

Kenya

CONTEXT

Kenya is a transit country for a variety of illicit drugs, including heroin and cocaine. Domestic drug consumption is growing. Precursor chemicals used to produce methamphetamines and other illicit drugs also transit Kenya. Heroin originating from Southwest Asia enters Kenya both from direct shipping across the Indian Ocean via south Asia and, increasingly, from countries to the south, such as Tanzania and Mozambique. Most of the heroin entering Kenya is destined for international markets, principally Europe. Cocaine enters Kenya primarily via trans-shipment through Ethiopia from South America. Domestic heroin use is a growing concern in Kenya, especially along the coast and in the main port city of Mombasa. The Government of Kenya and civil society emphasise vigilance against the drug threat, publicly reject the illicit narcotics trade, and support demand reduction and mental health efforts.

A 2018 report on heroin trafficking via East Africa details the role of politics, corruption and economics in the drug trade. Kenya's port in Mombasa is mentioned as one of the key locations where drugs transit into Africa. Miraa (khat) is (mostly) grown in Nyambene region of Meru County. It is widely distributed inside and outside Kenya. Most of it is exported to Saudi Arabia, Oman and Yemen, among other Arab countries. Cannabis is also produced in Kenya.

Kenya became a middle-income country leading the first (HIV) donors to transition their investments out. A 2019 policy brief from the Government of Kenya calls for more sustainable policy and government funding for programmes to combat communicable diseases, as 96% of funding comes from external sources. The government of Kenya contributes to HIV programmes across the country as follows:

- 31% of the 121 billion Kenya Shilling (KES) in the financial year 2014-2015, of which 4% was allocated to HIV prevention - where harm reduction is also categorised
- 29% of the 73.9 billion KES in 2015-2016, of which 8% for prevention

A 2021 Harm Reduction International policy brief on HIV and harm reduction financing shows significant gaps in funding. The government of Kenya, through the Ministry of Health (MOH) and the National Authority for the Campaign Against Drug Abuse (NACADA), supports rehabilitation centres countrywide. Major donors for HIV and harm reduction programmes include the Global Fund to Fight AIDS, Tuberculosis and Malaria, Open Society Foundations, USAID, United States President's Emergency Plan for AIDS Relief (PEPFAR),

United States Centres for Disease Control (CDC), ICAP, University of Maryland, Frontline Aids, Médecins Du Monde (MDM), as well as faith-based organisations and individuals.

POLICIES

Kenya is a state renowned for the criminalisation of the use, possession, trafficking and production of drugs. The rationale for the criminalisation of drugs is deterrence. Except for possession of cannabis (10 years imprisonment), no distinction is made between possessing other illicit substances (20 years imprisonment). The 2018 Alcohol and Drug Abuse policy does make explicit mention of harm reduction and calls for respect for human rights, and the several health policies in Kenya are generally progressive and evidence-based.

After a recent amendment in 2019, the National Authority for the Campaign against Drug Abuse (NACADA) recommended another revision to the Kenyan Narcotic Drugs and Psychotropic Substances (Control) Act of 1994. The NACADA recommendations seek to address the increase in drug trafficking in Kenya, and the changes were passed by the National Assembly on 19 May 2021. However, the Bill has not been signed by the President, and drug control is likely to become an essential topic in the 2022 general election. Kenya civil society sent a petition in 2021 pleading for more evidence-based approaches and expressing concern for unnecessary incarceration of petty offenders (including those charged with possession), which results in overcrowding of prisons.

In 2019 a bill was brought to Parliament to decriminalise cannabis. The Bill sought to have regulation for the growth and safe use of the drug, including the registration of growers, producers, manufacturers and users. The Bill was not passed, although in 2021, after the WHO rescheduled cannabis, a new attempt was made.

Decriminalisation is not a formal government policy, but local differences exist in how police and courts handle drug offences. In Shanzu court in Mombasa county, through the initiative of a progressive magistrate, more and more persons who've used or possessed drugs are being committed to harm reduction programmes or drug treatment instead of being sentenced to prison. The impact of this diversion is being documented, and legal jurisprudence is purposefully created.

