

**RAPID ASSESSMENT OF SUBSTANCE USE AND HIV
VULNERABILITY IN KAKUMA REFUGEE CAMP AND
SURROUNDING COMMUNITY, KAKUMA, KENYA**

**PART OF A JOINT UNHCR/WHO PROJECT ON RAPID ASSESSMENT OF
SUBSTANCE USE IN CONFLICT-AFFECTED AND DISPLACED
POPULATIONS**

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AIG	Alternative Income Generating
AP	Action Plan or Action Planning
CHWs	Community Health Workers
CSWs	Commercial Sex Workers
FGs	Focus Groups
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use
IDUs	Injecting Drug Users
IRC	International Rescue Committee
KI	Key Informant
KRC	Kakuma Refugee Camp
LWF	Lutheran World Federation
MHAs	Mental Health Assistants
NACADA	National Agency for the Campaign Against Drugs
NACC	National Aids Control Council
NASCOP	National Aids and STIs Control Programme
NCCK	National Council of Churches in Kenya
PTSD	Post Traumatic Stress Syndrome
RAR	Rapid Assessment and Response
SAFP	Substance Abuse Focal Point
SC	Surrounding Community
SOK	Sub office Kakuma
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

EXECUTIVE SUMMARY

Key Findings

1. Most commonly used substances in Kakuma Refugee Camp (KRC) and the surrounding community (SC) are traditional alcohol brews (Chang'aa, Busaa and Kaada).
 - a. Brewing occurs extensively in KRC (particularly among Sudanese; Uganda, Burundi and Rwanda communities) and in most parts of the SC.
 - b. Chang'aa brewing is illegal by the laws of Kenya, and other traditional liquors can be brewed and sold by individuals only after obtaining the licence to do so.
 - c. Brewing is made easy as the ingredients needed (maize, sorghum) are readily available. These are the same food rations regularly distributed to refugees, who use some of it for brewing and sell also to brewers in the SC.
 - d. Factors adduced for massive production of traditional liquors include economic, cultural, lack of alternative job, harsh weather conditions not conducive to farming, ready market, ready availability of ingredients from food rations and easy to prepare
 - e. Consumption of these brews is associated with multiple physical, social and psychological complications
 - f. Consumption also goes hand in hand with sex work which involves unsafe sexual practices. HIV vulnerability is thus increased among women in particular but the society at as a whole
 - g. Level of awareness about adverse consequences of alcohol use was low
 - h. Police interdiction is the only currently available intervention and this has been perceived as being ineffective
 - i. There is low capacity to address the problem in the service agencies and the communities
2. Next to alcohol is khat (miraa) chewing found mostly in the Somali communities and to some extent in the Ethiopian community.
3. Use of sleeping tablets (mainly D5 or diazepam) is common among khat chewers to help them sleep. Some of the latter use diazepam intravenously
4. Limited information was obtained about a small group of active drug users (less than 20) who discretely inject mainly diazepam but also other injectable medications (e.g. piriton, gentamycin) in groups as part of their poly drug use. No evidence of sharing of needles or drawing from the same ampoules. More investigation is required on this hard-to-reach group.
5. Bhang (cannabis) use is done discretely by young people along "laga" or Tarash river
6. There was no evidence of use of heroin or cocaine use or injecting of same
7. Some drug users report they sniff organic solvents and use ephedrine

Recommendations

Individual Level

1. Early identification, treatment and rehabilitation service should be established for individuals who are suffering from complications of substance abuse or those who are fully dependent.
2. A service should be established to offer help and support to individuals in the community (spouses, children and relatives of dependent individuals) who are indirectly affected by the effects of substance abuse

Community Level

1. Interventions are needed to increase the currently low community knowledge and awareness on substance use issues
2. Public awareness should be improved through sensitisation campaigns and workshops, distribution of IEC materials, audio-visual programmes, sports competitions, dramas etc.
3. Health education activities to address the minimisation of harms associated with substance use should be incorporated into the activities of Community Health Workers (CHWs) and Mental Health Assistants (MHAs). Further, there should be inclusion of alcohol/substance use and unsafe sex, unsafe injection into peer educators' activities
4. Health education should target returning refugees, out of school youths and identified IDUs
5. Alternative income generating (AIG) programmes should be expanded to alleviate poverty among women brewers/CSWs and reduce their vulnerability to HIV infection and other STIs
6. HIV prevention services specially designed for women brewers/CSWs are needed to improve their knowledge base on reproductive issues, protect their general health, increase access to physical care and treatment and assist them in family planning
7. There should be targeted availability of condoms, including in places where alcohol (chang'aa) is sold
8. There is need to further examine the interaction between the refugee and surrounding community with regard to substance abuse as well as commercial sex work and HIV.

Structural (Policy and Environment) Level

1. Two models of providing technical support for the development of substance use activities have been proposed. One model proposes the recruitment of a Substance Abuse Focal Point (SAFP) to be deployed within a service agency for 1-2 years. The SAFP will work closely with UNHCR, the implementing partners, government and non governmental agencies to formulate and implement substance abuse programmes. The SAFP will develop the capacity of service

- agencies, the security agencies, government and non governmental organisations, individuals and groups in the community through specially designed training and activities on substance abuse. However, views have been expressed that the first model is unlikely to be approved in the current climate of decreasing resources and is likely to encourage vertical programming. Hence, the second model proposes the engagement of consultant to work in KRC and SC periodically and undertake over a limited time period all the listed functions of the SAFF. Further discussion is needed among stakeholders before one of these models or any other workable model is adopted.
2. Substance abuse interventions should be scaled up through linkage with on-going or planned projects around food security, HIV/AIDS, human development etc
 3. Collaboration should also be established with intervention programmes of the National Anti-Drug Abuse (NACADA), the National Aids Control Committee (NACC) and other relevant governmental and non governmental agencies
 4. Some interviewees have recommended the need to strengthen current interdiction methods through the establishment of a “Special Task Force” comprising the Police, UNHCR Security Unit, UNHCR Protection Unit, community services and community groups. However, equally strong views have been expressed that such a measure is unlikely to minimise harms associated with substance use, may lead to price increases and may in fact increase harms by driving use underground. Similarly, arresting and prosecuting operators of illegal or unregistered chemists or “treatment places”, particularly those who sell injectable substances and syringes/needles to substance abusers may only serve to push IDU activities underground, encourage sharing and reuse of injecting equipment and increase users’ vulnerability to HIV infection. The balance of opinion seems to weigh more on the need to emphasise the provision of risk reduction information and education to substance users, law enforcement staff, illegal chemist operators and the community as a whole.
 5. There is need to train health workers in the identification of hazardous or dependent substance use and on brief interventions, as well as on management of withdrawal symptoms as appropriate
 6. More surveillance and assessment is needed to track the details of on-going injecting drug use practices and monitor the trends both in KRC and the SC.
 7. The use of bhang and its multiple effects could not be fully investigated in this study as interviewed users were very reluctant to volunteer information within the available time limit. More assessment is required in this area.

Action Plan (AP)

Based on the findings and above recommendations, the following are the main ingredients of the proposed Action Plan:

1. **Capacity building:** This has been identified as a very basic and urgent need as the assessment revealed a total lack of capacity on substance use and HIV issues in KRC and SR. Two proposals have been put forward for further discussion and agreement (See details in Recommendations above)
2. **Empowering individuals and groups with information on substance abuse:** All the people interviewed in this assessment expressed the need to sensitize individuals and various community groups with more information on substance use and HIV in order to increase their capacity for informed choice. Hence, the AP has emphasized the need to develop and disseminate culturally appropriate and acceptable IEC materials in KRC and SC. Efforts will be made to involve relevant individuals and community groups at every stage of the development of the IEC materials and the implementation of the interventions.
3. **HIV Prevention Programme for Women brewers/CSWs:** A key target group for AP is the brewers/CSWs in both KRC and SC. The AP would strengthen and expand already existing HIV prevention programmes for this group. However, care would be taken not to isolate and further stigmatise the group in the process
4. **Establishment of special services for individuals or groups directly and indirectly by substance abuse:** The AP would aim to increase the capacity of health workers in KRC and SC to implement services on early identification, treatment, referral and rehabilitation of these groups. This will be the main thrust of the AP on capacity building.
5. **Poverty alleviation among women brewers/CSWs:** The AP would focus on the strengthening and expansion of already existing alternative income generating (AIG) programmes being implemented by NCKK in KRC and the SC

1.0 INTRODUCTION

1.1 Assessment population and location

Substance Use and HIV vulnerability in Refugee Camp and Surrounding community in Kakuma, Kenya

Kakuma town is located in Turkana district, in the northwestern region of Kenya, half way between Lokichoggio and Lodwar, on the lands traditionally inhabited by the Turkana people (Fig 1). This is the hottest and most arid part of Kenya, temperatures in the day are near to 40 degrees and only drop to the low 30's at night. Turkana district has for a long time been noted to be a food insecure area. The district covers a total land of 77,000 square kilometres. With a population estimated at 447,000 inhabitants (1998 national census), the district has suffered significant losses by registering the largest animal population deaths and crop failure for the past several growing seasons. Kakuma town is characterised with dry and rocky lands, sandy soil and poor vegetation coverage. The area has limited economic potential given these conditions, therefore relies heavily on pastoralism as its primary source of livelihood (LWF/DWS Annual Report on Kenya Sudan Programme, 2005)

Fig 1: Map of Kenya showing Kakuma



The Refugee Camp: The Kakuma Refugee Camp was established in 1992 after the arrival of 12,000 “Lost Boys/Girls of Sudan”, a group of children who together with their caretakers undertook a hazardous five-year odyssey fleeing the civil war in Sudan to Ethiopia. When war erupted in Ethiopia they went back to an insecure Sudan before they

Substance Use and HIV vulnerability in Refugee Camp and Surrounding community in Kakuma, Kenya

finally reached Kenya in 1992. The same year, large groups of Ethiopian refugees who had fled their country following the fall of the Ethiopian government added to the camp population.

During the years, the caseload in Kakuma increased with inclusions of Ethiopian refugees from closed camps at Walda (North East Kenya) and Thika (Central Kenya) and Somali refugees from the closed camps around Mombasa at the coast province of Kenya, as well as refugees from the Great Lakes Region transferred from Nairobi. Today the camp has four sites -Kakuma I (has mixed nationalities), Kakuma II (predominantly Sudanese refugees), Kakuma III (has mixed nationalities) and Kakuma IV (predominantly Sudanese Refugees)

The Government of Kenya encampment and restrictive employment policies compounded by the erratic climatic conditions do not enable the refugees to engage themselves in agriculture or in pastoralism, thus the refugees depend entirely on relief. The Kenyan government is a signatory of both the 1951 UN Convention and the 1969 OAU Convention. Working in partnership with UNHCR, local legislation consistent with international standards and practices is tabled in parliament for enactment.

As at 10 September 2006, the number of refugees at Kakuma Refugee Camp stood at 94,707 refugees from nine countries namely: Sudan (76,245 or 80.5%), Somalia (11,825 or 12.5%), Ethiopia (4,891 or 5.2%), Uganda (483 or 0.5%), Rwanda (342 or 0.4%), Burundi (198 or 0.2%), Congo (640 or 0.7%), Eritrea (55), Namibia (1). A breakdown of the statistics by age shows that the majority (71.52%) of the camp population falls between the age of 0-25 yrs, a further 26.18% are aged 26-55 years while the remaining 2.31% are over 55 years. A further breakdown by gender that 59.5% are males while 40.5% are females.

Figure 2: Kakuma Refugee Camp by nationalities

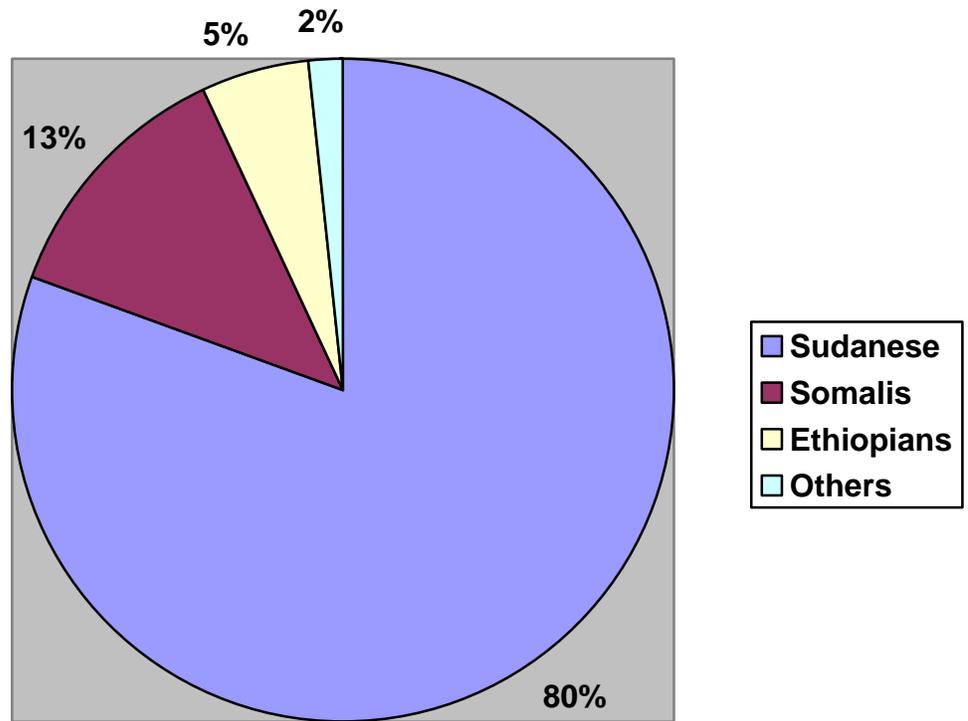


Fig 3: Kakuma Refugee Camp by age distribution

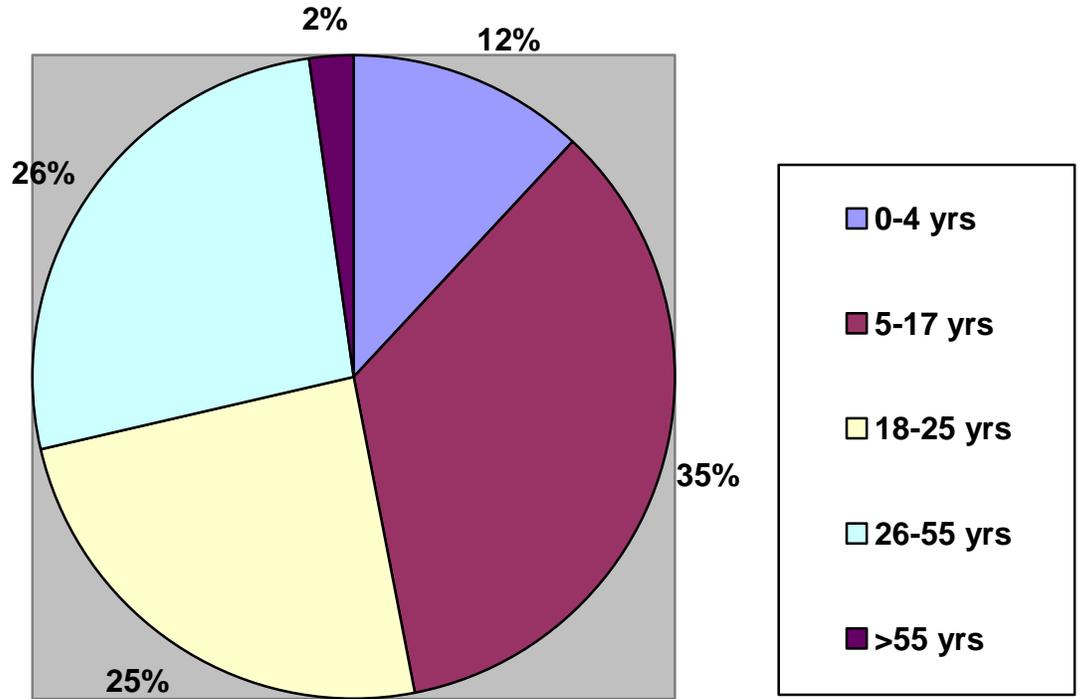
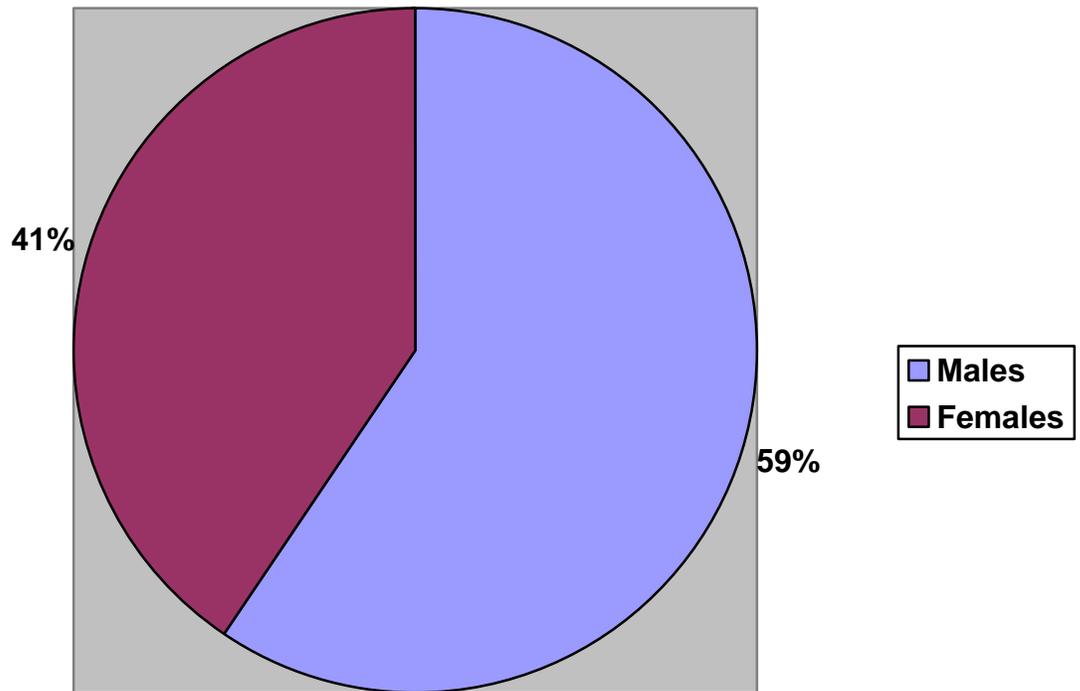


