MAINline

Stichting Mainline
Postbus 58303
1040 HH Amsterdam
T +31 (0)20 68 22 660
F +31 (0)20 68 13 003
E info@mainline.nl
www.mainline.nl

Drug Laws and Human Rights in Kenya:

Disharmony in the Law and Training Recommendations to Law Enforcement

A STUDY BY EMMY KAGEHA

People who use drugs in Kenya suffer from violence, harassment, prejudice and ill health. The government of Kenya increasingly recognises the very harsh realities drug users face. Important steps have been taken to provide more space for harm reduction programmes. This allows for a public health and human rights-based approach towards drugs. However, Kenya is still very much in transition. The change from a punitive approach to a tolerance strategy towards drug use requires time and energy.

Violence against drug users continues as harm reduction pioneers in Kenya set up services to improve the health and rights of drug users. This study describes the complicated mixture of drugs, health and human rights legislation in Kenya. With more progressive legislation in place it is now needed to concentrate on implementation of these laws on the ground. The current study provides concrete recommendations for law enforcers to use the law and their discretionary powers in favour of public health. And in favour of the human rights of all those people who use drugs in Kenya.

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Introduction

Drug use and trafficking have been on the international agenda for over 100 years. Globally, the dominant strategy has been to implement punitive laws. The accompanying law enforcement practices often result in the discrimination of drug users, widespread violations of human rights and negatively impact the health of users. At the same time, the need to reduce the negative health consequences to drug users has also been on the international agenda for over three decades. The current concern is how to address the health issues related to drug dependency, HIV, hepatitis C and other related health risks. The question also rises how laws contribute to as well as prevent risks.

Until recently, in Kenya, HIV interventions have largely ignored drug users (NACC 2009). However, since it has become clear that HIV prevalence among key populations is high (men who have sex with men, men in prison, sex workers and injecting drug users), steps have been taken to address HIV and hepatitis C among injecting drug users.
How do drug laws harm the health and lives of people who use drugs? How can we best engender concern for the health and well being of drug users? What is the best approach for PWID who are incarcerated? What works, how does it work and what does not work in relation to injecting drug use, drug laws, and health/human rights? These questions serve as the underlying theme of this document.

Methodology

This document draws upon a three week field study conducted in Malindi and Mombasa, and a desktop review of drug policies, practices and training manuals in use in Kenya. The focus of the desktop review was to provide an inventory of drug deterrence and human rights policies and laws in Kenya. Hard copies of the Constitution of Kenya and the HIV and the 2006 HIV and AIDS Prevention and Control Bill were obtained with help from KELIN. Internet searches provided links to the following websites: UNODC, Kenya Human Rights Commission, the 1994 Narcotic Drug Act, NACADA, Kenya police, UN Drug and Human Rights Conventions, African Union, International AIDS Alliance, National AIDS Control Council and the National AIDS and STDs Coordinating Program (NASCOP). The Director of KELIN was especially helpful in providing direction for desk review searches.

For the field study, a combination of qualitative research techniques was used to obtain empirical data. These include performing case histories, in-depth interviews, key informant interviews, observations, conversations and informal group discussions and one focus group discussion. Key informant interviewees included the director of KELIN, projects personnel including project coordinators, outreach workers, clinicians, counsellors and prison social workers. Informal group discussions were held with active drug users in drug dens. Case histories involved former drug users who had discontinued using hard drugs for over two years. Repetitive conversations and interviews were carried out with the Omari and MEWA project coordinator, five outreach workers, ten former drug users, MEWA clinical officer, The Omari HIV VCT counsellor and a drug dependency counsellor. A focus-group discussion was conducted with clients in MEWA's rehabilitation group and informal discussions were held with drug users in drug dens in Malindi.

To begin the study, two discussions were held with the director of KELIN, who provided information on the progress made in policy, on interventions targeting key populations, and

areas of concern with regard to punitive laws. The KELIN director recommended the inclusion of former drug user subjectivities and provided tips on how to engage them in the study, by building up a rapport. The majority of the empirical fieldwork was done in Malindi (Kilifi County): seventeen days in total. Two days were allotted to Mombasa in Mombasa County.

Background

Drug use and infectious diseases worldwide

Drug use presents a number of negative social, health, economic, political and development implications (UNODC 2012). Various studies have documented a significant link between injecting drugs and the transmission of HIV and Hepatitis C (Lindenburg 2006; Hagan 2001; Des Jarlais et al, 2001; Stimson and Choopanya, 1998; Ball et al. 1998; Hagan et al. 2001; Hagan et al. 2000). According to the World Health Organisation [WHO] guidelines for injecting drug use worldwide, 158 countries have reported injecting drug use, and 123 of these countries (78%) have reported HIV among PWID. In general, the rate of HIV infection is high among people who use drugs (WHO 2014). In most countries, the HIV prevalence is far higher among PWID than in the general population. The United Nations Office on Drugs and Crime (UNODC) - together with WHO, UNAIDS and the World Bank - estimated that in 2012, worldwide about between 8.9 and 22.4 million people had recently injected drugs and that, of these, between 0.9 and 4.8 million people (13.1%) were living with HIV.
Based on data from 49 countries, the average risk of contracting an HIV infection was 22 times greater in PWID than in the general population (WHO 2014). This is attributed to the use of contaminated needles and syringes, indirectly as an effect of punitive drug laws, and a lack of access to prevention information. Despite injecting drugs contributing significantly to HIV and hepatitis C infections, PWUD in developing countries have increasingly limited access to health care services, particularly to HIV services and treatment (Mathers et al. 2010).

HIV Among Drug Users in Kenya

Kenya has one of the highest prevalence rates of HIV in the general population (5.6%) in the world (NASCOP 2013). In Kenya, key populations (men who have sex with men, men in prisons, sex workers, and injecting drug users) were largely neglected, until the 2009 Modes of Transmission survey (NACC 2009). This survey showed that injecting drug users contribute 3.8% to the national HIV prevalence. These findings called for an extraordinary response in the fight against HIV in this community. The Kenya National AIDS Strategic Plan (KNASP) 2009/10- 2013 recognized the need to focus on injecting drug users as one of the critical key populations in HIV interventions (NACC 2009).