In May 2024, President William Ruto overturned bans imposed by several coastal counties on muguka, a potent variety of khat. These bans were created by concerns over muguka's alleged contribution to mental health issues and social problems, particularly among the youth. President Ruto asserted that muguka is a legal crop under national legislation, specifically the Crops Act 2013 and the Miraa Regulations 2023, rendering any conflicting local laws null and

void. The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) classifies muguka as a harmful substance due to its high levels of cathinone and cathine but has not banned it. The president also announced a government allocation of \$3.7 million to support the expansion of khat farming.

Moreover, in 2021 a progressive drug Bill was adopted in Mombasa County. This local response could inspire other counties to push for drug reforms on a national level from the ground up. In 2021 NACADA released a national guideline on alcohol and drug use prevention. Kenya's National AIDS and STI Control Program (NASCOP) released several guidelines (standard operating procedures) that speak to people who inject drugs: for the Comprehensive Management of the Health Risks and Consequences of Drug Use (2013), for Medically Assisted Therapy (2013), for Needle and Syringe Exchange Programmes (2013) and for drop-in centres for people who use drugs (2016). NASCOP released a guideline for STI and HIV prevention in 2014 that includes detailed guidance for harm reduction. A 2016 NASCOP key population guideline reaffirmed the commitment to comprehensive harm reduction interventions. The Ministry of Health released a protocol for treating substance use disorders in 2017.

The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) launched its 2023–2027 Strategic Plan to strengthen Kenya's national response to alcohol and drug abuse. The plan aims to reduce the national prevalence of substance abuse from 17.5% to 12.5% by 2027 through a multi-faceted approach that includes public education, stricter law enforcement, expanded access to treatment and rehabilitation services, and enhanced community engagement. It also emphasizes evidence-based policymaking, inter-agency collaboration, and alignment with national development goals such as Vision 2030 and the Bottom-Up Economic Transformation Agenda. Despite a funding gap of over Ksh 6 billion, NACADA plans to mobilize support from various stakeholders to fully implement the plan.

The Kenya AIDS Strategic Framework (II) (KASF II: 2020/21 – 2024/25) provides guidance for implementing an evidence-based HIV response. The 2020 policy brief on Latent Tuberculosis (TB) makes no specific mention of people who use drugs, however, TB treatment is free in Kenyan public health facilities. The 2014 treatment guide on HCV and HBV explicitly mentions injection drug use and ways to prevent infection. HBV vaccination is part of the childhood vaccination scheme (full immunisation coverage is 68%). Although the Constitution of Kenya guarantees access to SRHR for women and adolescent girls, access in practice is limited.

The repressive and punitive nature of Kenya's laws acts as a barrier towards providing health services to people who use drugs. The enforcement of drug laws has been documented to harm the uptake of harm reduction services by persons who use drugs for fear of incarceration.

DRUGS USE AND HEALTH

NACADA surveyed drug use in 2017 and reports that 18,2% of adults in Kenya use at least one drug or 'substance of abuse' of which 12% alcohol, 8,3% tobacco, 4,1% miraa/khat, 1% cannabis/bhang. For secondary school students report **ever use** as follows: 23,4% alcohol, 17% khat/miraa, 16,1% prescription drugs, 14,4% tobacco, 7,5% cannabis/bhang, 2,3% inhalants, thinner, petrol, 1,2% heroin, 1,1% cocaine.

According to the NACADA drug survey 2022 in Kenya, one in every six individuals aged 15 to 65 (approximately 4.7 million people) are currently using at least one drug or substance of abuse. Among males, one in three (around 3.8 million) are affected, while one in 16 females (around 949,000) report current use. The Western region has the highest prevalence, with 26.4% of the population using substances, followed by Eastern at 20.7% and Nairobi at 19.1%.

First reports of injection drug use coincided with the tourist boom in the 1980s/1990s. The real move to injecting was precipitated by the changes in the heroin supply that occurred in 1999. Brown heroin was replaced by white heroin, which is easier to inject.

A 2019 NASCOP size estimate of people who inject drugs in hotspots in 15 counties on a normal day ranged from 9,045 to 14,653, with the mean being 11,849. On peak days, the estimates of people who inject drugs ranged from 12,426 to 19,691, with a mean of 16,063. The majority of people who inject drugs can be found in Mombasa (3.656), Nairobi (3.317) and Kilifi (1.657). A 2021 study in Nairobi estimated a much higher number for Nairobi: 6.107 (range 5.031-10.937).