Fig 4: Kakuma Refugee Camp by gender distribution



1.2 Assessment start and finish dates

Start date: 4 September 2006

Finish date: 30 September 2006

1.3 Rationale

1.3.1 Refugees and substance abuse

1. Generally, exposure to extreme stressors (“trauma”) increases the risk for a range of mood and anxiety disorders, including post traumatic stress disorder (PTSD) (Agaibi and Wison 2005; Cohen and Hien, 2006). Available literature also points

- to the link between common mental health disorders (including PTSD) exposure to extreme stressors and substance use (Najavits et al, 1996; Chilcoat and Breslau, 1998). Many refugees from Africa have reported direct or indirect experiences of enormous losses and disturbing, anxiety provoking events (Tulba Malual 2004). It is conceivable therefore that refugees may have increased vulnerability to substance use;
2. Combatants may use substances - refugees and other displaced populations often include former combatants;
 3. Refugees living in camps often face a myriad of health and social problems including unemployment, poverty, violence, insecurity and lack of essential daily needs. Such problems can lead to frustration and depression and push some to engaging in substance abuse. For example, one study has found that recent job loss predicted increase in Khat use among newly arrived Somali refugees in England (Turning Point 2005).
 4. Substance abuse is often associated with physical, social and health complications and these can lead to a poorer quality of life or increased morbidity and mortality in refugee camps. It is thus essential to investigate the extent of substance use in refugee camps and institute preventative programmes as indicated.

1.3.2 Refugees, substance abuse, HIV and other STIs

1. Some refugees may engage in or be initiated into the practice of injecting drug use (IDU) in the camps. The IDU practice can lead to an increased risk of transmission of infections such as HIV, Hepatitis B and C;
2. Refugees who engage in excessive consumption of alcohol are more likely to engage in risky sexual behaviour, including multiple sexual partners, transactional sex as well as engage in none protected sex. They are also more likely to engage in gender-based sexual violence and crime including rape. All of the latter would increase the chances of the spread of HIV and STIs in such communities.
3. There is usually a good measure of social, economic and physical interaction between the refugees and their surrounding (host) communities. Such interactions involve shared engagement in substance abuse and risky sexual activities, which can expose both communities to increased vulnerability to substance abuse related disorders, HIV infection and STIs.

1.3.3 Why this assessment in Sub-Saharan Africa (SSA)?

1. Many SSA countries (for example, Liberia, Sierra Leone, Sudan, Ethiopia, Congo, Burundi, Rwanda) have either gone through or are currently experiencing major conflicts, war, genocide with all the attendant complications on its displaced or post-conflict populations. Such conflict and instability has been

observed to fuel increased drug and alcohol consumption and possibly increased vulnerability to HIV infection. However, there is lack of normative data on both the increased substance use and the HIV axes;

2. Prevention of substance use and its negative social and health effects after conflict is of increasing political interest, as evidenced, for example, by the 2002 Wilton Park Special Conference on “Drugs as a cross-cutting issue in Afghan reconstruction: Turning the rhetoric into reality”. Baseline data is needed to plan and implement such preventative programmes. There is a dearth of such data from developing countries, and specifically from the SSA region.

1.3.4 Why Kakuma refugee camp?

1. KRC was established in 1992. Currently, it hosts almost 95,000 refugees from nine countries. UNHCR, WFP and several Non Governmental Organisations (NGOs) have been involved in providing much-needed support services to the refugees in Kakuma. The surrounding community in turn have benefited from such services either directly or indirectly through their daily interaction with the refugees. Hence, provides a unique example of a refugee town with established service structures and well organised community groups that could facilitate a assessment of this nature;
2. More specifically, a 2004 UNHCR study titled “Behavioural Surveillance among Refugees and the surrounding population in Kakuma” reported that 31 (2%) of male respondents indicated that they had shared a syringe with another individual to inject drugs. All except one were from the surrounding population. This finding stimulated a special interest to further investigate IDU and related issues in Kakuma.

2.0 AIMS AND OBJECTIVES

2.1 Aims

- 2.1.1 To describe the current situation with respect to substance use and related harms in the Kakuma Refugee Camp (KRC) and the surrounding community (SC), with particular reference to HIV transmission
- 2.1.2 To identify a range of interventions that can be feasibly implemented to minimise harms related to substance abuse in KRC and SC

2.2 Objectives

- 2.2.1 To identify psychoactive substances that are of public health importance
- 2.2.2 To identify populations and settings most affected by substance use
- 2.2.3 To identify factors that determine the types of substances used
- 2.2.4 To identify benefits, harms and risks (including HIV transmission) associated with substance use)
- 2.2.5 To identify the factors that promote or prevent the development of harms associated with substance use
- 2.2.6 To describe existing resources and interventions relevant to substance use and related harms (incl. HIV)
- 2.2.7 To outline priority interventions that can be feasibly implemented at individual, community and policy levels

3.0 TEAM

1.1 Members and Responsibilities

1.1.1 The consultant (MLA) was supported in the implementation of the assessment at four levels, namely UNHCR/WHO (Geneva), UNHCR (Nairobi), UNHCR, Sub Office in Kakuma (SOK) and the service agencies at the field level.

1.1.2 **UNHCR/WHO Geneva (Institutional leads:** Mark van Ommeren (WHO); Paul Spiegel, Marian Schilperood (UNHCR); **Technical Officer:** Nadine Ezard)

1.1.2.1 Initial contacts

1.1.2.2 Contract issues

1.1.2.3 Development and input into the draft project protocol

1.1.2.4 Administrative support for travels

1.1.3 **UNHCR (Nairobi) (Focal point:** Njogu Patterson with assistance from Babu Swai and John Mbugua)

1.1.3.1 Supply of background documents

1.1.3.2 Assistance in obtaining Kenyan visa

1.1.3.3 Organisation of briefing and debriefing meetings with UN, governmental and non governmental agencies in Nairobi

1.1.3.4 Assistance in putting together a draft field work plan

1.1.3.5 Logistical and administrative support towards stay in Nairobi and trip to Kakuma

1.1.4 **UNHCR (SOK) (Focal point:** Bosco Muhindo with assistance by Fortunata Ngoyane of the Community Services Unit.

1.1.4.1 Logistical support: accommodation, transportation, office

1.1.4.2 Introduction to service agencies and key governmental officials in the surrounding community

1.1.4.3 Recruitment of interpreters and note takers

1.1.4.4 Organisation of the training for the interpreters and note takers

1.1.4.5 Relevant Heads of Unit granted key informant interviews and attended the debriefing meeting

1.1.5 **SERVICE AGENCIES**

1.1.5.1 **International Rescue Committee (IRC)(Focal point:** Dr Kahi, assisted by Tom Khamala): IRC is responsible for Health, Sanitation, Nutrition, Adult Literacy and Rehabilitation of physically/mentally challenged as well as older persons. It organized FGDs with 10 professional and ethnic community

groups from the camp and the local community; assisted in the recruitment of active drug users; IRC medical coordinator granted a KI interview and supplied relevant documentation; attended the debriefing meeting and contributed to the draft action plan

1.1.5.2 Lutheran World Federation (LWF) (Focal Point: Willy Tembu assisted by George Omondi and K. R Kamomo): This is the main Implementing Partner handling Camp Management, Food distribution, Education (Pre-School, Primary and Secondary), Peace education, Water, and Community Services. LWF organized FGDs with 3 groups from the camp (students, teachers and out-of-school youths); two staff granted KI interviews and supplied relevant documentation; focal point attended the debriefing meeting and contributed to the draft action plan.

1.1.5.3 National Council of Churches in Kenya (NCCK) (Focal Point: Raphael Nyabala supported by Dorcas Ewoi): NCCK offers reproductive health and HIV projects. It organized FGDs with 3 groups of women brewers/CSWs in rehabilitation and another group at the preparatory stage of rehabilitation; one staff granted KI interviews and supplied relevant documentation; one staff (DE) assisted in preparing the sketch of the local community being an indigene herself; focal point took the lead in formulating the draft action plan, attended the debriefing meeting and contributed to further discussion on the draft action plan.

1.2 Training

1.2.1 Twelve interpreters and note takers were trained on 9 September 2006 at UNHCR (SOK)

1.2.2 The decisions on the number, gender, ethnic distribution and minimal educational qualification required of the interpreters and note takers were taken at the initial briefing meeting between the consultant, the field officer (BM) and the head of community service (FG) on 7 September 2006. Due consideration was to be given to the ethnic mix in the camp, gender balancing and educational qualification. The minimum number of years of schooling required was set at 10 years.

1.2.3 The community service unit recruited the interpreters and note takers through established network of youth sports groups. The group recruited comprised 7 males and 5 females. All the key ethnic groups and sub-groups (Sudanese (Equatoria), Sudanese (Dinka), Sudanese (Nuer), Somalians, Ethiopians) each had one interpreter and note taker recruited from their specific ethnic group. A sixth group of nationalities with very low representation in the camp comprised the Ugandans, Congolese, Burundis, Rwandans had only one interpreter and one note taker recruited to service the group. Their ages range

from 16-28 years, and they have had 11 – 14 years of schooling. All of them belong to one sports group or the other, mainly football and basketball.

- 1.2.4 The training, which was run in an interactive manner by the consultant lasted for about 2.5 hours and addressed the following: (i) the aims and objectives of the assessment; (ii) a brief introduction to the concepts of substance use and its complications including HIV vulnerability; (iii) ethical considerations including confidentiality; (iv) methods to be adopted for note taking and interpretation; (v) indication of preference to be an interpreter or note taker; (vi) role playing in turn by each participant for interpretation and note taking; (vii) general group discussion on the substance use and HIV vulnerability in the camp and the surrounding community; (viii) incentives, (ix) and logistical planning based on the field work time table with emphasis on good time keeping and good conduct in the field. Each pair of interpreter/note taker agreed to accompany the consultant to the drugs hot spots in their own communities on mutually agreed dates.
- 1.2.5 All the interpreters and note takers except the 2 Ethiopians attended their sessions and performed their duties creditably, including taking the consultant round to drug hot spots. Some assisted in the recruitment of active drug users. The absent Ethiopians had expressed difficulty in undertaking their roles during training. One IRC staff, an Ethiopian, assisted with the interpretation at the FGD with Ethiopian group leaders while another IRC staff (TK) took the notes.

4.0 METHODS

- 4.1: **Assessment population:** This comprised (i) the refugees living in KRC and (ii) the local population (Turkanas) of Kakuma
- 4.2: **Sample size:** The qualitative method of assessment was used (see Section 5.1). Two main principles were applied to obtain an adequate sample size, (i) that the sample size would be selected to obtain saturation of cultural material, where further interviews, observations or focus groups provide no further information, and (ii) the principle of “pragmatic redundancy”, such that the number of interviews conducted is expected to provide adequate information on the range of relevant cultural experiences in the assessment population.

The project document had recommended a minimum of 15 Key Informant (KI) interviews, with the final sample size being guided by the information obtained during the assessment. The protocol also indicated that Focus Group Discussions (FGs) should be optional. However, a total of 17 FGs and 19 KI interviews were conducted (see reasons below in 4.3.1).

4.3 Sampling strategy

- 4.3.1 **Consultations:** Following the initial consultation the consultant held with UNHCR officials in Nairobi, the UNHCR Field Officer in Kakuma, the Community Service Unit in Kakuma and the service agencies (IRC, LWF, NCCK), it emerged that the best way to source information on the subject under investigation was to conduct FGs with well established ethnic and youth groups in the camp and community groups in the surrounding community. This is in addition to conducting KI interviews with relevant individuals. These recommendations were adopted and implemented by the consultant.
- 4.3.2 **The FGs:** Table 1 shows the list of FGs, which include: (i) All the main ethnic groups in the camp and a local community group; (ii) Health Care Providers; (iii) Youth Groups, in and out of school; (iv) Teachers; (v) People living with HIV ; (vi) Women Groups, brewers/CSWs in rehabilitation in the camp and local community and another Women’s Group in the process of engaging in the NCCK rehabilitation programme. The FGs were all conducted by the consultant. However, the three service agencies (IRC, LWF and NCCK) that already had close working relationship with established groups in the camp and the surrounding community facilitated the FGs by informing the identified groups about the aims of the assessment, the confidentiality issues, the number and gender distribution needed for the interviews and the timing of the FGs. In addition, the focal points arranged the venues and ensured that the groups assembled at such venues at the agreed times.

- 4.3.3 **KI interviews:** These were conducted with individuals identified by the consultant in the process of the assessment, based on three criteria, namely ability to (i) share personal experience on the issues under investigation (i.e. substance use and HIV vulnerability); (ii) provide useful information and/or data on the issues under investigation based on their official position or professional role and activities with the assessment populations, and (ii) influence and participate in any intervention programmes that would be implemented based on the findings of the assessment. As shown in Table 2, 19 KI interviews were conducted with (i) 3 local government officials; (ii) 7 active drug users recruited through the snowball sampling technique; (iii) 3 UNHCR staff ; (iv) 5 service agency staff and (v) short interviews with a miscellaneous group of 3 drug users met at drug joints during observation visits by the consultant.
- 4.3.4 **Interpretation and note taking:** Trained interpreters and note takers (See Section 3.2) worked alongside service agency focal points to assist the consultant in the planning and successful implementation of all the interviews. The consultant spoke in English. Where necessary, trained interpreters drawn from the ethnic group being interviewed carried out the interpretation. In some instances, interpretation was not necessary as the interview group members could communicate well in English. Note taking was done by trained note takers, but on other occasions, service agency staff and the consultant himself took notes. No tape recording was done in accordance with the agreed procedures in the project document.
- 4.3.5 **Data review and analysis:** Throughout the assessment period, the consultant reviewed, triangulated and summarised the data on a daily basis. The consultant summarised all the KI interviews and FGs (See Appendices 1 and 2) and also the secondary data (See Chapter 6). From the summaries, the consultant extracted the key findings of the assessment and made the initial conclusions and recommendations in the draft report. Useful comments received on the draft report from UNHCR focal points in Geneva (PS, MS, NE) and Nairobi (PN) as well as the WHO focal point in Geneva (MO) were incorporated into the final report.
- 4.3.6 **Ethical considerations:** For both the FGs and KI interviews, the ethical issues as contained in the project document were followed. Verbal consent was obtained at each interview following full explanation of the aims and objectives of the interview by the consultant. Confidentiality was assured. The venues were carefully chosen to ensure privacy and confidentiality. However, on one occasion, an active drug user who was being interviewed in a Resource Centre in the camp requested that the interview be discontinued and moved to the UNHCR compound where he would feel safer to divulge sensitive information about IDU practices. His request was granted. He was interviewed later same day at the UNHCR compound and he also brought

other “suspected IDUs” he recruited for interview at a later date in the same venue.

4.4 **Assessment methods**

4.4.1 The **Rapid Assessment and Response (RAR)** methods were employed in this assessment. These methods are well described in substance use, as well as in emergencies and other fields (Rhodes et al, 1999; Stimson et al, 1999, Trotter et al, 1999; Weiss et al, 2000). They are characterised by (i) Rapidity; (ii) Intervention focused; (iii) Multi-sectoral, community based approach; (iv) Use of multiple data sources and continued triangulation of data (verification of information by cross-checking with other sources) and (v) use of an iterative approach to hypothesis formulation and testing, evolving throughout the data collection and analysis period.

