COUNTY GOVERNMENT OF MOMBASA

DEPARTMENT OF HEALTH SERVICES

SUSTAINABLE HARM REDUCTION BUSINESS PLAN 2021–2026

UNODC
United Nations Office on Drugs and Crime

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
CBO	Community-Based Organisation
CECM	County Executive Committee Member
COVID-19	Coronavirus Disease 2019
CSOs	Civil Society Organisations
DOT	Directly Observed Therapy
FGDs	Focus Group Discussions
HIV	Human Immuno-deficiency Virus
HR	Harm Reduction
ID	Identification Card
IDI	In-Depth Interviews
IGA	Income Generating Activities
MAT	Medically Assisted Therapy
MEWA	Muslim Education and Welfare Association
MOE	Ministry of Education
MOH	Ministry of Health
MoV	Means of Verification
NACADA	National Authority for the Campaign against Alcohol and Drug Abuse
NACC	National Aids Control Council
NASCOP	National AIDS and STI Control Programme
NGO	Non-Governmental Organisation
NSP	Needle and Syringe Programme
OST	Opioid Substitution Therapy
PEPFAR	[The US] President's Emergency Plan for AIDS Relief
PWUIDs	People Who Use or Inject Drugs
SHRBP	Sustainable Harm Reduction Business Plan
STI	Sexually transmitted infections
SUD	Substance Use Disorder
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development

Message from the Governor

Around 275 million people globally use drugs with more than 36 million people suffering from substance use disorders (SUD) and requiring treatment services according to the United Nations Office on Drugs and Crime (UNODC) World Drug Report 2021. SUDs contribute significantly to the global disease burden, disability and death. The report also noted that cannabis use had increased four times in parts of the world with an influx of use by adolescents and later graduating into heroin abuse. The current statistics in Kenya indicate more than half of the drug users are aged 10-19 years. The youth are the backbone of any country for socio-economic development and any disruption to the social fabric within this age group results in a decline in literacy levels, loss of productivity and disruption to the country's economy. Evidence has shown that SUD has adversely affected the entire community, education, and workplace and destroying the social fabric leading to an impoverished society.

It is evident that a robust plan is needed to help address and manage the SUD problem affecting our society and I am both challenged and energised by the new and courageous **mission** that has emerged from our five-year Sustainable Harm Reduction Business Plan:

> *To provide leadership and resources to improve the individual, community and public health prevention, treatment, and recovery of substance use and its accompanying harm in Mombasa County.*

Underpinning this mission is a sole but powerful **purpose**:

> *To make the lives of those we serve better.*

I would like us to embark on this journey by taking bold steps through a collective contribution and support by all stakeholders, including public and private organisations, development agencies and donors, political and religious leaders, and local communities to jointly support the implementation of the Mombasa County Sustainable Harm Reduction Business Plan (SHRBP) 2021–2026. The SHRBP will strive to provide coordinated and quality prevention and treatment services to the community, particularly to adolescents, women, and people affected directly and indirectly by SUD.

I am very proud of the progress and improvements we have made together as a county in improving the lives of those affected by SUD and I look forward to engaging with all members of Mombasa County as we work together to deliver our first-ever county-led SHRBP to be developed in Kenya.

I call upon residents of Mombasa County and our partners to work together with us towards the timely realisation of the targets we have set for ourselves in this Plan. Together, we will build a prosperous and peaceful county where all residents enjoy high-quality life and are proud of our local heritage.

H.E. Hassan Ali Joho,EGH
Governor, County Government of Mombasa

Foreword

Substance use is an increasing public health concern in the world. Drugs and substance use has a considerable negative impact both at the individual and community level. One of the salient negative impacts of drug use is the transmission of infectious diseases through the sharing of injections. In Kenya, 1.5 million people comprising 18,327 injection substance users, were living with HIV at the end of 2016. Recent data shows that 18.7% of injecting drugs users are infected with HIV nationally, which is over three times the national prevalence of 5.6%. Indeed, the high prevalence of HIV among Kenyan PWID is consistent with PWID globally, suggesting that Kenya is indeed becoming an epicentre of drug use-related HIV epidemic. The significance of injecting drug use in driving the Kenyan HIV epidemic particularly manifests at the Coast where nearly half of all PWID live, and 20.5% of these are infected with HIV.

Annual approximated deaths from viral hepatitis globally are 1.34 million, superseding the current 1.3 million from HIV/AIDS. This burden is concentrated in sub-Saharan Africa: 25.7 million people are living with HIV; 60 million people are chronically infected with hepatitis B (HBV) and 10.2 million people are chronically infected with hepatitis C (HCV). These three infections share similar transmission routes, particularly exposure to blood, and to a lesser extent, exposure to other bodily fluids highly predominant among injecting drug users.

In response to the growing burden of HIV among people who inject drugs in Kenya, the Ministry of Health endorsed a harm reduction approach in the national HIV strategy in 2013. In 2015, medically assisted therapy using methadone was established at the then Coast Provincial General Hospital and the Kisauni Health Centre in Mombasa alongside the Needle and Syringe Programme, and HIV testing and treatment for people who inject drugs, supported by the civil society organisations and developmental partners.

While significant progress has been made at the national and county level concerning harm reduction interventions, there remains a profound need to have customised and targeted efforts at the county level that will strategically address the needs of PWUID in Mombasa County.

This realisation, and driven by available data, led to the development of this Sustainable Harm Reduction Business Plan 2021–2026 for Mombasa County. We envision a society in which high-quality services for prevention and treatment of substance use problems will be widely available and offered in a dignified manner to promote the prevention of HIV, HBV and HCV and promote recovery among drug users.

Dr.Godffrey Nyongesa Nato
Ag. County Executive Committee Member
Department of Health Services
County Government of Mombasa

Acknowledgement

This Sustainable Harm Reduction Business Plan (SHRBP) 2021–2026 was developed by the County Government of Mombasa under its Department of Health Services and is in line with the County Integrated Development Plan 2018–2022 and Vision 2030.

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CGM further acknowledges with thanks the steering team that supported the development of the SHRBP by reviewing early drafts and participating in the validation team in May 2021 (in alphabetical order): Mr. Abdalla Ahmed, Dr. Abdulnoor Ismail, Dr. Khadija Shikely, Ms. Rahma Hashim, Dr. Shem Patta, Mr. Taib Abdulrahman, and Ms. Zaituni Ahmed.

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Special thanks are due to Hon. Abdulswamad Shariff Nassir, the MP for Mvita, for his active support during the development of this SHRBP. We would also like to thank, Dr. Salma Swaleh, County Director for Public Health, Ms. Aisha Abubakar Chief Officer Culture and Ms. Pauline Oginga Ag. Chief Officer Public Health; Hon. Kibwana Baya Swaleh, Hon. Hamisi Musa Mwidani, and Hon. Milka Ngare all from the Mombasa County Assembly for their invaluable contribution; Hazel Koitaba, former CECM Health and Dr. Godffrey Nyongesa Nato, Ag. CECM Health for their support towards the development of this SHRBP.

Dr. Khadija Sood Shikely
County Chief Officer, Medical Services
County Government of Mombasa

Chapter 1: Introduction

1.1 County Geography and Demography

This section provides a short description of Mombasa County in terms of the geographical location, size, demographic profiles, administrative and political units. It also highlights a summary of the socio-economic and infrastructural information that has a bearing on the development of the County.

1.1.1 Geographical Location

Mombasa County is located in the South-Eastern part of the Coastal region of Kenya. It covers an area of 229.9 km^2 excluding 65 km^2 of water mass which is 200 nautical miles inside the Indian Ocean. It borders Kilifi County to the North, Kwale County to the South West and the Indian Ocean to the East. The County lies between latitudes 30 56' and 40 10' South of the Equator and between longitudes 390 34'and 390 46'east of Greenwich Meridian[1].

Mombasa County consists of six sub-counties, namely Mvita, Nyali, Changamwe, Jomvu, Kisauni and Likoni, and 10 divisions. These are further sub-divided into 30 county assembly wards and 57 sub-locations as shown in Table 1 and Figure 1.

Table 1: Administrative Units by Sub-County

Sub–County	Divisions	Wards	Sub-locations	Villages
Changamwe	1	4	10	58
Jomvu	1	3	7	65
Kisauni	3	6	9	200
Nyali	2	4	8	55
Likoni	2	6	9	145
Mvita	1	7	14	134
Total	**10**	**30**	**57**	**657**

Source: Second CIDP 2018–2022

1.1.2. Demographic features

Proximity to vital social and physical infrastructure networks such as roads, housing, water and electricity influences population distribution and settlement patterns in the County. Other factors that influence settlement patterns include accessibility to employment opportunities and security. Table 2 shows the County population projection by sex and age groups. The total population of the County in 2009 was

[1] https://www.mombasa.go.ke/wp-content/uploads/2020/08/Final-CHSIP-II-2018-2022-27.3.19-Abridged-Version-updated.pdf

939,370 persons, of which 486,924 and 452,446 were male and female respectively. It was projected to be 1,266,358 in 2018 and will rise to 1,433,689 persons by 2022 (KNBS, 2018).