Subsequent surveys confirmed this high HIV prevalence among injecting drug users. A 2011 UNODC study conducted in Nairobi and the Coastal regions estimated an HIV prevalence of 18.3% among PWUD and 18.7% among PWID in Nairobi (NASCOP 2012). The National AIDS Control Council (NACC 2012) estimates an HIV prevalence of 18.9% among drug users in Kenya. A survey conducted by the Population Council (2011) revealed that 29.8% of PWID had unprotected sex in the month preceding the survey. 51.6% of PWID report having used sterile injecting equipment the last time they injected, meaning almost half of injecting drug users did not (Population Council 2011). The risk of contracting and transmitting HIV among injecting drug users is not limited to drug use itself. The possibility also exists that drug users

contribute to HIV infection in the larger population and prisons through sharing of injecting paraphernalia and unsafe sexual practices. The criminalization of drug use has resulted in limited access to health care services, which in turn has increased the occurrence of HIV and hepatitis among drug users.

Harm Reduction

Harm reduction is one of the main HIV and Hepatitis C prevention strategies for PWID. The harm reduction approach refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs. The strategy is based upon a public health perspective and aims to reduce the negative health-related consequences of drug use and to improve the health and well being of PWUD (Hallam, et al. 2010). It aims to facilitate effective policies and practical law enforcement practices. An essential component of harm reduction is the provision of effective HIV and drug dependency treatment (UNAIDS 2011).

Harm reduction has been shown to be efficacious and cost-effective for HIV interventions among drug users. This approach can significantly reduce and prevent both drug related infections such as HIV and hepatitis and lower morbidity and mortality among drug users. Studies from countries that have emphasized and embraced harm reduction have clearly shown a significant reduction in HIV and hepatitis infections (UNAIDS 2012; Van Den Berg et al. 2007; Lindenburg 2006; Wodak 2006; Ljungberg et al. 1991). In order for these interventions to work effectively, they require an enabling environment, including supportive legislation, financial commitment, community empowerment, and policies that address stigma, discrimination and violence against key populations (WHO 2014).

The United Nations resolution UN 56/6 has laid out a comprehensive harm reduction package for PWID. This comprehensive package aims to minimize HIV and Hepatitis blood borne infections and includes: needle and syringe programs (NSP), prevention, vaccination, diagnosis and treatment for viral hepatitis, opioid substitution therapy, HIV testing and counselling, antiretroviral therapy (ART), prevention and treatment of sexually transmitted infections, condom distribution, targeted information, education and communication, and prevention, diagnosis and treatment of Tuberculosis (UNODC 2014).

Harm Reduction in Kenya

In 2011, the Kenyan National AIDS Control Council [NACC] introduced a harm reduction strategy, based on a public health perspective, which aims to get a cost effective HIV intervention off the ground in order to prevent HIV-infection for PWID. This has helped lay the groundwork for strategies and guidelines, e.g. in the adoption of Needle and Syringe Exchange Programs (NSEP) and harm reduction strategies among communities affected by drug use. The Kenyan government, through the National AIDS and STI Control Program (NASCOP) has endorsed NSEP and Opioid Substitution Therapy (OST) in affected communities in Nairobi, Malindi and Mombasa. In spite of these recent developments, the possibilities of NSEP and harm reduction strategy are threatened by punitive drug policy and law enforcement practices. Kenya is one of the many countries where harm reduction programs, and particularly NSEP, have been met with hostility by policy makers and within communities.

In order to deal with the ambiguity caused by punitive drug laws on the one side and laws allowing preventive services for drug users and promoting human rights on the other, Kenya is moving towards a tolerance strategy. Police could use their discretionary powers in favour of public health by not arresting drug users who, for example, are in the possession of clean needles. However, police at this stage don't seem to understand what is expected of them with reference to the new NSEP and methadone laws and continue to incarcerate drug users for possession of drugs or paraphernalia and drug use. This implies that training police and law enforcement officers is key to building relevant skills and capacity and to enforce favourable policies for effective health and human rights interventions.

An Overview of Harm Reduction Interventions in Malindi and Mombasa, Kenya

The Mainline Foundation, a Dutch organisation and partner in the Bridging the Gaps (BtG) project furthers the harm reduction goal by financially supporting four local Civil Society organisations: Reachout and Muslim Education and Welfare Association (MEWA) in Mombasa; The Omari Project in Malindi, and KELIN, a national organisation that trains law enforcement officers in human rights affairs that affect key populations in Kenya. Mainline's goal, in supporting these organisations, is to combine a harm reduction approach with a strategy enabling social justice and a training for health care providers, in order to establish effective interventions for PWUD.

Harm reduction activities by these organisations include:

- Needle and syringe exchange where injecting drug users are provided with new syringes in exchange for used syringes. The needle and syringe kit includes three new syringes and needles, 3 ampoules of 10 millilitres sterilized water, 3 alcohol/spirit cotton balls, 3 dry cotton swabs, rubber bands and condoms;
- Referrals for HIV testing, counselling and treatment;
- Referral for Tuberculosis diagnosis and treatment;
- Referral for STI diagnosis and treatment;
- Drug dependency counselling;
- First aid and referral for abscess management;
- Referral and linkages to health facilities and rehabilitation services;
- Condom distribution and promotion of safe sex;
- Targeted information, education and communication on prevention and treatment of HIV, sexually transmitted infections, tuberculosis, hepatitis, and HIV through talks and distribution of IEC materials;
- Creating awareness and educating communities on NSEP;
- Training of law enforcement officers.

The above-mentioned organisations both work from fixed sites and use a community outreach model to deliver harm reduction to seven drug dens (popularly known as *Maskani*) in the community. Fixed sites include project offices, rehabilitation and drop-in centres. These are staffed by nurse counsellors and two clinicians, as well as outreach staff (consisting of former drug users, and non-drug users). The clinicians provide clinical care services; nurse counsellors provide HIV testing and counselling, and drug dependency counselling. Outreach workers distribute NSEP kits in exchange for used needles and syringes, provide first-aid services such as abscess treatment, and help by referring or taking

clients to health facilities. In the *Maskani*, they also conduct community education on HIV and STIs, focusing on testing, diagnosis, prevention, care and treatment.

In addition, Reachout works with health care workers in public health institutions to create awareness of NSEP, and to empower health care workers to refer clients to clinical services. Case managers are used to link HIV positive drug users to HIV care and treatment in public health facilities. This helps in fast tracking drug users for services in public health facilities, and ensures access to these services. The organisation organises client feedback and uses radio to educate communities regarding drug use. They also run mobile clinics for drug users who cannot access regular health facilities due to long distances. They also run a psychosocial support group for former drug users.