4.4.2 **Secondary data:** These were gathered from UNHCR’s HIV behavioural survey (BSS), other agency documents, peer reviewed articles sought directly from authors or via internet search, reports of national health and drug authorities, non-governmental organisation (NGO) reports.

4.4.3 **Primary data:** This was collected as follows:

4.4.3.1 **Direct observation and mapping** of sites relevant to substance use and HIV vulnerability: Six of such visits were made by the consultant accompanied by service agency focal points and interpreters, four to drugs “hot spots” in the camp and two to similar areas in the local community. Following the observations, the mapping was completed progressively following the guide (Appendix 6, Annexes A and B) and triangulated during the KI interviews. Where consent was obtained, photographs were taken by the consultant at some drug joints (See Appendix 3)

4.4.3.2 **Key Informant (KI) Interviews:** Semi-structured interviews were conducted with 19 key informants (See Section 4.3.3 for details). The interview formats contained in the project document (Appendix 6, Annexes C and D) was followed and adapted to suit different situations depending on the role of the individual being interviewed and the implication of the interview for intervention.

4.4.3.3 **Focus Group (FGs) Discussion:** These were conducted with 17 ethnic and other relevant groups in the camp and the local community (See Section 4.3.2 for details). The format for FGs as contained in the project document (Appendix 6, Annex E) was followed and adapted depending on stage of data collection and the group being interviewed. For instance, in addition to general questions, in-depth questions on specific substances were directed mainly at groups that have been identified in earlier KI and FG interviews as

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being more involved in the production, sale or use of the particular substance (e.g. Somalis/Ethiopians and Miraa; Sudanese/Ugandans/Local community and traditional alcohol brewing and consumption). Further, as data on baseline information accumulated and became saturated, more attention was directed possible intervention issues.

5.0 TIMETABLE

The time table for the assessment is detailed in Appendix 5.3

5.1 Problems and successes

5.1.1 Problems

5.1.1.1 Number and size of attendants in FGs: One key limitation for the FGs was the inability of the consultant to influence either the number or the gender distribution of the participants that attended sessions. The community group leaders were initially instructed through the service agency focal points to recruit between 6-8 people with gender balancing for the FGs. However, as could be seen from the profile of the groups interviewed (Appendix 2), many of the groups exceeded the required number. The implication of the large number was that the group sometimes became unwieldy and the session then turned to more of a “general discussion” rather than a FG discussion. The large sizes of the group was explained by the service agency FPs on the basis that the ethnic group leaders were well established and have their own members and hierarchies, who they would insist should attend any interviews. This limitation, notwithstanding, most of the interviews yielded useful information. Also, for most of the groups, the male gender was over-represented, with the resultant effect that the voices of the few females present tended to be “downed” in some of the sessions. The female under-representation was explained from three angles. First, in most of the ethnic groups (e.g. Somalis), females were culturally expected to be busy looking after the household chores, hence their non-availability for the interviews. Secondly, some of the groups thought (perhaps rightly) that substance use issues was more of a male phenomenon and hence selected more males to attend the interviews. Another possible reason was that females were fewer in number in the camp. However, the opportunity to get the women’s perspective on the issues under investigation came through the NCKK-facilitated FGs with four purely women groups.

5.1.1.2 Time for the assessment: A total of four weeks approved for this study (field work and report writing inclusive) would appear to be fairly inadequate to complete the needed tasks in this study. As could be seen from the time table, the consultant had to work round the clock for the whole period of field work and report writing took about 3 weeks. In future similar studies, a minimum of 6 weeks for field work and report writing is recommended.

5.1.1.3 Obtaining Kenyan visa: The consultant experienced serious difficulty in obtaining the visa for the trip. This is despite having applied five weeks before the travel date and all the follow up efforts put in by UNHCR in

Nairobi and Geneva. Visa was issued only in the last 2 hours of the last working day before the trip. This delay apparently affected pre-field work communication and preparation, as no one was sure if the visa would be issued.

5.2.2 **Successes**

5.2.2.1 **Tasks completed despite limitations:** It is noteworthy that, despite the limitations highlighted above, the consultant was able to accomplish the aims and objectives of the assessment within the specified time period. This success could be attributed to the contributions of every member of the team (See Sections 3.1 and 3.2 for full list of team members). In particular, the service agencies facilitated the FGs and some KI interviews through their well established networks within the camp and the local community. The logistical support provided by UNHCR and the role of young and enthusiastic interpreters and note takers are worth mentioning.

5.2.2.2 **Mobilisation of stakeholders for intervention:** At the end of data gathering, the consultant was able to share his findings with stakeholders in Kakuma and Nairobi, where they also made input into the draft action plan. The consultant left Kakuma with the feeling that the stakeholders were quite motivated and prepared to implement agreed interventions at the appropriate time.

6.0 FINDINGS

6.1 Context

6.1.1 Political and economic situation

Political: As detailed in Chapter 1, KRC was established in 1992 after the arrival of 12,000 “Lost Boys/Girls of Sudan”. They have since been joined by refugees from other countries. As at the time of the assessment, about 4 in 5 of the refugees were Sudanese. Others were from Somalia, Ethiopia, Uganda, Congo, Burundi, Rwanda and Eritrea (See chapter 1 for full information on camp composition).

After the 17 December 2005 launch of organized Voluntary Repatriation in Kenya, Sudanese refugees in Kakuma are returning to their homeland with the assistance of UNHCR. The chief catalyst for the repatriation was the January 9, 2005 Comprehensive Peace Agreement (CPA) between the Sudanese government and the Sudanese People’s Liberation Army/Movement. The agreement ended more than two decades of war which had killed millions, devastated the land and froze all development in what was one of the world’s most underdeveloped regions. Given the Comprehensive Peace agreement and the UN’s commitment to support its implementation, UNHCR and the Government of South Sudan have established legal frameworks by concluding a Tripartite Agreement between the Government of Kenya, the Government of Sudan and UNHCR in January 2006. UNHCR presence in South Sudan has determined that while conditions on the ground are in transition, many areas are safe for return (UNHCR SOK Briefing Kit, Sept. 2006)

Since the launch in December 2005, a total of 1,362 Sudanese refugees have been voluntarily repatriated from Kakuma to different villages in Eastern Equatoria, Upper Nile, Unity, Jongole and the Lakes State of South Sudan by air and road. Between October and December of this year a planning figure of 4000 Sudanese refugees has been estimated to return to South Sudan with the assistance of UNHCR. Currently the registration rate for Voluntary repatriation within Kakuma 40 people a day- totaling to 800 people per month with the number expected to rise as momentum increases. This has been assisted by the Voluntary Repatriation Advisory committee established this year in August. It is envisioned that as from next year an estimated total of 12,000 refugees will be assisted to return home with an estimated 1000 Sudanese refugees voluntarily repatriating each month. Despite the voluntary repatriation programme, the camp continues to receive new waves of arrivals. In 2006, Sub-Office Kakuma received 3500 new arrivals from South Sudan. One of the major pull factors for southern Sudanese to the camp is education, due to this; the sector in the coming year will be gradually scaled down with the incremental closing of schools at all levels (UNHCR SOK Briefing Kit, Sept. 2006).

Economy in KRC and local community: For the significant majority of refugees in the camp, unemployment, idleness and dependency associated with stress and frustration are rife. The Kenyan government has not adopted the Refugee Rights Bill. Hence, the refugees in KRC still live in “encampment” with the implication that they cannot hold

official jobs. However, many refugees who came to the camp with some skills or have acquired such skills through trainings received in the camp are employed by NGOs and paid “incentives”. About 4500 refugees have been trained in the camp of whom 250 are employed by NGOs in the camp (UNHCR SOK Briefing Kit., September 2006). In 2005, 595 vulnerable individuals were issued with loans for income generating activity (IGA). The Kakuma Laundry Soap Project is the most successful refugee IGA run by refugees. The soap factory supply UNHCR with soap which is distributed to the refugee (UNHCR SOK Briefing Kit., September 2006). Another developing but relevant AIG programme is the NCKK-implemented “Vulnerable Women’s Project” which started in October 2005. This programme targets women brewers and/or commercial sex workers, who are grouped together in 10s’ and given grants to embark on small scale projects. Thirty-six of such groups were in operation as at the time of this assessment, 22 in the camp and 14 in the surrounding community. Although the programme currently faces challenges such as inadequate grants, lack of shelters in markets, lack of transport, the feedback received from the beneficiaries interviewed in the course of this assessment was fairly positive.

A number of successful self-reliance projects managed by the refugees themselves such as the women catering services groups, tailoring, carpentry, shops and restaurants. While some of these projects have been described as small and poorly income generating, it is noteworthy that some of the multipurpose shops located particularly within the Somali community appear very active and buoyant. The consultant received briefs to the effect that there is a vibrant remittance of funds to refugees from relatives and friends living abroad. Another important source of cash inflow is through the payment of dowry, which was in the range of 10,000 US dollars as at the time of this assessment. Families who have access to such monies are known to trade in wood, charcoal, cattle and camels.

Some women from mainly the Sudanese communities engage in production of traditional alcoholic brews as their means of livelihood. For many of the latter, the selling of alcohol goes hand in hand with engagement in commercial sex work. As bicycles (“border-border”) is the only means of public transportation in the camp, many young men engage in bicycle riding and repairs to make ends meet. Another thriving business in the camp is the cybercafés usually thronged by agile youths surfing the net. Another popular money generating venture is the bars where youths pay from 10-20 KSh to watch UK premiership football matches particularly at weekends.

The local Turkana community is one of the poorest communities in Kenya. Their main means of livelihood is pastoralism. The widespread poverty has been explained on the harsh weather conditions, coupled with the non arable land. However, since the establishment of the camp, the local community has benefited through a regular daily process of exchange of goods and services across the two communities. Many refugees are known to sell their food rations to the local community for the purpose of alcohol brewing which is widespread. Many Turkanas can also be seen to engage in petty work (e.g. water fetching) in the camp. The local community has also benefited from some of the AIG and skill building programmes being implemented in the camp. The local community’s economy has also been enhanced to some extent through other benefits the community have derived from UNHCR, the implementing partners and service agencies.

According to UNHCR records, these include: provision of two bore holes (one generator, one wind mill and fuel), provision of electricity for schools and hospital, access to health services, access to education, formal and informal as well as vocational training, supported schools with fencing, support to women groups, logistics support to the Kenyan police that includes vehicles, fuel, offices, residences (UNHCR SOK Briefing Kit, Sept 2006)

6.1.2 Socio-cultural features (demographics, religion, ethnicity, languages, literacy)

As highlighted in Chapter 1, about 72% of the camp population comprise of youths aged 25 years and below, a further slightly more 1 in 4 (26%) are aged 26-55 years while only 2.31% are over 55 years. The predominance of young people implies the need to continuously engage them in productive and gainful ventures, as the only way to detract them from investing their youthful energy to into socially disruptive and disapproved activities. The gender distribution by gender shows there are 59.5% are males while 40.5% are females (UNHCR data base, Sept 2006)

The KRC has a good mix of people from different ethnic backgrounds and from different countries. Even among the major ethnic groups, strong emphasis is placed on the tribal grouping in terms of agency programming, accommodation arrangement and social activities. A good example is the Sudanese that make clear distinctions between the Equatoria, Dinka, Nuer and Nuba tribal groups. Some people interviewed opine that this over-emphasis on ethnic and tribal leaning has not helped integration among the different groups in the camp.

The main religions in the camp and local community are Christianity and Islam, but there are also animists. For example, the Sudanese are mainly Christians while the Somalis are Moslems.

In terms of literacy levels, UNHCR records indicate that the total enrolment of children in school represents 63.7% of school age children between 5 -25 years enrolled in 6 Pre-Schools, 24 Primary Schools and 5 Secondary Schools. The breakdown is as follows: (i) Pre-School 5,771 (2,961 boys and 2,810 girls); (ii) Primary school 22,219 (15,998 boys and 6,221 girls) and Secondary school 2,981 (2, 619 boys and 362 girls). An Upper primary boarding school for girls constructed by funds from Angelina Jolie opened in June 2005. A Girls' only secondary school opened in July to increase girls' enrolment in secondary schools. However due to budget cuts the school was closed and the girls integrated into existing classes (UNHCR SOK Briefing Kit, Sept, 2006)

6.1.3 Current general problems being encountered in KRC and SC

The consultant enquired in every KI interview and FG conducted in KRC and the local community what respondents considered were their general problems.

In KRC, the most commonly reported problem was lack of security. Several violent, sometimes fatal attacks were mentioned by refugees, which they claimed were unleashed on them by some criminal elements in the local community. Sometimes, violent inter-ethnic clashes within KRC had occurred but these were said to be on the decline. Other general problems mentioned were inadequacy of food, fire wood, housing, daily needs and medical needs. Others include the restrictive refugee status that prevents them from being employed, idleness, poverty, hopelessness and helplessness around when they would be repatriated or resettled and the harsh weather conditions.

KRK, (Inspector of Secondary Schools, LWF) summarised the problems in KRC as follows but not in any particular order:

- Poor housing
- Inadequate basic needs
- Very harsh environment: weather is hot and dusty
- Insecurity: fighting common among the communities or between the surrounding community and refugees. They sometimes kill each other.
- “Idleness” from too much free time
- Poorly remunerated jobs and lack of employment even for skilled refugees
- Gender-based violence based on tradition
- Forced and early marriage causing conflict between role as a student and a wife
- Lack or inadequate parental supervision and support
- Post-traumatic psychological problems presenting as absentmindedness, depression and anxiety
- Western influence gained from electronic and print media
- Poor cultural mix resulting from strong affiliation along tribal and ethnic lines.

FM, Associate Field Safety Officer, UNHCR SOK also listed the general problems facing refugees in KRC as follows:

“The commonest problems in the camp are (i) illegal firearms in the district which spills into the camp and has led to the killing or maiming of some refugees; (ii) illicit local brews both in the camp and surrounding community. Hence, assault cases are very common including rape, physical fighting from fighting; (iii) use of other drugs like bhang which comes from the hills (Kenya-Ugandan border). Some small-scale traffickers were caught and prosecuted, and (iv) gambling, for which light sentences are usually given”

The local (Turkana) community residents interviewed listed the following general problems:

- Harsh weather: arid land leading to lack farms and also poverty
- Lack of water
- Lack of grazing vegetation, leading their cattle rearers to go into Uganda and this causes conflicts

- Medical services used to be a problem before the establishment of the camp but this has improved with the IRC hospital

6.1.4 Pre-emergency cultural norms regarding use of substances (for displaced and host populations, men and women)

Literature on substance use in refugees' home countries was only available for Sudan, Somalia and Ethiopia.

Sudan: The only published literature retrieved on Sudan was the report on drug use among prisoners in three main prisons in Khartoum, Sudan (Karim et al, 1998). Alcohol was the drug reported most commonly used by 32.2%, followed by hashish (17.6%), diazepam (valium) (3.3%) and barbiturates (1.8%). Other low use drugs reported were morphine, codeine and pethidine reported by 5%. Alcohol users reported that they frequently use alcohol with other drugs like hashish and valium. The Sudanese interviewed in this study mentioned that brewing of traditional alcoholic brews was their main occupation in Southern Sudan where they came from and that consumption of such brews is a cultural norm there. Internet search also revealed that sniffing of glue and solvents is a common practice among street boys in Khartoum (IRIN news, 26 September .2006). The dozen boys interviewed by IRIN news indicated that solvents made them braver when they attempt to pick pockets or pilfer from shops.