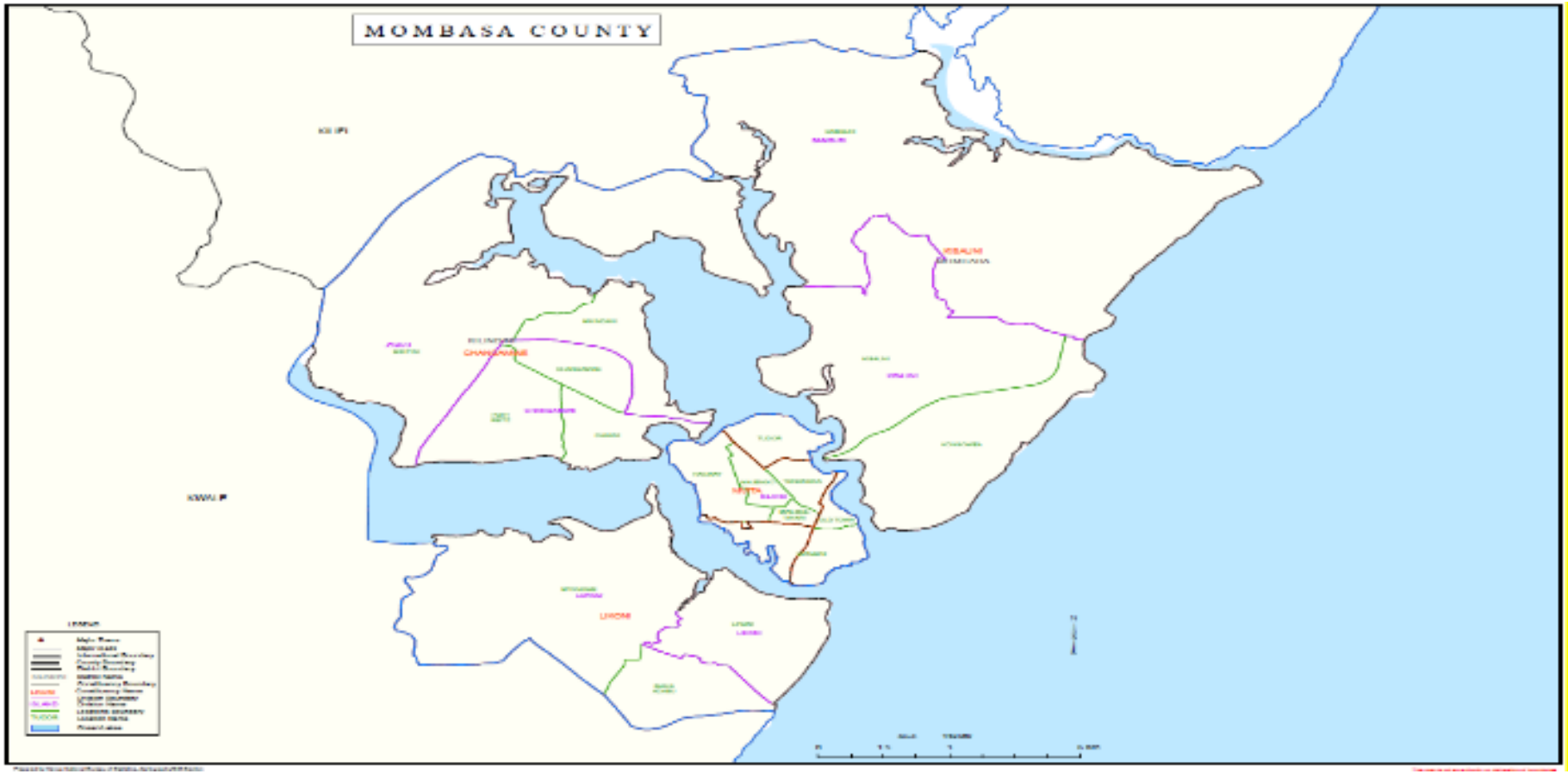

Figure 1: Map showing Mombasa County Administrative Units

Source: *Kenya National Bureau of Statistics, 2010*

Table 2: Population Projection by Sex and Age Cohort

Age Group	2009 (Census)			2018 (Projections)			2020 (Projections)			2022 (Projections)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	64,317	63,002	127,319	81,103	79,343	160,481	84,256	82,572	166,828	86,337	84,615	170,952
5-9	49,836	50,081	99,917	64,567	65,014	129,611	68,543	69,020	137,563	71,179	71,656	142,836
10-14	40,660	42,221	82,881	53,935	55,919	109,880	57,308	59,739	117,047	61,136	63,594	124,730
15-19	40,095	46,640	86,735	54,220	61,206	115,458	57,966	65,541	123,507	61,882	70,315	132,197
20-24	57,005	69,257	126,262	77,941	77,649	155,618	82,450	81,300	163,750	88,600	87,306	175,906
25-29	63,689	60,776	124,465	81,659	78,500	160,123	86,571	80,150	166,721	91,722	83,664	175,383
30-34	52,178	39,131	91,309	68,750	62,552	131,323	73,501	67,492	140,993	78,218	68,575	146,774
35-39	39,968	26,889	66,857	55,511	46,085	101,460	58,903	51,514	110,417	63,479	56,197	119,675
40-44	25,837	16,200	42,037	42,248	28,765	71,005	45,524	31,619	77,143	48,586	36,880	85,425
45-49	19,270	12,089	31,359	29,616	18,791	48,407	32,888	21,005	53,893	35,915	23,659	59,570
50-54	12,816	8,389	21,205	18,597	10,817	29,413	20,198	11,794	31,992	23,309	13,743	37,052
55-59	8,052	5,300	13,352	11,717	8,092	19,809	12,637	8,604	21,241	13,978	9,545	23,524
60-64	5,102	4,124	9,226	7,518	5,812	13,331	8,138	6,271	14,409	8,901	6,696	15,596
65-69	2,801	2,561	5,362	4,363	4,116	8,481	4,788	4,506	9,294	5,274	4,921	10,194
70-74	2,099	2,078	4,177	2,669	2,800	5,471	2,868	3,027	5,895	3,237	3,392	6,629
75-79	1,220	1,211	2,431	1,576	1,690	3,266	1,676	1,818	3,494	1,829	1,999	3,827
80+	1,979	2,497	4,476	1,299	1,920	3,220	1,302	1,951	3,253	1,359	2,060	3,419
Total	**486,924**	**452,446**	**939,370**	**657,288**	**609,069**	**1,266,358**	**699,517**	**647,923**	**1,347,440**	**744,941**	**688,817**	**1,433,689**

Source: *Kenya National Bureau of Statistics, 2018*

1.2 Considerations in Developing the Sustainable Harm Reduction Business Plan

1.2.1 Problem Overview

Globally, more than 35 million people are estimated to suffer from substance use disorder (SUD) with marginalised groups, youth, women and the poor being the most affected and requiring treatment services (UNODC World Drug Report 2020), yet many lack access to these services. In sub-Saharan Africa where the burden of SUDs is high and countries are struggling to end poverty, it is important that governments prioritise the strengthening of their SUD treatment and prevention systems (Jaguga and Kwobah, 2020). While Cannabis (bhang) is the most widely accessible drug in Kenya, heroin is the most frequently abused drug in Mombasa (49.4%) and Nairobi (18%) counties respectively (NACADA, 2013). Untreated SUDs are a major public health problem (Jaguga and Kwobah, 2020) Injecting drug use carries a significantly high risk of infection with bloodborne viruses such as HIV, hepatitis B and C. Modelling studies in Kenya estimated that 18.3% of the 18,327 PWID countrywide were infected with HIV (NASCOP 2014; NACC 2014). Injecting drug use significantly influence the Kenyan HIV epidemic particularly at the Coast where nearly half of the PWID live and 20.5% of these are infected with the virus (Kurth et al., 2015). Illicit drug use not only affects the health and lives of individuals but also undermines the political, social and cultural foundations of society. Substance Use Disorders are associated with significant costs to society due to lost productivity, premature mortality, increased healthcare expenditure and costs related to criminal justice, social welfare and other social consequences. With the advent of the COVID-19 pandemic, rising unemployment and reduced opportunities are also likely to disproportionately affect the people who use and inject drugs (PWUID) making them more vulnerable to drug use and drug trafficking to earn money (UNODC World Drug Report 2020).

1.2.2 Harm Reduction Programmes

Despite the known benefits of prevention and treatment services such as harm reduction (HR), these services continue to fall short globally with only one in seven people with SUD receiving treatment each year. Equally in Kenya, the Ministry of Health (MOH) started the HR approach in 2013, but less than a fifth of an estimated 18,327 people who inject drugs (PWID) are reached by the HR programme services. National and county governments need to step up interventions to address this gap.

HR is a set of practical strategies and ideas aimed at reducing negative consequences associated with substance use offered respectfully for people suffering from SUD with a long-term goal of stopping drug abuse. A comprehensive package for the prevention, treatment and care of HIV among PWUID include the following 12 interventions:

i. Needle syringe programme & condom promotion
ii. Medically assisted therapy & drug treatment
iii. Overdose prevention & management
iv. Prevention, diagnosis of HIV/AIDS & anti-retroviral therapy
v. Targeted information education & communication
vi. HIV testing & counselling
vii. Mental health & social support
viii. Promotion of human rights for people who use drugs
ix. Prevention, diagnosis and treatment of tuberculosis
x. Prevention, diagnosis and vaccination of hepatitis
xi. Drug addiction counselling
xii. Socio-economic reintegration

The Government of Kenya, with financial support from [the US] President's Emergency Plan for AIDS Relief (PEPFAR) and Technical Support from the United Nations Office on Drugs and Crime UNODC and the University of Maryland, through the MOH National AIDS and STI Control Programme (NASCOP), introduced Opioid Substitution Therapy (OST) using methadone, alias Medically Assisted Therapy (MAT) in late 2014. HIV Testing Services, ART treatment and Needle and Syringe Exchange programmes for PWU/ID had been introduced earlier in the country. Kenya's OST models entail a one-stop shop, where OST centres have been encouraged to provide comprehensive services such as screening and treatment for HIV, STIs, viral hepatitis and TB, among other co-infections among the target group. Being a controlled substance, national guidelines for the dispensation of methadone mandate Directly Observed Therapy (DOT) to minimise chances of diversion and misuse of methadone. In line with PEPFAR's strategic directions on **Journey to Self-Reliance**, the Government of Kenya and respective county governments have been slowly but steadily taking over key components of OST service provision, including Infrastructure, Human Resources for Health and Commodities. It is on this premise that the Department of Health Services in the County Government of Mombasa decided to play

a pivotal role in developing a participatory and inclusive Sustainable Harm Reduction Business Plan (SHRBP). The UNODC, with support from the USAID, provided financial support to facilitate the necessary technical assistance through engaging a consultancy to work with and support the Mombasa County Department of Health Services in developing the SHRBP 2021–2026.

The SHRBP 2021–2026 provides the blueprint for key actions derived from an evidence-based approach and local expertise. The SHRBP 2021–2026 was developed through high-quality input by the key stakeholders, including professional healthcare givers of the PWUID, highly passionate members of the PWUID community together with compassionate family members and caregivers of the PWUID. All these individuals collectively generate knowledge and develop solid and good practices on how to sustain the already good efforts of HR.