Rehab Centres

In this coastal region, the Kenyan government runs one rehabilitation centre: the Coast General Hospital. Civil society organisations provide an additional number of rehabilitation centres. Despite their prohibitive stance regarding drug use, the Omari Project in Malindi, and MEWA and Reachout in Mombasa have been providing inpatient rehabilitation services for over ten years. In all these centres, HIV testing is offered to clients. Additionally, Reachout, through its Tuonane project, also provides outpatient services that include outpatient detoxification, addiction and HIV counselling and testing, and risk reduction education.

The problem with rehabilitation centres, however, is that the staff believe that everyone who goes to a rehab centre wants to stop taking drugs. They fail to note that clients have different needs and reasons for participating in rehabilitation centres. Some people who enter these facilities do come with the intent to stop using drugs, while others just need a break from drugs. There are also individuals for whom rehabilitation offers safety from irate community members. Others, more well-off individuals, were coerced into participation by their families: they seduce drug using family members to enter rehab with the promise of gifts or travel abroad. A high rate of relapse was reported among those who went through these centres due to involuntary or coerced participation. Other factors leading to relapse were lack of economic and social skills, lack of support from one's community or generally, poor skills in reintegration into society.

Different approaches were used to address clients' lack of economic and social skills. MEWA, with financial support from Mainline, provided clients in rehab centres with the equipment or materials to start a business to allow meaningful reintegration into society. Reachout has in place a re-integration model to reduce the chances of a client's return to drug use. This model combines four months of inpatient behavioural therapy, followed by post care in outpatient drop-in centres.

While all organisations used community based models, involving community engagement, to reach PWUD, these organisations yielded different results. This could be caused by a variance in the models or methodologies applied. The Omari project embraces a peer-driven model, while MEWA and Reachout use an individual- or person-centred model.

Despite hostility from the community, progress has been made in targeting PWUD with HIV interventions in Mombasa and Malindi. The Kenyan government has been supporting NSEP, and opioid substitution therapy. In addition, the government has one established rehabilitation centre at Coast Provincial General Hospital in Mombasa.

Drug Laws, Health & Human Rights in Kenya

Drug Control, Health and Human Rights Laws

The next section presents an inventory of the existing laws on drugs, health and human rights, and discusses some of the problematic contradictions in these in Kenya. Kenya is a state renowned for the criminalization of the use of drugs: various laws under The Kenya Narcotic Drugs and Psychotropic Substances (control) Act no 4 of 1994 section 3 and 4 criminalize drug use within its jurisdiction. The rationale for the criminalization of drugs is deterrence. Kenya has adopted a 'war on drugs' policy that involves punitive laws and practices including incarceration and fines. At the same time, the government of Kenya has adopted laws protecting human rights and health rights. This ambiguity is explained in the chapter below.

The table below attempts to show the contradictions between a criminalization policy that involves punitive policies and incarceration on the one side with public health and human rights policies and laws on the other side:

Table1: Inventory of punitive laws against drug use, health and human rights

International and Kenyan Drug laws	International and Kenyan Health Rights laws	Other relevant Human Rights laws
UN Conventions The 1961 UN Single Convention on Narcotic Drugs article 36 (1)a, 36 (1)b criminalizes drug use The 1971 UN Convention on Psychotropic Drugs article 20 criminalizes drug use The 1988 UN Convention against illicit traffic in Narcotic Drugs and Psychotropic Substances.	Article 25 of the Universal Declaration of Human Rights,1948 The 1961 UN Single Convention on Narcotic Drugs article 38 (1) recognises drug use as a health condition deserving measures of treatment, education, after-care, rehabilitation and social reintegration. The 1971 UN Convention on Psychotropic Drugs article 22 recognises drug use as a health issue only after criminalization. Article 12 (1) International Covenant on Economic, Social and Cultural Rights, 1966 states, *"the states parties to the present*	1966 International Covenant on Civil and Political Rights (ICCPR). Article 9 recognises the right to liberty and security. It prohibits arbitrary arrests and detention, and requires any deprivation of liberty to be according to the law, and obliges parties to allow those deprived of liberty to challenge imprisonment through court. Article 1 (55) and (56) of the United Nations charter on human rights states, promote 'universal

	Covenant recognize the right of everyone to enjoyment of the highest standard of physical and mental health Article 16 (1) of the Organisation of African Unity - Bunjul Charter Act of 1982, states *"every individual shall have the right to enjoy the best attainable state of physical and mental health",* and 16 (2) mandates state parties to protect the health of their people and to ensure that they receive medical attention when they are sick. Constitution of the World Health Organisation, 1944. This constitution is dedicated entirely to health	respect for, and observance of, human rights and fundamental freedoms". The Principles of the 1948 Universal Declaration of Human Rights articles 4-7 which encompass various human rights declarations on torture, cruel and inhuman treatment and inhibition to health including: *International Covenant on Economic, Social and Cultural Rights (ICESCR) *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment (CAT) * Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) *International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) *Convention on the Rights of the Child (CRC) The 2010 Constitution of Kenya, article 21(1) and (2) states, "it is the fundamental duty of the state and every state organ to observe, respect, protect, promote and fulfil the rights and fundamental freedoms".
The Kenya Narcotic Drugs and Psychotropic Substances (control) Act no 4 of 1994 section 3 and 4 criminalizes possession and trafficking of drugs as follows:	The constitution of Kenya article 43(1) (a) provides every Kenyan the right to the highest attainable standard of health, which includes the right to health care services including	

Article 3 (1) criminalizes possession any narcotic or psychotropic substance Article 3 (1) states that any person who has in his possession any narcotic or psychotropic substance shall be guilty of an offence. Article 3 (2) section (1) a and b criminalizes drug use attracting fines and/or imprisonment Section 5 of the same Act list penalties for narcotic drugs. Section 5 (1) penalizes *drug use *being in areas where drugs are smoked, inhaled or sniffed *ownership or occupying any premises used for the purpose of preparation, smoking or sale, or the smoking, inhaling, sniffing or otherwise using any narcotic drug or psychotropic substance *Possession any pipe or other utensil for use in connection drug use These offenses attract a fine of Ksh 200 thousand or imprisonment to a term not exceeding 10 years or both. The National Drug Control Bill of 2011 that mandates the National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) put excessive focus on prevention and incarceration.	reproductive health care. Article 21(2) provided for state to take legislative, policy and other measures including the setting of standards to achieve the progressive realization of the rights guaranteed under article 43 (2). Article 35(1) The Health Care Bill of 2012 (Government of Kenya 2012) section 4 states, " it is a fundamental duty of the state to observe, respect, protect, promote and fulfil the right to the highest attainable standard of health including reproductive rights and emergency treatment. The Kenyan Narcotic Drugs and Psychotropic Substances (control) Act no 4 of 1994 section 52 of the same drug control act provides the Cabinet minister (now cabinet Secretary) the discretion to establish a number of rehabilitation centres for care, treatment and rehabilitation of persons addicted to narcotic drug or psychotropic substance The HIV and AIDS Prevention and Control Act section 19 section 19 stipulates that every health institution whether public or private and every health management organisation or medical insurance provider shall facilitate access to healthcare services to persons with HIV without discrimination.	

