populations and this needed a lot of government buy-in... That was the role of the national programme.” Helgar Musyoki, NASCOP

A national strategic plan and national programme were developed between 2009–13, which aimed to incorporate prevention among key populations at community level into government HIV prevention strategies and healthcare and social systems.

Steps to creating an enabling environment for harm reduction via the strategic plan were:

- key populations prioritized based on research data on HIV in vulnerable groups
- critical interventions identified, relevant indicators developed
- communities prepared for introduction of services
- resources leveraged



KANCO work and CAHR funding (especially for NSP, which was not permitted to be funded by the national programme) allowed harm reduction services to be scaled up to cover much of the country, integrated into the national GF-supported programme.

Vital ground work was laid by development of standard operating procedures (SOPs) by NASCOP, with WHO support in reviewing initial drafts and providing input. The SOPs define service packages and provision, providing a legal and administrative framework for NSP and MAT at national level. They indicate state support for a harm reduction approach even while the law on drug use remains unchanged.

“We had to push at the top and also facilitate provision of a service package – so in the end it’s not about us; it’s about government provision of services to its citizens. All packages have a government stamp.” Allan Ragi, KANCO

3.3 Tackling social resistance through sensitisation

“It was the same with immunization – at first people said the government wanted to reduce the population. So you always have to do education until people see the good side of something... People have different concepts and ideas that those using drugs are under witchcraft or it’s because of their ancestors, and then the church’s attitude is that it’s the will of god, just leave them, it’s their fate – but these people also need our help and concern and affection... Now users themselves are saying they don’t want to be responsible for passing on HIV.” Preacher, Ukunda

Innovative sensitization strategies in Kenya at community level have included a football match between teams of PWUD and local police (the PWUD team won 3-0) and door-to-door lobbying, where active or former users who are known in the community visited houses to explain to parents what the project would be doing.

While enabling drug users to talk about their lives and vulnerabilities, from issues like safe injection and sex to relations with family and law enforcement, projects were at the same time bringing family members on board. Now some parents will come to take clean needles for their children, or ask project staff to come to collect used needles.

Concerns that NSP would increase numbers of used needles on the streets were met by organising clean-up sessions and ‘pathfinders’ (volunteers who mop up used needles on a regular basis; most CSOs have an agreement with local authorities to incinerate used sharps for free).

The health benefits brought by treatment and prevention of abscesses, and providing clients with meals and the possibility to shower at drop in centres, helped reduce stigma towards PWUD by improving their appearance.

“Now we see changes. There are not so many needles in the community, and we used to see a lot of abscesses and bleeding, but now abscesses have disappeared... there are still some elders who don’t support NSP, they are concerned about children’s safety with dropped needles. When they saw equipment was being picked up they were less worried. Two months ago we had a meeting with community leaders about PWID dropping needles; I realised that compared to two or three years ago they were really understanding, they didn’t say the project should stop, they suggested that users move to a new area away from children.” Chief, Ukunda

3.4 Community Advisory Boards

A key to successful introduction of harm reduction, both utilising and introducing knowledge at community level, are the Community Advisory Boards (CAB) attached to

CSOs. The boards meet regularly, bringing together project beneficiaries with key local stakeholders who become champions within their spheres of influence.

Especially important in Kenya are village and town chiefs – elected local leaders who represent their regions in national governing structures and control access to districts under their jurisdiction including maskanis – and religious leaders (Muslim and Christian). Members of women's groups and human rights organisations, teachers, local police and NASCOP representatives are other key members.

In Malindi, the Omari project elected a preacher who was initially opposed to NSP as head of the nine-member CAB, and included religious leaders who had opposed distribution of condoms for HIV prevention projects. Often in private meetings, those who had opposed were persuaded to become champions.

“The chairman of Omari project told me ‘I know who will oppose this using the Quran, and those who will support it using the same sura [chapter]; I know exactly who to talk to’.” Onesmus Kalama Mlewa, KANCO

During training in drug use issues, stories from current and former users were a powerful tool to change minds. They helped to build links between project clients and other stakeholders with the power to advocate for and influence project success. In Ukunda, one CAB member whose son has used drugs for many years, heads an organisation promoting the rights of young people using drugs. The organisation does outreach in schools and with young people outside the education system, promoting healthy lifestyles but also providing a link to harm reduction services for those who need them.

