Perceptions and experiences of people who use drugs, regarding their lives in relation to drug use, and how it impacts enrolment to and retention in a MAT program in Kiambu county, Kenya

“I can change and transform my life”*
Disclaimer: The authors wish to emphasise that the views expressed in this report have been developed based on their study results and are theirs alone. The views expressed in this publication do not necessarily reflect the views of Médecins Sans Frontières (MSF) or of the MSF Vienna Evaluation Unit.

Study managed by the Vienna Evaluation Unit/Anthropology, OCB and Kiambu project teams in Kenya; Vienna/Brussels/Nairobi 2022/23.

The MSF Vienna Evaluation Unit started its work in 2005, to contribute to learning and accountability in MSF through good quality evaluations. The unit manages diverse types of evaluations, learning exercises and anthropological studies and organises training workshops. More information as well as electronic version of evaluation and anthropology reports are available at: http://evaluation.msf.org.

*Quote from a female participant in a FGD with active heroin users stating why she would like to engage in the MAT program.

Cover picture: Patient taking her methadon dosis. © Doris Burtscher/MSF 2022
Backpage picture: MAT patients attending a Yoga class in the Karuri MAT clinic. © Doris Burtscher/MSF 2022

© 2023 MSF Vienna Evaluation Unit. All rights reserved. Dissemination is welcome, please send a message to the Vienna Evaluation Unit to obtain consent: evaluation@vienna.msf.org
Author’s note

The anthropology team would like to thank all the research participants in Kiambu County who contributed to this study, trusted our small study team, and shared their personal stories and experiences regarding their life as active heroin users, MAT patients, peer educators, community health workers and all healthcare workers who engage with PWUD on a daily basis.

As a research team we cannot make immediate impact, but we hope that the information we have gathered and the conclusions drawn will enable MSF, LVCT and MoH together with the Kiambu team to strengthen the program to be able to respond to the needs of people who use drugs and MAT patients in a comprehensive and inclusive way.

My gratitude goes specifically to the anthropology study team Winnie and Morris, and also to the entire MSF project team in Kiambu, the coordination in Nairobi and the headquarters in Brussels for their valuable support. I particularly want to thank all the Kenyan and international colleagues who worked with me for their professional attitude, in-depth knowledge of the country and its people, and our enlightening discussions.

My experiences with MSF and in particular in this project, my colleagues and the people in Kiambu County are especially precious to me; they all have my deepest respect for their ability to cope with the difficult living conditions of people who use drugs and MAT patients and their endeavours of stopping using drugs or to engage in a medically assisted therapy.

This is dedicated to all those who are or will be part of the Kiambu project in Kenya in one way or another.

Research team: Doris Burtscher, Winnie Riitho, Morris Kariuki

Contact: doris.burtscher@vienna.msf.org, doris.burtscher@gmail.com

Support: Angela Thiong’o, Tolbert Ayuaya, Annelotte Speelman, Jesse Verschuere, Livia Tampellini, Umberto Pellecchia, Lucy O’Connell, Janet Ngethe, Annick Antierens

Study managed by the Vienna Evaluation Unit/Anthropology, OCB and Kiambu project teams in Kenya; Vienna/Brussels/Nairobi 2022/23

*Quote from a female participant in a FGD with active heroin users stating why she would like to engage in the MAT program.

Cover picture: Patient taking her methadone dose. ©Doris Burtscher/MSF 2022

Backpage picture: MAT patients attending a Yoga class in the Karuri MAT clinic.

© 2023 MSF Vienna Evaluation Unit. All rights reserved. Dissemination is welcome; please send a message to the Vienna Evaluation Unit to obtain consent.

Disclaimer: The authors wish to emphasise that the views expressed in this report have been developed based on their study results and are theirs alone. The views expressed in this publication do not necessarily reflect the views of Médecins Sans Frontières or of the MSF Vienna Evaluation Unit.
Abstract

‘I can change my life’: Perceptions and experiences of people who use drugs engaging in Medically Assisted Therapy (MAT) in Kiambu County, Kenya

Doris Burtscher¹, Winnie Riitho², Morris Karuri², Angela Thiong’o², Tolbert Ayuaya², Annelotte Speelman⁴, Edi Atte², Jesse Verschueren³, Livia Tampellini⁵, Umberto Pellecchia⁴, Lucy O’Connell⁵, Tom Ellman⁵, Janet Ngethe⁶, Annick Antierens³

¹Médecins Sans Frontières (MSF), Wien, Austria; ²MSF, Kiambu, Kenya; ³MSF, Brussels, Belgium; ⁴MSF, Operational Research (LuxOR) Unit, Luxembourg; ⁵MSF, Southern Africa Medical Unit (SAMU), Cape Town, South Africa; ⁶Ministry of Health, Kiambu-Kenya

Background

In 2020, approximately 284 million people worldwide used drugs, and around 60 million of them used opioids. The increasing availability of drugs such as heroin, cocaine, and methamphetamine, particularly in urban areas, compounds the burden of drug use in Africa. In Kenya, it was estimated that 26,673 people used opioids in 2021, with 3,312 of them in Kiambu County. The MSF Kiambu People Who Use Drugs (PWUD) project started in September 2019 in partnership with the Ministry of Health at the Karuri Level 4 hospital. By the end of April 2022, 590 PWUD had enrolled in the medically assisted therapy (MAT) program, with a retention rate of 69.8 percent. This study was launched to gain insight into PWUD’s perceptions and experiences regarding their daily lives and drug use behaviours, as well as the challenges they face in engaging in the MAT program.

Methods

This qualitative research study involved in-depth individual interviews (39), paired interviews (7), and group interviews (15). Purposive and convenience sampling methods were applied, and participants were selected by PWUD peer educators and LVCT members. All interviews were audio recorded and transcribed verbatim. The transcriptions were manually coded and further coded using NVivo 11 and analysed using qualitative content analysis. Methodological triangulation was applied to enhance interpretation.

The study was approved by the MSF Ethics Review Board (ERB) and the Kenya Medical Research Institute’s (KEMRI’s) Scientific and Ethics Review Unit (SERU) in Nairobi.

Results

The study found several challenges for PWUD to enrol and remain in the MAT program. Quitting heroin requires personal motivation and ‘exit strategies’ from the hotspots and dens that PWUD’s lives revolve around. Respondents reported the motivation to manage withdrawal with MAT, as expressed by one female participant in a focus group: ‘I can change and transform my life’. However, replacing heroin with MAT, or ‘the medicine’, was not sufficient to ensure meaningful recovery. Coping with a change in lifestyle and behavioural patterns and the need to develop new perspectives on how to deal with "idleness" were identified as barriers. Structural challenges ranged from accessing the program daily to maintaining a job or finding occupational opportunities.

Conclusion

The study revealed the complex realities PWUD are confronted with when trying to stop using heroin. MAT is necessary but insufficient without addressing the mental, social, economic, and behavioural conditions that contribute to opiate dependency. MAT programs need to be comprehensive and address medical, psychosocial and structural factors, supporting people as they re-build their lives and restore their broken social conditions through occupation and employment.

KEYWORDS: drug use, methadone engagement, heroin, opiate dependency, drug transition, harm reduction
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
</tr>
<tr>
<td>CHW</td>
<td>Community health worker</td>
</tr>
<tr>
<td>DFD</td>
<td>Decentralized Fixed Dispensing</td>
</tr>
<tr>
<td>DIC</td>
<td>Drop-In Centre</td>
</tr>
<tr>
<td>EC</td>
<td>Empowerment Centre</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency virus</td>
</tr>
<tr>
<td>HP</td>
<td>Health promotion</td>
</tr>
<tr>
<td>HPAM</td>
<td>Health Promotion Activity Manager</td>
</tr>
<tr>
<td>HQ</td>
<td>Headquarters</td>
</tr>
<tr>
<td>IDI</td>
<td>In-depth interview</td>
</tr>
<tr>
<td>IGA</td>
<td>Income-generating activities</td>
</tr>
<tr>
<td>KEMRI</td>
<td>Kenya Medical Research Institute</td>
</tr>
<tr>
<td>KP</td>
<td>Key population</td>
</tr>
<tr>
<td>LVCT</td>
<td>LVCT Health</td>
</tr>
<tr>
<td>MAM</td>
<td>Medical Activity Manager</td>
</tr>
<tr>
<td>MAT</td>
<td>Medically Assisted Therapy</td>
</tr>
<tr>
<td>MHPSS</td>
<td>Mental health and psychosocial services</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
</tr>
<tr>
<td>MSF ERB</td>
<td>Médecins Sans Frontières Ethics Review Board</td>
</tr>
<tr>
<td>OCB</td>
<td>Operational Centre Brussels</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid substitution therapy</td>
</tr>
<tr>
<td>PE</td>
<td>Peer educator</td>
</tr>
<tr>
<td>PI</td>
<td>Paired interview</td>
</tr>
<tr>
<td>PMR</td>
<td>Project Medical Referent</td>
</tr>
<tr>
<td>PSTC</td>
<td>Prison Staff Training College</td>
</tr>
<tr>
<td>PWID</td>
<td>People who inject drug</td>
</tr>
<tr>
<td>PWUD</td>
<td>People who use drug</td>
</tr>
<tr>
<td>SAMU</td>
<td>Southern Africa Medical Unit</td>
</tr>
<tr>
<td>SERU</td>
<td>Scientific and Ethics Review Unit</td>
</tr>
<tr>
<td>ToP</td>
<td>Termination of pregnancy</td>
</tr>
<tr>
<td>YPWID</td>
<td>Young people who inject drugs</td>
</tr>
<tr>
<td>YPWUD</td>
<td>Young People Who Use Drugs</td>
</tr>
<tr>
<td>WWID</td>
<td>Women who inject drugs</td>
</tr>
<tr>
<td>WWUD</td>
<td>Women who use drugs</td>
</tr>
</tbody>
</table>
# Table of contents