Clearly, there is a disharmony between drug laws, incarceration practices and human rights. Drug use in Kenya is a crime, and therefore little, if any, attention is paid to the medical and human rights aspects of drug use. The nature of drug control provisions violates the right to health, privacy, and freedom of association.

Overview of Relevant Laws Pertaining to Drug Users in Kenya

Article 2(5) states "the general rules of international law shall form part of the law of Kenya." Article 2(6) equally states that "any treaty or convention ratified by Kenya shall form part of the law of Kenya under this constitution." This means that any international law dealing with drugs that has been ratified by Kenya becomes part of its national laws. Furthermore, according to article 21(4) of the constitution, the state fulfils its international obligations by enacting and implementing legislation in relation to the use and trafficking of drugs. However, member states are given discretion to make their national legislation more precise as the UN conventions only provide a skeleton guidance for framing drug laws.

The 2010 Constitution of Kenya under the fourth schedule, part 2, section13, devolves the function of drug control to county governments, and gives the county governments the mandate to create drug control legislation. At the time of this study neither county governments of Mombasa nor Malindi had taken advantage of this provision. At best, in 2013 the governor of Mombasa County government declared a war against drugs that resulted in scarcity of drugs for a couple of days. The national government laws prevailed.

The Principles of Modern Drug Policy (2012) recognises that drug policies should be balanced, compassionate, and humane. Rather, drug laws collide with fundamental human rights and freedoms enshrined in the UN human rights conventions, the Kenya constitution, the African Union charter, and Kenya's 2006 HIV and AIDS Prevention and Control Act.

Negative Consequences Of Kenya's Legal System for Drug Users

The National Drug Control Bill of 2011 that mandates the National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) put excessive focus on prevention and incarceration. In spite of these punitive laws whose aim is to curb the presence of drugs in communities, drugs were readily available, both in prisons and in families and communities.

Section 21 of the Criminal procedure code prohibits the use of greater or excessive force particularly where there is no threat to escape or resistance of arrest. The Police Code of Conduct and Ethics forbids subjecting arrested persons to torture, hardship, and inhuman treatment. In dealing with drug users, police officers often overlooked the above codes.

Negative acts by the law enforcement agencies include beatings, demand for bribes, arrests, arbitrary detention at police stations, remand and denial of treatment for arosto (withdraw symptoms). Being locked in police stations for about 72 hours without any treatment or intervention for withdrawal symptoms was described as an enormous suffering in silence. Police officers who are knowledgeable about withdrawal symptoms encouraged drug users to persevere. Other police officers beat those who would complain about arosto. Such encounters with police compromised access to health care services.

Criminalization of drug use was linked to scarcity of needles and syringes. Before the needle and syringe exchange program, drug users encountered scarcity of syringes and needles. Needles and syringes, though available in chemists and pharmacies, were only sold with a prescription. Paraphernalia law has been used by pharmacy and poison board of Kenya to prohibit sell of clean needles and syringes to drug users resulting in sharing and reuse of contaminated syringes and needles.

Section 52 of the Kenya Narcotic Drugs and Psychotropic Substances Control Act no 4 of 1994 provides the Cabinet Minister (now Cabinet Secretary) with the discretion to establish a number of rehabilitation centres for care, treatment and rehabilitation of persons addicted to narcotic drugs or psychotropic substances. Section 53 allows the Cabinet Secretary to set up a special rehabilitation fund to be funded by the government and other sources. Despite these provisions in the law, in reality there are very few government rehabilitation centres. In fact, more drug users can be found in prisons than in rehabilitation centres. In the study area, for instance, there is just one governmental rehabilitation centre: in Mombasa General Hospital. Community based rehabilitation centres, led by civil society organisations, are too expensive for drug users who might be interested in using these services. Twenty seven-year old Simon*, who would like to stop using drugs, shared that he is waiting for his brothers to pay for him, so he can go to a rehabilitation program. Meanwhile, he continues to take drugs.
All former drug users we spoke to in this study had been able to afford rehab centres only as beneficiaries of scholarships. However, scholarships were limited, and demand is high.

While there is the need to rework laws with respect for human rights, one key informant cautioned a blanket change of laws could increase mob justice in communities. They suggested the repealing of laws that hinder harm reduction interventions and violate fundamental rights as well as laws that encourage arbitrary arrests and police brutality.

Experiences with Law Enforcement in Malindi and Mombasa

The chapter below discusses drug related crimes and incarceration practices in Kenya. Lastly, drug use in prison is discussed, followed by a snapshot of the consequences resulting from the politicization of tolerance strategy.

Despite its strict drug laws, the Kenyan government shows a certain amount of tolerance, for instance by allowing harm reduction interventions in Malindi and Mombasa. This tolerance presents both opportunities and challenges. The biggest opportunity is the introduction and rollout of harm reduction programs, with the inability to create a favourable environment for this approach as its main challenge.

In Malindi, Omari has engaged actively with law enforcement agencies and the larger community, which resulted in acceptance of harm reduction by those parties. This has lead to de-penalization and a decline in police harassment, as explained by this former drug user: "*Now the Omari project is helping a lot in the defense of drug users. The police focuses more on getting the source of the drugs rather than targeting drug users."*

In Mombasa, however, the organisations have failed to sufficiently engage with authorities. One drawback here is the high mobility of law enforcement officers. As one outreach

worker remarks: *"You work well with an officer, then she or he is transferred, and when you approach the incoming officer she or he will tell you, I am here to enforce the law without favour."*

The Omari project works with the Malindi courts on de-penalization, while the Mombasa-based organisations experience difficulty bringing on board law enforcement agencies. De-penalization and community engagement seem to have worked in favour of Omari. Reachout and MEWA are struggling with deterrence laws and the politicization of drug use, which hinders social justice and inhibits harm reduction efforts.

