Chapter 25

Best Practices in Reaching 'Hidden' Populations and Harm Reduction Service Provision

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Introduction

Kenya has a long and complicated history with the drug trade. The porous coastline and port of Mombasa on the East Coast of Africa situates the country as a transit point, and there has been a recent increase in heroin consumption. While there is greater visibility around the impacts that this has had on men, little or no information has been available regarding the effect on women. Neither the government nor local communities were prepared for the introduction of heroin into these zones and the implications of its increasing use (France 24 English, 2019).

Various laws were passed by the Government of Kenya with the aim of protecting citizens from the harms of drug consumption. Other measures included the ratification of three major United Nations Conventions and the Narcotic Drugs and Psychotropic Substances Act (1994), as well as the adoption of both the East African Community's Protocol on Combating Drug Trafficking in the East African Region and the Organisation of African Unity's Declaration and the Plan of Action on Drug Abuse and Illicit Trafficking Control in Africa. In March 2001, the Government also set up the National Agency for the Campaign against Drug and Substance Abuse (NACADA) to spearhead the war against drugs.

In 2001, with support from the United Nations Office on Drugs and Crime (UNODC), a 'community gap' was identified. Not only was there found to be a lack of community-based interventions, but coercive treatment practices were also present. This research was crucial in improving the lives of people who

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use drugs in Kenya. Through already established community-based rehabilitation centres, which employed abstinence-based programming, harm reduction interventions were introduced. These measures were backed by data from a survey conducted with 350 people who inject drugs (PWID) in Mombasa.

The survey was conducted by the UNODC in partnership with academics and community service organisations (CSOs) and involved a rapid situation assessment of linkages between drug use, injection drug use and HIV/AIDS in Kenya. Further studies found a 49.5% HIV prevalence among PWID in Mombasa and higher rates of HIV among PWID than in the general population (Deveau, Levine, & Beckerleg 2006; Ndetei, 2004). Addressing the high incidence of HIV among PWID required CSOs to embrace harm reduction approaches focused on HIV and other related blood-borne viruses.

The Muslim Education and Welfare Association (MEWA), a local non-governmental organization (NGO), pioneered and spearheaded intervention programmes that specifically targeted men by providing a variety of services, including outreach, clinical services, nutritional support, free detox programmes and residential treatment. Important strides were made in advancing harm reduction by working with law enforcement, religious leaders and the general community to overcome their resistance to interventions for people who use drugs (PWUD) and related public health concerns.

Unfortunately, women who use drugs (WWUD) in Mombasa are affected by culturally entrenched stigma and discrimination which present access barriers to services. These women are frequently impacted by gender-based violence (GBV) perpetrated by both law enforcement agencies and the community. Cultural taboos and religious restrictions have adverse effects on their physical, economic and social well-being, forcing them underground. Furthermore, because drug use is perceived to be a 'masculine' activity, programmes and interventions primarily target men. As a result, WWUD are less likely to access services and often experience discrimination from service providers, which fuels self-stigma. This has exposed WWUD to further exploitation and marginalisation.

Some women, including WWUD, turned to sex work within the tourism industry due to dwindling regional economic opportunities, de-stabilising incidents of terrorism and rising unemployment rates. Women also became more vulnerable to HIV and crime as rates of drug usage among WWUD increased in Mombasa. The high HIV incidence rate was evident as risky sexual behaviours were widespread alongside increased drug use and crime.

Pragmatic Context: Initial Approaches to Accessing Hidden Populations in HIV Prevention

In 2017, the national adult HIV prevalence rate was estimated to be 4.9% with a higher prevalence among women (5.2%) than men (4.5%). Although the HIV Spectrum results show a continued decline in HIV prevalence among the adult population aged 15–49 years over a period of time, the decline has been modest since 2010. Mombasa has an HIV prevalence of 4.1% with key drivers being

PWID, men who have sex with men and female sex workers (National AIDS and STI Control Program (NASCOP), 2018).