Somalia: There is extensive literature on khat chewing in Somalia. The practice was supposed to have begun in the country following the Second World War and has since been introduced to other countries in Africa and Arabian Peninsula including Kenya, Ethiopia, Djibouti, South and North Yemen, Tanzania and down to south eastern Africa (Elmi, 1983; Elmi et al, 1987). Khat chewing has a stimulating effect on the central nervous system, which is the reason for the widespread use of the plant. From the mid-1960s to the early 1980s, khat chewing spread from the limited area of the north western part of Somalia to the whole country, assuming epidemic proportions. Khat chewing was recognized as a real national problem with adverse consequences for the health and socio-economic development of the country. A law prohibiting the use, importation, cultivation and trade of khat was enacted in 1983, and it has been strongly enforced by a comprehensive national programme that has mobilized the country to achieve its objectives (Elmi et al, 1987). The available literature on khat cover aspects of its psychiatric complications (Pentelis et al, 1989; Odenwald et al, 2005), its transcultural usage (Nencini et al, 1989; Griffiths et al, 1997) and its socio-economic and health effects (Belew et al, 2000; Aden et al, 2006)

Ethiopia: Available literature indicates that substances most commonly used in Ethiopia are alcohol, khat and tranquillisers. Selasie and Gebre (1996) conducted a rapid situation assessment of drug abuse in 24 towns across Ethiopia. The study found that there was a significant increase in the number of Ethiopians chewing khat. Alem *et al* (1999) reported that 55.7% of people interviewed Butajira, in a rural

Ethiopian community reported lifetime khat chewing while 50% were current chewers. A total of 80% of the chewers reported they chew the substance to gain a good level of concentration for prayer. Muslim religion, smoking and high educational level showed strong association with daily khat chewing. Zein (1988) carried out an epidemiological survey on the pattern of use of khat, alcohol, cigarettes and tranquillizers among 479 medical and paramedical students in a boarding college in northwestern Ethiopia using an anonymous self-administered questionnaire. The prevalence rate of current use of alcohol, cigarettes, khat and tranquillizers was 31.1%, 26.3%, 22.3% and 7.7%, respectively. These substances were also used in combinations, the most frequent involved khat, alcohol and cigarettes. Kebede and Alem (1999) studied the epidemiology of alcohol dependence and problem drinking in a representative sample of 10,203 adults in Addis Ababa. At the first stage the study employed a 4-scale screening instrument (CAGE) and at the second stage the Composite International Diagnostic Interview (CIDI) was used to identify cases of alcohol dependence. Of the total population, 2.7% responded positively to at least 2 of the 4 CAGE items, fulfilling the definition of problem drinking. By use of the CIDI, the weighted lifetime and one-month prevalence of alcohol dependence was 1.0% and 0.8%, respectively. It occurred almost exclusively among men. Women had a 84% less risk of becoming dependent compared to men. Kebede *et al* (2005) conducted a study to describe the magnitude of risky sexual behaviour (unprotected sex and early initiation of sexual activity) and its association with Khat and alcohol consumption in Ethiopian youths. A probabilistic national sample of 20,434 in-school and out-of-school youths aged between 15 and 24 years was selected and interviewed regarding their sexual behaviour and substance use. The study found that over 20% of out-of-school youth had unprotected sex during the 12-month period prior to interview compared to 1.4% of in-school youth. Daily khat intake was associated with unprotected sex. There was a significant and linear association between alcohol intake and unprotected sex, with those using alcohol daily having a three fold increase odds compared to those not using it.

6.1.5 Baseline data on substance use, HIV prevalence or other associated problems

Baseline data on substance use and HIV is available for Kenya in general. Some limited data is available for HIV in the KRC but none for Kakuma township specifically. No baseline data was retrievable for KRC and the local community.

Substance use in Kenya: Mwenesi (1996) conducted a country-wide needs assessment study in 1994. The study, which was funded by the Government of Kenya and the United Nations International Drug Control Programme (UNDCP) revealed that drug abuse has permeated all strata of Kenyan society, youth and young adults being the most affected groups. The substances reported most commonly used by interviewed drug users were cannabis, alcohol, solvents, khat, heroin and cocaine in that order. Among street children, the first drug of abuse is usually tobacco, followed by gasoline and then glue. When a little older, they start on cannabis "and are ashamed to be seen sniffing glue". Abuse of solvents, however, is not confined to

street children. Adults also reported abusing gasoline and glue when "nothing else was available". Khat chewing was reported to have taken a hold in varying degrees throughout the country. Although herbal cannabis is widely abused, the abuse of resin or hashish was also found in the coastal region. Valium is frequently combined with khat in order to cancel out their opposing effects. Phenobarbital is also combined with alcohol for faster results. Other abused drugs include codeine-based painkillers and cough syrups that cause drowsiness". They are used as antidotes to khat.

The Information Needs and Resources Assessment (INRA) report of 2001 was commissioned by the UNODC, GAP and EADIS and findings showed that the commonest drugs of abuse among patients admitted at Brightside Drug Rehabilitation Centre, Nairobi, was alcohol (33.0%), followed by *Cannabis sativa* (29.0%) and heroin came a close third at (20.0%). This trend was similarly repeated at the Red Hill Drug Rehabilitation Centre, Limuru.

HIV in Kenya: Human immunodeficiency virus (HIV) probably started to spread in Kenya in the late 1970s or early 1980s. Since the first case of HIV infection was described in Kenya in 1984, over 87,000 cases of AIDS have been reported to the Ministry of Health as of June 1999. At the end of 1998, an estimated 1.9 million adults aged 15- 49 were infected with HIV including over 100,000 children. One commonly used measure of the extent of HIV infection in a population is adult prevalence, the percentage of adults between 15 and 49 who are infected with HIV. The National AIDS and STDs Control Programme (NASCO) estimates that by 1998, adult HIV prevalence had reached 13.9 percent, of which 17-18 percent or 430,000 HIV-infected adults were in urban areas and 12-13 percent or 1.4 million HIV-infected adults were living in rural areas. Although prevalence is higher in urban areas, the absolute or total number of people infected is larger in rural areas because 80% of the population lives in the rural areas. (Odek-Ogunde, 2004). According to Ndeti (2004), Kenya made strong efforts to control and prevent further spread of HIV infections in the year 1997 through Sessional Paper No. 4. This led to the creation of the National AIDS Control Council (NACC) and of the National AIDS & Sexually Transmitted Infections Control Programme (NASCO). NACC was assigned the responsibility of dealing with policy issues while NASCO dealt with operational issues and laboratory quality control. Since then, the HIV prevalence rate has dramatically fallen from above 20.0% then to 6.7% in the year 2003.

HIV and IDU in Kenya: A few studies have reported on the growing prevalence of injecting drug use (IDU) in parts of Kenya, particularly its contribution to the HIV pandemic in the country. A comprehensive review on the subject matter can be found in Dewing S. *et al* (2006). In summary, Beckerleg & Lewando-Hundt (2004) utilized a range of qualitative research methods in an attempt to estimate the number of drug users and IDUs in the coastal town of Malindi. The researchers estimated that in the town of 85,000 people, there were approximately 600 heroin users, 50% of whom were IDUs. Ndeti (2004) interviewed 1420 Kenyans. Eligible participants included active and former drug users with or without HIV, as well as people who had tested positive for HIV with or without a history of drug abuse. Of the total sample, 23.0%

were IDUs. Use of heroin was highest in Mombassa (22.3%), followed by Malindi (9.8%) and Nairobi (6.0%). Of those injecting in Malindi, 100.0% injected on a daily basis, while 86.5% and 67.9% injected daily in Mombassa and Nairobi respectively. Odek-Ogunde (2004) completed a Behavioural and Seroprevalence Survey among IDUs in Nairobi. A total of 348 heroin users were interviewed. Of the 156 IDUs in the sample, 106 had injected within the past 6 months. Serological tests were conducted for 332 participants. The overall prevalence rate for HIV was 24.3%. HIV was found to be highest among current IDUs with a prevalence of 52.5%. The key findings in all of these studies were (i) The HIV prevalence amongst injecting drug users in Kenya is significantly higher than the HIV prevalence rate for the general population; (ii) Needle sharing is a common practice amongst Kenyan IDUs and (iii) Rates of condom use amongst drug users were found to be low.

6.1.6 Relevant regulatory, legislative, judicial and policing framework

6.1.6.1 Regulatory framework: The National Agency for the Campaign Against Drugs (NACADA) was formed in 2001 to enhance advocacy against drugs abuse in Kenya. Its major objectives were coordination, implementation, monitoring and evaluation of programmes on the campaign against drug abuse in Kenya. NACADA had been holding consultative meetings to develop a strategic plan that would include public awareness campaigns, interventions for special groups, counselling services and rehabilitation for the vulnerable, the youth and support services. These included: Institutional framework of drug abuse control, strategies of drug abuse treatment and in prevention education activities. NACADA has been working with all stakeholders, both in the private and public sectors.

6.1.6.2 Legislative framework: Kenya Government has ratified the three major United Nations Conventions on Narcotic Drugs and Psychotropic Substances, namely: (i) The Single Convention on Narcotics of 1961, as amended by the 1972 Protocol (ii) The Convention on Psychotropic Substances of 1971 and (iii) The Convention against Illicit Trafficking on Narcotic Drugs and Psychotropic Substances of 1988. The Narcotic Drugs and Psychotropic Substances (Control) Act, 1994, is the latest Kenyan legislation against drugs trafficking and abuse. The KRC and the local community are governed by the Kenyan's statutory laws and regulations on alcohol and drug production, trafficking and use. Some information on some of these laws, gathered via the internet (www.kenyalaw.org) are presented below:

6.1.6.2.1 Chang'aa Prohibition Act (Chapter 70): This Act states that anyone who is arrested for brewing or producing chang'aa (meaning any spirits which are distilled otherwise in accordance with a licence issued under Part IX of the Customs and Excise Act, and by whatever name called and includes spirits commonly known as "enguli", "kali", "kangari", "kill me quick" etc) shall (i) be guilty of an offence and liable to a fine not

exceeding ten thousand shillings or to imprisonment for a term not exceeding two years or to both fine and imprisonment; (ii) On conviction of any person for an offence under this Act, the court shall order the forfeiture and destruction of all chang'aa and any implement, apparatus or utensil used in connexion with the commission of the offence

- 6.1.6.2.2 **Traditional Liquor Act (Chapter 122):** This Act sets out in detail the procedures to follow in order to obtain a licence for the production and sale of traditional liquors, defined as “any intoxicating liquor manufactured by traditional African methods, other than distillation, which is offered, or intended to be offered for sale in a state of continuing fermentation without further processing...” This Act covers the production and sale of traditional brews like busaa and kaada.
- 6.1.6.2.3 **Narcotic Drugs and Psychotropic Substances (Control) Act 4 of 1994 as amended:** Section 3 of the Act stipulates the penalty for possession of narcotic drugs, etc. For example, for cannabis, if it was intended solely for consumption by the person arrested, the penalty is 10 years imprisonment, and in every other case, it is imprisonment for 20 years. The penalty is stiffer for narcotic drugs or psychotropic substances, where for personal consumption, the penalty is 20 years imprisonment and in every other case a fine of not less than one million shillings or three times the market value of the narcotic drug or psychotropic substance, whichever is greater, or to imprisonment for life or to both such fine and imprisonment. Section 4 of the Act spells out even more severe penalties in the case of anyone arrested for trafficking in narcotic drugs, etc.
- 6.1.6.3 **Policing Framework:** KI informant interviews with the OCS (Kakuma), the DO (Kakuma), the Chief (Kakuma) and UNHCR's Chief Security Officer indicate that the greatest challenge they have is with respect to controlling the widespread practice in the camp and local community of the production and sale of traditional alcoholic brews (chang'aa, busaa, kaada, ginzee). The most serious in terms of illegality is the production and sale of chang'aa, which is the distilled brew. Their offices collaborate to carry out regular raids on brewers (particularly of chang'aa) and their facilities. During such raids, the production apparatus or implement are destroyed. Many of the brewers would run away for fear of arrest, but some are arrested and prosecuted. According to the OCS, this method of interdiction is not effective as those prosecuted are able to pay their fines and go back quickly to their business of chang'aa production. All the key security officers interviewed suggested the need to shift emphasis to programmes aimed at educating the public about the health hazards of consumption of these brews and the need to move to alternative means of livelihood.. The consultant, during the observation and mapping visits to the camp and surrounding community, was able to observe brewing and sale of traditional liquors done very much in the open. It was also noticed throughout the assessment that the sale and use of bhang (and perhaps other narcotic drugs) was done in a most discrete manner. This is understandable in view of the very stiff penalties attached to their use.

The following quotes reflect the views of key informants and the refugees on the interdiction measures and their apparent ineffectiveness:

“From time to time, we destroy the equipment and pour away the products. Occasionally we prosecute those arrested for production and sentences can vary from imprisonment for 1 to 2 months, fine of 500 – 100 K Shills and/or community service order” (*District Officer, Kakuma*)

“We conduct frequent raids on chang’aa producers in the camp. The producers run away and we pour away their products and destroy their equipment. This method has only reduced the problem slightly but has failed to eradicate it. Public awareness campaigns should be organized to educate the people on the bad effects of chang’aa. The people who produce chang’aa for economic reasons should be involved in alternative income generation activities” (*Officer Commanding the Police Station, Kakuma*)

“The control measures we use include (i) Raids and arrests – this involves destroying equipment and pouring away the drinks; (ii) Arrests and prosecution of a few brewers. This measure is not effective because those arrested can pay the fine and go back to their trade. This is why we encourage NCKK to sensitize the people about the bad effects of brewing chang’aa on the people. We also talk regularly with community leaders and community security guards to sensitize the people against the dangers of chang’aa production and drinking” (*FM, Associate Field Safety Adviser, UNHCR SOK*)

”Why are the Police only arresting chang’aa brewers in the camp, when it is sold and taken openly all over in Kenya?. The law says that chang’aa is illegal in the camp but when you go everywhere in Kenya, chang’aa is being used including in Nairobi where there is *ten ten* or *Kumi Kumi*” (*A Ugandan Community Leader during FG with Ugandan Group*)

6.2 Current Substance use Pattern

6.2.1 Availability and cost of most prevalent psychoactive substances, other supply chain information

6.2.1.1 Traditional alcoholic brews (Chang’aa, Busaa, Kaada)

- These locally brewed alcoholic products are very much available in both KRC and the local community. **Busaa** is the product of the fermentation of dried maize or sorghum. The cereals are ground, fermented, boiled and then filtered with a cloth. **Kaada** is the product of fermentation of yeast. The process involves the addition of water to yeast and sugar. **Chang’aa** is the product of the distillation of fermented millet, maize, yeast or sorghum.
- By the Kenyan laws, only chang’aa (the distilled product) is strictly illegal. Busaa and Kaada are also considered as illegal unless the brewer and seller has obtained a government licence. The consultant was not informed that any

brewer either in KRC or the local community has obtained or been denied licence to produce busaa or kaada

- The easy availability of the traditional brews is facilitated by the fact that the refugees collect as food rations from the UN maize and sorghum, which are the main ingredients needed to produce the brews. Many refugees therefore use their food rations to produce the brews. Others sell their food rations to ready buyers in the surrounding community or the camp, who also use the grains to produce their own brews.
- Production of traditional brews is widespread in the camp notably among the Sudanese (Equatoria), Ugandans and Rwandese communities. The Somalis are not known to engage in alcohol brewing.
- The brews are fairly cheap and affordable to many. A 50-100 ml cup or “bowl” of Kaada and Busaa costs 5 KSh while a 500 ml soda bottle costs about 20 KSh. Chang’aa is slightly costlier, with a 50 ml glass or “shot” costing 15-20 KSh and a 500 ml soda bottle costing 50 KSh. The more concentrated chang’aa (“first class”) costs 100 KSh for a 500 ml soda bottle

Quotes on most commonly available and used substances

“The main substances abused are illicit alcoholic brews (chang’aa, busaa) and Miraa. The production of illicit brew is to supplement the rations the refugees get from the UN. and is used as a means of obtaining non-food items. Miraa is used mainly by the Somalis. They do not consider it as a drug as it is legal and they chew it openly. It is grown in commercial quantities in Meruland in Eastern District of Kenya and transported by land and air to Kakuma. Also exported to Great Britain and neighbouring countries like Somali” (*Officer Commanding the Police Station, Kakuma*).