Author’s note ........................................................................................................................................1  
Abstract ..............................................................................................................................................1  
Abbreviations .....................................................................................................................................2  
Table of contents .................................................................................................................................3  
Executive summary .............................................................................................................................. ii  
1 Introduction ........................................................................................................................................1  
   1.1 Background ....................................................................................................................................1  
      1.1.1 Overview of drug use (Globe/Africa/Kenya) ........................................................................1  
      1.1.2 Context description ..............................................................................................................2  
      1.1.3 Problem statement ...............................................................................................................2  
      1.1.4 Rationale for the study .........................................................................................................3  
   1.2 Objectives of the study .................................................................................................................4  
      1.2.1 Primary objectives ...............................................................................................................4  
      1.2.2 Secondary objectives ..........................................................................................................4  
      1.2.3 Study aim .............................................................................................................................4  
      1.2.4 Research question ...............................................................................................................4  
2 Methods ..............................................................................................................................................5  
   2.1 Study setting ....................................................................................................................................5  
   2.2 Study design ....................................................................................................................................5  
   2.3 Study population ...........................................................................................................................5  
      2.3.1 Selection and recruitment of study participants ...................................................................6  
   2.4 Study process and data collection ...............................................................................................7  
      2.4.1 In-depth interviews ..............................................................................................................7  
      2.4.2 Focus group discussions ......................................................................................................8  
      2.4.3 Observations .........................................................................................................................9  
   2.5 Data management and analysis ...................................................................................................9  
   2.6 Quality control and quality assurance .........................................................................................10  
   2.7 Study limitations .........................................................................................................................10  
3 Ethical Considerations .......................................................................................................................11  
   3.1 Ethical review ..............................................................................................................................11  
   3.2 Informed consent .......................................................................................................................11  
4 Results ................................................................................................................................................12  
   4.1 The thin end of the wedge ............................................................................................................12  
      4.1.1 Why do people start using drugs? .......................................................................................13  
   4.2 Being ‘hooked on’ – active heroin use ......................................................................................15
4.2.1 Dosage and costs ................................................................. 15
4.2.2 Ways of using heroin .......................................................... 15
4.2.3 Challenges of heroin use ..................................................... 18
  4.2.3.1 Withdrawal – oesto ....................................................... 18
  4.2.3.2 Buying drugs, having a job ............................................ 19
  4.2.3.3 Community, mob justice, police, and prison ..................... 20
  4.2.3.4 Losing friends, quitting family ...................................... 22
4.2.4 Perception of heroin ........................................................... 23
4.2.5 Perception of PWUD – self-worth and self-esteem .................. 24
4.2.6 Women who use drugs ....................................................... 25
4.3 Behavioural patterns and ‘change of life’ ................................... 27
  4.3.1 A day as a drug user .......................................................... 27
  4.3.2 Life in the ‘den’ ............................................................... 27
  4.3.3 Quitting drug use – leaving the den .................................... 29
4.4 MAT – methadone and buprenorphine ..................................... 30
  4.4.1 Motivation to start MAT ..................................................... 30
  4.4.2 Preparation and enrolment to MAT ..................................... 32
  4.4.3 Perception of methadone ................................................... 34
  4.4.4 Perception of buprenorphine ............................................. 35
  4.4.5 Life after starting MAT ...................................................... 36
  4.4.6 Challenges to maintaining in MAT ..................................... 37
  4.4.7 Support during MAT ....................................................... 40
  4.4.8 The MAT clinic and its services ........................................ 41
4.5 Health experiences and access to health care ............................. 42
  4.5.1 People who use drug’s experience of their own health .......... 42
  4.5.2 Access to healthcare ......................................................... 43
4.6 Peer educators and CHW – the peer-led model .......................... 44
  4.6.1 Roles and responsibilities .................................................. 44
  4.6.2 Peer educators – empowerment ......................................... 45
  4.6.3 Peer educators’ challenges ............................................... 46
4.7 Harm reduction and outreach services ..................................... 49
5 Recommendations ....................................................................... 51
  5.1 General recommendations ..................................................... 52
  5.2 MAT clinic and DFDs ............................................................ 53
  5.3 Empowerment centre ........................................................... 54
  5.4 Person-centred for PWUD ....................................................... 54
Executive summary

Background

Around 284 million people used drugs worldwide in 2020, with approximately 60 million using opioids. The increasing availability of drugs such as heroin, cocaine, and methamphetamine, especially in urban areas of east Africa, compounds the burden of drug use. In Kenya, it was estimated that there were 26,673 people who used opioids in 2021, with 3,312 in Kiambu county alone. The MSF Kiambu people who use drugs (PWUD) project started in September 2019, in partnership with the Ministry of Health in the Karuri Level 4 hospital. By the end of April 2022, 590 PWUD had been enrolled in the medically assisted therapy (MAT) program with a retention rate of 69.8 percent. This study was launched to generate an understanding of PWUD’s perceptions and experiences regarding their daily lives and drug use behaviours, and challenges to their engagement in the MAT program.

Context description

The Kiambu project is an integrated medical care project for PWUD in Kiambu County. The project started in 2019 at Karuri Level 4 hospital. By end of April 2022, 590 PWUD have been enrolled in the program with a 69.8% retention rate. The project offers a One-Stop-Shop model of care where PWUD eligible for the MAT program have access to a comprehensive package of medico-psycho-social care. The clinic offers out-patient department (OPD) services, opioid substitution therapy (OST), wound care, sexual and reproductive health services (SRH), mental health and psychosocial services (MHPSS), nutritional advice provided by a nutritionist with management of those with malnutrition, a pharmacy, and laboratory. The MAT clinic is operated in collaboration with the Karuri L4 Hospital, NASCOP, Kiambu County Government and LVCT-Health. The global approach of our intervention is part of the harm reduction package of care. To increase access to services for PWUD, MSF opened the first decentralised fixed dispensing (DFD) in the Ruiru Prison Staff Training College (PSTC) health centre in May 2022 as an integrated model of care within the level 3 facility. The second DFD in the Thika Prison Health centre is expected to be operational by the first quarter of 2023.

Problem statement

Kenya, like other countries in Africa, experiences a high burden of drug use with about 37.1% of the national population reportedly having used a substance in their lifetime (NACADA, 2020). The increasing use of illegal drugs and substances among the young population in Kiambu county has had a devastating effect on their health, social, and economic functioning (NACADA, 2021). The Ministry of Health, through the National AIDS and STI program (NASCOP), incorporated the MAT programs as one of the mitigations in Human Immunodeficiency Virus (HIV) programming. This targeted the key population in Kenya with an overarching aim of reducing the HIV burden among the PWUD. This has enabled expansion of these services to further cover the medical needs of this population but with little information about perceptions, experiences, and behaviours of the PWUD population towards MAT services. Historically, accessing hard-to-engage populations like PWUD for harm reduction services has been challenging owing to the stigma, discrimination, and criminalization of PWUD. To provide better access to Opioid Substitution Therapy (OST) and other harm reduction services for PWUD, this qualitative study aimed to increase knowledge about the PWUD in Kiambu County, how this population can be reached, and how they would like to be engaged according to their experience in a better and appropriate manner.

Methods

This qualitative research study involved in-depth individual interviews (39), paired interviews (7), and group interviews (15). Purposive and convenience sampling methods were applied, and participants were selected by PWUD peer educators and LVCT members. All interviews were audio recorded and transcribed verbatim. The transcriptions were manually coded and further coded
using NVivo 11 and analysed using qualitative content analysis. Methodological triangulation was applied to enhance interpretation.

The study was approved by the MSF Ethics Review Board (ERB) and the Kenya Medical Research Institute's (KEMRI's) Scientific and Ethics Review Unit (SERU) in Nairobi.

Overview of findings

This report provides an analysis of the perceptions, experiences, and behaviours of people who use drugs viewing their lives in relation to drug use and how this impacts enrolment to and retention in the MAT program in Kiambu county in Kenya.

This results section will answer questions including why people started using drugs at all, how drug use influenced their lives and how it changed their life, how PWUD organise their lives, their relations, their drug use etc.; what PWUD think about MAT what they need to enrol and maintain in MAT; their perspective of harm reduction and outreach services and their expectations and suggestions how they could better manage their life being on MAT. These perspectives will be completed with PE and CHW experiences and perceptions of their role and challenges in the peer-led model. In addition, HCW’s views will be included to round up the results section.

The thin end of the wedge

How it all began? The very first question one might have in mind when talking to people who use drugs could be why they started using drugs, when they started and what kind of drugs they use. Our study team did ask these questions to better understand the reasons that lead to drug use. However, inspired by Gabor Maté’s book ‘In the Realm of Hungry Ghosts. Close Encounters with Addiction’ we added another approach and asked the participants who use or used drugs: “What did it [the drug] offer you, what did you like about it? Furthermore, in the short term, what did it give you that you craved or liked so much?” The answers to these questions lead to understanding why people started at all and are often not able to stop; in most cases, people answered that it helped them deal with emotional pain, stress, and that it reduced their suffering; it gave them peace of mind and helped them keep going through the day.

Why do people start using drugs?

The main reason why people—and these are mostly young people in their teenage years—started using drugs was the so called ‘peer pressure’. Most started using heroin because their friends used it, or they joined a group of young people and wanted to ‘fit-in’. Quite often such a journey started in school while already smoking weed, marijuana, or consuming khat or alcohol. Many didn’t know what they were smoking, when a friend offered them a joint laced with heroin and the effects it would have on their body. The second main reason was the psychological and emotional situation people got caught in. In most cases this was related to the family and traumatic events in their childhood.

Reasons for starting drug use, starting with the most frequently mentioned:

- Peer pressure, friends and to ‘fit-in’
- To relieve stress/depression/mental distress/pain/feeling sick/not to think too much, overcome hurt feelings (e.g., family rejection)
- Family (situation)
- Introduced by the partner
- Without conscious awareness and misinformation
- Pleasure and curiosity, experimenting and for fun
- Prison
- ‘Partnering’ – introduced by a friend to share drugs and costs
- Having money,
- having too much freedom
• Being a drug courier
• Imitating stars
• Coldness of the high-altitude area (Limuru)

Being ‘hooked on’ – active heroin use
Once heroin was used for a few times the person started feeling ‘sick’ and did not understand what they were suffering from until they learned that they were experiencing symptoms of withdrawal—the ‘aroosto’ in Kiswahili. When people finally understood that they were in a withdrawal stage, it was already too late to stop as they had already reached the addiction stage. This is the moment when the challenges with active heroin use started.

Dosage and costs
In the very beginning of heroin use people start in most cases with 1-2 sachets per day\(^1\) when smoking and end up using up to 10 sachets per day when they are fully addicted. When injecting which gives a much stronger effect and is the less frequent mode of heroin use in sub-Saharan Africa, people use less and can inject up to five sachets in a day when fully addicted. One sachet costs 100 KES\(^2\) in Mathare, the heroin depot in Nairobi. This price can rise up to 200 KES for one sachet in Limuru; in most other areas it costs 150 KES. Heroin is resold around 400-700 KES in the prison.

Ways of using heroin
In the project area where MSF works the main way of using heroin is smoking. Smoking heroin means that the heroin is laced into a joint with marijuana. Sometimes, the joints are pre-prepared and the PWUD would then suck up the heroin with the joint. Sometimes the joint with heroin is amplified with a paste made of Valium or Rohypnol or a sweet mixed with saliva smeared around the joint for a slower burning of the joint and to achieve a bigger high.

