Kenya serves as a transit country for various illicit drugs, including heroin and cocaine, and faces a growing domestic consumption. Despite harsh policies criminalizing drug use, there is support for harm reduction programs such as NSP and OAT, mostly via international funding.

This document

This policy brief aims to promote the realisation of health and human rights for people who use drugs in Kenya. It is intended primarily for policymakers and programme managers to inform decisions on policies, programs, and interventions for people who use drugs. The brief outlines the context in which people who use drugs find themselves in Uganda, paying particular attention to the national drug policy framework, drug use and health of people who use drugs, the existence of harm reduction services and peer involvement, the context of human rights, availability of care in prisons, and the situation of women who use drugs, and additional social issues and inequalities. Recommendations are provided based on the data gathered and community reviews. The brief is based on a database built within the framework of the Love Alliance program.

Policy

Kenya is known for criminalising drug use, possession, trafficking, and production, with severe penalties imposed regardless of the substance involved. However, recent amendments and proposed revisions reflect a growing recognition of the need for evidence-based approaches, harm reduction, and respect for human rights. Decriminalisation efforts, particularly regarding cannabis, have been introduced but not yet passed, while some local initiatives have diverted drug offenders to harm reduction programs instead of prison. National guidelines and policies on alcohol and drug use prevention, HIV and STI control, and substance use disorder treatment have been released, demonstrating a commitment to comprehensive harm reduction interventions. However, the punitive nature of drug laws in Kenya is a barrier to accessing health services for people who use drugs, as fear of incarceration hinders the uptake of harm reduction services. The limitations in implementing SRHR and the overcrowding of prisons with petty drug offenders remain concerning issues in the country.

Drug use and health

A 2017 survey by NACADA revealed that 18.2% of adults in Kenya use drugs or substances of abuse, with alcohol being the most commonly used (12%), followed by tobacco (8.3%), miraa/khat (4.1%), and cannabis (1%). Among secondary school students, alcohol use was reported by 23.4%, khat/miraa by 17%, prescription drugs by 16.1%, tobacco by 14.4%, cannabis by 7.5%, inhalants by 2.3%, heroin by 1.2%, and cocaine by 1.1%. Injection drug use emerged in the 1980s/1990s, driven by changes in the heroin supply. Estimates from 2019 indicated that on a typical day, 9,045 to 14,653 people inject drugs in hotspots, with the majority in Mombasa, Nairobi, and Kilifi. The number of drug hotspots decreased from over 900 in 2013

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to a little over 400 in 2019 due to the introduction of methadone. The prevalence of HIV among people who inject drugs is around 18.3%, with higher rates among women. Challenges include limited HIV testing, treatment, TB detection services, and interruptions in harm reduction services due to COVID-19. Mental health conditions are also prevalent among drug users, with approximately 17% reporting specific needs.

Harm Reduction

Kenya has implemented harm reduction services for people who use drugs, including NSP and OAT, since 2012 and 2014, respectively. Outreach programs provide HIV, TB, HCV/HBV, and STI care in Mombasa and Nairobi. Harm reduction has been part of the government's HIV strategy since 2011/2012. However, harm reduction services are concentrated in certain towns, leaving others without services. Kenya aimed to provide NSP to 21,000 people and enrol 9,500 in OAT through eight facilities over nine years—currently, only 30% of people who use drugs access harm reduction services. NSP coverage is estimated at 55%, and OAT programs enrolled 26% of estimated people who use opioids. Drop-in centres offer various services but face funding challenges. Overdose prevention and naloxone distribution are gaining attention, but data on overdose cases is limited. The NHIF supports drug dependence treatment, while the Ministry of Health lacks a specific budget. Further expansion and funding are needed. MEWA has piloted services for young people since 2021 and for women since 2018.

Peer Involvement

Harm reduction programs in Kenya are primarily run by Community Based Organizations, including faith-based and community-rooted organisations, with the active involvement of people who use drugs as outreach workers or volunteers. Often working for a stipend, peers are supervised by outreach workers in a micro-planning implementation model. The Kenya Network for People who Use Drugs (KenPUD) represents the drug user community. Still, it faces funding challenges, while the Kenya harm reduction network promotes collaboration among service providers and key population-led networks.