“Local alcoholic brews (chang’aa, busaa, kaada) are the commonly used substances. During the European time, many clubs existed where people sold and drank busaa (local brew). President Moi banned busaa but people continued to brew it underground. People later improved on the technology of brewing by distilling busaa to chang’aa. The brewers are local people, mostly women who produce both busaa and chang’aa. They also brew kaada through the fermentation of yeast and sugar although this is not usually produced in commercial quantity. When the refugees came, they (particularly the Sudanese) brought their own technology and further improvised on the brewing of the local drinks. Miraa is another substance commonly chewed by the Somalis. We have isolated cases of bhang users who behave strangely. I have never heard or seen people taking heroin or cocaine or injecting these substances” (*Chief, Kakuma*)

6.2.1.2 **Khat (Miraa)**

- Miraa sale and use is not illegal in Kenya. It is widely available, openly displayed and sold particularly in the Somali communities
- Miraa is grown in large amounts in Meru district, Eastern Kenya. From Meru, it is transported to Nairobi from where it is flown to Lokichogo, and from there it is brought in vehicles to Kakuma daily. Products transported this way are fresh and expensive. The alternative is to transport it by road from Meru to Kakuma, a distance of about 1000 Km.
- Miraa is fairly expensive particularly compared to the alcoholic brews. A bundle of miraa (usually referred to as a kilogram, but not anywhere close to the real kilogram weight) costs between 600 – 900 KSh depending on the freshness. The price tends to go up during periods of drought and tends to be cheaper during rainy season

6.2.1.3 **“Bhang” (cannabis, marijuana)**

- It is used rather very discretely by youths and some CSWs
- It is illegal and generally disapproved by the community. Users were described as “criminals”, “outcasts”, “social misfits”, “violent”
- Most of the current drug users interviewed claimed that the substance can be bought in some “joints” (i.e. drug selling places) but the sale is done very discretely (understandable on the basis of the severe penalty that could be meted out to a dealer, See Section 6.1.5.2.3)
- Bhang use is also done discretely around the “laga” (River Tarash) which some people refer to as “the bush”. Users are known to go to these hide outs at night time to use bhang and possibly other illegal drugs
- Some of the active drug users interviewed indicated that bhang is obtainable at many spots in KRC but were very reluctant to give further details.
- In terms of the source of cannabis, there was a general consensus that it is not locally grown, but brought from outside. Some interviewees mentioned the Uganda hills while others mentioned Nairobi or Southern Sudan
- A wrap of bhang costs 10 KSh

6.2.2 **Substances used and route of administration (including changing patterns of use such as transition from smoking to injection) by subgroups (e.g. farmer, ex-combatants, sex worker, ethnicity, religion)**

6.2.2.1 **Traditional alcoholic brews (chang’aa, busaa, kaada)**

- Used by males and females, old and young people usually above age of 18 years
- Only taken orally (drinking). No change in the route of use
- The noticeable change in the pattern of use is that the brews have become available and more widely used in the locality since 1992 when the camp was

established. Many refugees interviewed claim they drink “To kill time” as many are idle and have nothing else to do

- Another changing pattern is the availability of methanol – industrial alcohol – which in many settings in Kenya has caused death, blindness and liver complications. As alcohol users are demanding cheap and rapidly intoxicating products, the possible introduction of methanol is likely to worsen the alcohol-related health complications in the camp.

Quotes on traditional brews

On adulteration

“Traditionally, the brewing of these stuffs was done hygienically. But now, the drink is adulterated with chemicals and additives to make it stronger and to shorten the process of preparation. Last year, in Machakos District, following consumption of chang’aa laced with some poisonous substances, about 20 odd people died and about 50 hospitalised, others became blind” (*District Officer, Kakuma*)

On the economic significance of brewing traditional alcoholic drinks in KRC and SC

“Chang’aa and busaa production and use is rampant and is shared between the local community and the camp. The Sudanese (Equatoria) community is mostly affected, being the largest producer and consumer of chang’aa and busaa. The traditional business in this community is chang’aa brewing. Chang’aa brewing is illegal in Kenya. Hence, raids are conducted from time to time by the government and the Police. UNHCR distributes food rations comprising maize, sorghum or a mixture of both, as well as pulses (beans), vegetable oil and corn soya blend (CSB). Unfortunately, the maize and sorghum constitute the basic ingredients used in fermenting busaa (a form of beer, less powerful than chang’aa), and the distillation of busaa gives rise to chang’aa. Controlling chang’aa production in the camp is a complex and difficult issue as it is linked to the means of livelihood of many people. Further, the demand for the brews is high. Hence, in addition to Police interdiction activities, it is necessary to consider alternative income generation activities for producers” (*TM, Ag. Head of Office, UNHCR SOK*).

“Production (i.e. chang’aa) fetches good social income. Some of those arrested have claimed they use the proceeds to pay school fees for their children, and use it to supplement their means of livelihood” (*District Officer, Kakuma*)

“I have a family of 10 and the rations supply from UNHCR is inadequate. Hence selling chang’aa helps me to buy firewood, food, clothes” (*Elderly Ugandan woman during FG with Ugandan Community group leaders*)

”Brewing of traditional alcoholic drinks is income generating for many poor people. As a personal experience, my mother paid my school fees from the money she made from

brewing chang'aa" (SR, 29-yr old male during FG with Local Community Group Leaders)

On production and consumption of traditional alcoholic brews in KRC and SC

"Factors involved in brewing and drinking include: (i) Traditional practices – the drinks are freely used during ceremonies such as weddings and dowries agreements; (ii) It is easy to prepare as the food rations (grains) constitute the ingredients; (iii) Drinking is a major way by which people socialise in the camp; (iv) People brew chang'aa to earn a living and also due to idleness and lack of alternative income generating activities (FM, Associate Field Safety Adviser, UNHCR SOK)

"Chang'aa brewing has increased since the refugees came to the camp because the refugees get food rations which they use to produce the drinks. They also sell the rations to the local community and we use this to make our own drinks. We buy the food rations from the Equatoria, Nuer, Dinka, Acholi from Uganda. The Ugandans produce the best chang'aa. The communities that do not produce are the Congolese, Ethiopians and Somalis" (FG with Local (Turkana) Community Group Leaders)

6.2.2.2 Khat (Miraa)

- Chewed by both genders but predominantly males
- Use common among occupational groups who use it to stay awake to work for long hours (e.g. security guards, long distance drivers, students)
- Age of use is usually from late adolescence up to old age
- No change reported in the route of use.
- Some refugees claim they chew more because of "idleness" in the camp, while others mentioned they now chew less compared to when they were in their home country. To the latter, they cannot afford the high price of miraa in the camp.

Quotes on khat chewing

On khat production

"Miraa (Khat) is commonly chewed (the stem and shoot) by Somalis, but also by some Ethiopians and Sudanese people. Its use is being propagated via peer pressure. Its use is licit in Kenya, where it is grown in large quantity in Meru district and exported to different places including Kakuma. Ethiopia also exports Khat to Djibouti" (TM, Ag Head of Office, UNHCR SOK)

"Miraa is grown in large amounts in Meru district, Eastern Kenya. From Meru, it is transported to Nairobi from where it is flown to Lokichogo, and from there it is brought in vehicles to Kakuma daily. Products transported this way are fresh and expensive. The alternative is to transport it by road from Meru to Kakuma, a distance of about 1000 Km" (FG with IRC Mental Health Assistants)

Views expressed by khat chewers

“I started chewing miraa as a young trailer driver in 1961. I always chew miraa and take coffee with it. The good effects include that it makes you happy and energetic and you can work for long hours without sleeping and eating. It increases libido and sexual prowess. However, when you are not chewing, it gives you the bad effects which include lack of energy, not feeling happy and feeling temperamental” (62-year old *Somalian interviewed in a miraa bar*)

“I take miraa only during holiday time, when I have nothing to do. It makes me feel happy, you don’t sleep, you work more and have more energy. It makes me feel hot from inside and I am not interested in woman. When not chewing, I feel lazy, poorly and unhappy. I don’t take miraa regularly as it is expensive and you can spend up to 2- 3 thousand Kenyan Shillings on it per day. I always depend on my friends who get money remitted to them from overseas. Miraa is chewed mainly by men, as 7/8 out of 10 chewers are men. I can stop miraa chewing anytime I wish to” (20-year old *Somalian student, regular miraa chewer*)

“I chew miraa only, I don’t take chang’aa or Tuskel. I have been chewing for 16 years. I started chewing because of joblessness. I just wanted to forget what was happening in my country. I have no job, so I get miraa from friends. It is like any food, not different. When I chew, I feel sweaty, light and happy with a lot of energy. It increases my libido but I feel calm and do not experience perceptual problems. I get the opposite effects when I am not chewing. I have been without miraa for 3-4 days but hope you (*referring to myself*) can buy me some. About 5 out of 10 young people chew miraa, mainly boys. Miraa does not make people to commit offences, and people can control their use. I feel good about taking miraa. I have no knowledge about people taking heroin or cocaine or injecting in the camp” (34- year old *male Somali interviewed in a miraa bar in KRC*)

6.2.2.3 “Bhang”

- Only smoked
- Used mainly by young people, and predominantly males in a most discrete manner

Quotes on cannabis use

“Bhang (marijuana) is brought from outside of Kakuma, both from Sudan and other parts of Kenya. It is used discretely by the youth, some teachers and some people who engage in hidden form of prostitution” (TM, Ag. *Head of Office, UNHCR SOK*)

“It is difficult to know the number of people using it (i.e. bhang) because it is illegal and it is used secretly. It is used mainly by older and middle aged people. I have never seen women using it” (47-yr old, *Male, Sudanese current drug user*)

. “Bhang use is very illegal. You cannot see users. They use it mainly at night or early in the morning in the bush” (*FG with IRC Mental Health Assistants*)

”As bhang smoking is done very discretely, users are only found out if and when they present in the clinic with psychotic symptoms. Even then, they do not readily own up that they have been smoking bhang” (*FG with IRC Mental Health Assistants*).

“Bhang is used by youths from age 10 years. Older people don’t take it. Users take it to be powerful. They get it from Uganda. It costs 10 KSh per roll. Both men and women take it although more men than women. Women prostitutes take it more than other women. The users may become violent and engage in robbery attacks. Users behave like mental sick people. For example, one lady who took bhang committed suicide” (*FG with Local Turkana Community Group Leaders*)

“I used to take bhang. We buy and use it along the river. There are many users of bhang, male and female, old and young” (*A female brewer/CSW during FG with Brewers/CSWs from the Local Community in Rehabilitation*)

6.2.2.4 Sleeping tablets (D5 or valium; rohypnol)

- Use reportedly common among miraa chewers who have problems with sleeping. Most of the latter take the tablets but some claimed that they have requested to be given valium intravenously in the IRC clinic when they have suffered from severe sleep problems. Such requests have been granted on occasions purely on this medical basis. However, some current drug users noted that intravenous valium can be obtained in some illegal private clinics or chemists
- Another small group of drug users were reported to inject valium as part of their poly drug use, which includes in various combinations the use of alcohol, cannabis, glues and solvents, khat and amphetamine-like substances (See Appendix 1, KI interviews Nos 8 and 9)

6.2.2.5 Heroin or cocaine

- None of the participants interviewed in KRC and local community reported current use of heroin or cocaine
- A couple of current drug users claimed they have injected these substances in the past in some other camps in Ethiopia and Mombasa but not in KRC. They also claimed that only very few people who can afford the habit may be involved in heroin and cocaine use in the camp. It is generally assumed that such drugs can not be purchased within the camp and that they are brought in from Nairobi and other big cities secretly and used in a very discrete manner.

Quotes on heroin and cocaine

“There are no special areas in the camp where you can get to buy heroin and cocaine. People bring the stuff from Mombasa and they don’t share it” (30-yr old, Male, Somali, current drug user)

”We never heard of or seen people using heroin and cocaine or injecting them” (FG with Sudanese Equatoria Community group leaders)

“We have not heard or seen people in the community using sleeping tablets, amphetamine and like drugs, glue or petrol, mandrax and heroin. Someone mentioned he has heard about a Somali man in the camp who injects himself with cocaine” (FG with Local Turkana Community Group Leaders)

“We have heard about them (heroin and cocaine) but do not know of anyone who uses or injects them” (FG with Out-of-School Youths)

“We have never had any customers injecting themselves or using heroin or cocaine” (A female brewer/CSW during FG with a group of brewers/CSWs)

6.2.2.6 Petrol or glue sniffing

- This was reported to be very uncommon in KRC and the local community
- Only one of the 7 current drug users claimed he regularly sniffs petrol as part of his poly drug use (See Appendix 1, KI interview No 6)
- Some of the current drug users indicate that glue and petrol sniffing may not be uncommon among a small group of poly drug users

6.2.3 Any trends identified, particularly changes in pattern of use since displacement

- Since arriving at KRC, interviewees indicated there had been more involvement of the refugees (particularly from the Sudanese communities) in the brewing and consumption of traditional alcoholic brands, mainly chang’aa and busaa. It would appear many Sudanese, particularly the women, have taken to the business of alcohol brewing as their main source of livelihood in the face of chronic inadequacy in the supply of their daily needs by the UN and other service agencies in the camp.
- From the Somali community, some respondents also indicated that khat (miraa) chewing has become more rampant because of joblessness and idleness in the camp and need to “kill time”

6.3 Risks and harms associated with substance use

6.3.1 Associated medical problems (e.g. transmission of HIV and blood borne viruses, overdose events, withdrawal syndromes)

6.3.1.1 Chang'aa consumption (as identified by participants)

- Makes baby drowsy through breastfeeding
- Weakens immune system and general body strength
- Tuberculosis
- Diarrhoea
- Tremors
- Loss of weight
- Abdominal ulcers
- Liver cirrhosis
- Dry and scaly face or puffy face
- Sudden death
- Increased sexual “recklessness” with many brewers engaging in unsafe (often commercial) sex and many users also engaging in unsafe sex with multiple partners. However, no HIV data disaggregating for chang'aa consumption was available for KRC and the local community

Quotes on the adverse effects of the consumption of chang'aa and other brews

“Some users become fully dependent on it. They engage in physical assaults and lawlessness. They are at a higher risk of contracting HIV. Drinking chang'aa goes hand in hand with promiscuity” (*District Officer, Kakuma*)

“Users do not look healthy physically. They become dependent on the substance and their life revolves around its use. Changa'a use goes hand in hand with prostitution. Users also engage and suffer more from physical assaults” (*Officer Commanding the Police Station, Kakuma*)

“The face of the typical user is usually bloated up and he suffers from pitting leg oedema. He could also suffer from liver cirrhosis and tuberculosis. He typically engages in violent and criminal behaviour including breaking into houses at night. He is prone to HIV as he does not use condom and keeps several partners who are also chang'aa users” (*Chief, Kakuma who has a nursing background*).

“The commonest problem in KRC is domestic violence from chang'aa consumption in the Sudanese community. Other cases associated with chang'aa drinking include cases of defilement, violence, rape and child molestations” (*SK, Protection Officer, UNHCR SOK commenting on the common problems handled by her Unit*)

“Some of the effects of chang'aa consumption include (i) fighting and solving family differences; (ii) family separation as a result of assaults, diversion of family resources and

inability to play a positive role in the family (compares this to the effects of miraa chewing in the family, which are quite similar) and (iii) sexual indiscretion: people become “loose” and some become commercial sex workers” (FM, Associate Field Safety Adviser, UNHCR SOK).

”Due to the poor hygienic conditions associated with the preparation of busaa, diarrhoeal diseases are commonly found in areas of high production such as Groups 58 and 10D in the Sudanese Equatoria communities” (Dr K, Medical Coordinator, IRC)

6.3.1.2 **Khat (Miraa) chewing** (as volunteered by participants)

- Some become physically dependent on the substance, while others do not.
- Some report feeling apathetic, amotivated, restless, tired and irritable when not chewing (suggestive of withdrawal symptoms)
- Loss of appetite
- Loss of weight
- Poor sleep or reversed sleep pattern
- Gastritis
- Teeth decayed and coloured
- Goes hand in hand with alcohol consumption with all the sexual risk factors (unprotected sex, multiple sexual partners etc.). No HIV data disaggregating for khat chewing was available.