The estimates of people who use drugs without injecting ranged from 8,160 to 13,742, with a mean of 10,951. An estimated 15% of people who inject drugs is female. Estimates of people who inject drugs under 18 in the mapped hotspots ranged from 1,229 to 2,433, with the mean being 1,831. Injecting dens had the highest number of people who inject drugs younger than 18, followed by streets and alleys.

The NASCOP (2019) size estimation identified 402 hotspots where people inject drugs. Of these hotspots, 38% (151/402) were streets/alleys, and 32% (130/402) were injecting dens. About 10% (39/402) of the hotspots were uninhabited buildings. Friday and Sunday were

peak days. The morning was peak time in most (80%) of the hotspots. Of the 402 drug-injecting hotspots, Kilifi had the greatest share (29%), followed by Nairobi (18%) and Mombasa (13%). The mean number of people who inject drugs per hotspot on a peak day was 40. The most commonly injected drug was heroin (98%) which is widely available due to Kenya's status as a transit country for smuggling and very cheap. A small (2%) percentage of people inject cocaine.

The above numbers would signify a reduction of hotspots in the past years: from over 900 hot spots in 2013 to a little over 400 in 2019. This decrease is attributed to the introduction of methadone in the country starting in 2014. A VOCAL-led study, however, indicated that by 2020, there was an increase in the number of people who smoke heroin who had transitioned to injecting, an increase in the number of low-level heroin and cocaine sellers in the streets of major towns in Kenya and growth in the number of people using methamphetamine. In some towns, the number of sellers had doubled, while drugs like methamphetamine and tramadol quickly gained popularity among Kenyan youth. This is especially true for areas where there are established universities and colleges.

A recent (2021) study estimates an 18.3% HIV prevalence (15.3% for men and 44% for women who use drugs). This percentage seems consistent over time, with similar estimates dating back to 2012. It is noted that 'Kenya has not had a bio-behavioural survey since 2011 as there has been no consensus on a protocol and method. This has posed challenges in measuring programme outcomes and impact'.

In 2023, 1.4 million Kenyans were living with HIV. The prevalence among males in Kenya was 2.16%, while among females it was 4.46%. The prevalence among key populations were 29.3% female sex workers, 18.2% men who have sex with men, and 18.3% people who inject drugs.

The burden of blood-borne infections among PWID remains significant. According to a 2025 HRI report, HIV prevalence among people who inject drugs in Kenya is estimated at 11.3%, and hepatitis C virus (HCV) prevalence is around 20%.

An estimated 43% of people who inject drugs know their HIV status, compared to 90% of the general population. Of those who know their status, 68% are enrolled in ART, and 64% have a suppressed viral load. The national guideline (2018) on ARV treatment and HIV specifically mentions people who inject drugs as a group with complex needs and needing an integrated HIV response. Details are provided about ART provision, and even the use of oral PreP is advised.

Kenya is advancing towards the global 95-95-95 HIV knowledge of status, treatment, and viral suppression within all population groups. In 2023, about 95% of the estimated people living with HIV were of their status, and antiretroviral therapy coverage among people living with HIV increased from 41% in 2013 to 97% in 2023. Similarly, viral suppression among those on antiretroviral therapy increased from 85% in 2019 to 94% in 2023.

A 2018 report by KELIN states that in Kenya, 40% of TB cases go undetected. 83% of TB cases are found among HIV-negative people. The report narrows down several risk populations, including IDUs, prisoners and people with occupations common among people who use drugs (miners, fishermen, boda boda drivers). It also stresses the increased TB risks for people who are HIV-positive or who are malnourished. A Government of Kenya 2020 policy on latent TB infection rolled out a strategy to detect more TB cases, including among key populations such as prisoners

In 2022, Kenya recorded 90,560 cases of drug-susceptible tuberculosis (TB), marking a 16.7% increase from the 77,854 cases reported in 2021. Among those diagnosed with TB in 2022, approximately 23% were also living with HIV. Notably, a higher proportion of female TB patients tested positive for HIV (30%) compared to their male counterparts (18%). Additionally, TB screening coverage among people living with HIV reached 89% in 2022.