Chapter 2: Situational Analysis

2.1 Background

The consultant carried out a mixed-method study to collect data on the existing services, perceived strengths and weaknesses. Additionally, the process elicited information from community members on their perception of how these programmes can be made sustainable and achieve their goals. This situational analysis aimed to ensure that the views, perceptions and experiences of the different stakeholders in Mombasa County have been captured and included in the business plan.

2.2 Objective

- To elicit the opinions of PWUID, their families and other stakeholders on key considerations in creating a business plan for sustainable harm reduction programmes within Mombasa County.

2.3 Methodology

The methodology applied in the development of the SHRBP consisted of a mixed-methods design to facilitate in-depth understanding and triangulation of the findings between qualitative and quantitative methods. The data was collected simultaneously using two parallel cross-sectional approaches, including a survey administered during the stakeholders' meeting, and focus group discussions (FGDs) and in-depth interviews (IDIs).

The survey was administered to assess the awareness and attitudes of the strategic stakeholders towards HR programmes for PWUID. Secondly, it was administered to assess the comprehensive knowledge of sustainable measures towards HR interventions in Mombasa County and also to gather the views of the key stakeholders on what they see as potential solutions.

Additionally, 8 FGDs and 7 IDIs were conducted. Each FGD convened an average of 10 participants. The data collected through qualitative methods complemented the survey in eliciting information related to the level of awareness on harm reduction programmes, perceived barriers to implementation of harm reduction programmes and potential ways to address these barriers and develop a contextually relevant and locally-driven SHRBP.

The FGD participants were selected from the pool of MAT clinics (Shimo La Tewa, Kisauni and Miritini), MEWA Harm Reduction Programme and Reachout Centre Trust.

Participants for the IDI were served with invitation letters from the County Director of Health and later followed up by the consultant through phone calls to organise for the face-to-face interviews. Seven IDIs, a stakeholders' meeting with 27 participants, and FGDs involving 62 participants were held. Varying views from a diverse group of participants were received, and, to illustrate this, Table 3 presents the characteristics of participants in the FGDs, and therefore, the results from this situational analysis capture the views of the key stakeholders within Mombasa County.

Table 3: Demographic characteristics of participants

Demographic Characteristics	N (%)
Participants' group	
Caregivers	11(17.7)
Healthcare workers	21(33.9)
MAT/Drug user	7(11.3)
PWUID & MAT clients	7(11.3)
Recovering drug users	16(25.8)
Participants' age	
Mean, SD,	37.6(SD 10.1)
Range	20-66
Sex	
Male	43(69.4)
Female	19(30.6)
Educational level	
Primary	23(37.1)
Secondary	10(16.1)
Tertiary	28(45.2)
Missing	1(1.6)
Marital status	
Married	36(58.1)
Single	17(27.4)
Divorced/Widowed/Separated	9(14.5)
Occupation	
Healthcare workers (Nurses, clinical officers, counsellors, etc.)	21(33.9)
Peer educators	17(27.4)
Unemployed	10(16.1)
Businessman/woman	4(8.1)
Outreach worker	2(3.2)
Teacher	2(3.2)
Ambassador	1(1.6)
Boat operator	1(1.6)
Cleaner	1(1.6)
Programme manager	1(1.6)
Security	1(1.6)

2.4 Results

During the stakeholder engagement, the consultant started the discussions by asking the stakeholders to identify components of the HR programmes that were being implemented in Mombasa County. As can be seen in Table 4, people were most

familiar with MAT, and ARV treatment and care for HIV/AIDS. This knowledge may partly reflect the programmes where there has been the most investment.

2.4.1 Stakeholders knowledge and Harm Reduction

Table 4: Stakeholder knowledge about components of HR programmes being implemented in Mombasa County

Components of HR programmes	Frequency	Percentage
Medically assisted therapy and drug treatment	23	88.5
ARV treatment and care for HIV/AIDS	23	88.5
Drug addiction counselling	22	84.6
Counselling and testing of HIV/AIDS and viral hepatitis treatment	22	84.6
Needles and syringe exchange programme	18	69.2
Preventing diagnosis and treatment of STI	18	69.2
Mental health and social support	17	65.4
Prevention, diagnosis and treatment of TB	17	65.4
Preventing and managing overdose	16	61.5
Promotion of human rights fighting criminalisation and preventing violence	15	57.7
Socio-economic reintegration	13	50.0
Targeted information education and communication	12	46.2

MAT clinics were seen to be the most successful HR programmes by the stakeholders. The MAT programmes and the Needle and Syringe Programme (NSP) were considered to be the most successful programmes Figure 2. In the qualitative interviews, the benefits of these two programmes were further highlighted by those we spoke to.

> *In my recovery journey, methadone helped me a lot. I was helped with an economic livelihood programme which has helped me to support my children with school fees. I can't believe how methadone transformed my life, I used to be dirty and people could think I was a madman and or a thief because I was collecting scraps to get money but now I got reunited back to [sic] my family.*
>
> *[The] MAT programme is known, it has helped drug users to redeem themselves. NSP programme has worked well. In the programme, PWIDs are taught a safe way of injecting, there are hygiene programmes which donate soap to drug users.* ***(FGD with a caregiver of PWUIDs).***

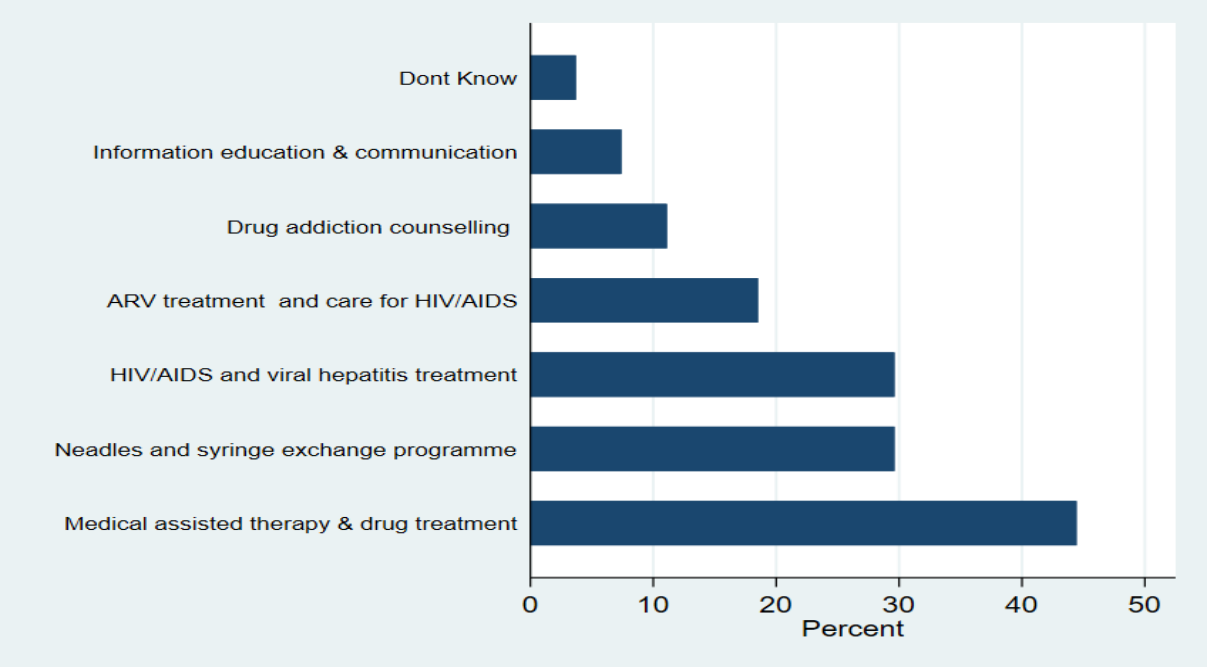

Figure 2: Which of the HR programmes mentioned above do you consider successful in Mombasa County?

2.4.2 Perceived benefits and challenges faced by HR programmes

Many of the respondents noted the real value of these HR programmes lies in their multifaceted approach.

> *I could say all because addicts face multiple challenges. Take, for instance, one may get infected with HIV; he or she needs to get counselling in order to have the courage to continue with self-medication. Secondly, hygiene is also important. In several instances, I have encountered addicts, and just by looking at them, one notes the deteriorating nature of his or her hygiene. Advocacy, most of the time the drug addicts are harassed and isolated. On many occasions, it's mostly us social workers who can hold their hand and listen to their plight* ***(FGD, healthcare providers).***

The challenges facing HR programmes were discussed in-depth. From the survey with stakeholders, the challenge that was most frequently mentioned was inadequate funding followed by a negative perception of HR programmes (see Figure 3). During the qualitative discussions, these sentiments were also raised again. It was noted that most programmes were implemented with tight timelines and funding; when they end the programmes tend to fail.