6.3.2 **Associated psychosocial and mental health problems (e.g. gender-based and other violence, suicide, child abuse and neglect, substance –induced mental and behavioural disorders, discrimination, criminalisation)**

6.3.2.1 **Chang’aa consumption** (as volunteered by participants)

- Frequent fights leading to multiple body damage
- Gender-based violence: Rape, defilement etc
- Domestic violence
- Child abuse and neglect
- Divorce and separations common
- Depression and suicides
- Psychotic symptoms: seeing what others cannot, talking to self, responding to voices
- Living rough and haggard
- Bizarre behaviour: stripping self naked, sleeping on the streets near dumps

6.3.2.2 Khat (Miraa) chewing (as volunteered by participants)

- Young users may drop out of school
- Some experience reduced libido, wife become frustrated and may lead to divorce and separations
- Psychological/Psychiatric: memory problems, poor concentration, anxiety, hallucinations, excessive talking

6.3.3 Associated high risk behaviours (e.g. unsafe sexual behaviour and injecting drug practices)

6.3.3.1 Chang'aa brewing and consumption (as volunteered by participants)

- FGs with brewers/CSWs indicated that chang'aa brewing/sale goes hand in hand with commercial sex work. Most of the customers who come to drink in the brewer's home or bar also solicit for or are offered sex.
- Such sexual engagement are unsafe (with lack of condom use being the rule rather than the exception) and involve multiple partners, sometimes minors
- There was a general consensus that a lot of women drinkers also exchange their body (sex) for drinks

Quotes on the relationship between consumption of traditional alcoholic brews and sexual behaviour

On the effects on sexual arousal and performance

“Drinking makes me feel sexually aroused. I may then sleep with anybody without caring about precautions” (*A female brewer/CSW during a FG with a group of Brewers/CSWs in Rehabilitation in the Local Community*)

“The effect on sex differs in individuals. Some people after drinking want to have sex while others become irritable, temperamental and lose interest” (*A female brewer/CSW during a FG with a group of Brewers/CSWs in Rehabilitation in the Local Community*)

“After taking chang'aa (siko), one feels like having sex, the desire increases. If one drinks too much, then one may have careless sex with women. In *Hong Kong*, some men take chang'aa in order to have sex with Turkana women” (*47-year old male Sudanese current drug user*)

On drinking and sexual risk behaviour

“People who take drugs get reckless with sex because they don't care who they go to bed with. They don't even use any protection to protect them from infections. In addition, they have multiple partners and everyday, you will find a man with a different woman. The drug user sees the world as if it has no end and they feel so happy” (*27- year old male Sudanese current drug user*)

“Yes, it frequently happens that, for instance, a woman drug abuser who lacks money to buy drugs will sell or give her body to anyone whom she knows can give her the money or buy her the drugs. It is the same case with men” (27-yr old, male Sudanese current drug user)

“Users (i.e. chang’aa drinkers) can go from one woman to another. Many suffer from STIs and HIV because they do not use condom when they have sex. Some may have condom and use them inappropriately” (FG with Sudanese Nuer Community group leaders)

“We cannot negotiate safer sex when our customers are drunk. We use female condoms under such circumstances” (A female brewer/CSW during FG with a group of Brewers/CSWs in Rehabilitation in KRC)

“I brew because I want my children to survive. When my customers buy my brew and buy my body, even if I die, my children will inherit my brewing business. I could get 1000 KSh per week from brewing. From selling my body customers give me 5 KSh per round and can make up to 200 KSh per week” (A female brewer/CSW during a FG with a group of Brewers/CSWs in Rehabilitation in KRC) **(Please note that one US\$ exchanges for between 65-70 KSh)**

“I get money by befriending young men “unaccompanied minors” who get incentive money from many agencies. They bring all the money to me. I give them good food, good alcohol and my body. When I am fed up with them, I chase them away and replace them with another one” (A female brewer/CSW during a FG with a group of Brewers/CSWs in Rehabilitation in KRC)

“A few customers will use condom. Others turn violent and refuse to use it saying they cannot suck a sweet with the wrapper on” (A female brewer/CSW during a FG with a group of Brewers/CSWs in Rehabilitation in KRC)

6.3.3.2 **Khat chewing** (as volunteered by participants)

- Although most khat users (Somalis and Ethiopians) rarely drink alcohol, a few combine khat chewing with drinking and are thus exposed to all the sexual risk factors (e.g. unprotected sex, multiple sexual partners) of the latter.

Quotes on khat chewing and risky sexual practices

“There is a type of miraa called “Mkoka”, when used increases libido. The other type called “giza” leads to loss of interest in sex” (16-yr old Ethiopian female during FG with Ethiopian Community Group Leaders)

“Female miraa chewers have been known to move around at night looking for males to buy the drug for them, and this encourages sexual exploitation and prostitution.....Some women welcome men to her house in order to obtain money to buy miraa” (*FG with Mental Health Assistants*)

“Some people become sexually aroused and look for women for sex while most loose interest in sex.....If a miraa chewing man fails in his sexual responsibility to his wife, she may seek for divorce or look for another man outside” (*FG with Somalian Community Group Leaders*)

”When people take miraa with alcohol, it can lead to promiscuity but miraa chewing alone does not. However, those who are addicted to miraa can do anything to get miraa including prostitution or attacking people” (*FG with Ethiopian Community Group Leaders*)

6.3.3.3 Injecting drug use practices

- Two of the current drug users interviewed independently volunteered information regarding a small group of injecting drug users in KRC. One of them said:

“Only valium is injected by Somali Bajuns (coastal people). There are about 15 of them, only males. They buy the ampoules of valium from a private clinic in the camp called XY. The injection plus the syringe/needle costs 300 KSh.. The clinic owner gets the drug from Nairobi. They go to the bush to inject as they don’t want anybody to see them. They take little quantity to feel high. They sometimes help each other to inject but they always use new needles and syringes. They don’t share needles. To get the money to buy the drug and needles, some sell their rations and some “do business”. After injecting, they use bhang. I know them very well as we used to take drugs together. They don’t draw valium from the same ampoule. Each own buys his own and some buy up to three ampoules. I have a friend called F who was injecting a mixture of piriton, diazepam and gentamycin. He started gradually until he became fully dependent on these injectables. F later developed psychiatric problem and had to be treated in Mathare Psychiatric Hospital, Nairobi” (*28- yr old Somali current drug user*)

Please note: It was not clear why some IDUs choose the combination of drugs they inject (e.g. piriton, diazepam and gentamycin) and the psychological and/or physiological effects such mixtures have on them. However, it should be noted that the use of such non-medically prescribed drug combinations could give rise to dangerous and sometimes fatal reactions.

The other said:

“I know up to 10 people who inject themselves with D5 (valium) to get high. Sometimes, they also inject heroin and cocaine but we don’t know where they get these from, maybe Mombasa. They inject when they have good money but at least twice in every week. They inject as group, and they sometimes help themselves to inject. They inject mostly in the bush or in one of their homes. Everyone comes with his own ampoule. They feel high and energetic after injecting. They are mostly men, but sometimes women. I know of someone who died after injecting “brown sugar” (i.e. heroin) and thereafter smoked bhang and sniffed substances” (*A 30-year old Somali current drug user*)

Other notable quotes on IDU

“We have heard of cases of Somalians and Ethiopians who inject themselves. But since I have been here since 2003, there have been no cases of arrest” (*District Officer, Kakuma*).

“Some of us have found used needles and syringes along the “laga” (i.e. River Tarash) when we go to fetch water” (*A female brewer/CSW during FG with Brewers/CSWs from the Local Community in Rehabilitation*)

Please note: It was not clear from the above quote where the needles and syringes come from. It is possible that these were products of IDU practice perpetuated along the river. On the other hand, the injecting equipment could have been used and dumped in the river by operators of illegal chemists or other unknown people and then washed onto the bank of the river at some point.

6.3.4 Socio-economic problems (e.g. households selling essential food and non-food items, drug/alcohol trafficking, drug-related sex trade)

- Diversion of family resources: (i) households use food rations for production of traditional brews (ii) sell food rations to other individuals in KRC and local community for brewing purpose (iii) money meant to look after the family is spent on buying drinks or miraa (iv) indebtedness from buying alcoholic drinks or miraa on credit usually from many customers
- Inability to engage in income generating activities for the benefit of the family when suffering from complications of alcoholic consumption or khat chewing
- Economic crises associated with one or more members of the family contracting HIV through drug related sex trade and suffering from its multiple consequences
- Economic crises caused by the bread winner of the family being incarcerated or paying heavy fine as a result engaging in illegal drug activity (e.g. chang’aa brewing)
- Loss of employment or inability to hold down any job as a result of drinking or other forms of drug use

6.4 Affected populations and settings

6.4.1 Groups and settings in which problem substance abuse is occurring

- Some members of all the community groups (both genders, young and old)) in KRC and the local community suffer from elements of problem substance abuse
- The commonly used substances are available in various “hot spots” throughout the camp and the local community (See Appendix 3 for observation maps)
- Some people, including women, become problem drinkers in view of their daily engagement in the business of producing and selling the traditional brews. They regularly taste the drinks for quality during the brewing process and share drinks regularly with their customers.
- Many refugees in the camp (including women, children, ex-combatants) have gone through major traumatic experiences in their home country. Some of these use drugs excessively to block out the distressing feelings
- There is a core group of poly drug users in the camp, who appeared to be dependent on most of the substances to varying degrees (See Appendix 1, KI interviews Nos 4 – 11)

6.4.2 Groups using alcohol and other substances

- Due to a breakdown of traditional family control in many communities in the camp, many young people tend to indulge in experimental and recreational drinking
- Other young people, of both genders use alcohol and other substances in the prevailing setting of unemployment, idleness, dependency, frustration, helplessness and hopelessness in the camp
- Some young people who have access to money remitted to them by relatives abroad may want to show off by financing drinking sprees for their peers
- Socialised group drinking in bars is very popular in both KRC and the local community. This occurs round the clock
- Many community groups in the camp and the local community also use alcohol during cultural festivities and ceremonies
- Khat chewing is common among some occupational groups (long-distance drivers, night guards, students) who want to keep awake and alert for long hours
- The use of hypnotosedatives (valium or D5) is reported to be common among Khat chewers who have problems with getting to sleep

6.4.3 Groups affected by others’ substance use

- Women brewers and commercial sex workers
- A large population of idle unemployed youths

- Children
- Dependent drug users suffering from various complications
- Students
- Families suffering from effects of substance abuse in family members

6.4.4 Factors that protect individuals and communities

- Prevailing community control systems, e.g. unmarried young people (males specifically) are not allowed to drink in most Sudanese communities
- Attendance at educational or skill building institutions or programmes
- Engagement of large number of youths in positive sporting and communal activities. Unfortunately, due to declining resources, sponsored sporting events is on the decline
- Religion appears to be a strong factor. There is a strong presence of both Christianity and Islam in the camp as well as the local community. Both religions preach against substance abuse
- Periodic interdiction activities of the Security agencies in chang'aa production sites, although this does not appear to be effective
- On-going AIG and other poverty alleviating programmes
- Other campaigns and programmes on social and health issues, which have cross-cutting effects on substance use and/or its complications (e.g. HIV , Gender-based violence, Peace Initiatives etc)
- On-going repatriation exercises are giving hopes to many that there may be some light at the end of the tunnel after all

6.5 Existing resources

6.5.1 Food, water, shelter and health services

6.5.1.1 Food

- WFP continues to provide and manage the distribution of relief food to over 94,000 refugees in Kakuma.
- Food distribution is done on a bi-monthly basis; an average of 1600Mt of various food commodities is distributed to the refugees on a monthly basis.
- WFP food basket for the General Food Distribution comprises of: maize grain, wheat flour, sorghum, pulses, CSB, oil and salt.
- In addition, WFP runs supplementary and school feeding programmes for malnourished children below 5 years, pregnant women in their third trimester and lactating women.
- WFP also provides general food ration to the in-patients.
- LWF provides wet feeding and dry rations for new arrivals.

6.5.1.2 Shelter

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- There are major problems around provision of shelters to refugees
- 1,139 shelters were constructed
- 800 vulnerable women are in need of shelter
- Approximately 10,000 new arrivals will be in need of approximately 3,000 new shelters. In addition 16,110 houses that need rehabilitation/replacement to mitigate hardship for 23,000 refugee households in 2006.
- Additional 2,000 units of shelter for urban refugees/referrals from Nairobi to camp under GOK encampment policy are required.
- The problem of shelter being addressed through relocation to vacated shelters and the provision of construction materials to households in order to construct/rehabilitate their own shelter/s by them-selves. However, refugees are hesitant to relocate due to security concerns.

6.5.1.3 Health facilities (These are the currently available health programmes run by IRC)

- A 90-bed primary care hospital with a minor operating theatre, out-patient department, a male and female inpatient ward, TB ward, laboratory, pharmacy and nutritional ward.
- Four first-level health care clinics providing curative outpatient services, ante- and post-natal care, an immunization programme (EPI), family planning services, and nutritional programmes for refugees and local population.
- A Nutrition Programme comprising of two Therapeutic Feeding Centres, and a 24-hour emergency feeding centre.
- An HIV programme focusing on Voluntary Testing and Counselling (VCT), Sexually Transmitted Infection (STI) syndromic management, surveillance, blood safety and precautions, home based care, TB treatment and control, early management of opportunistic infections and preventing mother-to-child transmission (PMTCT).
- A Community Outreach Programme focusing on preventative health care and education. The team includes Community Health Workers (CHWs), Traditional Birth Attendants (TBAs), EPI Vaccinators and Mental Health Workers (MHWs).
- A community-based Sanitation programme covering the areas of solid, liquid and human waste control, vector control, food quality and animal slaughter inspection, burial of the dead, plastic and waste paper recycling, and hygiene promotion and education.

6.5.2 Functioning community and cultural institutions

- There are well established community and cultural institutions organised along ethnic lines in KRC
- Community and cultural groups are also well established in the local community

- The UN and service agencies implement their programmes through well established cooperation and collaboration with the community and cultural institutions

6.5.3 Health, psychosocial and community services (including substance abuse services and self-help groups or associations of ex-users, if any)

- Community Services Unit of UNHCR SOK conducts workshops for community leaders on community participation and mobilization with emphasis in organization, power-sharing, self-support and gender sensitivity. It also supports community initiatives through micro finance and trained on business management.
- There are in addition well established community services run by the different service agencies – IRC on health and HIV , NCCK on Reproductive Health and LWF on Camp Management, Food distribution, Education (Pre-School, Primary and Secondary), Peace education, Water, and Community Services
- Drug and alcohol abuse prevention talks are held occasionally with community groups within the context of the other community programmes implemented by the UN and the service agencies. However, there are no dedicated substance abuse programmes and no self-help substance abuse groups in KRC or local community

6.5.4 Safe spaces for those at risk of alcohol and substance related violence

- UNHCR Protection Unit runs a “Protection Area”, a safe space located near the Police Station, Kakuma for refugees who are especially at risk of violence of any type including severe gender based violence and those related to alcohol and substance abuse. The space can take up to 60-90 people.
- There is also a “Safe Haven” run by Jesuit Refugee Services (JRS) for top security cases, mainly females and children. People are kept there only for a short term, maximum of six weeks and are then referred for help elsewhere.

6.5.5 Educational, recreational and employment opportunities (if any)

6.5.5.1 Educational

- There are 6 Pre-Schools, 24 Primary Schools and 5 Secondary Schools in KRC
- The total enrolment of children in schools represents 63.7% of school age children between 5 -25 years. The enrolment breakdown is as follows: (i) Pre-School 5,771 (2,961 boys and 2,810 girls); (ii) Primary school 22,219 (15,998 boys and 6,221 girls) and (iii) Secondary school 2,981 (2, 619 boys and 362 girls).
- Upper primary boarding school for girls constructed by funds from Angelina Jolie opened in June 2005.

6.5.5.2 Recreational

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- LWF runs age-based category sports leagues in football, basketball, volleyball and netball.
- There are 1341 teams of which 188 are female teams. A total of 4595 have been registered in girls activities. A total of 304 (251 male, 53 female) physically challenged persons participate. However, the number of registered teams and participants in the past year has been dwindling due to termination of funding by two major funding partners (See KI interview with Mr Omondi, LWF Youth Protection and Development Officer)
- Competitions are organized among the refugees as well between refugees and surrounding community to promote peaceful co-existence
- Sports programmes are organised for the physically challenged especially the amputees. There is a physically challenged basket ball team
- Special sports competitions are organised for girls and women in order to change attitude with regard to how the community perceives the female gender.
- LWF also runs in-door sports facilities such as dominos, cards, scrabble and these are frequently used by the disabled and older people in the community.

GO, Youth Protection and Development Officer, LWF, summarised the problems of dwindling resources for sports activities in KRC and SC as follows:

- Before, sports programmes used to be funded by “Right to Play”, a Canadian – based sports humanitarian organisation. They had only a 3-year contract. Cultural activities were funded by “Wakachai” Project from Japan. Both of these projects have no funds at the moment. This means we now can only run activities that have no financial implications.
- Compounding this funding problem is the high turnover rate of refugee staff. Trained peer educators have either been resettled to places like USA, Australia or Canada or have voluntarily gone back to Sudan. Some are no longer motivated to serve as there are no educational (e.g. advanced training) or material incentives (e.g. T-shirts) for them
- There are about 1050 registered teams now in the camp down from 1500 last year due to lack of sports equipment
- Last year, there were 37,000 active youths in sports, but the number is currently 28,000 and is likely to further decrease
- GO is worried that the youths dropping out of sports are likely to be engaging in less productive and socially unhealthy activities.

5.5.5.3 Employment Opportunities

- Refugees cannot be “fully employed” in view of their refugee status. However, the skilled ones are being engaged by service agencies and paid “incentives”
- Refugees are trained in different skills and involved in the revolving fund project that primarily benefits women, youth and vulnerable men.

Substance Use and HIV vulnerability in Refugee Camp and Surrounding community in Kakuma, Kenya

- About 4500 refugees have been trained of whom 250 are employed by NGOs in the camp
- In 2005, 595 vulnerable individuals issued with loans for Income Generating Activities (IGA)
- Another AIG programme is the NCCK-implemented “Vulnerable Women’s Project” which started in October 2005. This programme targets women brewers and/or commercial sex workers, who are grouped together in tens and given grants to embark on small scale projects. Thirty-six of such groups were in operation as at the time of this assessment, 22 in the camp and 14 in the surrounding community.
- The Kakuma Laundry Soap Project is the most successful refugee IGA run by refugees. The soap factory supply UNHCR with soap which is distributed to the refugee.
- There are a number of successful self-reliance projects managed by the refugees themselves such as the women catering services groups, tailoring, carpentry, shops and restaurants.