Existing drug laws, law enforcement practices and political 'gimmicks' present major challenges. The consequences of these political gimmicks are threefold: 1) they create a temporary scarcity of drugs which causes a number of clients to shift from smoking to injecting; 2) in the absence of qualified detoxification programs, drug users are suffering from withdrawal symptoms, and 3) they lead to arbitrary arrests.

1&2) Often, these political 'gimmicks' cause a temporary scarcity of drugs, which causes drug users unnecessary suffering. After a couple of days, these drugs reappear on the market again. For example, after the most wanted drug barons in Kenya's 10th parliament were named, this lead to reports of scarcity and as a result, drug users flooded public health facilities presenting with severe withdrawal symptoms. Another example occurred after the new Mombasa governor took office, who announced that his priority would be to deal with the drug menace in Mombasa. For a few days, there were reports of dried-up supplies of drugs, with drug users suffering from withdrawal symptoms as a result.

Two drug users in Watamu town, Kilifi County mentioned that they shifted from smoking to injecting heroin during one such shortage caused by a political 'gimmick', because one or two shots are sufficient for the day as opposed to having to smoke several times a day. *"In times of scarcity, injecting is effective because of the long lasting effect. I also found, because of the long lasting effect, that injecting was cheaper than smoking"* (Active female drug user, Watamu).

3) Besides temporary drops in the availability of drugs, drug users also reported experiencing police brutality, e.g. during the President's visits to Mombasa. The police were ordered to rid the streets of drug users and corral them to confined areas - the police posts or remand - until the end of the presidential visits, unfairly harassing and incarcerating both drug users and outreach workers. There were also reports of police swops characterized by beatings, harassment, arbitrary arrests targeting drug users or those suspected of using drugs.
Police officers were deployed in the streets and communities to flush out drug users. Any gathering of drug users, even outside *maskini mbaya* (drug dens) was considered a crime. Even after showing the police an employment identification card, an Outreach worker was accused of encouraging his clients to use drugs. In this context, despite the harm reduction efforts, police continue to regard possession of (harm reduction) paraphernalia as a crime, or as supporting drug use.

"I was coming from church and I saw my clients (drug users) sitting down and I joined them. Suddenly policemen were harassing us and even though I told them that these are my clients and I was only checking on them, they became violent and accused us of taking drugs. I told them we were not doing any drugs. They ordered us to accompany them to the police station. I resisted and showed them my employment identification card, but they claimed I was encouraging my clients to do drugs. I did not understand what I was being charged with and was told that drug users are fined 3000 shillings per person. I called my father who was willing to pay, but I was not going to leave my clients at the police station to be arraigned in court. We spent a night in the police cells until our fines were paid." (Outreach worker, Mombasa)

Drug users' experiences with law enforcement

In the interviews conducted for this study, all interviewees associated drugs with violence, crime and health vulnerabilities. Arbitrary police swops, beatings, harassment, bribery, remand, prison, theft, mob justice, sharing contaminated syringes and needles, overdose, abscess, neglected health are common elements in the life of a drug user.

While on one hand, criminalization of drug use set the stage for arrests, bribery, beatings, harassments and imprisonments, the crime rate amongst drug users did not change. The drug users were on the run from incarceration practices as well as from mob justice. Most violence and crimes were associated with heroin and cocaine use. From that perspective, prison seemed a safe place to be.

Almost all former drug users reported involvement in spontaneous crime-related activities to get money to sustain their drug use. The majority report being driven into crime by *arosto* (withdrawal symptoms), as they did not have any income to sustain their drug use. The majority of the drug users I met were redundant or out of work (some never got employment, others were sacked due to chronic absenteeism or mistrust by employers when found out they were on drugs, while others just left unemployment to spend most of their time in *Maskani*). A few engaged in small time fishing and precarious beach boy (male prostitution) activities to buy drugs. Others collected used papers and plastic bottles which they sold to sustain drug use. Others sold their personal items, or stole from family members and communities to sustain drug use. In Mombasa, three of the interviewed drug users at the MEWA rehabilitation centre had completed secondary school, five were post secondary. In Malindi, however, the majority of drug users and ex-drug users only completed primary school and a few were secondary school drop-outs.

"I did not know addiction would be a struggle to stop. It was difficult to stop, you need support. I was employed and married. When my boss came to know about it, I was sacked from job. I could not be trusted. I had moved on to injecting, which I did for 19 years". (Former drug user Mombasa)

Those with businesses sold their businesses, property and personal effects, then moved on to begging and stealing, the latter becoming their main source of income. Consequences of these crimes included damaged social relationships, physical harm inflicted by mob justice and police arrests, fines and imprisonment. Mob justice put them at risk of personal injuries.

Clinical officers working with PWUD reported that fresh wounds, caused by mob justice, were a common health problem drug users presented with in clinics.

With the exception of one former drug user in the study, all had been involved with law enforcement officers in their community, at police stations or posts, in court, and in remand or prison. In the communities, drug users encountered police in drug dens, and during police swops they were flushed out of streets, houses or other places they frequented. They were charged with several crimes, including being in possession of drugs or drug paraphernalia, being found in drug dens, loitering or merely being a known drug user or being suspected of being one. Being a known drug addict was enough reason to convict people for purported stealing, as all drug users are thieves, in the eyes of both the community and the court. Drug users described that beatings, harassment and bribery were common when dealing with police, and that mob justice was a common occurrence in dealing with community members.

John (39) from Mombasa narrates how he was treated by law enforcement officers:

"In 2000 I started injecting. We encountered violence at the hands of the police. If found by the police in masikani mbaya (drug dens) you are caught or beaten or all the money you have on you is taken by the police. For many years my life was characterized by crime, hiding from police, being caught, beaten, money taken away, sometimes taken to police station or jailed. I used to get watches at retail price and sell, and then buy drugs. But because I was a drug user, I was wrongly accused of stealing. One is always branded a criminal irrespective of committing a crime or using drugs..."