Injecting heroin is used when people want to get a ‘higher high’ or when they have not enough money to continue smoking. Smoking heroin is safer, and some people feel that they can better manage their drug consumption and the ‘high’. Injecting bared higher risks not only in terms of an infection with HIV or Hepatitis C virus (HCV) but also regarding a ‘miss’, meaning that the vein is missed and the place where the person tried to inject gets infected.

‘Flashblood’ is a syringe-full of blood passed from someone who has just injected heroin to someone else who injects it in lieu of heroin. ‘Flashblood’ is a way of sharing heroin with another person and mostly when money is short.

Smoking vs injecting
Smoking is less harmful; between smokers and injectors there appears to be a certain competition in terms of perception. Smokers look down on injectors and vice versa.

In most cases, it was a friend or a partner who motivated a person to move from smoking to injecting. In other cases, it was the money and to use heroin ‘more efficiently’. The main motivating factors for switching from smoking to injecting were explained to be able to have a ‘higher high’.

Challenges of heroin use
Being an active heroin user is associated with well-known challenges. This is not very different from what other drug users experience around the world. The main challenges are linked to the vicious cycle of dealing with the addiction and withdrawal and generating money to buy the drugs. Other challenges refer to the loss of home, family, and friends, quitting school, loss of job, loss of personal hygiene, self-rejection, risking their health and life with an overdose, engaging in petty crimes, change of behaviour, and rejection and mistreatment by society in general.

---
\(^{1}\) One sachet is referring to one dose.
\(^{2}\) 100 KES are 0.80 USD.
Withdrawal – arosto

PWUD fear mostly the withdrawal stage. This is not only related to the active heroin use practices but also when PWUD think of starting MAT and all the conditions for preparation going along with it. PWUD explained that they are not ‘functional’ when in a withdrawal stage; they are not able to talk ‘normally’, to work, to care for their families, to socialise, to maintain their daily life they used to before starting with heroin. Many compared the withdrawal stage with feeling sick; for example, having malaria, a high-grade fever, headache, sweating, joint pains, itching, cold sweats, and the feeling of things crawling all over the body.

Buying drugs, having a job

The main preoccupation of all the active drug users was thinking about how to get the money for the next dose. Jobs are not easily found and most active drug users and even some MAT patients do face stigma and discrimination when looking and applying for a job. People do not trust them anymore as they are seen as unreliable people and very often as criminals, who would steal, lie, and commit petty crimes. Money is generated through casual jobs and mostly through breaking into houses, stealing from someone and selling the item, e.g., laundry or washed blankets hanging outside overnight, fruits and vegetables in the markets, phones, side mirrors or tires or vehicle name tags like Porsche, Toyota, Mercedes and X-Trail to sell them off. When an active drug user is still within the family, he or she tries to cheat and tell family members and friends that they are sick, they must go to the hospital, or need money for the school, etc. The main jobs drug users can perform are touting at the bus station and collecting scrap metals or plastic bottles or carrying goods for people at the market.

Community, mob justice, police, and prison

Community perceptions of PWUD and even of some MAT patients were negative. PWUD are criminalised by the society. It is widely accepted that PWUD choose to do drugs of their own volition or free will. Addiction is complex and consists of many different underpinnings that cannot merely be reduced to psychological or neurological elements. We dare say that an addicted person does not consciously decide to take a next dose; there is always something stronger within that pushes them to continue. Most people in the community or surroundings of a drug user have a judgemental attitude towards them; they do not understand why they continue using drugs. HCWs insisted that viewing it as a disease might help them understand that the problem is the addiction, not the person. These attitudes become even more severe when it concerns women who use drugs.

Mob justice was mentioned a lot by the respondents. As active drug users stole if they did not find any other means to generate money, people got angry and aggressive. Whenever they caught one of them, others would join in = beating up the person, sometimes to death. It was also said that mob justice was getting more frequent and represented a considerable risk for drug users.

PWUD frequently suffer from police harassments. How the police interact with drug users differs from area to area. In some places, they continuously reach out during the night to the hot spots to chase and dispel the drug users, to beat them up, and to bring them to prison. In other places, drug users explained that they bribe them to be left alone. Many interview participants also recounted that the police and the community report and condemn them for things they have not done.

Losing friends, quitting family

The family is a crucial factor shaping community perceptions of drug use. Many respondents highlighted that community acceptance of drug users often depends on whether their families accept them. Almost all respondents described how drug use strained their family relationships. Some had to leave their families, either because they were expelled or because they felt ashamed of their drug use and stealing.

Many PWUD come from disadvantaged family backgrounds. Some come from single-parent families, with mothers or fathers raising them alone. Others are orphans or homeless, lacking a stable place to sleep. Most have limited education. For these individuals, reconnecting with their families can be challenging, as the family ties may have already been broken prior to drug use. When PWUD lose
their family connections, they often find new ‘families’ among other drug users at hotspots and dens where they gather and use heroin.

**Perception of heroin**

Heroin was perceived in various ways. When first starting drug use, it was perceived to be a drug they craved and became a desired object. Over the course of drug use and increased addiction, heroin became increasingly associated negatively. Heroin was called ‘selfish’, ‘to be the devil’, and was also compared to a hole where it was easy to enter but very difficult to get out. It was also referred to ‘slavery’, as heroin would enslave one’s mind as explained here by a patient who stopped MAT—’because everything you think and the actions you take are geared towards getting more and more of it’. People said that although heroin was a sickness, they would feel sick without heroin. They called heroin their healer and their sickness at the same time. Contrary to what has been said, some opined that with heroin, people did not get sick as heroin numbed everything. Almost all the respondents talked about heroin as being their everything. It was said to give the ‘sweetest high’. Others told us that they were ‘married to heroin’, that ‘heroin is their wife their family, their number one’.

**Perception of PWUD – self-worth and self-esteem**

Active drug users talk as ‘junkies’ about themselves. Being a ‘junkie’ was associated with heroin use, being dirty and careless, being homeless, living in the streets, being a thief and engaging in petty crimes, being a bad person, a person one cannot trust. Given the effects of heroin and the nodding off, drug users called themselves ‘the walking dead’ and that they looked like zombies. PWUD are rejected by the society and other people do not like them. These negative perceptions along with their own lived experience of being a heroin user made them reject their own self. Expressions like ‘I don’t like myself anymore’, ‘I hate myself’, ‘I feel useless’ or ‘I brought shame to my family’—for what they did and what they became—were common testimonies. One active drug user said: ‘Like me now, I am a village crack’.

**Women who use drugs**

It is a considerable finding that less women were found in the dens and hotspots and less women came in for MAT. Participants referred to the ‘culture’ in the country, that women were not ‘expected’ to be using drugs, and that it was unexpected and for some, unheard of, for a woman. However, a few female interviewees insisted that this is not so much the case anymore. A female HCW also reflected on the notion that women and girls are less exposed to risks such as drug use as they have less freedom in terms of going out and moving around.

When we talked with women who were active drug users, all of them denied engagement in commercial sex work to be able to provide for their drugs. However, they acknowledged the feeling of deep stigmatisation in their social environment. Women who did engage in sex work left their social environment; they moved either to Nairobi or to smaller cities to ‘sell their body’ and to be closer to drugs.

**Behavioural patterns and ‘change of life’**

Behavioural patterns do change because of the challenges that go along with drug use. How do drug users manage their days and how do they live in the dens?

**A day as a drug user**

The daily routine of many PWUD involves waking up around 3 AM in search of items to steal or sell to obtain the money for their first dose of heroin. They then spend the day searching for more money to continue purchasing drugs to sustain their addiction. This cycle continues until they take their final dose, known as the ‘locker’, in the evening to allow them to sleep before repeating the process again the next day.
Life in the ‘den’
In the world of drug use, dens play a significant role in the lives of most drug users, primarily men. Here, they gather with their friends and ‘family’ to exchange, bond, and partake in drug use. Despite its protective nature, living in a den can also be a dangerous experience. To avoid detection by authorities, individuals living in dens often adopt a nickname. Some dens are organized hierarchically, with pushers and leaders, who buy and sell drugs within the den. For most PWUD, the den is everything—their home, their family, and their company. It is where they feel connected and accepted, and it provides them with a sense of belonging. Living in a den often means sleeping under market stalls, in construction sites, empty buildings, houses, or even in the forest or open air. Basic necessities are hard to come by, and a plastic sheet from a rice sack serves as a blanket, while a piece of cardboard doubles as a mattress.

Quitting drug use – leaving the den
PWUD often express feeling exhausted by their current lifestyle and express that they are "sick of being sick". They have often disappointed family members and neglect their responsibilities, including their relationships and children, due to their drug use. In hindsight, many PWUD regret ever starting heroin as they realize the losses they have experienced cannot be replaced by the drug. Encounters with former users who are now clean, as well as peer educators (PE) or community health workers (CHW) who have a better life after quitting heroin, can also be a trigger for individuals to stop using heroin and start MAT. However, quitting heroin and starting MAT is not a simple process of replacing one drug with another. A holistic approach is necessary, considering psycho-social, economic, financial, personal, and empirical factors to create a supportive environment.

For a drug user, this process can mean leaving behind their social networks, friends, family, and even their home to engage in a new lifestyle and break with their accustomed conduct and behaviours. It is a complex process that requires comprehensive support.

MAT – methadone and buprenorphine
Motivation to start MAT
In the words of MAT patients, readiness of the mind is paramount, and it is incumbent upon the individual to display a resolute commitment to eschew heroin and commence MAT. While some are inspired by the progress of peers in the program, others are galvanized by informational sessions and the medical provisions offered at the Karuri MAT clinic. However, the impetus to begin MAT can be encumbered by lack of accurate information or even misinformation, such as the belief that methadone is akin to heroin or that it may cause death. Moreover, the fear of experiencing withdrawal symptoms during the initial phase of dose calibration can be a significant deterrent to initiating MAT.

Preparation and enrolment to MAT
Before PWUD are enrolled to the program they are visited by a team in the dens and informed and sensitised about how they can stop using heroin and start MAT. To be enrolled to the program PWUD must be registered at LVCT to get a file and a unique identifier code. This is not only for the methadone but also for the other services that are provided. These services include reproductive health services, HIV testing and counselling, treatment of STIs, harm reduction services through the distribution of needles and syringes, and condoms and lubricants for those who need it. After filling the form, the person visits a counsellor for more information and to receive in-depth advice. Initially, LVCT requested a five-day preparation phase which was then reduced to three days, and now to one day. LVCT does the information and preparation sessions directly in the dens and hotspots now.