MEWA, in partnership with Mainline Foundation, delivers evidence-based harm reduction services for PWUD under the Bridging the Gaps programme. MEWA's 2016 early client records indicated that approximately 1% of their clientele at the drop-in centres (DICs) were women. However, observations from peers and outreach workers in Mombasa's drug dens indicated a high number of women who were not accessing services.

In the coastal region, religion and culture are major influences on people's lives. The abstinence-based approach of providing residential rehabilitation services through the 12 step programme, relapse prevention strategies and behavioural therapy followed by family reintegration had a success rate of preventing relapse cases by 40% (MEWA, 2018). However, limited bed capacity at rehabilitation centres and the exclusion of women was a significant issue. Punitive approaches such as mob killings, condemnation and isolation, physical abuse from police officers and incarceration with no existing support for HIV care management and legal rights also created further barriers to services for PWID.

Knowledge of harm reduction, health and rights has evolved within different institutions through community dialogues, trainings and stakeholder engagement. This indicates the importance of contextualising harm reduction, health and rights services through networks of imams, health workers and actors from the criminal justice system. Therefore, MEWA Health and Harm Reduction partnered with local imams and held parenting workshops organised for 100 family members in December 2009. This was followed by family protests calling for a halt to the supply of heroin through the port of Mombasa and, in 2010, there was a major 'heroin crisis' evidenced by severe withdrawal symptoms among users. In response, actors from different government bodies, CSOs and networks of religious leaders worked together to develop guidelines for the Needle and Syringe Programme (NSP) and Medically Assisted Therapy Programme (MATP).

The NSP intervention was met with resistance from the community, religious leaders and government officials, especially the Ministries Health and Interior Security. MEWA and other CSOs, with support from the Kenya AIDS NGOs Consortium, organised a training on media engagement regarding NSP in Kenya. This debate brought together major actors in the coastal region, including those from the health sector, interfaith organisations, PWUD, media organisations and CSOs. The debate was aired on national television stations (NTV, Citizen TV and KTN) from May to July 2012, while conversations on drug use continued on different radio stations and in newspapers (*Daily Nation* and *The Standard*). The national debate was a positive driver for the introduction of NSP and MATP into the community.

In the early months of 2014, MEWA, Nairobi Outreach Services Trust, The Omari Project (TOP) and Reach Out Centre Trust (RCT) received funding from Mainline Foundation. This, in addition to support from Nai Zindagi Trust in Pakistan transformed the NSP programming in the coastal region. An individualised,

client-centred approach was established in which cohorts were clustered from different hotspots. Outreach workers were then assigned to monitor these hotspots on a daily basis. There was a personal approach to programming as PWID and PWUD were reached with a comprehensive HIV prevention package, although there was limited access to methadone, sexual and reproductive health services (SRHS) and Hepatitis B and C services. The programme adopted an attitude of persistent and consistent outreach to clients' needs at identified drug use settings. Motorbikes were utilised and proved a crucial means of service provision between the community, and the health care and judicial systems, as well as a medium of harm reduction programme visibility. The community members recognised and had mutual respect for outreach workers and supported in the provision of services through peer navigation and secondary needle distribution.

MEWA's Multi-agency Approach to Reaching Hidden Populations in the Fight against HIV

While PWID had access to NSP in addition to other harm reduction interventions, uptake for women injecting and using drugs was non-existent. Coincidentally, when MEWA introduced a livelihoods programme in Kilifi County through the OPEC Fund for International Development under the UNODC, the support was extended to Mombasa County where PWUD were provided with a daily meal. This marked an important moment for the programme as women came out in large numbers with their infants for the daily meal. While some women requested residential rehabilitation services and support for their children, MEWA had limited knowledge of the needs of these women. The introduction of free meals was an incentive for the uptake of services alongside other related harm reduction services. In addition, clients had access to free reproductive health and basic social services. For clients on antiretroviral therapy and TB treatment, free accommodation supported treatment adherence at low volumes.