The prevalence of HCV among PWID in Kenya is relatively low (11-36%) compared to other global settings, likely reflecting the recency of injecting drug use (IDU) in sub-Saharan Africa (SSA). The Kenyan government has recently secured direct-acting antiviral (DAA) treatments for 1,000 people, with their national HCV guidelines recognising the importance of treating PWID. HCV prevalence was higher in Mombasa (59%), where people regularly inject drugs throughout the year, than in Watamu (13%), where most of the participants reported seasonal drug use limited to the high tourist season (July, August, and December). A recent MFS-led session identified many challenges to HCV testing and treatment.

The COVID-19 Presidential guidelines are implemented by the police, which has led to arrests of people who use drugs, stressing further the critical need for services for people who use drugs. Researchers who visited the medical facilities were faced with questions on how to support people who use drugs who were missing their daily doses of methadone because they had been arrested. Harm reduction services have been largely interrupted after the government halted plans for the implementation of methadone take-home doses and community distribution. Many people have lost jobs and cannot afford transport costs to and from the facilities daily, making many skip methadone doses and go back to using heroin. An OHCHR report (2020) documents how COVID-19 provided a policy window in

Kenya to open a MAT clinic in prison. An MFS project reports challenges for PWID amid the COVID-19 pandemic. These challenges range from difficulties keeping the (OAT) service open and for people to come there daily to people struggling to find work during the lockdown. A 2020 KENPUD presentation mentions similar challenges: less access to treatment (although OAT seemed to have continued), more homelessness and poverty among people who inject drugs, and more violence (from police and partners).

Anecdotal evidence suggests that non-fatal overdose is very common. No real data about (non)fatal overdose is available: this could be a point of attention in harm reduction programming.

A 2024 qualitative study among people who inject drugs (PWID) living with HIV in Nairobi highlights overdose as a serious but under-addressed health concern. Nearly 40% of participants had experienced a non-fatal overdose themselves, and nearly all had witnessed one within their networks. Most overdoses involved heroin, often in combination with other substances. Despite this high risk, only 25% of participants were aware of naloxone, and access to the medication remained extremely limited. The study also pointed to broader health system and structural barriers, including stigma in healthcare settings, police harassment, and lack of transport to services.

Kenya's mental health strategy (2015-2030) explicitly mentions substance use disorder. An assessment completed by MEWA in 2021 among young people who use drugs indicated a high prevalence of serious mental health conditions. Around 17% of the respondents reported specific mental health needs, including suicidal thoughts, depression, psychosis and paranoia.

HARM REDUCTION

Kenya first established Needle and Syringe programmes (NSP) in 2012. This was followed by introduction of Opioid Agonist Therapy (OAT) in 2014/2015. Currently, at least one prison also offers OAT. There are extensive outreach programmes, particularly in Mombasa and Nairobi, which link to HIV, TB, HCV/HBV and STI care. Harm reduction has been mentioned in formal government policy since 2011/2012 and is an integrated part of the government's HIV strategy.

Most people inject drugs in specific geographical towns such as Nairobi, Kilifi, Kwale, Mombasa, Lamu and Kisumu. However, despite the growth of injecting drug use, areas like Lamu, Busia, Homabay and Migori, Uasin Gishu and Kisii still lack established harm reduction services.

Over nine years, Kenya aimed to provide NSP to over 21,000 people who inject drugs and enrol 9,500 in OAT through eight healthcare facilities. Some of the WHO-recommended interventions, like community distribution of naloxone and vaccination for HBV, are not yet implemented. The average cost of providing harm reduction services in Kenya per client per day, excluding transport and nutrition, was 149 KES (US\$ 1.49). Mogaka et al. (2021) show that 86% of total costs are due to personnel costs. Programmatic evidence showed that only 30% of people who use drugs in Kenya access harm reduction services. This is because harm reduction is only available in 5 counties out of 12 regions in Kenya with growing numbers of people who use drugs.