> *Most programmes have a timeline, maybe that is a factor contributing to the failure. Additionally, there are instances where the budgetary allocation does not meet the demand in the instance of an increase in the number of the target population. Our*

organisation had a food programme targeting only 20. However, with the increase in number, we were not able to sustain the food relief programme. ***[in-depth interview, health care provider]***

Well, the others it is because, huh, we rely like I said that we need staff to go out and, and give the services out there, so it is not sustainable because now we rely…we rely on donors maybe to support us. Now, if that programme of the donor now ceases, there is that gap, maybe almost six months the guys will not get proper services outside there…yeah. **[in-depth interview, healthcare provider]**

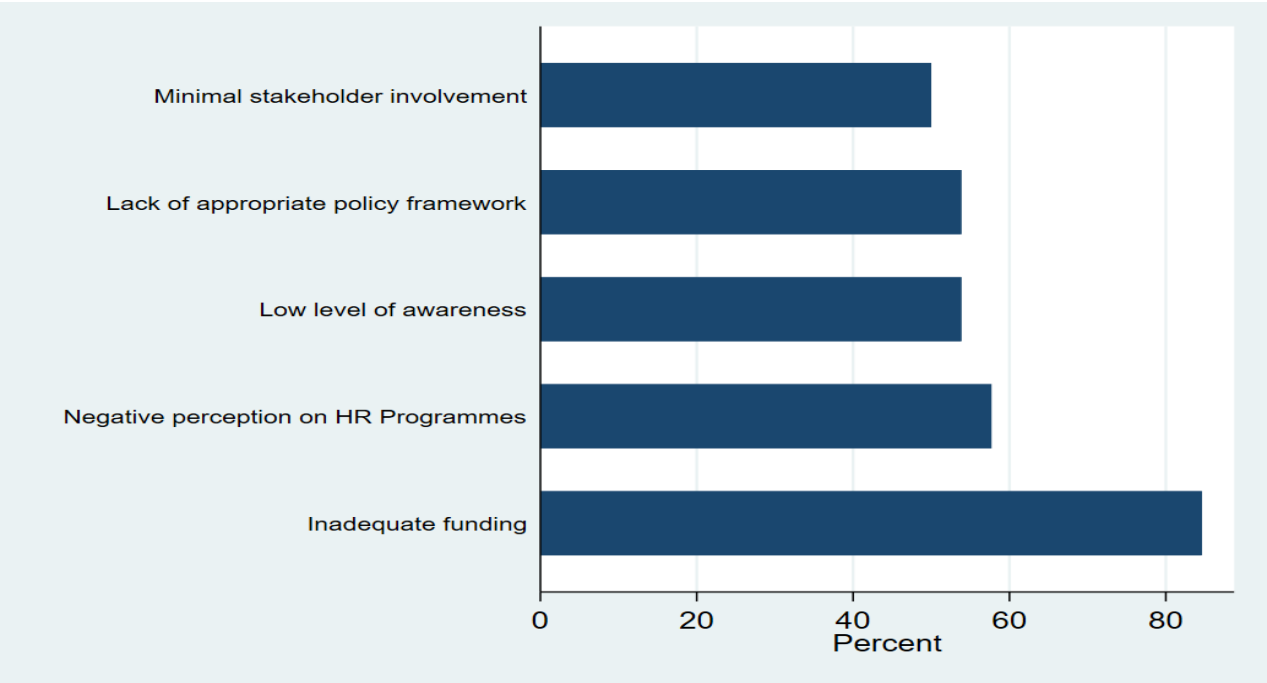

Figure 3: Which among the following pose a challenge to the HR programme in Mombasa County?

It was interesting to observe that some of the challenges mentioned during the qualitative discussions were not related to the HR programmes per se but larger issues within the communities. For instance, it was noted that one of the key challenges to HR programmes was the ease with which drugs could be accessed within the community.

Just like she said, it is true because I take care of my brother. I have witnessed how he takes methadone and other drugs with his friends. How then can we stop drug abuse? It's very difficult because people who are supplying these drugs are known. Giving them methadone is just a waste of time." ***[FGD, caregiver of PWUID]***

These challenges were further exacerbated by a perception that, for most clients, reaching service providers would be difficult, and sometimes even when they did, the services received would be sub-optimal due to a shortage of personnel.

> *"MAT is very far from clients; transportation is a challenge for those taking the dose daily. There are drug users who wish to access MAT but are unable; the HR programme should look for an alternative way of making MAT accessible on time."*

> *I can say that when we started methadone, I mean, you used to take methadone after a week and you were seen by the doctor and counsellor. But nowadays, you can go up to six months on methadone and if you want to reduce the dosage you are being told there is no doctor and even the counsellor will tell you I don't have time. I mean, it has become worse. Someone comes drunkard [sic] carrying a bottle of alcohol and is given methadone yet methadone and alcohol is [sic] contraindicated and one can die if he/she uses [them] for long. I mean, they are not working as it is expected there". **[FGD, PWUIDs]***

2.4.3 Sustainability of HR programmes

Factors that were likely to contribute to the sustainability of HR programmes were discussed. Most of the respondents in the online survey during the stakeholder engagement pointed out that involving various stakeholders, including the PWUIDs, Civil Society Organisations (CSOs) and law enforcers, and having a multi-sectorial approach to programming is are key ways to ensure sustainability. Secondly, adequate funding was perceived as another potentially powerful way to ensure sustainability.

Table 5: Factors that can contribute to the sustainability of HR programmes

Factor	Frequency
Stakeholder involvement and multisectoral collaborations (e.g. County government, CSOs, law enforcement agencies, PWUIDs, community)	21
Adequate funding	7
Stop corruption cases among officials, transparency	3
County support	1
Appropriate policy framework	1
Good mentorship programmes	1
Livelihoods support	1
Attitude and behaviour change and prioritisation of mental health support	1

In the qualitative discussions, the role of the different stakeholders was further elucidated and their contribution to the success of HR programmes was raised.

We have seen [name of the specific CBO redacted] work very well. They tried working with the community to rescue the drug users. We have seen changes with our kids. They serve the community without discrimination ***[FGD caregivers of PWUIDs].***

2.4.4 Public-Private Partnerships

Right from the start of the consultation and engagement with informants to develop the HR business plan, it was noted that the development of a public and private partnership is key to the development of robust funding mechanisms. Additionally, these partnerships bring together different groups of like-minded people to ensure that those who undergo treatment stay sober.

Figure 4. Categories of potential partners in HR programmes

Some of the very specific potential partners mentioned include:

- The National and County Government
- Ministry of Youth, Sports and Gender
- Business community
- Family members of beneficiaries
- Police and criminal justice system
- Policymakers both at the county and national levels
- Kenya Ports Authority

- Kenya Revenue Authority
- Hotel and Tourism industries
- Faith-Based Organisations
- Social and education sectors, youth and children's departments
- Youth of Mombasa from the grassroots, recovering drug users
- Mental health board/professionals

Table 6 presents the many suggestions that were made regarding ways in which the different public and private partners can contribute to ensuring the success and sustainability of HR programmes. The most frequently mentioned way was their potential contributions to developing a robust funding mechanism within the County. Additionally, providing training and employment opportunities to recovering drug users can contribute to continued sobriety and community integration.

Table 6: Ways in which different stakeholders can contribute to the sustainability of HR programmes

In your opinion, how best can each stakeholder contribute to enhancing the sustainability of the HR programmes in Mombasa County?	**Frequency**
Adequate funding and helping manage selected centres	7
Offering training and employment opportunities	7
Coordinating and providing adequate support to HR programmes, including giving ideas to the County Government of Mombasa participating in decision-making	4
The County government can link clients to other financial entities	2
Involving youth in HR programmes	1
The recovering PWUIDs can support with counselling and health promotion	1
Reducing discrimination	1
Carrying out follow-ups	1
Private sectors ensuring they include HR programmes in their Corporate Social Responsibility activities	1
Food relief programmes	1
Lawmakers to criminalise drug sale and entry in the County	1
MOE to hold sessions in the schools on the effects of drug use (early prevention) and provide medical services required by the PWIDs & PWUDs.	1
Local admin to root out drug dens and provide referrals of the PWIDs and PWUDs	1
For parents, consistent supervision and guidance of their children is needed.	1
Law enforcement officers need to desist from illegal arrests and refer the PWIDs and PWUDs to needed help.	1
CSOs — reaching out to PWIDs and PWUDs in their dens, support in initiation to MAT programme, IGA programmes. NASCOP-supply of MAT and NSP.	1
There is a need for a coordinating technical working group	1
Bring on board the psychosocial team in every stage of the programmes.	1
There is a need to enhance harm reduction programmes for key populations	1
Strategic partnership	1

In an in-depth discussion of some of the factors that hinder the effective participation of multiple stakeholders in HR programmes, various issues were raised (Table 7).

Some of the key barriers include financial challenges, lack of information by the community and lack of clear stakeholder engagement. However, a key theme that kept being repeated in different ways was the lack of trust and issues of accountability.

> *"Probably, I think one is trust. I think we have heard… ah, ah… a long spell where certain players or the private sector do not have trusted partners that they can channel funds to and they are used in a good way and one of the biggest problems has been government. Uh, people find a lot of misuse within government; misuse of funds. But it is not only government; I think this [is] a culture that has permeated on our society because you will find even in Non-governmental Organisations, you will find in a lot of other areas because you cannot blame politicians and politicians come from us. So, I think we have a culture of corruption that is becoming endemic. So, a lot of people are not ready to give money directly to certain players because of trust issues, and mainly that is brought by… eh, eh… non-accountability. So, if people are accountable, then they build this trust, then it might be different."* ***[In-depth interview, Director of a CBO]***

Table 7: Barriers to optimal stakeholder participation in building sustainable HR programmes

Description	Frequency
Financial challenges (my biggest concern is how to create and manage the resources and funds in an HR programme.)	10
Lack of information on harm reduction by the community	9
Lack of a clear engagement framework/lack of involvement or appreciation of individual efforts	6
Distrust, negativity and stigmatisation	6
Government restrictions on the donors/political interference/ lack of goodwill/support from government	4
Accountability issues	4
Unethical conduct/corruption	3
Restrictions on implementation of the programme/strict policies	2
Lack of cooperation among stakeholders (e.g. competition among stakeholders)	2

2.4.5 Policy environment in Mombasa County

During the stakeholders' meeting, it was clear that most of the participants (57.7%) felt that the policy environment is not conducive to ensuring the sustainability of HR programmes (Figure 5). The sentiments were also echoed by participants in the qualitative study who not only identified the gaps but provided some suggestions on how these gaps could be addressed.