Women in need and those lacking a social support system were seeking residential services. However, the numbers gradually decreased because services were scattered and were not designed for the specific needs of women. To address this gap, MEWA commissioned a needs assessment from Mainline Foundation in two counties, Mombasa and Kilifi, where harm reduction services by MEWA, RCT and TOP already existed. Following the assessment, a clearly defined package was designed in line with UNODC recommendations. MEWA gained an understanding of how to meaningfully involve women in health, harm reduction and rights services and address their needs through the appraisal and coping mechanism.

The invisibility of WWUD makes it difficult for health and harm reduction service providers to reach them. In addition, women themselves identified various obstacles, including a fear of accessing health services. MEWA reported that 90% of their respondents had come into contact with the police; while the Mainline Foundation study in Omari found that 60% of respondents had been jailed and all of them feared being arrested (2016). All respondents from the Omari study complained about police harassment and 72% of MEWA's respondents reported

having suffered social injustice from law enforcement institutions. WWUD often experience abuse, including sexual abuse and become physically and psychologically traumatised during arrests. Many WWUD, especially those involved in sex work, face physical violence not only from police officers but also by clients and male partners. The Omari study reported that 48% of respondents had experienced physical violations, due to the constant fear of reprisal women often refrain from reporting sexual and gender-based violence (SGBV).

According to Mainline (2016), failure to report SGBV may be attributed to fears of losing child custody due to drug use. This is also likely a factor in the Kenyan coastal region where most WWUD reported having children, while only a small percentage of them have custody. For instance, while 85% of the Omari respondents had children, only 30% had them under their custodial care. Around 66% of WWUD who did not have custodial care mentioned that their loss of custody was related to their drug use (Mainline, 2016).

Maineline's (2016) findings suggest that WWUD often lack confidence in and trust of health care providers and face legal barriers in accessing facilities. Judgmental healthcare personnel can also deter women from accessing services. However, the women interviewed by MEWA and Omari mentioned having confidence and trust in health care providers and outreach workers (Mainline, 2016). The obligation to identify oneself in order to access health facilities hinder WWUD in their willingness to access services, and many WWUD lack identity cards or prefer not to identify themselves in order to protect their privacy. The lack of identification cards can also prevent their children from accessing school.

MEWA worked closely in areas of advocacy and service integration with support from the Open Society Initiative for Eastern Africa (OSIEA) to address the concerns identified by WWUD. The women-only hours were an important aspect of the programme that created personal connections between WWUD and staff within the organisation. There was positive and open communication, empathy and support because of this personal approach. Paralegal officers also worked to ensure that WWUD and their children had access to identification cards, birth certificates and school leaving certificates. Through the HUDUMA Centre, a programme designed to provide a wide array of government services within a single facility, our paralegal officers built mutual trust with government officials to fast track document processing.

In addition to providing gender-sensitive services, MEWA also maintained good working relationships with village elders who work within the Ministry of Interior Security and are familiar with kinship relations. In Kenya, knowledge of kinship is mandatory in acquiring identification cards. Therefore, MEWA acted as a sponsor and presented letters of bonding to the local government administration that affirmed clients were within MEWA's cohort. With a confirmation letter, the local administration could then forward the affidavit letter to the HUDUMA Centre. Through this arrangement, MEWA created a platform where WWUDs and their male partners would receive social security documents in a shorter time and in a non-discriminatory and non-judgmental environment.

Acquiring papers allowed PWUD to gain full legal citizenship rights. With documentation, PWUD are less likely to have money extorted by law enforcement,

thereby reducing their fear of police. They can also seek employment or initiate their own business, their children are allowed in school, and landlords can rent them homes. In the words of a paralegal officer, this effort made 'the impossible, possible' (NTV, 2018).