Before the inception of NSP services, an estimated 52% of people who inject drugs reported using sterile injecting equipment. In 2016 this had risen to 89%. A 2015 study by Ndimbii et al. emphasises the positive impact of the NSP programmes but calls for peer distribution models to maximise the program's reach. As of 2018, approximately 135 needles and syringes were being distributed per person injecting drugs yearly. NSP coverage is estimated at 55% in a recent modelling study by Stone et al. (2021). Anecdotal evidence suggests people without access to NSP get their needles via dealers, pharmacies or by searching for needles in hospital waste. However, in 2016, UNAIDS found nearly 90% of people who inject drugs had used a clean syringe the last time they injected, compared to 51.6% in 2012.

OAT programmes are only found in government healthcare facilities and monitored by government-registered doctors, in line with the ministerial guidelines on harm reduction. Since 2015, Kenya has set up eight public OAT clinics across the country, namely, Kisauni in Mombasa County, Malindi in Kilifi county, Kombani in Kwale, Shimo la Tewa prison, Mathari in Nairobi, Ngara in Nairobi, Karuri in Kiambu county and Kisumu clinics as part of the national harm reduction strategy for HIV prevention. According to a 2021 review of key population strategies, Kenyan OAT clinics had enrolled 5208 PWID (26% of the estimated number of people who inject drugs). Enrolment of opioid users in the OAT programme fell short of the 40% target. This suggests that programmes need further expansion. According to Mogaka et al., 2021, the sum of the total cost of OAT in Kenya per year was Ksh. 37,619,300 (US\$ 376,193) in 2021. The average daily cost of methadone treatment was US\$ 1.49 per individual with average personnel cost constituting most of the cost (86.4%), while methadone cost comprised a tenth of the total. OAT is budgeted through the national domestic budget.

Overdose prevention is gaining attention in Kenya, with some first pilots with peer distribution of naloxone. In general naloxone is only provided via medical/health staff. Reliable data on overdose cases is lacking.

Drop-in centres (DIC) are available in the country and managed by civil society organisations. They run on external donor funding (100%). A standard drop-in centre offers needles and syringes, HIV testing and counselling, sexual and reproductive health (SRH) screening, dressing wounds, screening for hepatitis C, overdose management, pregnancy tests, psychosocial support and sometimes nutritional support. DICs are managed by a site coordinator, a medical officer, a pharmacist, a lab technician, peer educators and outreach workers who participate in community-based activities.

Despite Kenya's policy commitments to harm reduction, implementation remains limited and underfunded. According to a 2024 HRI Global report, needle and syringe program (NSP) coverage in Kenya remains below international benchmarks, with only 189 syringes distributed per person who injects drugs (PWID) per year—falling short of the UN-recommended minimum of 200. Opioid substitution therapy (OST) coverage is also low, reaching just 13.3% of people who use drugs (PWUD).

CSOs in the harm reduction field are: the Kenya Network of People who Use Drugs (KENPUD), Reach Out Center Trust, Omari Project in Kilifi County, Teens Watch in Kwale County, the Muslim Welfare and Education Trust (MEWA), Support for Addiction Treatment (SAPTA) LVCT Health and VOCAL Kenya. In 2019, there were close to 15 DICs across Kenya, however as of 2020, 4 DICs had closed down due to lack of funding, including the two DICs sponsored by KANCO in Watamu and Kajiado and the two DICs sponsored by MDM in Kawangware, Nairobi.

The National Hospital Insurance Fund (NHIF) supports drug dependence treatment up to Ksh60,000/- for NHIF-accredited rehabilitation centres. The Ministry of Health has no specific substance use disorder treatment and prevention budget. In contrast, the National Authority for the Campaign Against Alcohol and Drug Abuse has an annual resource gap of about US\$ 5,000,000.

MEWA in Mombasa ran a pilot in 2021 for young people who use drugs and pioneers women-specific services since 2018.

In February 2025, Kenya's Ministry of Health launched a nationwide campaign to combat the escalating crisis of drug and substance abuse. Targeting all 47 counties, grouped into 10 clusters, the initiative aims to equip communities with knowledge and resources to prevent

addiction and support recovery efforts. Key strategies include awareness campaigns, capacity-building programs, and collaboration with stakeholders to dismantle drug networks and ensure effective rehabilitation programs. The campaign also emphasizes integrating mental health services into the broader healthcare system, recognizing the link between substance abuse and psychological issues.