> *Okay. The bill…one thing the bill should just indicate that there is this problem; we are drug users, people who use drugs and therefore a certain amount, the government is*

now committed that a certain amount if it is 25% or if it is 30% a certain amount each year has to go to this people for the sustainability of the programmes. So, whether it needs staffing, that thing will pay for you, you need what that thing will pay, to go out and give services, so unless it is in writing the government and so the government cannot, I mean it will not be sustainable [sic] ***[In-depth interview, government official]***

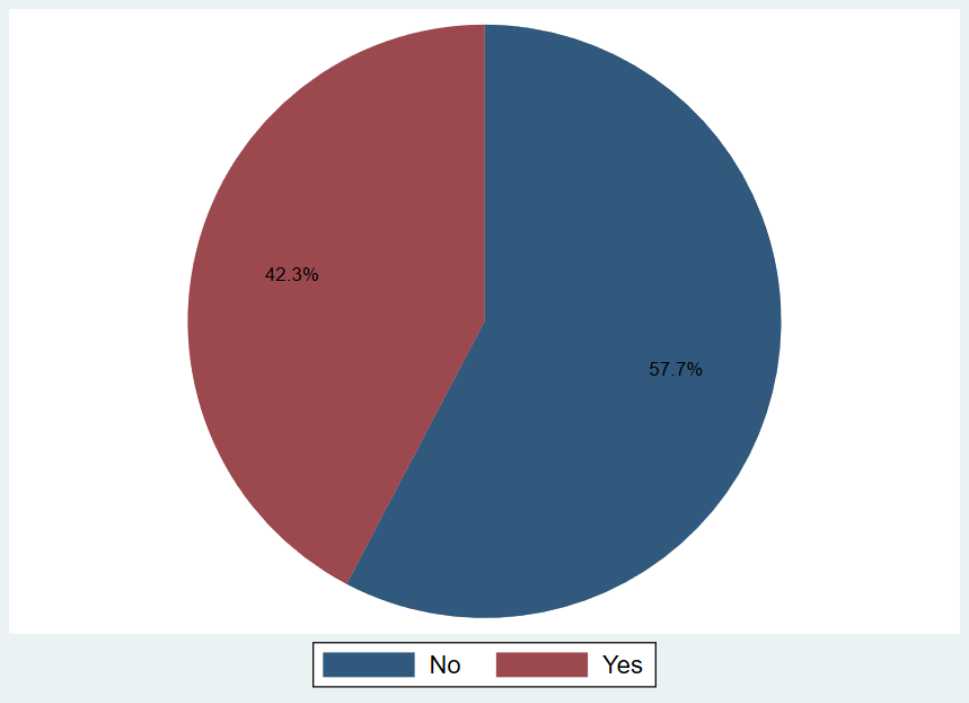

Figure 5. The policy environment in Mombasa County

The good news is that the development of this SHRBP is happening simultaneously with the development of a Drugs and Substance Abuse Control Bill and a policy to address some of these challenges and gaps by the County Assembly of Mombasa

Hmm…aah…I think we are about to have a bill on drugs harm reduction, which we want to be gazetted. It is in the process of being gazetted one, then it will be taken to full public participation. So, I think we can, within that…that policy, this will be a major milestone on this programme because any fund that you're going to use must be captured in a… in a policy. So, I think this idea that we need the other stakeholders also to come together and move forward this…eeh…the policy, so at least when we make a budget, then we have that policy on that budget." ***(In-depth interview, County Assembly Representative)***

2.4.6 Community re-integration

2.4.6.1 Which challenges do PWUID experience when they try reintegrating into their communities?

The three major challenges faced by PWUIDs on reintegrating into the community were stigma, lack of trust from community members and inadequate employment opportunities. Similar views emerged from the participants in the qualitative interviews.

> *Okay, one thing I have not been involved in is community re-integration but…eeh…the issue of stigma is really one of the things that are hindering people from going back to the community. Yeah, I think only stigma, that fear that this person will steal from us, will harm us and what have you.* ***[In-depth interview, government official].***

> *"Okay. The biggest challenge is (that) they do not have a job; it could be there is no job, it can be because they do not have skills or it could be people still do not trust them…* ***[In-depth interview, Healthcare provider].***

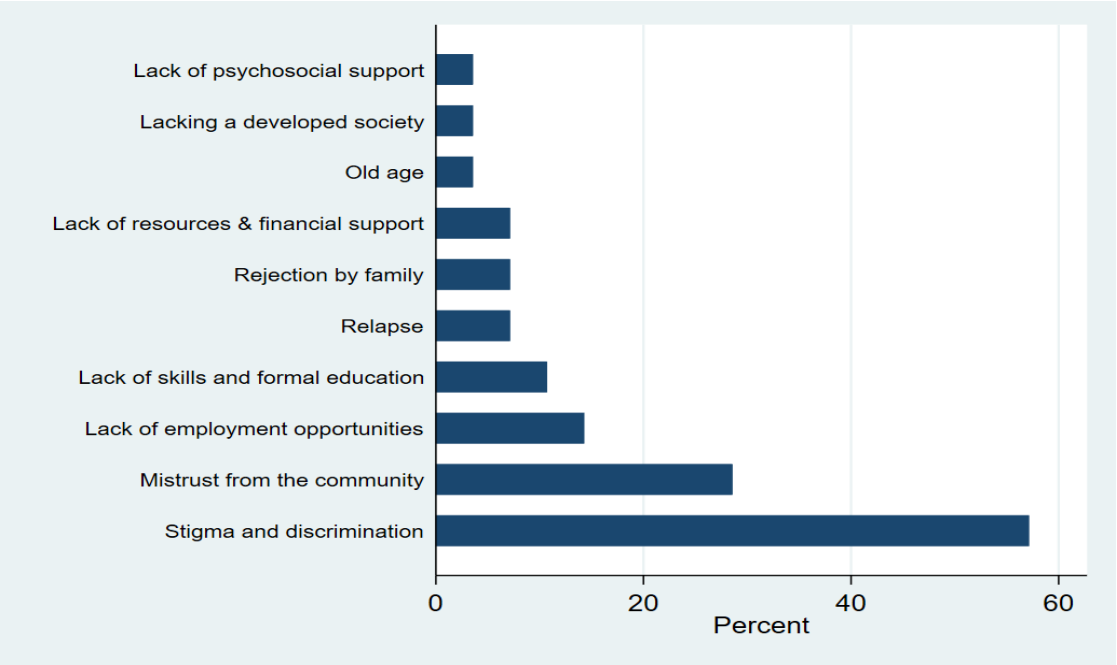

Figure 6: Challenges in the social integration of PWUIDs

Several strategies for addressing these challenges were mentioned by participants (Table 8). However, two strategies seemed to be the most emphasised: a) community engagement to fight stigma, and b) training on entrepreneurial and technical skills. One interesting point to arise from these discussions was the potential role of religious leaders and institutions in implementing HR programmes. A few of the stakeholders who attended the consultative meeting noted the need to include a religious

component in the HR programmes. This request highlights the key role of spirituality in this setting.

Table 8: Strategies for overcoming challenges of PWUID

In your opinion, what are some of the strategies that could help overcome the challenges mentioned in 1b above to ensure adequate integration of the recovering drug users into the community?	FREQUENCY
Community engagement and sensitisation on HR, drug use, stigma reduction and acceptance of drug users	20
Training and skills applied/ Financial support to start small businesses/ also getting the PWUIDs to activities they can do	9
Include a religious component in the HR programme	2
Putting up more clinical facilities	1
Empowering the PWUD/PWID	1
Provide ID cards	1
Client follow up	1
Joint effort by the government and the stakeholders	1
support IGAs for recovering drug users	1
Family counselling	1

2.4.6.2 What are the challenges faced by PWUID to earn a living?

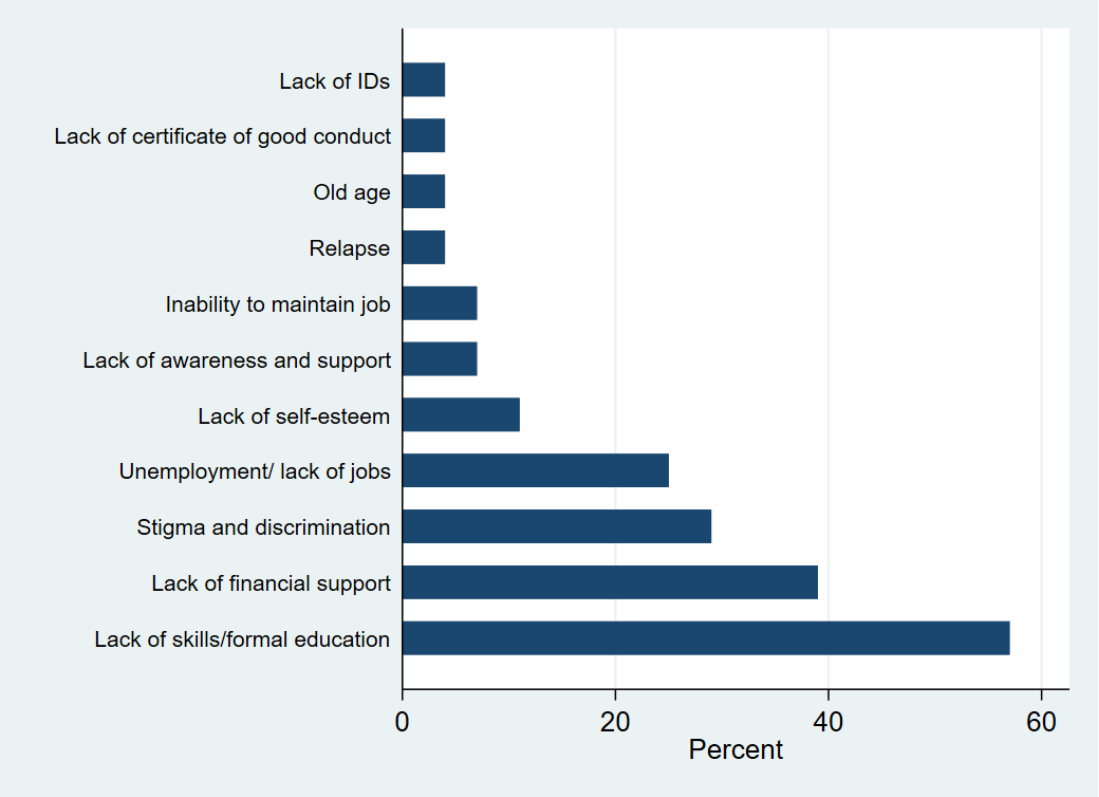

Figure 7: Challenges faced by PWUIDs to earn a living

> *Lack of trust, stigma, I think also motivation; if they are not motivated, can they? They cannot. Yeah, there is that self-esteem that might also be affected because already they view themselves as people who are found to be… who are found… the… yaani, (as in) the community does not accept them already, so that one will also affect them*

because they are not motivated wanaona tu hapa (they see) yeah but now that sasa (now) is the self, they have not tried. So, it hinders them because the self-esteem is still low, but then things like psychosocial support is [sic] very important." ***(In-depth Interview, County MoH Official)***