Access to Social Justice and Legal Rights

In 2010, Kenya promulgated a constitution with a Bill of Rights (Chapter 4) supporting the needs and rights of vulnerable populations (Articles 43 and 46). However, Kenya still has the punitive Narcotic and Psychotropic Substance Control Act of 1994. Section 5 (1) (b) & (d) criminalises the use and possession of drugs and drug paraphernalia. These charges carry a fine of 250,000 Kenyan shillings, 10 years' imprisonment or sometimes both (Kenya Law Reports Online, 2012). The danger in its implementation is that while harm reduction practices like the provision of clean syringes and needles is encouraged, police continue to arrest and charge those providing these services. In addition, drug use is routinely criminalised because of the above provision.

In late 2015, through the support of OSIEA, prison wardens and police officers were trained to better understand the health and rights of PWUD. Prosecutors were targeted to both facilitate and participate in the training. Because people who use drugs fall victim to the 'maeneo policy', which targets areas known for drug consumption and involves imposing vague charges on drug users, it was important for MEWA to work closely with the prosecutors. The objective was to shift punitive sentencing practices by developing an understanding of the needs of PWUD and then by examining articles in the constitution that could support positive changes. The articles that were utilised as advocacy tools included Article 43, which guarantees the right to health; Article 2, which states that all ratified international instruments form part of the laws of Kenya; Article 10, which includes the respect of the rights of marginalised peoples; Article 27, which protects the right to equality and equal treatment before the law; and Article 56, which protects the rights of minorities and marginalised groups.

As a result of the training, prosecutors became ambassadors for change within the criminal justice system. Custodial and non-custodial sentences were practiced for the first time in Mombasa courts targeting PWUD. Our paralegal officers were given days to represent PWUD in court through case profiling and support for the residential rehabilitation services. Magistrates and probation officers became active supporters of the non-custodial services as paralegal officers complimented the community reintegration programme. MEWA used the existing government machinery, including the court user committee, which monitors court performance and provides awareness on court proceedings, as well as the probation committee, to influence drug policy changes. The court now stands out as a ray of hope for PWUD. To entrench this position, in April 2019 the Chief Justice directed judges and magistrates to ensure all prosecuted PWUD are sent to rehabilitation centres and not prisons during the official opening of a rehabilitation centre in Lamu County (Kazungu, 2019). Through this machinery, we are able to sustain the transformative changes within the criminal justice system.

Over the past two years, MEWA managed to penetrate the criminal justice system through a 'deflection' mechanism in which PWUD had access to residential rehabilitation services and methadone as well as the non-custodial and community service orders for petty crimes. This innovative approach of 'deflection', supported by the Senior Principal Magistrate, helped opioid dependent and other PWUD to 'deflect' through community-based counselling and health services, rather than incarceration. Moreover, incarcerated opioid users were provided with opioid substitution therapy in prison. With the 'deflection' intervention in action since September 2017, over 3,140 opioid users and other PWUD in the region have been treated, with no deaths reported. The intervention has also strengthened family system networks and access to economic support through social justice programmes. The 'deflection' mechanism has already been rolled out in the coastal counties of Kilifi and Kwale.

To support the programme, UNODC provided USD 100,000 to the Shanzu Law Court to establish a rehabilitation court, which is unique within the sub-Saharan region (MEWA, 2018). In addition, UNODC has started establishing a drug treatment centre in a coastal region prison to support rehabilitation. Consequently, Shanzu has been marked as a learning site by both local and international partners. Other legal service providers from Afghanistan, Sierra Leone, Tanzania, Uganda and Ukraine are in the process of adopting the 'deflection' intervention.

This innovative approach has helped with the first ever designed court orders that promote the rights of PWUD and help to decongest prisons (MEWA, 2018). The provision of greater liberties has reduced the tendency of those convicted of crimes to reoffend and has also made drug use settings much safer and friendlier towards the actors within the criminal justice system. WWUD also have improved access to legal aid as well as family reintegration support and access to methadone.