DE, Social Worker NCCK gave the following details on the “Vulnerable Women’s Project”

- Started in October 2005 with 8 women (CSWs/Brewers) who were given 8000 KSh to start alternative business. These women proved to be very “strong” and managed their business well. The returns on the grant was 17,230 KSh within a 5-month period (October 2005 to February 2006)
- Following the above pilot study, NCCK has recruited 133 women in the camp and 152 women in the surrounding community. It has held a total of five workshops, three in the camp and two in the surrounding community.
- NCCK would normally approach the chairladies of the Women Groups to help in the identification and selection of potential members.
- NCCK has trained 12 peer educators (former CSWs), 5 in the camp and 7 in the surrounding community. NCCK then conducts HIV and Reproductive Health training for three days for the women selected to join the scheme. Topics covered include anatomy and physiology of the male and female organs, STIs, HIV, family planning, income generating activities, finance management and record keeping. NCCK then comes up with an Action Plan on life skills, negotiation for safer sex, and building a bridge from information to behavioural change.
- NCCK trains 55-60 people at once. It then gives them time to work together in groups of 10 and choose their officials namely chairlady, secretary and treasurer. They also pick a name for the group. NCCK then meets individual groups after two days to give them the grant.
- There are currently 36 groups (each of 10 members) in operation, 22 in the camp and 14 in the surrounding community.
- Conditions attached to the grant are: (i) Ownership belongs to the group and not an individual; (ii) It is agreed that NCCK can visit them in the market place and at home; (iii) No member of the group should continue in the business of CSW and

brewing. Whoever does should immediately be excluded to be replaced by another vulnerable woman; (iv) Profit should be shared equally in a fair and transparent manner; (v) to benefit from the shares, a member must be seen to be fully participating in the trading.

- NCCCK evaluates the income of the grant on a fortnightly and monthly basis.
- Factors militating against good income at the moment include: (i) The grant amount is quite limited. If increased, the returns will also increase; (ii) The women cannot compete favourably with bigger businesses in the market; (iii) There are currently no sheds or structures for the women and they put their stuff on the bare ground; (iv) No transportation (bicycle) to transport their good to and from the market.

Below are some quotes made by brewers/CSWs in KRC and the local community being rehabilitated on the prospects and challenges of the “Vulnerable Women’s Project” so far:

- “People now respect us”
- “We have more money and are able to give our children more balanced diet than before”
- “Domestic violence has reduced”
- “We feel better being able to negotiate safer sex”
- “We are happy since NCCCK has taught us a lot concerning HIV and Reproductive Health. We have been delivered from the claws of HIV and alcohol, which were risking our lives and that of our children”
- “The money NCCCK gives us is really helping us. Compared to the time when we used to sell our body and receiving gender-based violence, we can now feed our children in a morally acceptable way. We don’t want to go back to Sudan and we would like to resettled elsewhere in the world apart from Sudan”
- “Drinking has reduced. A habit once formed is difficult to stop, but drinking and sex work have reduced”
- “We now spend less money on alcohol, but now spend more money on ourselves, our children and household expenses”
- “We feel much happier now as we are more sober. If you have come before, you would have met us drunk by now (i.e. at 10.00 a.m.)”
- “Those of us who are HIV positive used to suffer from discrimination and stigmatization, but now, we are more accepted”
- “NCCCK has brought us from darkness to light. Some of us have lost our husbands from HIV. We have many children and we don’t know their HIV status. From the training received from NCCCK, we now understand better HIV issues and we don’t want to spread it to other people”
- “The grant is small, hence the profit is small, and cannot still cater fully for our family needs. This is leading us into temptation to continue drinking and sex work. Although we are now more careful about HIV and the impact on our children. If the programme is scaled up, we will forget about CSW and drinks”
- “We cannot compete with the bigger businesses in the market”

- Lack of shelter to place our goods. “We have to pay for rented spaces, and this further reduces our profit margin”

6.5.6 CSW in KRC and SC

- There are no hard core data on the profile and activities of CSWs in both communities. It is generally known that CSWs do exist in both communities, but their activities would appear to be quite discrete particularly in KRC
- However, NCKK, working through women groups under the “Vulnerable Women’s Project” in both communities, has initiated AIG programmes for CSWs, most of whom were also brewers (For further details on this project see Appendix 1, KI interview No 15 and Section 6.5.5.3 above)

6.5.7 HIV in KRC and SC

- **KRC:** According to UNHCR Kenya Country Report for 2005, the only HIV data available on the camp population is that collected via Voluntary Testing and Counselling (VCT) services, which serve as the entry point to various programmes including Prevention of Mother-to-Child Transmission (PMTCT). The report indicates that PMTCT data were collected from January to December 2005 from the KRC. This shows that out of the 3,910 clients, 2,138 (54.7%) accepted to be tested for HIV and 31 (1.5%) were found to have HIV antibodies.
- **SC:** The influx of refugees and local nationals to Kakuma town is thought to have altered the population dynamics and increased the risk of HIV transmission. According to information contained in the report on “Behavioural Surveillance Surveys Among Refugees and Surrounding Host Population, Kakuma, Kenya” (UNHCR, 2004), a 2003 sentinel surveillance conducted in Kakuma indicated the HIV prevalence rate of 5% while the nearest national surveillance in Lodwar Town was 18%.
- The consultant gathered in the course of this assessment that a sentinel surveillance to collect a more comprehensive HIV data sets was going on in the KRC and SC since mid-July 2006.

6.5.8 Unmet need for substance use services

- There is no specially trained personnel (Focal Point) in any of the service agencies to implement and coordinate substance use issues in KRC and the local community

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- There are no specially designed programmes to manage the health and social complications of substance abuse in substance abusers and those indirectly affected
- There are no specially designed rehabilitation programmes or services for dependent individuals although such cases are being managed by the IRC mental health team
- Substance use prevention programmes or campaigns are not conducted in a regular, consistent or coordinated manner
- Very little IEC materials available on substance use issues

7.0 RECOMMENDATIONS

7.1 **The framework for the recommendations:** The following key findings of the assessment have formed the basis of the recommendations:

- a. Most commonly used substances in KRC and SC are the traditional alcohol brews (chang'aa: the distilled drink; busaa and kaada: the fermented brews). Of these, the one mentioned as being mostly associated with physical, medical and psychological adverse consequences is chang'aa;
- b. Although illegal by Kenyan laws, the brewing of chang'aa and the other traditional alcoholic drinks occurs on a wide scale in KRC (particularly among the Sudanese, Ugandans, Rwandans and Burundis) as well as among the local Turkana people;
- c. Brewing, selling and consumption of traditional alcoholic brews in KRC and SC has strong economic, cultural, social and psychological basis. Brewing was found to be the main means of livelihood to many families both in KRC and SC;
- d. Brewing and consumption of traditional alcoholic drinks was found to go hand in hand with commercial sex work in many instances. Evidence was obtained that such sex work, usually undertaken in a state of inebriation, generally involves unsafe sexual practices. Hence, this increases HIV vulnerability to women in particular and the society at large;
- e. The only currently available intervention for alcohol use in KRC and SC is the periodic Police raids involving the destruction of the brewing equipment and prosecution of arrested brewers. This measure was described as being generally ineffective even by the law enforcement officers interviewed, and brewing continues unabated;
- f. Chewing of khat (miraa) was found to be common largely in the Somali communities and to some extent in the Ethiopian community in the camp. Although not illegal by Kenyan laws, interviewees identified several physical, psychological and social adverse consequences of khat chewing. Some khat users were reported to use sleeping tablets (mainly diazepam or D5) to help them counter the state of poor sleep induced by khat chewing;
- g. Limited information was obtained on a small group of drug users who discretely inject mainly diazepam but also other injectable drugs in different combinations within the context of their multiple drug use. There was no evidence of sharing of injecting equipment or solutions or reuse of needles among the group. The information obtained in this assessment would suggest that IDU practice was not a major source of

concern as a possible spread of HIV infection in KRC and the SC. However, more time is needed to fully investigate the extent of the IDU practice in both communities;

- h. The use of “bhang” (cannabis, marijuana) was reported to be done discretely by youths regarded as “criminal elements” and some CSWs
- i. The assessment did not find any evidence of heroin or cocaine use or injecting of same in KRC and SC;
- j. Possible factors identified as contributing to substance abuse and increased HIV vulnerability in KRC and SC, and which could form the basis of the recommendations, include: (i) economic – brewing as the sole means of livelihood. Many women practise hidden prostitution alongside their brewing business; (ii) harsh environmental conditions not conducive to farming; (iii) cultural – e.g. pervasive drinking has always been the norm among the Sudanese communities even in their home countries; (iv) psychological stressors from current refugee status and past traumatic events; (v) predominance of youths with 2 in every 3 refugees being aged between 13-26 years; (vi) reduced or absent parental influence and cultural control on the youth supervision; (vii) joblessness and idleness among many; (viii) long-term dependency on subsidies from international organisations as a result of refugee status in KRC; (ix) feeling of hopelessness and helplessness arising from lack of engagement and the refugee status.
- k. The assessment has revealed that the following groups that use alcohol and other drugs should be the focus of the recommendations: (i) young people, including students and out-of-school youth; (ii) adults, both males and females; (iii) female brewers many of whom engage in commercial sex work with increased vulnerability to HIV infection; (iv) professional groups (long distance drivers, night guards, students) who engage in khat chewing and could suffer a higher risk of the adverse consequences; (v) a small “hidden” group of IDUs who need to be further investigated and targeted for harm reduction interventions
- l. Recommendations also need to target women, men and children who are indirectly affected by the adverse consequences of alcohol and other drug use such as violence, neglect, family separations
- m. The assessment revealed the following factors that could militate against the implementation of any recommendations regarding substance use and HIV vulnerability in KRC and SC: (i) absence of trained personnel in any of the service agencies to implement and coordinate substance use and HIV related issues; (ii) absence of any dedicated interventions regarding substance use and HIV in KRC and the SC. The few substance use

prevention programmes were not conducted in a regular, consistent and coordinated manner; (iii) no evidence of availability of IEC materials on substance use and HIV in KRC and SC

7.2 **Guidelines:** The following relevant recommendations from the draft Action Sheet on Substance Use from the IASC Guidelines for Mental Health and Psychosocial Support in Emergencies have been used as guidelines for the recommendations

a. **Manage withdrawal and other acute problems**

- Clinics and hospitals should develop protocols for the management of withdrawal, intoxication, overdose and other common presentations as identified in the assessment.
- Health agencies should train and supervise health workers for the management of withdrawal or other acute presentations, together with provision of sufficient medication including benzodiazepines for alcohol withdrawal. Community agencies should train and supervise community workers in the identification, initial management and referral of common acute presentations such as withdrawal.

b. **Prevent transition to harmful and dependent use**

- Health agencies should train and supervise health workers on:
 - non-medical approaches to dealing with acute distress
 - rational prescription of benzodiazepines and (where available and affordable) use of non-addictive medication alternatives;
 - detection of hazardous, harmful and dependent substance use;
 - brief interventions to motivate people at risk of harmful or dependent use to reduce substance use (see Key resources below);
 - identification, treatment and referral of mental illness
- Agencies should discuss use of psychoactive substances in stress management training of health and other workers (see Key resources below for guidance on self-help strategies).
- Agencies should engage both men and women from the community in prevention and response, as well as members of any existing self-help groups or associations of ex-users.
- Community agencies should train and supervise community workers to identify and target at-risk groups for additional support (e.g. survivors of violence, families of dependent substance users).
- The responsible emergency response coordinating body should facilitate that education facilities, recreational activities and non-drug-related income generating opportunities are re-established as soon as possible

c. Facilitate harm reduction interventions in the community

- Agencies should provide condoms at sites where substance users congregate, such as alcohol sales points, with the support of community leaders.
- Provide risk reduction information to targeted groups (e.g. concerning injection drug use and unsafe sex).
- Ensure access to safe injecting equipment for injection drug users, if indicated by assessment.
- Conduct substance use and harm reduction awareness sessions among male and female community leaders, as appropriate. For example, in some settings interventions to reduce harm from heavy alcohol have included teaching safe distillation methods for local brew, restricting sales hours, requiring payment at time of serving, and agreeing on no weapons on premises where alcohol is sold or consumed

Key resources

1. Inter-Agency Standing Committee (2003). 7.5. Ensure IDU appropriate care. In: *Guidelines for HIV/AIDS Interventions in Emergency Settings* (pp.76-79). Geneva: IASC.
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2. WHO (2001). *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care*. Geneva: WHO.
http://whqlibdoc.who.int/hq/2001/WHO_MS_DMSB_01.6b.pdf
3. WHO (2003). *Brief Intervention for Substance Use: A Manual for Use in Primary Care*. Draft Version 1.1 for Field Testing. Geneva: WHO.
http://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf
4. WHO (2003). *The Alcohol, Smoking And Substance Involvement Screening Test (ASSIST): Guidelines for Use in Primary Care*. Draft Version 1.1 for Field Testing. Geneva: WHO.
http://www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf
5. WHO (2003). *Self-help Strategies for Cutting Down or Stopping Substance Use: A Guide*. Draft Version 1.1 for Field Testing. Geneva: WHO.
http://www.who.int/substance_abuse/activities/en/Draft_Substance_Use_Guide.pdf
6. Costigan G, Crofts N, Reid G (2003). *The Manual for Reducing Drug Related Harm in Asia*. Centre for Harm Reduction. Melbourne.
http://www.rararchives.org/harm_red_man.pdf

7.3 Recommendations based on Sections 7.1 and 7.2

(I) Individual Level

In view of the finding of lack of dedicated services for the early identification, treatment and rehabilitation of individuals directly or indirectly affected by substance abuse, it is recommended that IRC (the health agency in KRC) should train and supervise health workers on:

- non-medical approaches to dealing with acute distress
- rational prescription of benzodiazepines and (where available and affordable) use of non-addictive medication alternatives;
- detection of hazardous, harmful and dependent substance use;
- brief interventions to motivate people at risk of harmful or dependent use to reduce substance use;
- identification, treatment and referral of mental illness
- a counselling service to offer help and support to individuals in the community (spouses, children and relatives of dependent individuals) who are indirectly affected by the effects of substance abuse

(II) Community Level

i) Increase community knowledge and awareness on substance use and HIV

- In view of the current low level of awareness and information on substance use issues in KRC and the local community, intervention should focus on strengthening the provision of authenticated and locally generated and relevant information through public awareness campaigns, distribution of IEC materials, films etc.
- Established community health programmes and other services, sports programmes and competitions, schools, AIG activities could serve as entry points for such community interventions

ii) Strengthening the economic base of individuals and groups

- This assessment has revealed that the brewing of chang'aa and other traditional liquors is strongly tied to the economic survival of the brewers
- There is need therefore to support and strengthen existing AIG groups, and also fund the establishment of more groups.
- New AIG programmes could be established in horticulture, grinding mills, production of laundry soaps

iii) **HIV prevention programming**

- This assessment has revealed the very close connection between brewing, sale and consumption of alcohol and linkages with commercial sex work as well as high risk sexual practices. This increases the vulnerability of HIV infection to brewers, CSWs, their clients as well as their spouses/partners to HIV
- HIV programmes should therefore be set up to specifically target brewers and CSWs
- Such programmes should promote the use of condoms, regular medical screening and enhanced HIV awareness.
- A service should be specifically established to give brewers and CSWs access to health care and regular screening for STIs and HIV. However, such services should be mainstreamed into existing ones to avoid stigmatisation of the group
- Brewers and CSWs should be trained on family planning issues
- HIV programme should also target the men (consumers of alcoholic brews and khat and customers to the women brewers/CSWs). Such programmes should cover general health education, screening and treatment for HIV and other STIs.