James (40) from Mombasa shares how he started committing crimes to sustain his use:

"It is suffering, and those who support you end up sympathizing and buying drugs for you to end the suffering. I had to be very creative to sustain my steady use. For five years, I impersonated a doctor in high-end hospitals and stole from patients. Next I bought a gun and stole cars for a couple of years. My life was lived on the run... from the police and from the community. Since I was a heavy user my priority was to organise robberies, hide from the police, get money, inject drugs and dealing with arosto, because the withdrawal symptoms are very intense. I never had time to visit a clinic, and no one to tell me about it. All my friends were only thinking about how to get drugs. Finally I was caught and convicted for life for a violent crime. After my mother bailed me out of jail, an outreach worker visited me and told me about rehab. I found I am HIV and hepatitis C positive."

Jemima (48), a former drug user, shares her experiences in dealing with the police:
"I am 48 years old and am HIV positive. I was on drugs for 20 years. The worst point in my life was when I progressed to injecting heroin. We also encountered violence at the hands of the police. If found by the police in places where drugs are smoked or injected you are caught or beaten or your money is taken by the police. Syringes and needles were very scarce. Chemists and pharmacies did not selling syringes and needles without a medical prescription. Syringes and needles found on us by the police were taken away for exhibits, so we would resort to sharing syringes and needles. If you have your drug, you're in 'arosto' and have no syringe or needle or it is too blunt to inject, you now ask a friend… we reused

and shared the syringes and needles we had... When the needles we had were too blunt to work, we would get sharp needles from the hospital. If lucky, we could get clean ones from the hospital's injecting room, or picked used ones from sharps bins, and sometimes the hospital's garbage sites… Or we used to go to the health facility and pretend to be very sick. In the consulting room, we would convince the doctor or nurse to get out of the room, and take syringes. Alternatively, if there were no syringes we go to the injection room and get from the bin (sharps) or garbage dump and pick used injections from there. There was no consideration about the medical condition of the previous user. We just needed the syringes and the needle. Moreover, if friends came to ask for syringes, we empathized and shared with them." It is better nowadays that there are free clean syringes and needles, they do not even reuse them and people are taught how to inject properly. They also get clean water and swabs. For us we suffered."

Drug Use in Prison

According to a Malindi prison social worker, over 75% of the prison population were incarcerated for drug related crimes. The majority of former drug users who participated in this study had been in remand and jail more than five times.

As correctional institutes, the strategy of prisons is to restrict access and availability of drugs through confinement. However, drugs are very much present in prison. During an informal discussion with 24 prisoners, Stover et al. (2006) found that some prisoners who arrived as non-drug users, had embraced drug use while in prison, and exited prison as active drug users.

Former drug users described prison as a 'safe' place to use drugs: safe from police harassment and mob justice. Some even preferred prisons because they were seen as human beings instead of just drug users, they held responsibilities, worked, and found better ways to earn money. They felt freer inside the prison than outside of it. Paradoxically, at the same time, prison was also an unsafe place, because the drug supply wasn't as plentiful as out on the street. This led some drug users to injecting, in order to get more effect from a smaller amount of drugs.

Former drug user Geoffrey (39) describes his experience with drug use in prison:

"For 18 good years I was a drug user. I was in jail 13 times: six times I was taken there by community members for suspected stealing, although I never stole; seven times my imprisonment was drug-related. I was a very active drug user every time I was in prison, and each time I was released I got out and started looking for drugs straight away.

"Aah! Prison is a safe place to do drugs; you just have to know how to get it. I was caught only once. It came to a point where I preferred to be in jail because it was safe from both police and community harassments. There are many ways to get money while in remand or prison. In remand you go to court where you meet family members and friends who give you money. Some would bring drugs which you then smuggle into prison. Inside prison you have to work as a punishment. When working outdoors, you meet the public, talk to them and get money from them. You can also get money from visitors during visits. Some people sell personal items and you can do jobs for prisoners like looking after personal items. The only

problem was getting the syringes. Just like in the community, we shared syringes, and I think up to now drug users in prison still share. Taking addicts to prison does not help at all."

Kenya, like many other countries, has a high HIV prevalence in prisons (NACC 2009; Stover and Lines 2006). Prison serve as incubators of HIV and hepatitis C, as none offered a harm reduction strategy, provide NSEP or rehabilitation services. The ensuing scarcity of clean needles and syringes continues to expose drug users to serious health risks. Syringes and needles were reused and shared. Drug dependence prevention, treatment and support services were absent, despite drug using inmates expressing their interest. Prisoners who were hiv-positive were taken to public health facilities for treatment, but had to rely on their families for opportunistic infection treatment and other drugs, as these were not available in public health facilities. Nutrition recommendations for hiv-positive prisoners were often not implemented by the prisons. Only Omari in Malindi were able to offer some drug related information and education, and limited psychosocial support.

Drug Use and Health Risks

Drug use and dependence are associated with a number of health risks and vulnerabilities that include physical injuries and adverse psychological effects, such as social isolation and depression; unsafe injecting practices; HIV; tuberculosis; overdose; abscess; hepatitis; malnutrition; upper respiratory tract infections; inability to access health facilities and poor quality of health.

Principles of Modern Drug Use policy recognises drug addiction as a chronic disease of the brain and suggests that prevention, treatment and recovery support services be integrated into health care system for effective intervention (UNODC-WHO 2009).

As explained above, drug laws and incarceration practices compromise the health of drug users. The health aspect of drug use is often overlooked and criminalisation of drug use has been associated with scarcity of needles and syringes and limited access to health services. Sharing and reuse of contaminated syringes and needles was a common practice. In prison, HIV services including testing and counselling however care and treatment were absent.

Drug users' knowledge of health risks

While other factors may have contributed to HIV infection in this community, all former drug users linked an HIV-positive status to the sharing of needles and syringes. Two former drug users had never shared syringes and needles and were hiv-negative, despite having engaged in unprotected sex with multiple partners. One of them mentioned using fake medical prescriptions to purchase clean syringes from pharmacies. The other was aware of the risks of hiv-transmission and thus never shared syringe or needle. Those who did share syringes and needles did so out of ignorance and compassion:

"Initially we did not know what was killing drug users. Many of our friends who were using drugs died. We thought it was the effect of too much drugs in the blood system, but then the deaths increased and we got scared. We later realized that it was AIDS that was killing us. We did not know that AIDS was contracted from sharing needles because before AIDS was linked to unsafe sex. We were very scared because we knew most of us were infected

because we shared needles and syringes with those who had died". (Former drug user Malindi)

The drug users in study all heralded harm reduction interventions for the resulting increase and availability of clean syringes and needles.