MAT enrolment was nonetheless challenging regarding readiness and determination. The fear of experiencing withdrawal symptoms is still prevalent and might prevent PWUD from starting the process as they have to wait until they get the first methadone or buprenorphine dose. Then they
have to wait and be monitored for withdrawal symptoms until they are adjusted to the right dose during the coming days.

Several PE experts suggested that the initial preparation phase of five days is too long and should be divided into two parts. The first part, which involves essential counselling, should be attended before individuals are put on methadone or buprenorphine. The second part, which is more informative, should be followed when individuals are already on MAT.

For some individuals who could not be linked to a family member during their treatment period, they would require a close friend who is also on MAT to accompany them, motivate and encourage them daily, or a treatment supporter or buddy. A big challenge is the transport fare, not only for reaching the MAT clinic when someone is already enrolled, but also to encourage PWUD to start MAT. PEs experienced contests with active drug users. They often had to pay the transport fare for the active drug user to bring them for enrolment.

**Perception of methadone**

Most respondents did not differentiate between MAT and methadone or buprenorphine, and everything was referred to as MAT. The phrase 'I take my MAT, I go for MAT' was frequently heard when individuals talked about taking methadone. When people talked about MAT, it did not necessarily refer to other services at the clinic.

Respondents who were stable in using MAT and were able to regain a healthy and steady life spoke very positively about MAT. We received numerous encouraging feedback on how MAT had influenced people's lives and helped them reunite with their families, go back to their jobs or continue their education, and rebuild their image in their social environment. However, we also encountered MAT patients who, despite receiving treatment, still struggled with their lives. Perceptions ranged from viewing methadone as a drug like heroin, some said it would be stronger than heroin whereas some compared it to heroin because they would still experience withdrawal symptoms when they did not take it. Others said that one would even get a greater addiction with methadone. A remarkable perception was that methadone had to be taken alone by the person while heroin can be shared with others. Two particularly interesting perceptions arose during the interviews. Firstly, people referred to methadone as 'budget' or 'to be high on another money', alluding to the fact that they received methadone for free. Secondly, people referred to MAT as 'the heroin from the government'. This perception came from their observation that the methadone was delivered to the clinic with armed guards.

**Perception of buprenorphine**

**Buprenorphine was preferred over methadone because:**

- I liked it because it balanced my mood.
- One can miss Bup dose for up to two days without adverse effects.
- You can travel – can get take-away dose if arranged with Dr + counsellor.
- Bup is quickly absorbed, and one can feel its effect in 20 minutes.
- Bup aids in quick recovery = Kunawiri – glowing in good health – increased appetite, increased body weight and better health.
- You do not need to use a high dose, a little goes a long way e.g., three days (on 20 mg) without arosto (withdrawal).

**Experiences with buprenorphine**

- Sex is better with Bup (no premature ejaculation), with methadone it takes too long before 'coming' or one comes to soon (ejaculation).
- Performance during sexual intercourse is ok because you feel a bit high.
- Less people use Bup, less chance of grouping and related misdirection, misinformation.
• Bup can aid in stopping cigarette smoking.
• Bup is easier to stop (wean-off).
• Most fear mixing Bup with other drugs – less cross addiction.
• Satisfied with Bup.

Life after starting MAT
Life after starting MAT is largely related to community perception and acceptance, family reintegration, occupational opportunities and income generating activities. It refers again to the question of leaving the accustomed social environment and is closely related to the notion of belonging. The ones who could move from a life as a drug user to be a stable MAT patient with family reintegration and support will view it conversely.

Challenges to maintaining in MAT
The main challenges people face to maintain their MAT include distance to the MAT clinic and daily transport fees. Second, lack of occupation and joblessness, and third, homelessness. The MAT program was criticized for focusing only on medication and not on providing opportunities to find jobs and access shelter for the homeless. On a positive note, people reported a change in their behavioural patterns, as they no longer want to engage in petty crimes.

Homelessness and lack of occupation went hand in hand with cross addiction during MAT. Most patients took other drugs while on MAT to either feel a high or because they were not satisfied with the methadone or buprenorphine dose, or because of peer pressure or as acknowledged by many, because they had nowhere to stay and nothing to do. Examples of cross addiction were:

• Methadone and Heroin
• Methadone and Marijuana
• Methadone and Alcohol
• Methadone and MCII called mic or microphone = ‘Jet-fuel’
• Methadone and Diazepam (or Cozepam) called ‘Ma yellow’, ‘C’s’
• Methadone and benzhexol called ‘Ma white’

Marijuana or alcohol were used for attaining a feeling of being high. Alcohol is widely accepted in general but bears a high risk of overdose for MAT. Alcohol is used in the form of spirits either legal/standardised or homemade and often laced with harmful chemicals. The jet-fuel consumption outside the clinic is one good example to show how people are pushed into cross addiction unintentionally. MAT clients have admitted that they are using jet-fuel because it was offered, it was cheap and because their peers or friends were using it too.

Positive outcomes that encouraged MAT patient to continue with the treatment were related to getting support from Matatu [minibus] drivers who gave them free lifts to go to the MAT clinic or DFD. Others received support for transport expenses from a family member and other participants said they moved closer to the clinic to be able to go for their daily dose and others again stated that they come by foot every day as transport fare is not affordable. Support in general from family members or other ‘treatment supporters’ was paramount to maintain MAT.

The MAT clinic and its services
Perceptions and experiences with the services provided at the MAT clinic differed if we talked with HCWs or with MAT patients. HCWs insisted very much on the need for more counselling and group counselling not only in the clinic but also in the DFD and the communities, including the families. One HCW even suggested that a counsellor could act like a family member when support from the family is not given. It appeared that the notion of counselling and the provision of mental health services in

---

3 Jet-fuel is referred to the fuel used by aeroplanes.
general was not so much known to the patients as only a few talked about it as a service they could take up. However, as said earlier, from the HCWs perspective, counselling was very much needed and therefore, more awareness should be created about it. From a MAT patient’s perspective, the clinic was especially appreciated for its accessibility and its medical services. The empowerment centre and the activities they could engage with was very much appreciated as were the income generating activities like the farming group.

Health experiences and access to health care

People who use drug’s experience of their own health

Individuals who use drugs often have a unique perspective on their own health. Their top priority is to alleviate withdrawal symptoms and obtain their next dose of heroin, rather than focusing on overall health and well-being. During interviews, participants emphasized that while using heroin, they do not experience physical discomfort, as the drug serves as a form of anaesthesia. However, they also acknowledged that their addiction to heroin is in itself a sickness, and the only treatment they seek is more heroin. Some individuals even referred to the drug den as their ‘health centre’ and heroin as their ‘doctor’. Some female interview participants referred to their body and how it had changed because of drug use. They referred to getting slim, their skin getting darker in texture and that they did not perceive themselves as good looking anymore. Women also spoke of their sexual and reproductive health, saying that they experienced irregular menstruation and sometimes menstruation stopped altogether but that it come back when they started MAT.

Access to healthcare

People who used drugs acknowledged that access to healthcare was hampered by their own appearance, their looks, and their attitude. This was reflected by the HCWs attitude towards them. All this together resulted in not seeking care when they needed for example in the case of an accident. In a private hospital or clinic, they would need to pay which they could not afford and in the public sector, they faced stigma and discrimination. In short, people simply did not go. As PWUD could not afford formal healthcare when sick, in most cases they self-medicated. People who live and use drugs together in a den showed great attitudes of solidarity. They continuously referred to helping each other be it for buying and using drugs or to help one of them to get medical attention. When a person is in a condition wherein, they absolutely need medical care, his or her peers from the den would put the money together to bring the sick person to the health facility. Accessing healthcare at the MAT clinic was positively acknowledged, as said before.

Peer educators and CHW – the peer-led model

The peer educators and community health workers play a crucial role in linking the MAT program to active heroin users in the dens as well as to link MSF activities with LVCT services. This peer-led approach is based on an LVCT/MSF partnered microplanning outreach system with a strong component of community-led monitoring, to ensure social networks of PWUDs are regularly engaged with and supported with access to health care.

All PE and CHW are former active heroin users and are in the MAT program. PE work with LVCT and receive a stipend of 3,500 KES (28 USD), an amount that is set by the government; the CHW are employed by MSF and receive a salary.

Roles and responsibilities

In their role as PEs, they mainly work in the dens directly with the PWUD and support them in every way they can. This includes informing and sensitizing them about MAT and providing them with clean needles and syringe kits (NSP kits), condoms, and helping them to link with the clinic if they have medical issues or if they are in contact with the police due to an arrest. When active heroin users inject in an area, PEs should also clean the place to remove dirty needles and monitor if they have enough NSP kits. PEs can also give naloxone in case of an overdose directly in the dens and hotspots. CHWs are more active in different facilities like the Karuri MAT clinic and the DFDs.
Peer educators – empowerment

Being a PE or a CHW helped significantly to support a MAT patient in their life situation, first by having an occupation or a job and second by feeling motivated in continuing their MAT treatment. PE and CHW felt valued and worthy, they saw themselves as role models for other PWUD to follow their path. It was a way for them to rebuild their lives and regain respect by the community and their families. Many participants mentioned that being a PE or CHW immensely helped them in their recovery for themselves and helped rebuild their life and the ‘change’ they were able to achieve.

Peer educators’ challenges

Being a PE or a CHW gives people a sense of value, increases their self-esteem, and helps them in being occupied and regain respect from the community and families among others. However, when we had an FGD with PEs, we understood that they faced various challenges ranging from the renumeration to reaching the target of enrolling new MAT patients to worries in their relationship with PWUD in the dens. Going back to the dens also meant going back to the old environment that the PE spent their time and day while they were still active drug users. It meant being exposed to the drug user’s environment and activities of buying, smoking, and injecting. On the other side, when PE went back to the hotspots and dens, they were not always received with open arms. PWUD did have expectations towards them and often asked them for money to buy drugs. PEs recounted that PWUD told them that they did this job only for the money, and that if they wanted them to join MAT, they should give them something in return.

Harm reduction and outreach services

The people-centred approach of harm reduction endeavours to establish a trustworthy bond with individuals who use drugs and enhance their overall well-being. The services provided should not only be available but also accessible, acceptable, affordable, and of superior quality to guarantee that drug users can exercise their right to healthcare. Drug use, especially heroin use, is an inherently social phenomenon and must always be evaluated within its social context. Most of the harms associated with drug use are either caused by or exacerbated by the social risk environment in which it takes place.

Active drug users were familiar with services like the distribution of NSP and testing activities that they were encouraged to make use of and the distribution of condoms.

As presented in the interviews all harm reduction aspects are relevant to improved health outcomes for people who use drugs.