(III) Structural (Policy and Environment) Level

i. Capacity Building

- Two models have been proposed to develop the capacity to establish, implement, monitor and evaluate substance use and HIV interventions in KRC and SC;
- The first model proposes the recruitment of an international staff with the title Substance Abuse Focal Point (SAFP) to serve within a service agency for 1-2 years. Here, the SAFP will work closely with UNHCR, the service agencies, government and non governmental agencies to formulate and implement substance use and HIV programmes. The SAFP will develop the capacity of service agencies, the security agencies, government and non governmental organisations, individuals and groups in the community through specially designed training and activities on substance abuse. Target groups for training should include CSWs, youths, group leaders, teachers, Police officers. External technical oversight will be provided for the SAFP by an international consultant who would visit and review the project periodically.
- The other model proposes the periodic recruitment of a Consultant to spend about 4 weeks in KRC and SC annually and implement essentially similar capacity building and programming functions of the SAFP as listed above. Proponents of this model have noted that appointing a full time SAFP would lead to vertical programming. Secondly, they have pointed out that obtaining

approval for funding the SAFP post may be difficult to achieve in this period of dwindling resources;

- The consultant is of the opinion that further discussion is needed among the funding bodies and relevant agencies on which of the above models (or other possible ones) would be most workable and effective in the short and long term. An undisputable fact is that there is total lack of capacity in KRC and SC on substance use and HIV issues, and this problem needs to be addressed urgently as the basis for further interventions.

ii. Collaboration with other programmes

- Interventions should be scaled up through linkage with on-going or planned projects around food security, HIV, human development etc
- Collaboration should also be established with intervention programmes of the National Anti-Drug Abuse (NACADA), the National Aids Control Committee (NACC) and other relevant governmental and non governmental agencies

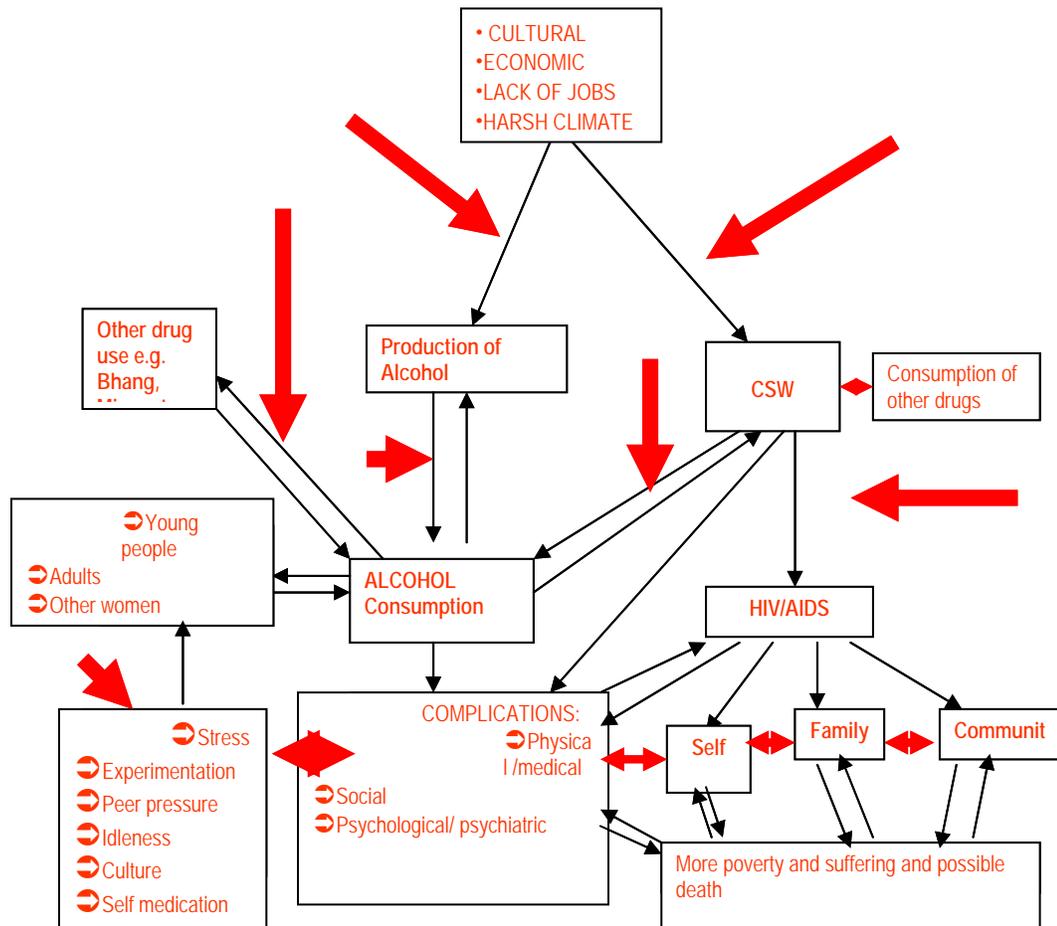
iii. Addressing law enforcement issues

- The findings of this assessment indicate that the current interdiction efforts (periodic raids, destruction of apparatus and implements, arrests and prosecution) being implemented by the security agencies on chang'aa production is not effective. This is obvious as chang'aa brewing continues very much in the open in many parts of KRC and local community visited by the consultant. A second source of concern is the activity of some illegal clinics and chemists, where IDUs obtain their needles, syringes and injectable drugs. Some interviewees have therefore expressed the need to strengthen interdiction efforts through the establishment of a "Special Task Force" comprising the Police, UNHCR Security Unit, UNHCR Protection Unit, community services and community groups.
- However, another school of thought expressed by other respondents is that increased interdiction measures would only serve to drive substance use underground, lead to price increases, and further increase the risks associated with sourcing for and using the substances. This school of thought would therefore not support the strengthening of interdiction measures. Rather, it has been proposed that IEC techniques should be used more to sensitize the refugees and the local people on the multiple adverse consequences of alcohol and substance use.
- This issue needs further discussion among stakeholders. However, the consultant would recommend "more sensitization" rather than "more interdiction"

7.3.4 Further Assessment

- Information collated from a few active drug users interviewed in this assessment indicate the presence in KRC of a few hard-core substance abusers who engage in the practice of injecting of injectable substances (mainly D5 or valium) within the context of poly drug use. However, limited time did not allow for full investigation of this practice. More surveillance and assessment work is needed to track the details of on-going practices and monitor the trends both in KRC and the local community.
- The use of bhang and its multiple effects could not be fully investigated in this study as interviewed users were very reluctant to volunteer information within the available time. More time and work is needed in this area

**FIG 5: SUBSTANCE ABUSE AND HIV VULNERABILITY:
THE VICIOUS CYCLE AND
POSSIBLE INTERVENTION POINTS**



8.0 ACTION PLAN

8.1 Process for Action Planning

- 8.1.1 During the process of data collection, action planning discussions were held with KI interviewees and during FG discussions. Attempts were made by the consultant to check what the interviewees considered as feasible, culturally relevant and potentially helpful interventions. Their responses, details of which are highlighted in Appendices 1 and 2, were duly considered in subsequent AP meetings.
- 8.1.2 The AP has also taken due cognizance of the views expressed and recommendations made at the debriefing meetings the consultant held with the following individuals and groups at the completion of data collection: (i) UNHCR focal point (Dr Njogu) and the Field Officer (FO) Kakuma, Dr B Muhindo; (ii) Service agencies focal points (IRC, LWF, NCCCK, Film Aid International); (iii) UNHCR Heads of Unit; and (iv) In Nairobi: UNHCR staff, representatives of UN agencies, service agencies, governmental and non governmental organisations
- 8.1.3 A draft AP table was shared with the FO (Kakuma) and the service agencies. The plan is for the group to further deliberate on the AP and to produce a final AP that can be implemented in 2006 and later in 2007 and 2008.

8.2 Priority interventions

8.2.1 Capacity Building

- (i) **Aim**
- To provide capacity to service and implementing agencies in implementing substance abuse programmes.
- (ii) **Objectives**
- Two models being proposed (see full discussion on this in Chapter 7).
 - The first model proposes to recruit a Substance Abuse Focal Point (SAFP) to work from within a service agency for 1-2 years to coordinate substance use programming and interventions in KRC and SC
 - The second model proposes the recruitment of a Consultant to carry out similar functions as the SAFP on a periodic (perhaps annual) basis
 - Further discussion needed to adopt one model
- (iii) **Outputs** (Target numbers to be determined yearly for 2007 and 2008)
- Collaboration and coordination of the planning and implementation of substance use programmes with UNHCR, service agencies, governmental and non-governmental agencies, and community based groups enhanced
 - Substance abuse issues mainstreamed into other health and social programmes being implemented by other agencies and organisations

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- Specified number of individuals, service agency focal points, community and youth groups, teachers, security staff (Police, UNHCR security) and other relevant individuals and groups trained on substance abuse issues
 - The establishment of specific services for individuals and groups directly and indirectly affected by substance abuse (e.g. early identification and treatment services for drug dependent people, counselling and support services for relatives of dependent people, AIG services for women brewers/CSWs etc) facilitated.
- (iv) **Outcomes**
- Public awareness and educational activities on various aspects of substance abuse delivered to targeted individuals and groups
 - Collaboration with other programmes on substance abuse issues facilitated and increased
 - Identified individuals and groups and trained on substance abuse issues
 - Specific services established for individuals and groups
- (v) **Target Populations**
- UN and service agencies, governmental and non-governmental organisations
 - Youths
 - Community groups
 - Security agencies
 - Women brewers/CSWs
 - Other vulnerable men and women
- (vi) **Responsible agencies**
- UNHCR to provide the funding allocation for the recruitment of either the SAFFP or a Consultant recruited periodically
 - Close collaboration will be needed between UNHCR and the 3 main service agencies (IRC, LWF, NCCCK)
- (vii) **Resources needed**
- Funding allocation for the post of the SAFFP or the periodic recruitment of a Consultant
 - If SAFFP model is adopted, funding will be needed for recruitment of external consultant for technical oversight
 - Logistical support for either the SAFFP or the visiting Consultant
- (viii) **Acceptability**
- This need to increase capacity was accepted as very basic and urgent in all the debriefing meetings
- (ix) **Obstacles**
- All the funds highlighted in (vii) need to be identified and agreed

- (x) **Possible sources of support** –subject to further discussion and agreement
- UNHCR
 - Service agencies
 - Established community groups

8.2.2 Empowering individuals and groups with information on substance abuse

- (i) **Aim**
- To empower the public with relevant information to enable people to make informed choice on substance abuse
- (ii) **Objectives**
- To provide relevant information to individuals and groups in KRC and SC on all aspects of substance abuse through culturally appropriate and acceptable communication channels
- (iii) **Outputs (Number per year to be determined by service agencies)**
- Sensitisation trainings and workshops held for adolescents, brewers, active substance abusers, bar and lodging owners etc
 - Performing Theatre (PET) Group to create awareness through dramas
 - Awareness created among men through in-door competitions (e.g. Bao tournaments)
 - Awareness raising sports competitions organised all year round
 - Awareness disseminated through printed materials (banners, bill boards, posters, and fliers) and audio-visual materials (e.g. Daytime video screening, Open air evening films and video based workshops)
- (iv) **Outcomes**
- Improved knowledge and awareness on various aspects of substance abuse improved among individuals and groups in KRC and SC
 - Reduced substance use related morbidity and mortality
 - Reduced alcohol and substance use related violence
 - Reduced alcohol and substance use related illnesses
- (v) **Target Populations**
- Students in school
 - Out-of-school youth
 - Teachers
 - Security staff
 - Sports men and women
 - Vulnerable adults (unemployed males, women brewers/CSWs)
 - Active drug users

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- Community groups
 - Religious leaders
- (vi) **Responsible agencies**
- IRC, NCK, LWF, Film Aid International
 - UNHCR (SOK) Community Service Unit
- (vii) **Resources needed**
- Trained personnel to organise and deliver the workshops
 - Trained actors/actresses to develop local and culturally relevant video films on substance abuse
 - A community-based coordination group needed to ensure the correctness, quality and appropriateness of information being disseminated through the different channels
 - Transportation for outreach programmes
- (viii) **Acceptability**
- Almost all KI interviews and FGDs recommended this intervention highly
- (ix) **Obstacles**
- None anticipated
- (x) **Sources of support**
- All service agencies
 - UNHCR Community Services Unit
 - NACADA
 - Service agencies especially NCK
 - Women community leaders

8.2.3 HIV Prevention Programme for brewers and CSWs

- (i) **Aim**
- To prevent HIV transmission among brewers/CSWs in KRC and SC
- (ii) **Objectives**
- To reduce the vulnerability of brewers and CSWs to HIV and other STIs
 - To enhance the general health of brewers and CSWs
- (iii) **Outputs** (Number to be determined by relevant agency)
- Reproductive health trainings and workshops organised (emphasis on condom use) for women brewers/CSWs
 - Routine general health checks (with special attention to screening for HIV, syphilis and other STIs) organised for brewers/CSWs
 - Treatment facilities for HIV and other STIs provided for brewers/CSWs
 - Family planning trainings organised

- (iv) **Outcomes**
 - Reduced prevalence and incidence of HIV and other STIs among women brewers/CSWs
 - Improved general health of brewers/CSWs
 - Reduced morbidity and mortality associated with brewing and sex work
 - Reduced number of abortions and unwanted children
- (v) **Target Populations**
 - Brewer/CSWs in KRC and SC
- (vi) **Responsible agencies**
 - IRC and NCKK
 - UNHCR SOK Community Services Unit
- (vii) **Resources needed**
 - Trained workers to conduct the reproductive health trainings
 - Equipment for screening for HIV and other STIs
 - Medications for treating AIDS and other STIs
 - Adequate supply of good quality female and male condoms
- (viii) **Acceptability**
 - This intervention is highly recommended by service agencies and acceptable to the women's groups interviewed
- (ix) **Obstacles**
 - Possibility that some women will continue to brew and be involved in unprotected sex work
 - High poverty level, hence need to mainstream this intervention into AIG programmes
 - Special care should be taken to avoid stigma that may result from the provision of the services to the brewers and CSWs as "separate and special" groups. This could be achieved by mainstreaming the services into existing ones.
- (x) **Sources of support**
 - UNHCR community services
 - Service agencies especially IRC and NCKK
 - Women community leaders

8.2.4 Establishment of special services for individuals or groups directly and indirectly by substance abuse

(i) **Aim**

- To provide medical, social and psychological support to individuals or groups directly or indirectly affected by substance abuse

(ii) **Objectives**

- To identify individuals or groups directly or indirectly affected by substance abuse in the community
- To provide counselling, treatment, rehabilitation, and follow-up services for individuals directly affected by substance abuse
- To provide counselling, security and social support services for individuals and groups indirectly affected by substance abuse

(iii) **Outputs**

- Establish a dedicated community outreach service for the early identification and prompt referral for treatment of individuals or groups (e.g. IDUs) becoming or already fully dependent on substances
- Establish a hospital-based service for the treatment and rehabilitation of such referred individuals and groups
- Establish a counselling, security and support service for individuals (spouses and children of established substance abusers) or groups (e.g. peer groups)

(iv) **Outcomes**

- Number of individuals and groups progressing to full dependence on substances or to more risky pattern of use (e.g. from smoking to injecting) reduced
- Morbidity and mortality in dependent substance abusers reduced
- Quality of life of dependent substance abusers improved
- Substance use related violence cases reduced
- A specified number of security services (“Safe Havens”; “Protection Areas”), counselling and support services provided for individuals and groups indirectly affected by substance abuse

(v) **Target Populations**

- Young people (experimenters) at the risk of becoming dependent on substances
- Fully dependent individuals
- High risk and hard-to-reach groups (e.g. IDUs)
- Women brewers/CSWs
- Relatives (spouses and children) of drug dependent individuals
- Vulnerable adult males
- Other vulnerable men and women

(vi) **Responsible agencies**

- IRC mainly
- Perhaps NCKK and LWF through cross-linkage of activities

(vii) **Resources needed**

- Trained personnel for the outreach, treatment and counselling programmes
- Transportation for outreach programmes
- Security for drug workers engaging with dangerous individuals or groups

(viii) **Acceptability**

- Highly accepted by service agencies, individuals and groups interviewed

(ix) **Obstacles**

- None anticipated

(x) **Sources of support**

- IRC
- UNHCR, Other service agencies
- Established community groups

8.2.5 Poverty alleviation among women brewers/CSWs

(i) **Aim**

- To reduce poverty levels and HIV vulnerability among women brewers/CSWs

(ii) **Objectives**

- To initiate new and strengthen existing alternative livelihood projects in KRC and SC

(iii) **Outputs**

- Give additional grants of 10,000 KSh to each of the existing 35 AIG groups
- Build one shelter and purchase two bicycles for each of the established 35 groups
- Establish an additional 15 groups (10 in KRC and 5 in the local community) and organise training workshops for them on reproductive health, micro financing etc

(iv) **Outcomes**

- Reduced brewing of alcohol by the women in the programme
- Reduced levels of sex work
- Increased level of “safe” sexual activity
- Reduced alcohol and substance use related violence
- Reduced alcohol and substance use related illnesses
- Evidence of improved income, self reliance and self esteem

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(v) **Target Populations**

- Women groups in RC/SC

(vi) **Responsible agencies**

- Primarily NCKK
- UNHCR SOK Community Services Unit

(vii) **Resources needed**

- Initial funds to be allocated in 2006, and project continued into 2007/8

(viii) **Acceptability**

- This intervention has high acceptability among the service agencies, brewers/CSWs interviewed, security agents and other people and groups

(ix) **Obstacles**

- Initial teething problems and low profit margins may discourage some of the women and tempt them into going back to brewing and sex work
- Fears have been expressed that some women may divert the grants to execute their personal projects or on non-AIG projects and that some may also use the grants to further enhance their alcohol brewing capacity. NCKK has built in strict checks and controls in their on-going AIG projects

(x) **Sources of support**

- UNHCR community services
- Service agencies especially NCKK
- Women community leaders

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