Crucially, the CAB advises on services and their reception within the community, reporting back to the project.

“We need them not just to advocate, but to give us feedback.” Outreach worker, Omari project

3.5 A voice for people who use drugs

“Active users came forward and thought about how to get our voices heard. We had a lot of problems – sharing needles, problems with the police and communities and our own families, we were thrown out by our families and living on the streets... and community policing groups [mob justice]– when they see a drug user and something has been stolen they just lynch the drug user... it's called 'funga file' or 'closed file', it means no one bothers to arrest drug users accused of a crime, they are just lynched. We're really trying to change this; we are also human beings with rights... now there is more

understanding that these people are your children and brothers and sisters.” John Kimani Waweru, KENPUD

KENPUD began with 40 members in 2012, who were trained by KANCO with facilitators from the International Network of People Who Use Drugs (INPUD) in organisational issues, advocacy and harm reduction and documenting rights violations. Supported by Mainline in 2015, it now numbers more than 5000 membership and two paid staff.

KENPUD acts as a watchdog challenging stigma and discrimination within CSOs, brings harm reduction principles to ‘maskanis’ and is represented on key government platforms like the NACC board developing the national AIDS strategy framework, and the NASCOP technical working group drawing up guidelines for work with key populations.

“We’re in the process of strengthening local networks of PWUD and CSOs so they can access resources and speak for themselves. They are moving from supplying needles to pushing for policy change.” Allan Ragi, KANCO

Female users and sexual reproductive health

There is still a great deal of stigma around female drug use in Kenya which is often linked (in actuality and in social perception) with sex work. Women did not come for harm reduction services in traditional settings (sites for outreach or drop in centres) and so projects designed SRH services to fit within state health services. They provide focussed referrals, whereby social workers accompany clients to state medical facilities, and distribute personal hygiene 'dignity kits'. Kenyan CSOs have successfully engaged women in peer educator roles.

“It’s a challenge because women can’t admit to using drugs and ask for support. CSOs helped women to come forward and they are now working as peer educators... even men will listen to them. This is different than other [African] countries.” Faizal Sulliman, UNODC

3.6 Medically Assisted Therapy

Introduction of medically assisted therapy (MAT) with methadone in 2014 is a great success of the harm reduction programme in Kenya. Funded by PEPFAR (US) supported by UNODC and the University of Maryland, sites are located in three government healthcare facilities (Mathare Referral Clinic, Malindi Health Centre, Coast General Hospital; two more sites are in development), but clients are recruited and prepared by outreach projects in CSOs. Links with case management, follow up and other services provided by CSOs are strong in places like Malindi, where peer educators accompany new clients through a three-day induction and have found sponsors for some MAT clients to enrol in vocational training so they can then get jobs.

MAT is offered to all female users who have been through at least one unsuccessful course of rehabilitation; male users have to be injectors to be included. Sites are currently limited, partly because of staff shortages. This means there is a long waiting list and some potential clients are unable to travel the long distance every day for their dose.

The government has committed to funding 1000 MAT clients. The programme aims to make MAT services accessible to 6000 PWID by 2018.



In introducing MAT as a medical treatment – without using the term opioid substitution therapy – Kenya has successfully avoided the kind of social concerns that accompanied condom or syringe distribution, seen as encouraging sexual contact or drug use. However there is some concern that MAT is being regarded as a 'silver bullet' in Kenya (reflecting something of a worldwide trend) to tackle the HIV epidemic among PWID, to the detriment of other harm reduction strategies especially NSP. Although the GF-funded national programme is supporting some NSPs, there is a gap in provision for all PWUD who need services, and NSP client numbers have fallen since the CAHR project ended.