- NSP program stopped sharing of needles, syringes and other injection paraphernalia.
- Less HIV/Hep C Hep B, STIs, TB, c/o tests, treatment and mainly no sharing of sharp body piercing instruments.
- Encouragement for consistent and correct condom use (if available).
- HP education brings awareness to users and community.
Recommendations

As a premise, access to MAT should be possible for every individual. Therefore, MAT provision should be close and easily reachable for every PWUD who would like to engage in a MAT program and for MAT patients to maintain. We should tackle the factors that influence and impede access.

Advocate towards the MoH and NASCOP not only for medically assisted therapy treatment and psychosocial treatment of MAT patients, but also to look at life circumstances that disempower individuals to stay on MAT treatment.

Entail a holistic approach with patient-centred attitudes, using non-judgmental language and harm reduction approach. The clinic should not just focus on medication or stopping heroin as the overall objective but should also include social and mental services as well as counselling. These services should be complemented by support for homeless and jobless MAT patients to reduce defaulting and relapsing.

Provide continuous information on MAT. MAT is still a new concept in Kenya, as many healthcare workers have noted, and would need to be explained and promoted on all levels—society, community, family, and MAT patients themselves. People often know only about a rehabilitation concept where PWUD are referred to a facility and undergo 'cold turkey,' which can result in quick relapse to heroin.

Engage in a health navigator system—having a buddy for newcomers to MAT, who can be supported and guided from the beginning by someone who has been longer and stable on MAT. Those who are stable on MAT can be leaders in educating others in hotspots and dens, serving as peer educators with LVCT. Having 'buddies' or health navigators for new MAT patients could help them ease into MAT and motivate continuation.

Let us create a place of belonging at the MAT clinic for patients attending it. Maybe this concept can be triggered through the health navigator or buddy system? Ensure to update a mapping of CBOs and CSOs in the area and find out with which ones we could collaborate for which topic and how they could help to bridge the gaps. For sustainability, when MSF leaves, the CBO can continue working with LVCT. Again, in the realm of sustainability, train employees to be able to continue once MSF has left.

Help to support capacity building to create a community-led organisation to have a half-way/re-engagement house for homeless MAT patients, with someone in charge who comes from a lived experience to help MAT patients in their transition from their 'old life' in the dens to a 'new life' as a MAT patient.

There are already some great initiatives of self-help groups led by social workers. We encourage further assistance and support for self-help groups where MAT patients and family members come together, at least occasionally, to talk about what is happening in their lives. Such interventions could focus on mutual support and avail opportunities that will improve the self-esteem of the patients. Such support groups could take place at the CBO.

The MAT approach is focused mainly on patients, but we need to include significant others, such as family and community. Family and community members could meet at the CBO rather than at the clinic for specific topics to raise awareness, ask questions, and discuss fears and uncertainties.

Continue with the MAT patients working on their skills and talents and let them present these to the community. Dance performances, a choir, a theatre group, a concert performance - one MAT patient said he is a graphic designer, another is a computer specialist. Ask MAT patients about their talents and let them propose something. MAT patients can show the community that they are individuals with skills and talents. This will help reduce stigma and discrimination and create a supportive environment in the MAT clinic, DFDs, and surroundings.

---

4 Please go to the main report for the full range of recommendations; writing a summary here would be a limitation.
5 It looks like that this is already done, so look into it again.
6 The creation of a CBO has already started.
1 Introduction

1.1 Background

1.1.1 Overview of drug use (Globe/Africa/Kenya)

Around 284 million people used drugs worldwide in 2020, while over 36 million people suffered from drug use disorders, according to the 2021 World Drug Report, released 24 June 2021 by United Nations Office on Drugs and Crime (UNODC, 2021). Lower perception of drug use risks has been linked to higher rates of drug use; the findings of UNODC’s 2021 World Drug Report highlight the need to close the gap between perception and reality to educate young people and safeguard public health (UNODC, 2021). The increased availability of illicit drugs such as heroin, cocaine, and methamphetamine especially in urban areas has compounded the burden of drug abuse in Africa (Syvertsen et al., 2015). In Kenya, the use of cannabis (bhang) and khat (also known as miraa, a legal substance in Kenya) is widespread across the country. The use of heroin and cocaine has also been reported in the country since the 1980s. Recently, heroin has become the second most widely used narcotic drug in Kenya, after cannabis (NACADA, 2021). The increased availability of ‘white heroin’ powder has led to a rise in heroin injection since the late-1990s, supplanting the previously prevalent ‘brown heroin’ (Beckerleg et al., 2005). Subsequently, the drug market also shifted in the late-1990s when ‘brown sugar’ heroin was replaced by ‘white crest’ heroin, which users in Kenya believed to be from Thailand (Beckerleg et al., 2005). Following the heroin shortage that occurred between December 2010 and March 2011, which had severe implications for the health of heroin users (Mital et al., 2016), Kenya included harm reduction measures in its national HIV strategic plans (NASCOP, 2013). In Kenya, there are an estimated 26,673 people who use drugs (PWUD) (NASCOP, 2021). Kiambu County ranks 5th amongst the counties in Kenya with the highest number of PWUD after Mombasa, Nairobi, Kilifi, and Kwale counties. According to the key population size estimation (KPSE) in 2021, an approximated 1310 PWUD were mapped from Kiambu County (NASCOP, 2021). In August 2021, MSF and LVCT Health conducted another size estimate with an expected 3312 PWUD mapped within the county. The HIV prevalence of PWUD in Kiambu county, a wealthier area in comparison to others, was estimated to be 18.7% compared to that of general population which stands at 4.6% (Ayon et al., 2019). Drug use is criminalized and illegal in Kenya. Carrying drug injection paraphernalia is also considered illegal, which adds to the stigma and social exclusion experienced by people who use drugs (PWUD). Due to the criminalization of drug use practices, PWUD face difficulties accessing necessary services (Mburu et al., 2018). In Kenya, between 2004–2006, PWUD interventions were sparse with limited evidence to support interventions. Prior to 2013, despite available evidence, Needle and Syringe Programs (NSP) and Medically Assisted Therapy (MAT)/Opioid Substitution Therapy (OST) services were not available for PWUD. 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 (NASCOP, 2013), and introduced harm reduction interventions for opioid dependence in the following year (NACC and NASCOP, 2012), primarily consisting of needle/syringe exchange programs, MAT with methadone (WHO, 2009), and HIV testing and treatment for PWUD. The first MAT clinic started in December 2014 in Nairobi. By 2021, there were nine other MAT clinics in the country offering services to PWUD. MAT is a component of a comprehensive approach of harm reduction to address illicit drug use and is endorsed as a best practice by the World Health Organization (WHO) (Ministry of Health, 2017). The MAT program aims to help individuals who use opioids to decrease or discontinue their use, with the objective of preventing the transmission of HIV and other negative outcomes linked with illicit drug use practices.

---

7 Formerly Liverpool Voluntary Counselling & Testing Health now called LVCT-Health.
This is accomplished by alleviating the symptoms of withdrawal and cravings associated with discontinuing opioid use.

1.1.2 Context description

The Kiambu project is an integrated medical care project for PWUD in Kiambu County, run by MSF. The project started in 2019 after construction of the MAT clinic was completed in September 2019 at the Karuri Level 4 (L4) hospital. By the end of April 2022, 590 PWUD had been enrolled in the program with a 69.8% retention rate. The project offers a one-stop-shop model of care where PWUD eligible for the MAT program have access to a comprehensive package of medico-psycho-social care. The clinic offers out-patient (OPD) services, opioid substitution therapy (OST), wound care, sexual and reproductive health services (SRH), mental health and psychosocial services (MHPSS), nutritional advice by a nutritionist with management of those with malnutrition, a pharmacy, and laboratory. The MAT clinic is operated in collaboration with the Karuri L4 Hospital, NASCOP, Kiambu County Government, and LVCT-Health. The global approach of our intervention is part of the harm reduction package of care. To further increase access to services for PWUD, MSF opened the first decentralised fixed dispensing (DFD) in the Ruiru Prison Staff Training College (PSTC) health centre in May 2022 as an integrated model of care within the level 3 facility. In October of the same year, an assessment of health facilities and prisons was done within the county with an objective of identifying a suitable facility within the MoH structure or prison that will accommodate an integrated model of care for PWUDs. The aim was to increase access for PWUD, including those incarcerated, while also offering a comprehensive package of care including OST. Thika Prison Health centre was chosen as the proposed site for the second DFD and is expected to be operational by quarter-1 2023. Both DFDs will offer an integrated model of care for the PWUD. While OST is provided in the clinic, the patients can access other services like OPD services, HIV/TB/Hepatitis treatment, wound care, SRH, MHPSS, or nutrition services, and mental health care as part of the services offered to other non-PWUD patients accessing the services within the health centre. This approach is viewed as a more sustainable model as compared to a standalone MAT clinic.

To provide better access to OST and other harm reduction services for PWUD, this qualitative study aimed to (1) increase knowledge about active PWUD in Kiambu County, (2) how MAT services can reach these active users, and (3) how PWUD can reach the MAT services more easily. Investigating perceptions, experiences, and behaviours of PWUDs in relation to their lives, their drug use, and access to healthcare will deepen overall understanding of the determining characteristics that influence enrolment and retention in a MAT program. During the study process, the interaction with active drug users and patients who are enrolled into the MAT clinic, the project team, and LVCT facilitated ongoing discussions to support the operationalization of the findings. Based on the anthropological findings and analysis, the anthropologist intends to help inform adaptations of the activities at the MAT clinic, and the access to care approach towards patients.

1.1.3 Problem statement

The increasing availability of illicit drugs such as heroin, cocaine, and methamphetamine especially in urban areas compound the burden of drug abuse in Africa (Syvertsen et al., 2015). Kenya, like other countries in Africa, experiences a high burden of drug use with about 37.1% of the national population reportedly having used a substance in their lifetime (NACADA, 2020). There is also an increasing use of illegal drugs and substances among the young population in Kiambu county with devastating harmful effects taking a toll on their health, social, and economic functioning. Some of the social effects include emotional dysregulations, anti-social behaviour and poor relationship patterns. Economically, individuals’ productivity and potential are adversely affected (NACADA, 2021).