PEER INVOLVEMENT

In general harm reduction programmes in Kenya are run by Community Based Organizations (CBO), some being faith-based, others rooted in the community in other ways. People who use drugs are usually part of these organisation and can be found in roles such as outreach worker or peer worker/volunteer. Outreach staff usually no longer actively use drugs, or may be enrolled in the OAT programme. Involvement in planning, implementation and management differs greatly per CBO but is more rare. People who use drugs are involved in needs assessments at the start of new pilots or programmes.

Peers in Kenya are most commonly (semi-) volunteers who work for a stipend. The Global Fund programmes work with micro-planning. In this implementation model an outreach worker supervises several peers from the local drug use community.

The Kenya Network for People who Use Drugs (KenPUD) represents the drug user community and is based in Nairobi. Over the years they have struggled to find stable funding. In addition, there is the Kenya harm reduction network: a loose collaboration between the different harm reduction service providers in the country. There is contact and collaboration between different key population-led networks, a key population member has a seat in the CCM and on several occasions the various networks have (successfully) joint forces.

HUMAN RIGHTS

Where it concerns health Kenya has exceptional policies in place. All health policies mention the importance of respecting individual human rights. On the other side, the strict drug laws in Kenya restrict or even obstruct the implementation of health policies in daily practice and sometimes condone human rights violations among people who use drugs. A 2016 Mainline report provides an overview of laws that negatively impact the societal position of people who use drugs. This overview emphasises the importance of getting law enforcement on board to protect the rights of PWUD and guarantee their access to services. According to a

2018 KELIN report, under Sections 5(1)(b) and 5(1)(d) of the Kenya drug law, anyone found on any premises where drugs are being used conflicts with the law. Possession of paraphernalia used in the administration of drugs is also illegal. These provisions in the law hinder the effective implementation of the plan to address HIV prevention and treatment. Law enforcement officers, for instance, arrest and charge outreach workers assigned to provide PWID with clean syringes and needles. This not only scares the outreach workers, but people who inject drugs respond by staying away from centres that provide essential HIV and harm reduction services that they may need.

The Criminal Procedure Code Section 21 prohibits excessive force, particularly where there is no threat to escape or resisting arrest. The police code of conduct and ethics forbids subjecting arrested persons to torture, hardships and inhuman treatment. In dealing with people who usedrugs, police officers often overlook these codes and beat up, demand bribes, arrest and arbitrarily detain drug users, and deny them treatment for withdrawal symptoms (Kageha, 2015, p. 12).

A report by UNAIDS 2016 documents that among people who inject drugs, 57% of them reported being arrested or beaten by police or askaris in the last six months. In 2021, in a reflection on 10-year key population work in Kenya, 44% of people who use drugs reported having experienced police violence. As a result of being criminalised and stigmatised, key populations do not seek protection or redress from the law. The impact of anti-violence programmes for key populations - in the context of criminalisation - has been evaluated in a 2018 case study. Over the preceding four years in Kenya, the reports documented an increase in reports of violence among female sex workers and PWID and an increase in violence response among all key populations. The case study demonstrates that violence against key population members can be effectively addressed under the leadership of the national government, even in an environment where key population members' behaviours are criminalised. Community organisations in Kenya over the past years have invested heavily in sensitisation training for local police. These efforts have yielded positive results, although the high staff turnover among police officers hinders the sustainability of these efforts.

Mob justice still plays an essential role in Kenyan society, and people who use drugs often fall victim to this. The numbers of cases among people who use drugs are not recorded, although the government of Kenya did start to record general numbers of mob justice victims.

According to UNAIDS (2016), people who use drugs encounter systematic levels of stigma and discrimination. Women who use drugs generally experience even greater stigma than men. The report notes that drug use and dependency generally represent a descent into impoverishment with few social safety nets to help people who inject drugs and their partners. In 2016 FHI360 published a report on the nexus between gender norms and how they impact women who use drugs in several negative ways. Women who use drugs are more prone to violence, stigma and discrimination and less likely to access health information and harm reduction services.