Conclusions

People who use drugs, and injecting drug users in particular, face a number of health risks. Drug laws contribute immensely to health vulnerabilities of drug users. The prevalence of HIV among drug users is high in many countries. A harm reduction approach is a key strategy in mitigating health risks among drug users and their contacts.

Law enforcement officers and policy makers are a significant stakeholder in drug use control. Their most significant and relevant role they can play is in helping dispense with incarceration practices and by protecting fundamental human rights of drug users. In order to accomplish this, annex 1 provides a selection of training topics for law enforcement officers.

Annex 1: Training recommendations of law enforcement agents

Law enforcement officers include: magistrates, all police officers including police commissioners and all prison staff including prison commissioners. Also included is the project staff working at MEWA, Omari and Reachout. In particular, MEWA staff needs training on law enforcement, HIV and drug use. As recommended by KELIN and The Omari Project, trainings on drug use should be included in Kenya's judiciary training curriculum.
The following topics should be included in a training:

Familiarization with Drug Policies, Health and Human Rights Laws
Adoption of harm reduction interventions into HIV programmes requires endorsement by health and law policy makers.

Transmit **knowledge** on existing international drug policies including UN conventions; principles of (effective) drug policies; Kenyan drug, health and rights laws. Proper understanding of WHO international guidelines on HIV/AIDS and human rights, as well as WHO guidelines on HIV/AIDS and key populations.

Capacity to understand what to do with a drug user when they are arrested.

Drug Use, Dependence and Health Risks

Knowledge on the harmful consequences of drug use. Knowledge on the harmful consequences of injecting drug use: contracting HIV and hepatitis C; getting co-infections; social, economic and development issues. Knowledge of how drug laws and incarceration / harassment practices lead to harmful consequences for drug users.

Capacity to ensure drug users have access to HIV and hepatitis C services, including diagnosis, treatment, care and support. Capacity to provide and refer to HIV and hepatitis C counselling and testing, treatment, care and support. Build capacity to understand what to do with drug users when they are arrested, and to re-evaluate incarceration laws and practices.

Drug use and Human Rights Laws
Train law enforcement officers on HIV, drug users' human & health rights and consequences of incarceration practices.

Build **capacity** to recognize and protect the human rights of people who use drugs. Capacity to understand the effects of drug laws and incarceration practices on health/human rights laws. Capacity to understand the role of the law and law enforcement officers in protecting the rights of people who use drugs. Capacity to understand the negative consequences of imprisonment and review laws. Capacity on positive interpretation of law and to offer cost effective alternative strategies, and to harmonize drug laws and health/human laws.

Rework effective strategies to protect drug users from health harms and mob justice. How do you treat them: as patients, criminals, human beings? Do they have rights? Should they be provided with detoxification or let them endure suffering? Is it safe to arrest them or release them? What are the consequences?

Harm Reduction Approach
Due to drug use being criminalized, most people perceive harm reduction as promoting drug use and thus crime.

Provide sufficient **knowledge** on a broader perspective of the harm reduction strategy including a comprehensive package not only limited to HIV, hepatitis C, and other related health risks but also prevention measures.

Build **capacity** to support the harm reduction strategy, and to decriminalize the distribution of clean needles and syringes. Capacity to understand injecting drug use, HIV and hepatitis C, and role of harm reduction interventions in communities including prisons. This should also include the principles of harm reduction, NSEP, and opioid substitution therapy. Include social, economic, and development aspects. Build capacity to advocate for harm reduction strategy in community as well as in prisons, and in drug policy.

Management of withdrawal symptoms
The ability to manage withdrawal symptoms. Prison officers and police officers who are in contact with arrested drug users in the first 72 hours of abstinence of drug use should be **knowledgeable** regarding withdrawal symptoms including presentation or diagnosis.

They should have the **capacity** to carry out detoxification as well as provide information on the same to drug users. They should also have capacity to refer to health facilities.

Stigma and decriminalisation
In Malindi and Mombasa drug users face the stigma of being drug users, ex-prisoners and HIV-positive.

Capacity to de-stigmatize drug use, and to reduce discrimination of drug users, ex-prisoners and drug users living with HIV. Capacity to understand implications of negative attitudes (stigma and discrimination) towards drug users, and fundamental human health rights.

HIV Post-exposure Prophylaxis (PeP) Management.
Law enforcement officers, particularly those who conduct arrests and swops, should have **knowledge** of post-exposure prophylaxis management. Rapid **availability** of PEP kits for NSEP is recommended in NSEP standard operations procedure manual (NASCOP 2013).

Networking and Collaboration
Capacity to collaborate and network with other stakeholders. In Kenya law enforcement officers (judiciary and police force) should collaborate with relevant government offices, people who use drugs, the civil society implementing projects on drug use, and human rights groups. Capacity to learn from best practices in Kenya and internationally.

Para-legal training
Outreach workers should be trained as para-legals with capacity to understand and advocate for drug users' rights. Capacity to address and document any police harassment.

Other training recommendations: Training policy makers (parliamentarians and county assembly), religious leader and media professionals on drug use and harm reduction, and how to report drug related issues.

Abbreviations

HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
KELIN	Kenya Legal and Ethical Issues Network on HIV and AIDS
NACADA	National Authority for Campaign against Alcohol and Drug Abuse
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Program
NSEP	Needle and Syringe Exchange Program
NSP	Needle Syringe Program
PMCTC	Prevention of Mother to Child Transmission of HIV
PWUD	People Who Use Drugs
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDOC	United Nations Office on Drug and Crime
WHO	World Health Organisation

Terminologies

People Who Use Drugs (PWUD): - include people who use psychotropic substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal) or transdermal. Often this definition doesn't include the use of such widely used substances as alcoholic and caffeine-containing beverages and foods. (WHO definition).

People Who Inject Drugs (PWID): - refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes – referred to as "therapeutic injection" – are not included in this definition. The definition also excludes individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance. (WHO definition)

Harm Reduction:-This is any policy or program designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, family, community or society. It provides drug users with the knowledge, tools and resources which will enable them to live as healthy as possible.