Partnership with Mombasa County Attorney's Office

In an effort to cascade down the reforms on drug policy, the County Attorney's Office in Mombasa was involved in training the Members of County Assembly (MCAs), different police service units and inspectorate officers. MEWA worked closely with police officers through the AIDS control unit to build their capacity on harm reduction in relation to legal rights services, especially around the 'maeneo' clause of the Narcotic and Psychotropic Substance Control Act, which is used to target drug hotspots. This subsequently fast tracked drug policy reforms on the Act with NACADA, National AIDS Control Council, NASCOP, Office of the County Attorney, MCAs and CSOs. Following a residential workshop conducted in 2017 on 'maeneo', MEWA, in partnership with the Office of the County Attorney and Shanzu Senior Principal Magistrate, went further to draft the first ever contextualised bill on substance use disorder in East Africa, which is currently at the public participation phase prior to adoption in Mombasa County, with plans for replication in other counties.

A Mombasa County Member of Parliament has tabled an amendment to the Narcotic Drugs and Psychotropic Substances Act No. 4 of 1994. The framing of

the Act currently disproportionately affects the poorest and most marginalised Kenyans, particularly women and young people, who are often unable to pay fines if arrested in targeted drug hotspots. The amendment seeks to enhance the penalties relating to trafficking of drugs and supporting harm reduction intervention. Both MEWA and Katindi Advocates are part of the steering committee of the Caucus on Harm Reduction and Drug Policy Reform in Kenya that is currently seeking to influence positive change in the legal environment by taking advantage of the ongoing amendment; a long-awaited opportunity for lawmakers to carefully rethink the criminalisation of drug use in Kenya. The caucus has drafted a policy brief intended for law and policymakers to inform meaningful engagement on the proposed amendments to the Act.

Achievements of the Community Paralegal Model

With funding support from Mainline Foundation, UNODC and OSIEA, MEWA rolled out a strategic combination of health and human rights programmes in Mombasa. Within this framework, in 2015, MEWA initiated the Paralegal and Advocacy programme, aimed at influencing policy change, the establishment of supporting legislation and the adoption of a conducive environment for PWUD. A community paralegal unit was initiated, comprised of 10 outreach workers with knowledge of the criminal justice system, arrest procedures and police authority.

The community paralegal model was able to achieve the following:

- There are established platforms for dialogue between MEWA and the criminal justice system (law enforcement officers, probation, prison and judiciary actors) to solve problems.
- MEWA is a Member of Court Users Committee with supportive role on social reintegration.
- MEWA has developed and built community leadership structures in dispute resolution.
- MEWA facilitates health referrals for drug use and alternative non-custodial sentencing.

Through the community paralegal model, crime rates in the community have decreased by 65% (MEWA, 2018). Furthermore, networks of PWUD in Mombasa were empowered through the project to advocate for their rights and became actively engaged in the programmes design and implementation. The community paralegal model also had positive impacts specifically for WWUD. Sources of alternative household finances were secured through financial support from families support contribution. WWUD participated in entrepreneurship trainings focussed on business models, product packaging, use of social media marketing and client communication. As a result, 60% of participants started small scale businesses. Furthermore, WWUD gained an understanding of their rights and that of their children and developed positive parenting skills, which resulted in numerous family reunions. Those WWUD who are survivors

of domestic and sexual violence, and who had been reluctant to escalate cases to the judicial system, have now been monetarily compensated by the perpetrators of violence.

MEWA also operates a shelter house, which has housed approximately 250 women since 2015. At any given time, the centre accommodates 10–15 women whose duration of stay depends on the healing, social support and gaining financial independence through employment as peer educators or owners of small businesses. MEWA programmes are currently designed to support the survivors of violence in shelter houses where services such detoxification, addiction treatment, psychosocial support and mediation have been ongoing with additional skills development. The centre has managed to reduce the vulnerability of women as reported cases of violence have reduced among those sheltered.

Further support is provided to the children of PWUD through the provision of school fees, meals and accommodation at the shelter house to increase school retention and performance.