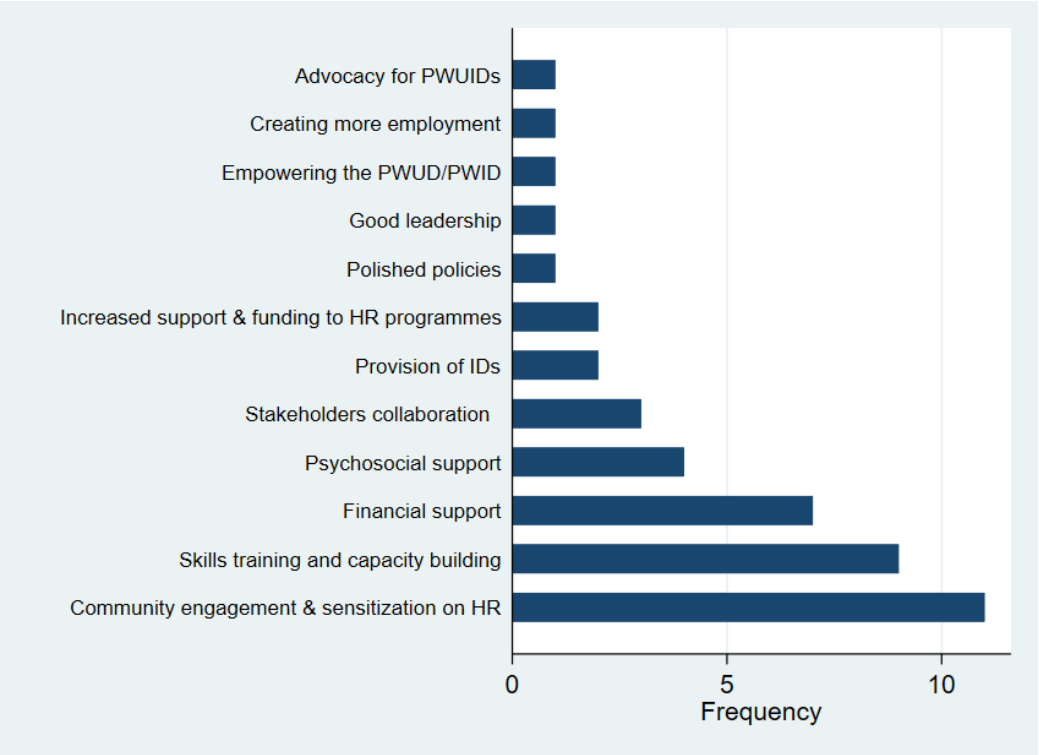

Figure 8: How best can each of these challenges be addressed?

2.5 SWOT Analysis

Based on the findings from the situational analysis, a basic SWOT analysis was carried out. The results of the situational analysis coupled with this SWOT analysis (Figure 9) advised the development of the business plan and its implementation plan.

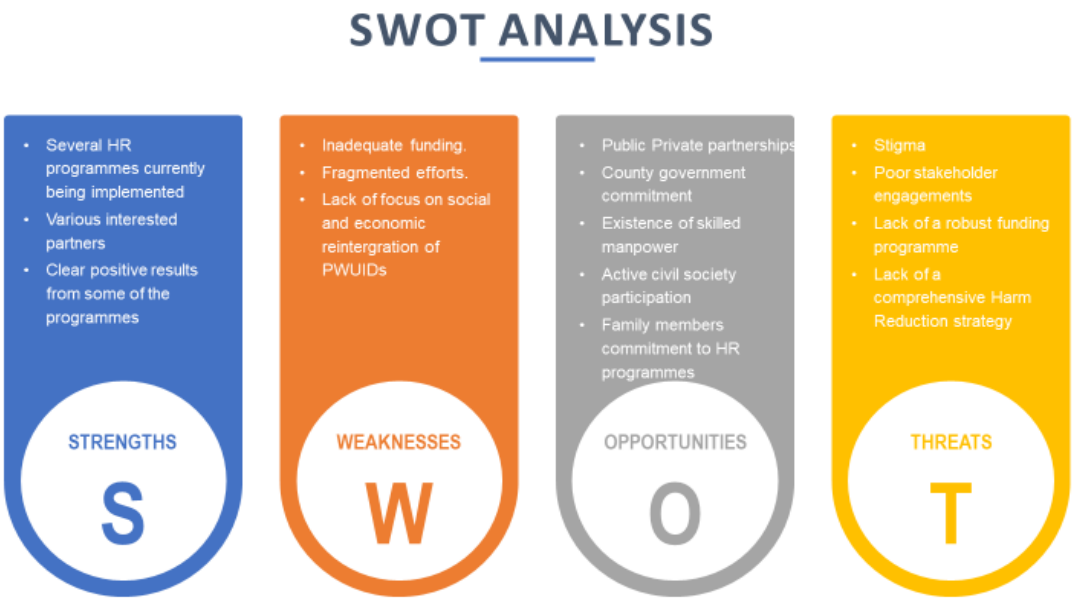

Figure 9: SWOT analysis findings

2.5.1 Conclusions and Recommendation

Mombasa County needs a comprehensive HR business plan that ensures:

- resource mobilisation
- social and economic reintegration for the PWUIDs, and
- awareness creation for stigma reduction.

Chapter 3: Business Plan

In this section, we present the vision, mission and goals of the business plan.

3.1 Vision, Goal & Objectives

3.1.1 Vision

A County free of substance abuse and its accompanying harm.

3.1.2 Mission

To provide leadership and resources to improve the individual, community and public health prevention, treatment, and recovery of substance use and its accompanying harm in Mombasa County.

3.1.3 Goals

3.1.3.1 Long-term goal

To implement comprehensive public health interventions that contribute to the reduction of substance use disorder and its accompanying harm in Mombasa County by 2026.

3.1.3.2 Medium-term goal

- To achieve 80% of harm reduction (HR) programmes funding from local resources within Mombasa County.
- To achieve an 80% success rate in harm reduction (HR) programmes within Mombasa County.
- To achieve an 80% success rate in work integration for those recovering from Substance Use Disorder (SUD) within Mombasa County.

3.1.4 Objectives

3.1.4.1 Broad Objectives

- To strengthen the policy environment and advocacy for PWUID in Mombasa County.
- To enhance social integration and protection for PWUID in Mombasa County
- Improve the quality of harm reduction service delivery for PWUID in Mombasa County.

- To enhance monitoring, evaluation, research & learning for harm reduction (HR) programmes in Mombasa County.
- To strengthen resource mobilisation learning for harm reduction (HR) programmes in Mombasa County.

3.1.4.2 Specific Objectives

- To develop or update guidelines and policies on harm reduction services in Mombasa County by year 3.
- To support family reintegration of PWUIDs in Mombasa County by year 5.
- To empower persons recovering from substance use disorder in entrepreneurship and life skills in Mombasa County by year 3.
- To strengthen the capacity of key stakeholders (county government, CBOs, families and service providers) to provide sustainable harm reduction (HR) programmes in Mombasa County by year 3.
- To strengthen quality service delivery, networking and linkages within MAT clinics in Mombasa County by year 3.
- To provide integrated mental health and comorbidities services in harm reduction (HR) programmes in Mombasa County year 4.
- To develop a monitoring and evaluation framework for harm reduction (HR) programmes in Mombasa County by year 1.
- To mainstream a liquor licensing committee in harm reduction (HR) programmes in Mombasa County by year 1.
- To harness political, technical and community leadership goodwill towards a common goal of sustainable harm reduction programmes in Mombasa County by year 3.

3.2 Expected Results

- Robust multi-stakeholder (including private sector and communities) engagement and participation in harm reduction (HR) programmes in Mombasa County.
- Increased county and domestic private sector financing of the key harm reduction programme requirements, including support for MAT clinics, livelihood programmes, and needle exchange, among others, in Mombasa County.

- Harmonised monitoring, reporting and dissemination of strategic information on harm reduction programmes across the public and private sector in Mombasa County.
- Meeting of short-term, medium-term and long-term goals of the Mombasa County Sustainable Harm Reduction Business Plan (SHRBP).

3.3 Strategic shifts and areas of focus

Moving forward, Mombasa County will shift its focus and prioritise these areas:

- Setting up a robust leadership and coordination committee for harm reduction (HR) programmes in Mombasa County.
- Focus on the reduction of substance use-related stigma and discrimination in Mombasa County.
- Setting up multifaceted, robust and sustainable harm reduction (HR) programmes in Mombasa County.
- Enhancing public-private partnerships to boost resource mobilisation harm reduction (HR) programmes in Mombasa County.
- Prioritising social and economic reintegration of PWUID in Mombasa County.
- Developing a monitoring and evaluation framework for harm reduction (HR) programmes in Mombasa County.

Chapter 4: Financing the Business Plan

4.1 Sustainability of HR programmes

Mombasa County needs a comprehensive and systematic approach to ensure the sustainability of harm reduction (HR) programmes. This comprehensive approach will ensure fewer people need care in HR programmes in the long run. To meet this goal, the County aims to:

- ensure the HR programmes sustainably get resources.
- ensure the PWUID receive services that reduce their exposure to health-related harm and infectious diseases.
- ensure that the PWUID who come into the programmes are successfully rehabilitated.
- ensure that PWUID stay usefully engaged in the community.
- ensure the PWUID are properly integrated into the community.

4.2 How do we ensure the success of HR programmes?

- Resource mobilisation to sustain HR programmes.
- Preparing PWUID to engage in meaningful work.
- Systemic changes at the community level to ensure sustained sobriety.

4.3 Funding and resource mobilisation for HR Programmes

The SHRBP proposes multiple streams of funding be sought to ensure a robust funding stream that can sustain all HR activities. Funding is anticipated from the County Government of Mombasa, private-public partnerships within the County, international donors and the community/public. The next section outlines how this can be done.