Harm reduction hierarchy
1. If you use drugs, avoid injecting (consider alternative methods of use);
2. If you inject drugs, use sterile injecting equipment and never share;
3. If you use non-sterile equipment and share equipment, use bleach to clean.
4. If bleach is not available, flush needle and syringe three times with clean water.
Source: http://www.ceehrn.org/index.php?ItemId=4805 for more information

OST(OST):- Is an evidence-based intervention for opiate-dependent persons that replaces illicit drug use with medically prescribed, orally administered opiates such as buprenorphine and methadone. OST reduces HIV-risk behaviours and harms associated with injecting (such as abscesses, septicemia, and endocarditis), overdose and participation in criminal activity, thereby improving the quality of life and health of PWIDs. It is endorsed by UNAIDS, UNODC and WHO as part of a comprehensive package of eleven core interventions for PWID Programs that collectively maximise impact for HIV prevention and treatment (South Africa Key population training manual).

Needle Syringe Exchange Program (NSEP):- Provision of sterile syringes and needles in exchange for used syringes and needles to reduce transmission of HIV and other blood-borne infections associated with re-use of contaminated syringes and needles by PWIDs. Often, the Programs also provide other public health services such as HIV testing, risk-reduction education and referrals for health care). The NSEP kit includes three syringes, three ampules of sterile water, a swab, condoms and a rubber band. To minimize harm from using contaminated needles, NSEPs should also provide for, and encourage, the safe disposal of used injecting equipment in puncture-proof boxes. The idea is to exchange used needles and syringes for sterile ones. However, if used gear isn't returned it is important to ensure they have continued access to sterile needles and syringes. NSEPs form part of a comprehensive package of eleven interventions recommended in the WHO, UNODC, UNAIDS Technical Guide (National AIDS and STI Control Program [NASCOP] 2014).

PEP treatment: - An emergency medical response that can be used to protect individuals exposed to the HIV virus. PEP treatment consists of preventive medications, laboratory tests and counselling.

Local terminologies

Arosto: - refers to withdrawal symptoms such as restlessness, agitation, body pains, body malaise, nausea and vomiting, diarrhoea, abdominal cramping, and headache, insomnia, strong craving for drugs, hallucinations and depression.

Unga: – Refers to both heroin and cocaine.

Mteja: - (client or customer) Refers to the drug user.

Junkies: – A popular terms used to refer to drug users and former drug users. To former drug users, a junkie is a derogatory term.

References

Ball, A., L, Rana, S., Dehne, K., L. 1998. HIV prevention among injecting drug users: responses in developing and transitional countries. Public Health Reports. 113, (Supplement 1), 170-81

Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), *entered into force* June 26, 1987.

Convention on the Elimination of All Forms of Discrimination Against Women G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, *entered into force* Sept. 3, 1981.

Convention on the Rights of the Child G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), *entered into force* Sept. 2, 1990.
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Des Jarlais, D. C., Dehne, K., Casabona, J: 2001. HIV surveillance among injecting drug users. AIDS, 15(Suppl 3):S13-S22.

Des Jarlais, D., C. 1999. Preventing HIV infection among injecting drug users: intuitive and counter-intuitive findings. Applied and Preventive Psychology, 8, 63-70

Government of Kenya. 2010. The Constitution of Kenya (Kenya). 2010.

Government of Kenya. 2006. HIV and AIDS Prevention and Control Act 14 of 2006

Government of Kenya: Act No. 4 of 1994. The Narcotic and psychotropic Substances (Control) Act 1994 (Kenya), 2010.

Hagan, H., Thiede, H., Weiss, N., S et al. 2001. Sharing of drug preparation equipment a risk factor for Hepetatis C. Americal Journal of Public Health. 91 (1), 42-46

Hagan. et al. 2000. HIV and HCV infection among injecting drug users. Mount Sinai Journal of Medicine, 67 (5-6), 423-428

Hallam, C., Werb, D., Lai G., Nougier, M., Melis M. and Curtis. M. 2010. International Drug Use Consortium. Drug Policy Guide

International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976 (Hereafter ICCPR).

International Covenant on Economic, Social and Cultural Rights .A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976 (Hereafter ICESCR).

International Convention on the Elimination of All Forms of Racial Discrimination 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969.

Lindenburg CEA. 2006. Decline in HIV incidence and injecting, but not in sexual risk behaviour, seen in drug users in Amsterdam: a 19 year old prospective cohort study. AIDS. 20: 1771-5 (PubMed)

Ljungberg, B., Christensson, B., Tunving, K., K et al. 1991. HIV prevention among injecting drug users: Three years of experience from a syringe exchange program in Sweden. Journal of Acquired Immune Deficiency Syndrome, 4: 890-895

Mathers, B., L. Degenhardt, et al. 2010. "HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage." Lancet 375: 1014-1028.

National AIDS Control Council of Kenya. 2012. The Kenya AIDS epidemic update, 2011.

National AIDS Control Council of Kenya. 2009. The mode of transmission survey

National AIDS Control Council of Kenya. 2009. Kenya National AIDS Strategic Plan 2009/2013

NASCOP, 2013. Kenya National Guidelines For HIV Prevention and Management of People Who Use Drugs (PWUD). National AIDS and STI Control Program/MOPHS, February, 2013.

Stimson, G. and Choopanya, K. 1998. Global Perspectives on Drug Injecting. In Drug Injecting and HIV Infection. Edited by Stimson G, Des Jarlais DC. Ball A London: UCL Press; OpenURL

StoverH. And Lines R. 2006. 'Silence Still=Death: 25 years of HIV/AIDS in Prisons'. In: Matic S, Lazurus JV, Donoghoe MC (eds). *HIV/AIDS in Europe. Moving from Death to Sentence to Chronic Disease Management*. Copenhagen. World Health Organisation, 2006
United Nations. 1971. Single Conventions on Narcotic Drug use 1961 and 1971. (https://www.unodc.org/unodc/en/treaties/psychotropics.html)

UNODC Scientific Consultation. "Science addressing drugs and HIV: State of the Art". A Consensus Statement. Vienna, 11 March 2014

UNODC, World Drug Report 2012 (United Nations publication, Sales No. E.12.XI.1).

Van Den Berg C, Smit C., Van Brussel, G., Coutinho, R., and Prins, M. 2007. Full participation in harm reduction Programs is associated with decreased risk for HIV and hepatitis C virus: Evidence from the Amsterdam Cohort Studies among drug users. Addiction, 102, 1454-1462

Wodak, A. 2006. Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. Substance Use Misuse. 41: 777-813. (PubMed). http://idpc.net/sites/default/files/library/Harm-reduction-low-cost-high-impact.pdf