PRISON

In 2021 the general prison population is 42,596, with 18% being female. It is unclear what percentage of inmates is imprisoned for drug-related offenses.

Kenya has a total number of 134 prison facilities (2024), with a density of 177%. In 2024 the general prison population was around 60,000. In 2021 the general prison population is 42,596, with 18% being female. It is unclear what percentage of inmates is imprisoned for drug-related offenses.

Within the criminal justice system in Kenya, those arrested for drug-related offences are often put into pre-trial detention with unaffordable or strict bail terms (Heard & Fair, 2019; Muntingh & Redpath, 2016). This is despite the Constitution of Kenya stipulating that a person arrested must be arraigned in court within 24 hours, regardless of the nature of the offence, and that they must receive bail (Government of Kenya, 2010). The Kenya Prisons Service stands at the end of the criminal justice system. It has little power to influence the court's determination regarding punitive or rehabilitative measures and alternative, non-custodial sentences for people convicted of drug-related crimes.

Alternatives to incarceration need to be implemented at all levels of the Criminal Justice System according to the Community Service Order Act and the Probation Act. These recommend converting sentences of less than three years to orders of either probation or community service. The Narcotic Act of 1994 also outlines guidelines for the rehabilitation of people who use drugs, yet this option is not widely enforced in practice. One exception is a magistrate in Mombasa County, who offers alternatives to prison for people convicted of minor offences. People convicted of a drug-related crime are assessed and referred to harm reduction services or drug treatment. The assessment includes a comprehensive familial and social component.

From 4 to 6 December 2018, UNODC brought together over 40 justice and health practitioners to promote treatment and care as alternatives to conviction or punishment for people with drug dependence in contact with the criminal justice system. Participants discussed non-custodial options to provide treatment and care at different stages of the criminal justice process, exchanged information on challenges and opportunities and identified priorities for action to use treatment as an alternative and address the specific needs of women with drug dependence in Kenya.

Since 2012 a new approach has been forged based on the practical implementation of international human rights standards in the Kenyan correctional system. A critical national investigation into its operations in 2008 served as a catalyst, prompting the Kenya Prisons Service to initiate several critical steps towards penal reform and respecting human rights. Changes included initiating an 'Open Door' policy and advances in critical areas such as outlawing institutionalised corporal punishment. Kenya Prisons Service has a human rights desk and point person at each station. A 2019 study looks into the effectiveness of prison reforms. It mentions Kenya Prisons Service has been implementing bold steps towards realising health projects for inmates to access health care. The Kenya prison health projects are financed from two primary sources: the government of Kenya and donor funding. Unfortunately, the current budget is insufficient to adequately cater to all incarcerated inmates. Donor funding is sporadic and does not fully address the general basic needs apart from targeted interventions (Mugo, 2018).

According to the Kenya Prisons Service, one in 10 prisoners is infected with HIV. While TB rates are primarily unmeasured, one recent study found that TB prevalence in one of Kenya's prisons was seven times higher than that of the general population. Prisoners are mentioned as a key population in several government health policies. In September 2021, a campaign was launched to vaccinate all prison inmates against COVID-19. Those inmates with drug dependence are linked to psychological counselling and support.

Further referrals to external medical interventions, such as OAT, are being provided to eligible cases under a programme launched by the UNODC, county-level governments and NASCOP (Atieno, 2018). The first OAT clinic in prison was established during the COVID-19 pandemic.

As of February 2023, 148 incarcerated individuals across four Kenyan prisons were receiving daily opioid substitution therapy (OST), with 139 on methadone and 9 on buprenorphine. The need for such interventions is underscored by findings from Eldoret GK Prison, where 66.1% of inmates reported lifetime use of at least one psychoactive

substance. Among them, 65% had consumed alcohol, 21% had used cannabis, 9.4% amphetamines, and 1.3% reported heroin use.

Despite the roll-out of best practice guidelines, incarceration does not necessarily result in the termination of drug use or the provision of treatment and rehabilitation services. Drugs are often more accessible within prison institutions despite stringent measures designed to curb supply (MOH, 2017). PWUD can find it easier to access drugs inside prison than outside, often complicating the rehabilitative measures of decreasing or suspending drug use in prison custody.