4.3.1 County government funding

- Allocation of 1% of the County health budget to HR programmes
- Allocation of 20% of the taxes collected from bars, joints and other such businesses to HR programmes.
- Setting up income-generating opportunities within the organisations running HR programmes. Example:

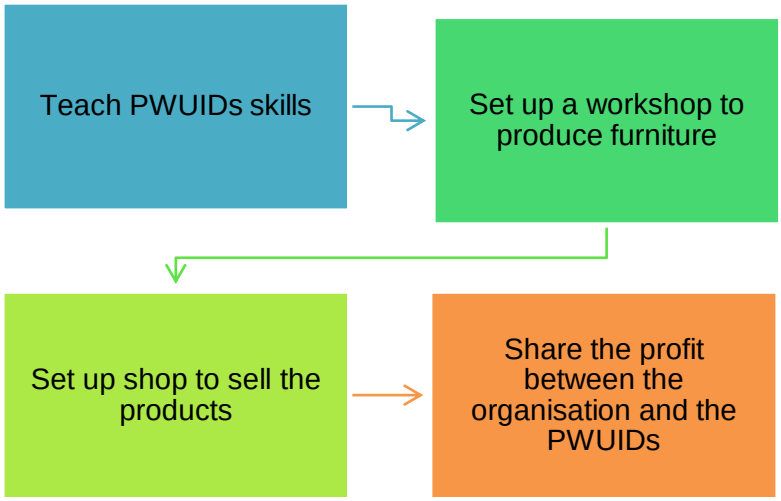

Figure 10: An example of an income-generating strategy

4.3.2 Private-Public Partnerships

The implementation team of the County Government of Mombasa will actively set out to enter into a Memorandum of Understanding (MOU) with prominent business entities within the County to raise funds from them. Additionally, the implementation team will work closely with philanthropists to open up another stream of funding. The MOU between the County and private entities or individuals can be used to raise funds in different ways such as:

- asking for yearly donations and sponsorship from private companies and philanthropists to the HR programmes;
- securing employment for PWUIDs in private companies;
- securing contracts to sell goods and services produced by the PWUIDs to private companies.

4.3.3 International organisations

International non-governmental organisations and multilateral agencies have always been important partners in terms of funding HR programmes. This business plan envisions them continuing to play an important role. A two-fold approach to getting these funds is anticipated. First, through directly funding the County Government of Mombasa and its activities. Secondly, community-based organisations within Mombasa County can access the funds through competitive funding-raising activities. The implementation committee for this business plan will facilitate training opportunities for CBO staff to acquire skills in grant writing and resource mobilisation.

4.3.4 Local community

The community within Mombasa County can be an important source of funds for HR programmes. This business plan proposes the organisation of events such as and fundraising drives *(Harambee)* by the County Government in partnership with the civil society and other providers.

4.4 Preparing PWUID to meaningfully engage in the workforce

- Skill training
- Potential for setting up technical and vocational skills training programmes within the MAT clinics and other centres attending to PWUIDs
- Starting programmes for linking PWUIDs with employers
- Supporting Small and Medium Enterprises:
    - Small and low-interest loans
    - Teaching Entrepreneurship
    - Providing mentorship on business management
    - Helping them set up self-help groups

4.5 Systemic changes at the community level to ensure sustained sobriety

- Fight stigma
- Create awareness
- Train peer counsellors
- Train more professional counsellors

Chapter 5: Implementation Plan

5.1 Background

A multisectoral steering committee should be set up to contribute towards achieving the vision, goals, and objectives of this sustainable Harm Reduction Business Plan (SHRBP). The steering committee will provide a platform for

- strategic planning.
- resource mobilisation.
- implementation of programmes.
- Monitoring of programmes.

The group will meet biannually and will be accountable to the CECM for Health.

5.2 Proposed membership to the Leadership and Coordination Committee

- County, sub-county and facility health management teams
- County Social Protection Department
- Implementation partners at both facility and community level
- Members of the police force
- Donor agencies
- Representatives from the private sector
- Representatives of communities of people with substance use disorders
- Representatives of community leaders
- Representatives from Technical and Vocational Education and Training (TVET) colleges
- Representatives from the local private business owners
- Representatives from the judicial system
- Representatives from civil society
- Representatives of youth advisory councils
- Representatives of faith-based organisations
- Representatives of political leadership

- UN agencies

5.3 Functions of the Steering Committee

- Monitoring the implementation of the business plan.
- Leading **advocacy and mobilising resources** for the HR programmes.
- Ensuring annual operational plans and budgets are in place.
- Leading **a community awareness programme** to ensure both social and economic re-integration of the PWUIDs.
- Identify priority interventions and best practices for scale-up within and outside the County.
- Identifying gaps and needs, and allocating programme targets for the County, sub-counties, facilities levels and implementing partners.

5.4 Costing Assumptions

Table 9: Annual cost estimates

ANNUAL SUMMARIES					
Broad Objectives	**YR1**	**YR2**	**YR3**	**YR4**	**YR5**
Strengthen the policy environment and advocacy	6,674,500	7,262,200	7,988,420	8,787,262	9,665,988
Social integration and Protection	11,928,000	17,173,200	18,890,520	20,779,572	22,857,529
Quality harm reduction service delivery	226,236,500	219,338,790	444,290,462	470,133,424	318,285,677
Monitoring, Evaluation Research & Learning	18,409,460	5,831,232	13,789,765	12,035,727	10,146,799
Strengthening Resource Mobilisation	22,584,750	20,493,825	22,779,158	25,057,073	27,277,281
Administration	26,944,740	7,954,694	8,750,163	9,625,180	10,587,698
ANNUAL TOTALS KES	**312,777,950**	**270,099,247**	**507,738,325**	**536,793,059**	**388,233,274**
ANNUAL TOTALS USD	**2,817,820**	**2,433,327**	**4,574,220**	**4,835,974**	**3,497,597**
GRAND TOTAL 5 YEARS					**2,015,641,854 KES** **20,156,419 $**

5.5 Monitoring and Evaluation Plan

- The steering committee will develop a monitoring, evaluation and learning framework.
- This framework will be instrumental in providing the policymakers and implementers with timely information and data necessary for effective adjustment and realignment of efforts for implementation and realisation of the aspiration of the harm reduction programmes.
- The HR indicators shall be the cornerstone of progress monitoring. Monitoring reports shall be prepared every 6 months at the county level and every 3 months at the sub-county level which shall be shared among the stakeholders and shall be used as a basis of HR review and re-planning.
- An end-term evaluation will be implemented in assisting the Mombasa County harm reduction stakeholders to identify key aspects such as effectiveness, efficiency and outcome of the Mombasa County Sustainable Harm Reduction Business Plan. This plan will be reviewed at the end of the 5 years of implementation. Baseline data will be compared to end-line data and will provide key statistics for measuring success.

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List of the Steering Committee

NAME	ORGANISATION /INSTITUTION
Dr. Khadija Shikely	Department of Health Services
Dr. Shem Patta	Department of Health Services
Dr. Mohamed Hanif	Department of Health Services
Ms. Esha Yahya	Department of Health Services
Ms. Zaituni Ahmed	Department of Health Services
Dr. Abdulnoor Ismail	Department of Health Services
Mohammed Abdalla Mwakazi	Department of Health Services
Ms. Rahma Hashim	Department of Health Services
Dr. Fayzal Sulliman	United Nations Office on Drugs and Crime
Mr. Soud Alli Tengah	Mental Health Innovations & Research (MEHIR) Consultancy
Ms. Naima Zamzam	Mental Health Innovations & Research (MEHIR) Consultancy
Mr. George Karisa	National Authority for the Campaign against Alcohol and Drug Abuse (NACADA)
Mr. Wilfred Mbogo	National Authority for the Campaign against Alcohol and Drug Abuse (NACADA)
Mr. Omari Mwanjama	National AIDS Control Council (NACC)
Ms. Mwanaisha Hamisi	Kenya Red Cross Society
Mr. Mohammed Rajab	Kenya Red Cross Society
Mr. Taib Abdulrahman	Reachout Centre Trust
Mr. Abdalla A. Badrus	Muslim Education and Welfare Association (MEWA)
Ms. Christine Mududa	Mombasa County Assembly – Legal Department
Mr. Lawi Muatwa Tariko	Kisauni MAT Clinic
Mr. Benazir Nero	Kisauni MAT Clinic

Annex I. Logical Framework

Intervention logic	Key indicators	Means of verification	Assumptions
GOAL/IMPACT LEVEL			
GOAL: To contribute to the elimination of drugs and substance abuse in Mombasa County by 2026.	Percentage of people who use drugs in Mombasa County	National Key Populations size estimates (NASCOP)	Size estimates exercises will be conducted by NASCOP
	Percentage of HR programme funded by the County Government of Mombasa	Mombasa County Annual Budget	The approved county budgets will be readily available
	Percentage of successful HR programmes in Mombasa County	County Department of Health Services annual reports/bulletins	There will be end-term evaluations done and reports readily available
OBJECTIVES/OUTCOME LEVEL			
Broad objective 1. Strengthen policy environment and advocacy	Number of county by-laws in favour of harm reduction beneficiaries and programmes	Mombasa County Assembly depository	The County Assembly depository will be easily accessible
Broad objective 2. Enhance social integration and protection	Percentage of recovering PWUID with income-earning activities	County Department of Health Services annual reports/bulletins	There will be end-term evaluations done and reports readily available
Broad objective 3. Improve quality harm reduction service delivery	Percentage of quality harm reduction service delivery improved	Concerted structures developed for all harm reduction partners and coordinated by the Mombasa County Government	Harm reduction partners collaborate and support the County Government
Broad objective 4. Enhance monitoring, evaluation, research & learning	Quality monitoring, evaluation, research & learning strengthen	Monitoring, evaluation, research & learning framework developed	Mombasa County Government will allocate budget
Broad objective 5. Strengthening Resource Mobilisation	Percentage investment of health budget allocated to harm reduction programmes	Mombasa County approved funding under the Health Department	Mombasa County Government will allocate budget
OUTPUTS LEVEL			
Strengthen the policy environment and advocacy			
Policies developed to create an enabling environment for harm reduction programmes	# of policies developed that create an enabling	Programme reports	The county government and key stakeholders will collaborate