The Ministry of Health, through the National AIDS and STI program (NASCOP), incorporated the MAT programs as one of the mitigations in HIV programming to target key populations in Kenya to
reduce the HIV burden among PWUD (NASCOP, 2013). This has enabled expansion of these services covering the medical needs of this populations; however, with little information on perceptions, experiences, and behaviours of the PWUD population towards MAT services. Historically, accessing hard-to-engage populations like PWUD for harm reduction services has been challenging owing to the stigma, discrimination, and criminalization of PWUD. To provide better access to OST and other harm reduction services for PWUD, this qualitative study aimed to increase knowledge about the PWUD in Kiambu County to better reach the population and appropriately engage with them according to their lived experiences. Since OST is individualised, the national MAT guideline states that the patient needs to be consistent for a minimum of at least 12 months to effectively wean off and improve retention for PWUD enrolled into a MAT program (Ministry of Health, 2017). This is not always the case as some PWUD drop out of MAT prematurely. This is also consistent with reducing retention rates in the MAT clinic in Kiambu as well as across other MAT clinics throughout the county. The objective of this study was to explore the obstacles that individuals face in remaining enrolled in the MAT clinic. As of April 2022, the retention rate at the Kiambu MAT clinic was 69.8%. Considering that the MAT clinic has only been in operation for three years, with the majority of enrolments taking place between 2020 and 2021, it is anticipated that the retention rate will be even higher. However, despite offering a comprehensive care package that included SRH services, as well as female peer educators and community health workers as part of a peer-led model, women who use drugs (WWUD) account for only 5.6% of ever-enrolled PWUD in the MAT clinic. As a result, this study sought to investigate how services could be adapted to encourage more women to access MAT and other harm reduction services offered through the drop-in centre (DIC) and outreach.

1.1.4 Rationale for the study

The research aimed to provide a comprehensive and in-depth understanding of the perspectives of various stakeholders, including peer educators, community health worker MoH staff, collaborating partners such as LVCT Health, family members of PWUD, PWUD themselves, community members living near the clinic, and others throughout Kiambu county. This research has provided recommendations on how to enhance the services provided to PWUD through MSF in the Kiambu project. Additionally, the study has provided valuable data on how active drug users experience their daily lives and perceptions of their health. Addressing stigma towards PWUD and especially women who use drugs is crucial to mitigate its negative impact on their ability to access healthcare services. The study findings may significantly impact further operational choices for MSF, and the main recommendations can be incorporated into strategies and activities aimed at developing a more compassionate model of care for PWUD. On a national and international level, the study results may help improve services and strategies for PWUD based on the innovations and experiences shared by MSF, drawn from the study's recommendations.
1.2 Objectives of the study

1.2.1 Primary objectives

To conduct an anthropological study on the perceptions of active drug users in Kiambu County.

The purpose of this study is to explore and better understand:

1. Active PWUD’s daily lives, patterns of behaviour and socioeconomic profiles in Kiambu County.
2. Active PWUDs challenges and resources to enrol and remain in MAT programs.
3. Active PWUDs perspectives of harm reduction and outreach services provided and the collaboration between outreach, DICs, DFDs, and MAT clinics.
4. What are PWUDs expectations of the MAT program and how do these expectations change along the way. Are the expectations realistic and how does this influence their stay in the MAT program?

1.2.2 Secondary objectives

Furthermore, the assessment focussed on turning the above-gained knowledge into recommendations to easily be implemented as part of the project’s strategy and support the creation of tools or guidance to facilitate implementation.

1.2.3 Study aim

The study aimed to generate evidence and understandings of how PWUDs organise their daily lives, their patterns of behaviour, their socioeconomic profiles, challenges to enrolling and staying in MAT programs, and lastly, perspectives of harm reduction and outreach services.

1.2.4 Research question

What are perceptions, experiences, and behaviours of PWUDs regarding their lives in relation to drug use and how does this impact enrolment to and retention in a MAT program?
2 Methods
2.1 Study setting
The study was conducted in the MSF Kiambu PWUD project in Kenya operated by the Belgium section of MSF.

2.2 Study design
A qualitative research design was used to gain multiple perspectives (active drug users, MAT patients, peer educators (PE), CHWs, MoH, MSF and LVCT staff) on the complex factors of the daily lives of active heroin users (Pope & Mays, 2006). The methods used for data collection were face-to-face in-depth interviews (IDIs), informal observations, paired interviews (PIs), and focus group discussions (FGDs). A methodological triangulation of findings was undertaken to enhance the interpretation of data, in-depth individual interviews were combined with focus group discussions, informal observations, and a literature review. Triangulation enables an accurate representation of reality through use of multiple methods or perspectives for data collection (Patton, 2002). The choice of methodology encouraged rich text and reflective narratives from the main participants to answer the research question.

2.3 Study population
The study population was a composition of different groups of respondents (Table 1) looking at a diversity of gender, years of drug use, method of drug intake, hot spots of drug use and location, and enrolment to a MAT program; this is further extrapolated in Tables 2 and 3. The individuals that were approached for data collection consisted of PWUD not yet enrolled into MAT, including women and young people above the age of 18, MAT patients, PE and CHW (LVCT and MSF), and healthcare professionals (MoH, MSF and LVCT).

Table 1: Study participants:

<table>
<thead>
<tr>
<th>Background</th>
<th>Total: 232</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active heroin users</td>
<td>103</td>
<td>44%</td>
</tr>
<tr>
<td>MAT methadone</td>
<td>46</td>
<td>20%</td>
</tr>
<tr>
<td>MAT buprenorphine</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>MAT/defaulter</td>
<td>22</td>
<td>10%</td>
</tr>
<tr>
<td>MAT/active*</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>MAT weaned off</td>
<td>4</td>
<td>1.5%</td>
</tr>
<tr>
<td>PE/CHW</td>
<td>29</td>
<td>12%</td>
</tr>
<tr>
<td>HCW</td>
<td>13</td>
<td>6%</td>
</tr>
</tbody>
</table>

*This participant seemed to be on MAT and at the same time used heroin.

9 We will use throughout the report the term patients and not clients as suggested by the PMR of the project. While I suggest that we use patients, the PWUD identify themselves as clients. From the perspective of a medical organisation and viewing addiction/substance use disorder (SUD) as a chronic and relapsing disease, I propose we use the term ‘patients’.

10 On one occasion we had a 14y old boy coming with his older buddy. He was his guardian as this boy was a homeless street boy from the Mathare slum who moved with his buddy to Juja. We did not send him away as during the FGD we had tea and mandazi served instead of a paid rental at the hall. The boy did not actively participate in the interview, he was allowed to stay to get a cup of tea and a mandazi.
Table 2: participant’s characteristics:

<table>
<thead>
<tr>
<th>Time using heroin</th>
<th>Total No 232</th>
<th>100%</th>
<th>Ways of using</th>
<th>Total No 232</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 3 years</td>
<td>56</td>
<td>24%</td>
<td>Smoking</td>
<td>141</td>
<td>61%</td>
</tr>
<tr>
<td>4 – 6 years</td>
<td>49</td>
<td>21%</td>
<td>Smoking/injecting</td>
<td>42</td>
<td>18%</td>
</tr>
<tr>
<td>7 – 9 years</td>
<td>40</td>
<td>17%</td>
<td>Injecting</td>
<td>8</td>
<td>3.5%</td>
</tr>
<tr>
<td>10 – 15 years</td>
<td>36</td>
<td>15.5%</td>
<td>Sniffing</td>
<td>3</td>
<td>1.5%</td>
</tr>
<tr>
<td>16 – 20 years</td>
<td>11</td>
<td>5.5%</td>
<td>Injecting/sniffing</td>
<td>4</td>
<td>1.5%</td>
</tr>
<tr>
<td>N/A</td>
<td>40</td>
<td>17%</td>
<td>N/A</td>
<td>34</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

Table 3: Education and gender:

<table>
<thead>
<tr>
<th>Education</th>
<th>Total No 232</th>
<th>100%</th>
<th>Gender</th>
<th>Total No 232</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary school</td>
<td>68</td>
<td>29%</td>
<td>Male</td>
<td>201</td>
<td>87%</td>
</tr>
<tr>
<td>Secondary school</td>
<td>120</td>
<td>52%</td>
<td>Female</td>
<td>31</td>
<td>13%</td>
</tr>
<tr>
<td>University/College</td>
<td>27</td>
<td>12%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No School</td>
<td>1</td>
<td>0.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>16</td>
<td>6.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3.1 Selection and recruitment of study participants

Purposeful sampling was applied for the interviews with PWUD in general, with individuals enrolled in the MAT program, peer educators, CHWs, and HCWs. The sample size was not determined in advance as we followed the information saturation principle (Green & Thorogood, 2018). In all, we did 61 interviews, 39 IDIs, seven PIs and 15 FGDs. Twelve interviews were done with active drug users, 13 with MAT patients, eight with MAT ‘defaulters’\(^{11}\), two with persons who had weaned-off with the MAT program, and two with buprenorphine patients; twelve other buprenorphine patients were asked in a small survey about their experience and perception of buprenorphine. Nine interviews were done with healthcare staff (MSF/MoH/LVCT) and 15 with PEs and CHWs. In total, 232 people participated in 61 interviews. In terms of gender proportion, we had quite a good balance of male and female participants except for the FGD where there were more men\(^{12}\):

- IDIs: 17 women, 14 men
- PIs: 2 mixed, 2 f/f, 3 m/m
- FGDs: 6 mixed*, 9 men only (*with very few women)\(^{13}\)

---

\(^{11}\) I would rather suggest using a more inclusive language (thinking of all the aspects that might have led to such an action) and talk of patients who have disengaged. After discussion with the PMR I was advised as follows: For PWUD however and for those on follow up for HIV, the terms are still in use and are indicated as such in the guidelines as follows: Defaulter – anyone who has missed his/her dose for at least five days consecutively; Lost to follow up is someone who has missed 30 doses consecutively.

\(^{12}\) This is due to the fact that the FGD were mostly organised with PEs who were looking for participants in the dens. Very often, women do not stay in the dens and therefore were rarely available for FGDs.

\(^{13}\) Since the FGD were mostly done in or organised from the dens it is self-descriptive that fewer women attended.
Informal observations were ongoing and a part of every encounter with PWUDs, PEs, MAT patients during the interviews, or in the open space at either the Karuri clinic or Ruiru DFD and Ruaka DIC.

PWUD were approached with the help of LVCT Health PEs and MSF CHWs, who knew them and who were trusted by them. Mappings of hotspots and the number of drug users in the sub-counties have been done at project level and did support the selection and frequency of sites that were visited.

Any person or group that was interviewed was informed and asked beforehand for consent to perform for the interview and if they agreed, where they preferred to be interviewed. The PI along with a local study assistant and a PE of the chosen area and hot-spot or ‘den’ to be visited approached potential participants, introduced themselves, explained in detail the purpose and the aim of the study and ask them if they were willing to participate in an IDI and/or FGD.