“NSP is what brought drug users to services and to ART. Now we’re seeing that NSP is no longer important and we are leaving drug users hanging, it’s all about MAT; we’re not seeing relations between NSP and MAT.” Caleb Agirra, NOSET

4. Conclusions

In a short time Kenyan harm reduction programmes overcame social opposition to reach large numbers of drug users in their communities with a range of services. Whilst continuing to expand to new regions and population groups in Kenya, the Kenyan government and non-government sectors have very valuable experience to offer to other countries in the region looking to introduce or scale up harm reduction.

4.1 Challenges and recommendations

Kenyan specifics: preventing transition to injecting

Most projects offer health and social services to both injectors and non-injectors (many people will engage in both types of drug use). However NSP is aimed at injectors, and MAT is only available for injectors (among male users). Some are concerned that this focus, with the perception that injectors get more services, causes tension within PWUD communities and problems for outreach workers, and may encourage transition to injecting.

“Non-injectors found out that injectors were getting paid to come to education sessions on safe injecting... they got very aggressive with us.” Outreach worker, Teenswatch.

CSOs have experimented with packages for non-injectors and are developing strategies to prevent the transition to injecting, with more education on the risks of injecting. These strategies need to be evaluated before scaling up.

Legislation

“The multisectoral approach is really lagging behind; so much more can be done to help by the ministries of internal affairs and defence and the police.” Helgar Musyoki, NASCOP

Drug legislation remains repressive in Kenya although harm reduction is included in the national HIV/AIDS programme. Operating within the SOPs, CSOs find that they can cooperate effectively with law enforcement and judicial systems, often able to intervene when project clients are detained by police just for being in a drug den. But if there is a staff change at local level, or a new government drugs crackdown, CSOs often have to start again from scratch, as in August 2015 when the president issued a directive on drug use and terrorism. A large maskani in Nairobi was shut down by police, leading PWUD to move out of hidden areas into residential areas and throw needles in the street in protest. MdM’s NSP project in the area was attacked by local communities and an outreach worker briefly arrested.

NASCOP is working with CSOs and KANCO to include harm reduction in police training curricula, to embed principles and make cooperation more sustainable. They emphasise the differentiation between drug suppliers and users, healthcare as a right for all citizens independent of their lifestyles, and the health and social benefits of harm reduction for the population as a whole which has already seen HIV become ‘normalised’.

Social reintegration, sustainability

With a combination of NSP, medical and psychosocial services and now MAT, more and more project clients are able to stabilise their lives. However, stigma against drug users, and practices like mob justice, remain strong, and jobs are scarce in Nairobi and especially in coastal regions which were used to rely on tourism.

UNODC's sustainable livelihood programme, which supported small enterprises like a soap-making venture in Malindi, came to an end in 2015. Some projects are able to find sponsors, like the MP providing car-washing equipment to Teenswatch, but are seeking a more sustained approach towards reintegrating clients into society. More advocacy is needed to change attitudes toward the employability and social acceptability of PWUD and support MAT.



"It's the most difficult part of the project... You need to do very strong social marketing to get [MAT clients] accepted by wider society and by employers... Ultimately what will happen is they will have their own social group, we are going to create small pockets of people who are rejected: they sit together, they eat together, they walk together, they go to get their methadone together. We need to break this. We need to help them join back into wider society."
Faizal Sulliman, UNODC

Healthcare: integration into healthcare systems, hepatitis treatment

While some drop-in centres have a nurse on site providing basic medical services, there is no standardised access for project clients to services in general healthcare facilities – excepting ART and TB treatment – without stigma and for free. Hepatitis treatment is not available at all in Kenya.

MdM is piloting a drop-in centre located in a general health clinic in Nairobi. Such practices should be systematised both to ensure healthcare provision for all and to support integration of key populations into mainstream society.

4.2 Key lessons learned from the Kenya experience

- Start small and then scale up
- Develop standard operating procedures and project milestones at government level
- Use facts and figures and best practices; everything backed up by data
- Recruit champions; create cross-sector partnerships
- Differentiate between drug sellers and users; emphasise social and health benefits for all society, and universal healthcare access
- Secure community support especially in areas where dens are; establish a feedback mechanism; meet community concerns

- Ensure technical and international support
- Have a clear, targeted advocacy agenda; accurately analyse the policy framework so as to know what to promote and what not