Studies show that up to 70% of people who have been incarcerated are arrested again within three years, and the dire state of mental health care in prisons is said to play a significant role in this high rate of reoffending.

WOMEN WHO USE DRUGS

Estimates of women who inject Drugs range from 1,647 to 3,158, with a mean of 2,405.

There is low service uptake among women who use drugs, and the need to include them better in SRHR and harm reduction services. According to 2020 research, women who use drugs in Kenya suffer from high levels of (gender-based) violence.

The Muslim Education and Welfare Association (MEWA) is a Kenyan civil society organisation that provides quality HIV prevention, treatment, care, support services, socio-economic rehabilitation, reintegration and human rights-based and gender-sensitive services for people who use drugs. To date, the services have been scaled up to include the provision of shelter to homeless women who inject drugs and are experiencing homelessness and their children, as well as engaging women in health education and economic empowerment activities. MEWA's work with women who use drugs is detailed in the report Shifting the Needle (2021).

New interventions that seek to counter gender-based violence have recently been evaluated. As positive features, 521(99%) of the respondents reported MEWA providing additional commodities, services or activities; 519 (98%) indicated services at MEWA being discreetly located, low-threshold (516 or 98%), easy to access (506 or 96%), include women-friendly hours (416 or 79%), women-only peer support groups (375 or 71%) and 268(51%) reported provision of childcare. As points to improve, the majority (55%) of the women who use drugs reported lack of transportation cost to MEWA as a significant barrier to accessing the harm reduction services. Another 241 (45.90%) indicated being too busy at work as a barrier, and

177 (33.71%) attributed the barrier to service hours for delivery of the harm reduction services not suiting their daily schedules.

Beyond Mombasa, it is unclear how easily women can access harm reduction services and which organisations provide gender-sensitive interventions. NASCOP, with the support of Mainline, designed a training manual for peer educators to carry over the lessons learned in Mombasa, published in 2019.

At the 2025 Commission on Narcotic Drugs in Vienna, Kenya, led by NACADA Chair Dr. Stephen Mairori, advocated for drug policies that address gender-specific challenges. The delegation emphasized that while men have higher drug use rates, women face more severe social and health impacts. Key initiatives include women-only rehabilitation centers, free treatment for women at the Miritini facility in Mombasa, and policy reforms to remove treatment barriers. Kenya called for global collaboration to promote inclusive, gender-responsive drug strategies.

SOCIAL ISSUES AND INEQUALITIES

Drug use is seen as a significant societal problem with a negative impact on morals, mental health, health and relation with the law. Drug trafficking is also viewed and approached as a significant societal problem, as are gang violence and drug dealing. A 2020/2021 Nairobi city case study by UNODC describes the environment of crime and drugs in Kenya's capital. Poverty and unemployment are drivers of crime, gang culture and drug use.

A 2014 stigma index on HIV includes a chapter on stigma against Key Populations and mentions that many respondents feel that sex workers are responsible for spreading HIV and that MSM 'deserve' to get HIV. Stigma and discrimination among healthcare workers are similar to that of the general public. Many efforts have, however, been put into sensitising health care workers and curbing stigma among them. The impact of these programmes is unknown, as there is relatively high staff turnover in the health sector in Kenya

There are very negative reports in media on drug use, addiction and gang violence. A 2020 study looked into the Government of Kenya's efforts (via NACADA) to curb the use of alcohol and illicit drugs via social media campaigns. It found these campaigns have limited impact as long as they don't connect to platforms popular among youth.

In 2018, the Kenyan government piloted a universal health coverage programme in four of its 47 counties, easing access to health services for millions of people. It has since added

more than 200 community health units, with 7700 community health volunteers and over 700 health workers have been recruited. The first year of the pilot phase saw over 1.6 million more hospital visits recorded. The abolition of all fees at local and secondary level [county referral] health facilities widely expanded access to health services in the four pilot counties that were selected because of a high prevalence of communicable and non-communicable diseases, high population density, high maternal mortality, and high incidence of road traffic injuries. The pilot will be upscaled with the support of the WHO. This pilot does not cover services for people who use drugs.