Human Rights

Kenya has health policies emphasising the importance of human rights, but strict drug laws hinder their implementation and contribute to human rights violations among people who use drugs. The criminalisation of drug use leads to arrests, beatings, and arbitrary detention by law enforcement, deterring people who use drugs from seeking necessary HIV and harm reduction services. Mob justice is also a concern. Stigma and discrimination against people who use drugs, particularly women, are widespread, limiting their access to healthcare and support. Efforts to sensitise local police and address violence against key populations have shown progress but face challenges due to staff turnover. Gender norms further compound the negative experiences of women who use drugs.

Prison

Kenya's prison system is severely overcrowded, with a 190% occupancy rate and a total population of 42,596, but the percentage of inmates imprisoned for drug-related offenses is unknown. Pre-trial detention for drug-related charges is common, despite constitutional provisions for prompt arraignment and bail. Alternative sentencing options like probation and community service exist but are not widely enforced. Efforts have been made to promote treatment and care as alternatives to punishment, particularly for individuals with drug dependence in contact with the criminal justice system. The first OAT clinic in prison was established during the COVID-19 pandemic. Despite the roll-out of best practice guidelines, incarceration does not necessarily result in the termination of drug use or the provision of treatment and rehabilitation services, and the high rate of reoffending is attributed in part to inadequate mental health care in prisons.

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Women who use drugs

The estimated number of women who inject drugs in Kenya ranges from 1,647 to 3,158, with an average of 2,405. Service uptake among these women is low, highlighting the need for better inclusion in sexual and reproductive health and harm reduction services. The Muslim Education and Welfare Association (MEWA) is a civil society organisation in Kenya that provides comprehensive support to women who use drugs, including shelter, health education, and economic empowerment. However, barriers to accessing harm reduction services, such as transportation costs and service hours, still exist. Efforts are being made to replicate successful interventions beyond Mombasa, but the availability of gender-sensitive interventions across the country remains unclear.

Social Inequalities

Drug use and drug trafficking are perceived as significant societal problems in Kenya, with negative impacts on morals, mental health, overall health, and legal issues. Gang violence and drug dealing are also prevalent issues. Poverty and unemployment contribute to crime, gang culture, and drug use in Nairobi, as described in a 2020/2021 UNODC case study. Stigma and discrimination against key populations, including sex workers and men who have sex with men, persist in society and among healthcare workers. However, efforts have been made to address these issues. Social media campaigns targeting alcohol and drug use have limited impact without reaching the platforms popular among youth. While the Kenyan government has implemented a universal health coverage program in selected counties, it does not currently include services for people who use drugs.

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Recommendations

Based on data gathered via desk research and key informants and on the extensive consultation done by UHAI's baseline in Kenya, we propose the following recommendations:

Advocacy & policy reform

→ Implement a health rights approach to create awareness among stakeholders, including policymakers, police, healthcare workers, religious leaders, and the general public, about the rights of people who use drugs.
→ Develop and implement policies and guidelines that promote mental wellness for people who use drugs and intersections through a multi-sectoral approach.
→ Conduct advocacy at the international level to hold Kenya accountable to its international commitments on drugs policy and promote access to sexual and reproductive health rights (SRHR) and harm reduction for people who use drugs.
→ Foster a coordinated approach to advocacy by involving all relevant stakeholders, including NASCOP, advocacy sub-committees, expert committees, harm reduction CSOs, and people who use drugs, to avoid working in silos and maximise impact.
→ Ensure consistent funding for community groups to support grassroots movement operations.

Harm Reduction services

→ Establish a robust monitoring, supervisory, and reporting mechanism for services.
→ Invest in sustainable livelihoods for the community of people who use drugs to address the impact of low socio-economic status on organising efforts.
→ Include a gender lens in current programs, establishing more women-friendly DICs and programs for SRHR and harm reduction for women who use drugs.
→ Support the basic needs of women who use drugs in current and new programs, including food, clothing, shelter, and sanitary needs.
→ Integrate harm reduction into all other key population programs and provide capacity building for program staff on harm reduction.

Capacity building

→ Strengthen training and mentorship programs for community paralegals to enhance their knowledge and confidence in providing redress for violence experienced by people who use drugs.
→ Support the establishment of strong governance structures for grassroots movements and provide skill-building opportunities for people who use drugs in movement formation and leadership.
→ Train and sensitise health workers on the health needs of women who use drugs, including their unique maternal health needs.
→ Empower the community of people who use drugs by providing training, sensitisation, and support to enhance their advocacy for resource allocation, develop a national communication strategy that facilitates information sharing between the community and national level, and build their capacity in all aspects of funding.

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