	environment for harm reduction programmes		
Harm reduction service providers capacity built and strengthen for better service provision	# of HR service providers' capacity built and strengthened.	Training reports	Funds will available
Enhanced procurement system for Harm reduction commodities	# of functional procurement systems available for enhanced commodity procurement	Programme reports	Funds will available
Enhanced coordination of harm reduction stakeholders	# of coordination meetings for harm reduction stakeholders	Meeting reports	Funds will be available and stakeholders will collaborate
Enhance social integration and protection			
Enhanced family re-integration services	# of recovering drug users successfully re-integrated back to the society	Programme reports	Communities will allow the reintegration of recovering drug users back into the society
Enhanced access to civil legal documents by harm reduction beneficiaries	# of recovering drug users successfully accessed key civil legal documents	Programme reports	Government agencies will collaborate
Enhanced employment opportunities for recovering drug users	# of recovering drug users in income-generating activities	Programme reports	Employers will not discriminate against recovering drug users
enhanced psychosocial and mental health care support to harm reduction beneficiaries	# of harm reduction beneficiaries provided with psychosocial and mental healthcare services	Programme reports	Funds will be available and service providers will be recruited
Increased rehabilitation and rescue centres	# of rehabilitation and rescue centres in Mombasa county	Programme reports	The county government will allocate budget
Improve quality harm reduction service delivery			
Enhanced capacity in Harm reduction implementers	# of HR implementers capacity-built in harm reduction programming	Programme reports	Funds will be available.
Enhanced community referral pathways	# of HR beneficiaries referred for HR services	Programme reports	There will be a referral network established at community and site levels
Enhance monitoring, evaluation research & learning			

Enhanced implementation framework for harm reduction programmes	# of policies and guidelines developed to guide HR programmes	Programme reports	Stakeholders will collaborate in jointly developing policies and guidelines
Enhanced implementation of harm reduction interventions	# of harm reduction programme in Mombasa County	Programme reports	there will be capacity building opportunities for HR implementers
Evaluations conducted to review and inform HR interventions	# of evaluations conducted on HR programmes	Evaluation reports	Evaluation funds will be available
Strengthening Resource Mobilisation			
Integrated costing model for the Business plan developed	# of integrated costing models developed for the business plan	Programme reports	Stakeholder collaboration and political goodwill
Enhanced public-private partnership in Mombasa county	# of Public-private engagement frameworks developed	Activity reports	Stakeholder collaboration and political goodwill
Mainstreaming Liquor licensing committee to support HR	# of joint plannings conducted with the liquor licensing committee	Activity reports	Stakeholder collaboration and stakeholder collaboration
Enhanced engagement with Mombasa county MCAs	# of for a conducted with county MCAs	Activity reports	Funds availability and political goodwill
ACTIVITY LEVEL			
Strengthen the policy environment and advocacy			
Training of existing and new staff on HR services	# of HR service providers trained	Training reports	Funds and participants availability
Strengthening of security personnel through training	# of security personnel trained	Training reports	Funds and participants availability
Conduct and hold stakeholders training and meetings to support HR Services	# of trainings and meetings conducted to support HR services	Activity reports	Funds and participants availability
Arrange mobile outreach services with communities	# of community mobile service provision outreaches conducted	Activity reports	Funds will be available and security at the community level ensured
Enhance social integration and protection			
Monthly home visit on PLHIV, recovering clients and their partners	# of home visits conducted	Activity reports	Funds availability
Family therapy meetings to discuss enabling and co-dependency amongst clients and family members	# of therapy meetings conducted	Activity reports	Funds availability and clients' disclosure

Conduct outreaches in mobilising, screening clients in having primary legal documents	# of outreaches conducted	Activity reports	Funds will be available and security at the community level ensured
Conduct mobile ID clinics at the Drop-in centres, MAT centres for PWUID and recoveries	# of mobile clinics conducted	Activity reports	Funds will be available and security at the community level ensured
Quarterly meeting with chiefs, village elders and Huduma Centre on the support of legal documents for PWUD and recoveries	# of meetings conducted	Activity reports	Funds availability and political goodwill
Conduct Provision of one-to-one, group and family counselling services on risk reduction, drug use prevention and treatment, with community reintegration	# HR beneficiaries reached with counselling services	Activity reports	Funds and service providers' availability
Improve quality harm reduction service delivery			
Training of CSO and MAT facility staff on quality harm reduction strategies and service delivery	# of staff trained	Training reports	Funds and participants' availability
Ongoing Community engagements with key stakeholders including religious leaders, chiefs, law enforcement officials, CHVs among others	# of community meetings conducted	Meeting reports	Funds availability and political goodwill
Establishment of a "Harm reduction" toll-free line to encourage referral and linkages among community members.	# of toll-free lines established	Activity reports	funds will be available
Enhance Monitoring, Evaluation Research & Learning			
Conduct a 5-day workshop to develop the data collection and reporting tools	# of tools development workshops done	Activity reports	Funds and participants' availability
Conduct a 5-day training for the implementors on Results-Based Monitoring and Evaluation, Learning and Accountability (This includes the MEA&L Framework, guidelines and reporting flow, reporting and data tools)	# of implementers trained on RBME	Training reports	Funds and participants' availability
Periodic documentation of human-interest stories	# of HR articles developed and shared	Documentation depository	Funds availability
Strengthening Resource Mobilisation			
Sensitisation of private sectors on the framework for ownership	# of sensitizations done	Activity reports	Funds availability and political goodwill
Organise annual round tables with donors and development partners	# of meetings conducted	Meeting reports	Funds and participants availability

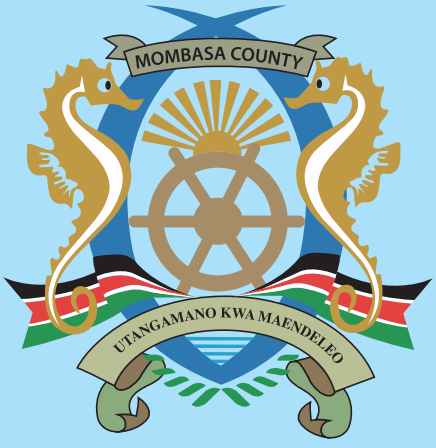
Conduct joint plannings with the liquor licensing committee	# of joint plannings conducted with the liquor licensing committee	Meeting reports	Funds availability and political goodwill
ADMINISTRATION			
Monitoring visit for HR TWG members	Number of Monitoring visits for HR TWG members	**Resources:** Lunch allowance, Transport allowance, **MoV:** Participants list, mission report	Funds will be available
spot-check visits by County senior staff	Number of field spot-checks by county senior staff	**Resources:** Lunch allowance, Transport allowance, **MoV:** Participants list, mission report	Funds will be available
Periodic stakeholders review meetings	Number of stakeholder review meetings	**Resources:** Conference package, Participants transport **MoV:** Participants list, payment list, meeting report	Funds will be available
HR Staff salaries (MOH)	HR Staff salaries (MOH)	Administrative Cost	Funds will be available
Administration costs	Administration costs	Administrative Cost	Funds will be available
Administration costs	Administration costs	Administrative Cost	Funds will be available

Annex II. Budget

Broad Objectives	YR 1 - 2021/22				YR 2 - 2022/23			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strengthen the policy environment and advocacy	**1,650,500**	**1,723,000**	**1,650,500**	**1,650,500**	**1,815,550**	**1,815,550**	**1,815,550**	**1,815,550**
Social integration and Protection	-	3,687,000	4,799,500	3,441,500	4,322,450	3,785,650	5,279,450	3,785,650
Quality harm reduction service delivery	**43,239,500**	**161,269,900**	**3,912,600**	**17,814,500**	**1,397,000**	**177,396,890**	**19,463,950**	**21,080,950**
Monitoring, Evaluation Research & Learning	**-**	**-**	**16,276,460**	**2,133,000**	**1,116,830**	**3,234,572**	**1,116,830**	**363,000**
Strengthening Resource Mobilisation	**4,577,000**	**11,219,250**	**1,631,000**	**5,157,500**	**4,820,200**	**5,180,175**	**4,820,200**	**5,673,250**
Administration	**1,752,885**	**13,525,085**	**9,913,885**	**1,752,885**	**1,928,174**	**1,928,174**	**2,170,174**	**1,928,174**
Total	**51,219,885**	**191,424,235**	**38,183,945**	**31,949,885**	**15,400,204**	**193,341,011**	**34,666,154**	**34,646,574**

Broad Objectives	YR 3 — 2023/24				YR 4 - 2024/25			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strengthen policy environment and advocacy	1,997,105	1,997,105	1,997,105	1,997,105	2,196,816	2,196,816	2,196,816	2,196,816
Social integration and Protection	4,754,695	4,164,215	5,807,395	4,164,215	5,230,165	4,580,637	6,388,135	4,580,637
Quality harm reduction service delivery	189,267,353	210,702,019	23,068,045	21,253,045	208,526,838	214,650,237	23,245,250	23,711,100
Monitoring, Evaluation Research & Learning	8,283,273	2,274,219	2,832,973	399,300	3,116,270	2,148,926	3,116,270	3,654,261
Strengthening Resource Mobilisation	5,538,170	5,698,193	5,302,220	6,240,575	5,832,442	6,268,012	5,832,442	7,124,178
Administration	2,120,991	2,120,991	2,387,191	2,120,991	2,333,090	2,333,090	2,625,910	2,333,090
Total	**211,961,587**	**226,956,742**	**41,394,929**	**36,175,231**	**227,235,621**	**232,177,717**	**43,404,822**	**43,600,079**

Broad Objectives	YR 5- 2025/26			
	Q1	Q2	Q3	Q4
Strengthen the policy environment and advocacy	2,416,497	2,416,497	2,416,497	2,416,497
Social integration and protection	5,753,181	5,038,700	7,026,948	5,038,700
Quality harm reduction service delivery	28,249,077	236,115,261	25,935,799	27,985,539
Monitoring, Evaluation Research & Learning	1,941,397	1,880,666	6,324,736	-
Strengthening resource mobilisation	6,415,686	6,894,813	6,415,686	7,551,096
Administration	2,566,399	2,566,399	2,888,501	2,566,399
Total	**47,342,237**	**254,912,335**	**51,008,168**	**45,558,231**



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