PWUD inclusion into the study followed their own choice, availability, and informed decision to participate within a given period for enrolment. The study team encountered slight difficulty in engaging active drug users for interviews because many potential participants were unsure of the benefits of participating in the study and were hesitant to engage with the PEs. Usually, active drug users would look for money in the morning through touting at the bus stations or collecting scrap metals; staying an hour or more for an interview was a loss of time and income for them. However, the PE did manage to explain and encourage PWUD to participate in IDIs and FGDs. As a result, we were able to talk a total of 230 individuals. During the study, on two occasions, some participants expressed withdrawal symptoms, both verbally and physically, and requested to complete the interview as soon as possible. In other instances, some participants requested compensation in the form of heroin from the PI for the time they spent in the interview. To address this issue, the study team explained that providing such compensation would be unethical, given their role in harm reduction.

2.4 Study process and data collection

The data collection process took place in three phases:

**Phase I** was a preparatory phase, which lasted six months and focused on literature search and writing the study protocol, followed by the validation and ethical approval (received on 7th July from MSF ERB and on 29th August 2022 from KEMRI SERU).

**Phase II** started on the 29th of August 2022 with a field stay of six weeks for data collection including qualitative IDIs, observations, and FGDs. The study team consisted of the PI, a female study assistant who also acted as a translator, a young male transcriber, and female and male PEs who together with the study assistant organised the interviews.

In **phase III**, data collection was completed. The recordings from the interviews were transcribed electronically, coded manually and with Nvivo©11, and analysed, resulting in a final report.

2.4.1 In-depth interviews (IDIs)

The study team conducted individual IDIs with various individuals, including active PWUDs (some of whom were MAT patients), MoH, LVCT and MSF staff, peer educators (PEs), and community health workers (CHW) who preferred to be interviewed individually. Focus group interviews, on the other hand, were conducted with a group of PEs, LVCT members, and active drug users. In some cases, the group of active drug users included a mix of MAT patients and individuals who had disengaged from MAT. One FGD was specifically organised with a group of MAT patients who use jet-fuel outside the Karuri MAT clinic. A few respondents chose to participate in the interview as a pair, such as MAT patients who wanted to be interviewed together with a friend or buddy. In addition, one paired

---

14 The hotspots are likewise called ‘dens’. It refers to places where PWUD meet, hang around, stick together, and buy and use heroin.
An interview was conducted with a LVCT healthcare worker, and another with an outreach worker and field officer who were interviewed together.

For data collection related to perceptions and experiences with drug use, enrollment and maintenance of the MAT program, IDIs were conducted using a topic guide (Appendix 7.1). The topic guides were flexible and only used to support the interview. The topic guide was discussed in-depth with the study assistant and the HP supervisor and modified where necessary. After a few days of interviewing, the PI and study assistant modified a few interview questions and added some local expressions employed by drug users for withdrawal and names for drugs. The interviewers’ team always followed the answers and information the interviewees provided to further explore the topics and gain an emic perspective, i.e., the ‘insider’s perception’ (Harris, 1976). IDIs were applied to allow ‘enough time to develop their own accounts of the issues important to them’ (Green & Thorogood, 2018, 116).

Study participants were identified with the help of MSF teams, CHWs, and LVCT peer educators. Upon individual consent after having been informed in detail about the study, the team tried to find a convenient and quiet place to do the interview. When the team was in the field, in places close to the dens, we often rented a hall to conduct interviews. These halls were occasionally bars where the noise level was not always conducive to proper recording. Moreover, some PWUD spoke in a very low voice, making it somewhat challenging to transcribe the interviews accurately. However, all participants provided their consent to be audio-recorded.

### 2.4.2 Focus group discussions

FGDs were organized and conducted with groups of participants with similar characteristics (e.g. active heroin users, MAT patients, jet-fuel users, etc.). For example, we tried to organise groups with only active drug users or of only MAT patients. In practice, we ended up with groups of active drug users, some of whom were MAT patients some who had disengaged with MAT or some who had already weaned-off. The team understood that it was a real challenge for the PEs to mobilise interview participants and did not insist to exclude the ones that did not match the exact criteria. A MAT patient was an active drug user before joining MAT so there were no clear-cut realities. Rules were set up prior to the FGD to discuss how communication would proceed and what would be done in case of disagreement or escalation. All participants were asked not to use names when discussing to ensure that no names were recorded. To prevent increased stigma and loss of confidential information, locations were rented to conduct the FGD in ‘safe spaces’. However, it was noted that these rented places were not always very quiet. The PI then asked the PEs if it would be possible to do the interview in the den itself. The decision on where to conduct the interviews depended on the safety of the study team and the participants and was usually determined by the participants themselves. In some cases, active drug users preferred to have the interviews in their dens or places where they could continue smoking heroin during the discussion. However, the study team made sure to explain the importance of confidentiality, legal concerns, and data protection to all participants in group discussions. The group discussions were performed according to the FGD topic guide (Appendix 7.1). The FGD had between four and eighteen participants; the number and composition of the groups depended on the area, the hotspot or den visited on the time of the day the FGD was conducted, and on the condition of the study participants. The study team and a field officer from LVCT planned the area and hotspot/den to be visited every Friday for the following week (see map below). The study team contacted the PEs of the respective area and specific hotspots in advance, requesting them to prepare and mobilize the members of a specific den for the visit. They also explained the purpose of the interview and motivated them to participate.

---

15 Dens and hotspots are places where people get and use drugs.
2.4.3 Observations

Observations were carried out by the PI as part of the data collection. Participant observation is a crucial qualitative method as it gives account to what people say and what they actually do (Coffey & Atkinson, 1996). Observations were not carried out explicitly but were partially informal observations during the interviews at the dens or hot spots. For example, during an interview at a hotspot, participants continued to sell, prepare, and smoke heroin which allowed the PI to observe group dynamics, behaviours and drug use, and drug intake practices. At another hotspot, the interaction with the direct neighbourhood was observed, i.e., how they communicated with or acted towards the drug users. In a hotspot close to a bus stop and market, the PI could observe food preparation and eating. Active drug users showed the study team the hotspots where they buy, prepare and use drugs during a transect walk conducted on an additional occasion.

Nevertheless, it was crucial to consider that the observer influenced the research setting with her presence and by being a foreigner. This is also referred to as ‘Hawthorne effect’: people may deviate from their normal practices due to the presence of an ‘outsider’ who is conducting the study (McCambridge et al., 2014). This was mainly the case when observing hotspots close to a neighbourhood.

2.5 Data management and analysis

This study used an applied medical anthropological approach to generate insight and understanding of PWUDs and how they perceive and experience their drug use for MSF to take these perceptions into account for future programming and interventions. The analysis and interpretation of data was drawn on social and structural factors as the key determinants for the challenges in enrolling and maintaining participants in a MAT program.

Data analysis was conducted by the PI using NVivo©11 qualitative data analysis software. All interview transcripts were imported into NVivo after translation and transcription, where they were then coded. A coding framework was developed based on themes emerging during the interviews, as well as themes pre-identified by the study team. Emergent categories and themes were identified based on meticulous and systematic reading and coding of the transcripts. Codes and sub-codes were refined during the analysis. Data coding and analysis began whilst data collection was ongoing, to allow for the refining of questions and the in-depth exploration of certain themes if required. Codes and themes were discussed with the study assistant for accuracy and quality assurance. The analysis
involved a thematic content analysis by Mayring (Mayring, 2010). The transcripts were screened for relevant information, organised, coded, categorised, and interpreted. A category (label) was attached to the statements to structure the data. The content was analysed in two ways: (1) describing data without reading anything into it and (2) interpretatively by focusing on what is meant by the responses (Hancock, 2002).

Continuous reflection on data was part of the creative process of analysis and necessary for contextualising and linking of findings with theory. To work with principles of good practice, the research process was clearly described in the report; validity of data is therefore ensured by presenting a ‘thick’ description16 (Geertz, 1973) of the research context and by also presenting deviant cases if they occur.

A methodological triangulation was applied. The content and emerging themes of the individual IDIs were combined with FGDs, observations, and a literature review (Brikci, 2007). Various data types (IDIs, FGDs, and observations) that were used for triangulation were harmonized by coherent translation, transcription, and coding, and therefore integrated into a cohesive analysis.

2.6 Quality control and quality assurance

All the English interviews were conducted by the PI. Interviews in the local language were conducted with the help of a translator and transcribed into English by the transcriber. The interviews were transcribed verbatim. Quality control and quality assurance were ensured through constant discussion and feedback with the research team at the project level. Sample recordings were reviewed by colleagues who spoke the local language and collaborated with the research team. To ensure quality control during the analysis, ongoing discussions were held, notes were shared, and themes were coded with the help of study assistants. Additionally, colleagues within the research team were consulted for further discussion.

2.7 Study limitations

The interviewees clearly associated the study team with MSF, potentially resulting in response bias. To mitigate this potential bias, the team provided a thorough explanation of the principal investigator's and her assistant's roles, their neutrality, and strict assurance of anonymity and confidentiality.

Working with an interpreter can be limiting, as the quality of interpretation depends on the interpreter's soft and hard skills. To address this limitation, the interpreter was trained in the necessary skills for the job.

Participants' drug use prior to the interview may influence their responses, leading to shaped answers. To address this limitation, interviewees' condition was carefully assessed to determine their ability to participate in the interview and remain vigilant and focused.

Some dens were deemed too dangerous to access, resulting in a lack of perspective from these locations. To address this limitation, peer educators and community health workers were engaged to speak with participants from other dens in the same area.

Finally, the presence of the researcher at the field site and her background (gender, cultural and ethnic background, age, social status, origin, etc.) may influence the qualitative data obtained. Therefore, the researcher took a critical stance towards her position in gathering data and analysing findings, with special attention paid to discussing the results and recommendations with the project team.

---

16 Originating from Geertz (1973), a “thick” description of human behaviour is one that not just explains the behaviour but its context as well, such that the behaviour becomes meaningful to an outsider.
3 Ethical Considerations

3.1 Ethical review

The study protocol was submitted to the MSF Ethics Review Board (ID 2251) and to the Kenya Medical Research Institute’s (KEMRI’s) Scientific and Ethics Review Unit (SERU) in Nairobi (ID SERU 4490). MSF ethical approval (ID 2251) was obtained on 7th July 2022. The KEMRI’s Scientific and Ethics Review Unit approved the study on 29th August 2022.

3.2 Informed consent

Informed consent was required by all respondents of the study. Oral informed consent was obtained in all cases. Informed consent was sought at the beginning of any individual IDI or FGD. The research team explained the purpose of the study and its aim. Any questions from a potential interviewee were answered and clarified by the PI or translator. Assurance that non-participation in this study would not impact their future care, treatment provision, or work in the case of healthcare staff was ensured.