Experience and Lessons Learnt during Implementation of SRHS for WWUD

WWUD are open to SRHS especially when integrated within the MEWA DICs. However, uptake of family planning and condoms remains low because some women want to have children and those engaged in sex work can earn 10 times more when having unprotected sex (Ayon et al., 2019). Maternal and child health services improved and among all women sheltered within MEWA there were no maternal or fetal deaths. Uptake of immunisation services among women in the MEWA cohort is at 100% with positive results for children's developmental milestones. Screening for sexual transmission infection is at 100% with positive a reduction in the incidence and prevalence of STIs. The reduction in positive cervical cancer diagnoses was especially notable, going from 5% to 0% following risk reduction counselling on multiple sexual partners and provision of consistent sanitary towels and undergarments.

Incidences in which WWUD have reported cases of sexual, physical, verbal and emotional abuse to the DICs have demonstrated an understanding of GBV. Cases of at-home abortion, whether voluntarily induced or forced, are later referred to the DIC for post abortal care, especially management of sepsis before referral to health facilities. For HIV testing and services, uptake is at 100% with seroconversion rate at 3.1%, while those enrolled at HIV care management is at 100% and sustained viral load suppression is at 94%. This practice has been recognised as a best practice in May 2019 by NASCOP (MEWA, 2018). Assisted Partner Notification Services, which involves disclosure of HIV status and uptake of pre-exposure prophylaxis among discordant couples, has been positively accepted following data security and confidentiality from adherence counsellors and social mobilisers. Through Hepatitis B and C screening at the Medically Assisted Therapy centres, the government through NASCOP will roll out screening and treatment for 1,000 PWUD infected with Hepatitis C.

Recommendations

There is visibility to meet the needs of 'hidden' populations in Kenya, including WWUD. Through OSIEA and Mainline support, the women's harm reduction and rights programme gained international recognition at this year's International AIDS Conference held in Rwanda and through a publication by the International Drug Policy Consortium. Furthermore, the community led programming influenced religious leaders to accept harm reduction and rights services as a best practice. As a result, WWUD in the coastal region have access to legal recourse, protection and justice through the MEWA shelter house and community legal aid support. Women experience less endemic violence and exclusion within their communities and families, which was made possible through community and weekly legal aid literacy programmes conducted by paralegal officers.

Women report ancillary services (e.g. showers, nutritional support and washing) as critical services that have increased access to health services, methadone and NSPs. Members of the self-support group are also engaged in income-generating activities. The introduction of residential adherence services for HIV and TB and the provision of methadone enabled compliance with the 90-90-90 UN HIV treatment cascade. The benefits of a gender-sensitive service model relevant to WWUD have attracted the attention of the Ministry of Health through NASCOP and the Global Fund, which has expressed and extended its interest in using this model when implementing other harm reduction programmes in Kenya.

In addition to the continuation of these successful interventions, the programme still needs further support in a number of areas.

Mental health services should be recognised as a vital component towards achieving comprehensive integration and provision of harm reduction and rights services for women in the DICs, who continue to be misdiagnosed and are prone to excessive intake of illicit drugs and further exposure to violence and exploitation.

Most WWUDs engage in sex work, which brings with it an increased health risk and stigmatisation (MEWA, 2018). In addition, when WWUDs become older they are less likely to continue doing sex work. Providing income generation support is therefore recommended. WWUDs can be provided with skills-training and start-up capital or be trained to perform peer-outreach work. In order to best design such interventions research is advised.

Most children of WWUDs lack parenting care. Children are also used to beg in the streets to support parents' drug use, and as such, lose their child protection rights and end up abused in drug dens (MEWA, 2018). While the current education system in Kenya provides free primary education, parents still pay for uniforms, books, shoes and meals. Therefore, further advocacy work with the Ministry of Education is required to support vulnerable children whose families are unable to afford these expenses.

There is a need for sound monitoring and evaluation systems at the community level that analyse captured indicators on SRHS, HIV, and legal rights that

would translate into research-based information, for influencing policy direction on gender impacts and drug policy. This would widen the scope of the translated research on drug policy and gender impacts to advocate for funding for comprehensive women-centred programming. Finally, the work of women-centred programming must be sustained and replicated by inculcating a research culture within MEWA, which would demonstrate cost effectiveness, programmatic efficacy and the importance of peer-led interventions.