It was guaranteed that participant confidentiality would be respected. All data obtained through IDIs were anonymised and stored on password-protected computers, without the inclusion of personal identifiers such as names (Richards & Schwartz, 2002). Verbatim quotations in dissemination materials like this report are designated by the interview number, age, sex, and category of participant (e.g., I36, female MAT patient 24y, etc.). Interviews were audio-recorded after the respondent gave permission, which was obtained in all conversations. Additionally, the primary investigator took notes after the interview. Each respondent was assured of the confidentiality and privacy of the interview and informed that s/he was free to stop at any time or refuse to answer any questions, although, this did not happen in any of the interviews. For the FGDs, informed consent was also obtained verbally. The translator introduced the aim and objective of the study. Participants were advised that they were free to leave the group at any time and could choose their level of participation throughout the session.
4 Results

This report provides an analysis of the perceptions, experiences and behaviours of people who use drugs regarding their lives in relation to drug use and how this impacts enrolment to and retention in a MAT program in Kiambu county in Kenya.

The results section answers questions such as why people started using drugs, how drug use impacted their lives, and how it changed their lives. It also provides insights into how people who use drugs organized their lives and relationships, as well as their thoughts on medication-assisted treatment (MAT) and what they need to enrol and maintain in MAT. Furthermore, the section includes perspectives on harm reduction and outreach services, as well as suggestions on how to better manage life while on MAT. These perspectives are complemented by the experiences and perceptions of peer educators and community health workers in the peer-led model. Additionally, the section includes the views of healthcare workers to provide a comprehensive overview of the results.

Given that the collected data is analysed from the viewpoint of PWUD, patients enrolled in a MAT program, and healthcare providers, the results will be presented based on these distinct perspectives. The findings are underlined with quotations to give a voice to people who were interviewed during the field visit. A significant number of interviewees shared their difficulties in either continuing to use drugs or being a patient in a MAT program and proposed recommendations on how the project and program could be improved.

After one week of conducting interviews with various groups of respondents, it became apparent that addiction and the financial gain associated with it were the primary issues and challenges of drug use. Participants also highlighted the changes in behaviour that occurred when under the influence of drugs. The most significant concern that emerged was the process of leaving behind the lifestyle of a drug user—often living in a den—and transitioning to MAT, including what this transition would entail and what the ‘exit strategy’ would be from their current situation. The interviews revealed a pressing need for a transition plan to facilitate the shift from the ‘old life’ of drug use to the ‘new life’ as a MAT patient.

In the upcoming results section, we will refer to individuals who have enrolled in medically assisted therapy (MAT) as MAT patients rather than clients, as we aim to emphasize the importance of viewing methadone and buprenorphine as legitimate medications.\(^{17}\) For quotes, we will indicate the interview number and the interviewee’s designation, such as MAT patient, active drug user, defaulter, weaned off, or HCW. For individual IDIs with active drug users and MAT patients, we will also include the interviewee’s gender and age. To safeguard the interviewee’s identity, we will combine the quotes from PEs and CHWs as one.

4.1 The thin end of the wedge

How did it all begin? The very first question one might have when talking to PWUD could be why they started using drugs followed by when they started and what kind of drugs they use. Our study team did ask these questions to better understand the reasons that lead to initiating drug use. However, inspired by Gabor Maté’s book ‘In the Realm of Hungry Ghosts: Close Encounters with Addiction’, (Maté, 2008), we added another approach and instead asked the participants who use or used drugs: ‘What did it [the drug] offer you, what did you like about it? And what in the short term, did it give you that you craved or liked so much?’ The answers to these questions led to understanding why people started in the first place and were often not able to stop; in most cases, people said that it helped them deal with emotional pain and stress and that it reduced their suffering. It also gave them peace of mind and helped them get through the day.

\(^{17}\) Furthermore, this is also attributed to the aforementioned reasons provided by the medical team of the Kiambu project.
“When you take a hit of heroin, it reduces the stress and mental anguish that you might be having. When someone is sleepy after using, they don’t think about the problems they have but enjoy the moment of ecstasy and try and savour it. That is the reason we look for it, it helps us cope with the problems we have already.” I21, FGD active drug users

Such an answer explains that addiction is not a voluntary decision, but rather an attempt to cope with emotional pain, overwhelming stress, and a sense of discomfort with oneself.18

4.1.1 Why do people start using drugs?

As per the initial paragraph of this chapter, it was comprehended that drug use is not solely triggered by emotional distress. We heard various other accounts on how people started using drugs. The main reason why people—these were mostly young people in their teenage years—started using drugs was due to ‘peer pressure’. Most respondents explained that they started using heroin because their friends used it, or they joined a group of young people and wanted to ‘fit-in’. Very often, such a journey started in school while already smoking weed, marijuana, or consuming khat or alcohol. Many also insisted that they did not know what they were smoking, when a friend offered them a joint laced with heroin. They did not know what it was and the effect it would have on their body. A few explained that they were misinformed about heroin and decided to use based on this wrong information.

The second main reason for drug use was linked to the psychological and emotional situations individuals found themselves in. These situations often related to family and childhood trauma. Participants reported various experiences such as parental abandonment during childhood, drug use within their family, abuse from family members or stepparents, and the death of a parent. Some participants expressed feeling overwhelmed by their responsibilities as the firstborn and their obligation to provide for their families.

In many cases, a person’s partner was found to have introduced or encouraged them to use drugs. However, it is worth noting that a partner can also be a positive influence in encouraging a person to start using MAT, as can be the case with friends and peer pressure.19

Another account revealed that drug use could also originate in prison to protect oneself by ‘fitting in’ with a group or gang that provided security during incarceration.

Some participants reported that they sought out a partner to share the burden of drug use and the associated financial strain. Others attributed their drug use to a lack of parental guidance during their upbringing, which exposed them to PWUD. Some participants mentioned having access to money and the freedom to use it for drugs. The desire to emulate the lifestyle of a celebrity or wealthy individual who used drugs was also a factor for some. Additionally, some participants became involved in drug use by initially working as drug couriers and then being offered free heroin until they became addicted when they were offered a few sachets.20

In one specific area (Limuru), young people cited the cold weather as a reason for their drug use. They reported using heroin ‘to feel good and not to feel the cold’ (I23).

Reasons for starting drug use, starting with the most frequently mentioned:

- Peer pressure, friends and to ‘fit-in’
- To relieve stress/depression/mental distress/pain/feeling sick/not to think too much, overcome hurt feelings (e.g., family rejection)
- Family (situation)

19 We will further explore on this element of ‘peer pressure’ and think of it as ‘peer empowerment’ as a motivation for MAT enrolment.
20 A sachet is referred to one does of heroin.
• Introduced by the partner
• Without conscious awareness and misinformation
• Pleasure and curiosity, experimenting and for fun
• Prison
• ‘Partnering’ – introduced by a friend to share drugs and costs
• Having money,
• having too much freedom
• Being a drug courier
• Imitating stars
• Coldness of the area (Limuru)

Here are some quotes from the interviews that refer to various reasons that motivated someone to start using drugs.

**Peer pressure, friends and to ‘fit-in’**

“What I mean by peer pressure is, when I saw that my friends were using heroin and it seemed appealing because of how fun they described their experience, so I ended up trying it so that I could experience what they were feeling.” I21, FGD active drug users

“I was in form 4, in November 2018, when I started using drugs. One of my friends came around and asked me whether I had used something like this, and I told him that I had neither seen it nor used it much less. But because of that school pressure, you don’t want to show the other kids that you are behind in times.” I34, male MAT patient, 18y

“I think number one is peer pressure because most of them have started the drug at a very tender age i.e., in their teenage years. And then those who are starting later are doing it out of peer pressure and also the fact that now the drug is more available than in previous years so many are falling into it.” I27, male HCW

**Distress, frustration and family situation**

“… why they found themselves using drugs … in most cases some of them are from dysfunctional families, and most of them, you will realize they are either brought up by their grandmother or their mothers, especially those brought up by single mothers. ... So, you realize that it’s like there is something special about those that have been raised by their mothers, and in most cases, some of them are mothers who were not very well off. So, you will find that they will tell you as early as age 5,6,7, they had the freedom to go out without any supervision. You realize that during that time they have the freedom of going wherever they’d want to go, and in such cases, you realize it is something that started a long way back. Maybe they felt neglected.” I50, female HCW

“Joblessness, since someone is idle and doing nothing, they ease their frustrations by using drugs.” I40, FGD active heroin users

**Doing it for fun, trying out**

“Yeah. So, all of us never knew the effects of the drug. We used to use it for fun and we didn’t know that one day we would end up like this. So, this is the first batch since the drug entered Makongeni, we were the first people who used it because we thought it was fun.” I46, FGD active drug users and MAT defaulters

**Without knowing**

“I would buy the bhang and my friend would say she is going to light the joint but would then put in the heroin…that is how most people get into drugs without intending… one of my friends is now living in the streets as a chokora [street-kid] and another has abandoned her children and both got into drugs without knowing it was heroin.” I6, female drug user, 31y

**Start using in prison**

“You know, prison is like another different world. When I was taken there, I was very afraid because the people there look like real gangsters and some have done very horrible things, and now I would be living with them. So, I just wanted to fit in somewhere as early as possible and find security in a group of people.
By using heroin, I became part of a group of individuals who were also using, and we could look after one another.” I32, couple, male MAT patient, 25y

‘Partnering’

“Her intention was to make me an addict so that we could help one another…. Starting Heroin, one tends to have money, and this attracts those who have none to trick them into using until they become addicted ……then comes arosto [withdrawal] and the new user will need the drug…. She/he cannot dare to be mean and will share what they have with their newfound ‘friends’. They need one another.” I6, female drug user, 31y

4.2 Being ‘hooked on’ – active heroin use

As all the respondents suggested that once they had used heroin for a few times—even one or twice was enough—they started feeling ‘sick’ and did not understand what they were suffering from until they learned that they were experiencing symptoms of withdrawal, called the arosto in Kiswahili. When people finally understood that they were in a withdrawal stage it was already too late to stop as they had already reached the addiction stage. This is the moment when, for most, the challenges with active heroin use started.

“I was smoking marijuana before, and when I tried heroin, the high was not comparable to that of marijuana. It was a better high and one that I desired to experience again. The first time I felt like I was in heaven. But now it feels like a sickness.” I14 FGD active drug users

4.2.1 Dosage and costs

At the very beginning of heroin use, in most cases, people started with 1-2 sachets per day (Fig 1 and 2) when smoking and ended up using up to 10 sachets per day when they were fully addicted. Injecting gives a much stronger effect and is the less frequent mode of heroin use in sub-Saharan Africa; (Morgan et al., 2019) people use less and can inject up to five sachets in a day when fully addicted.21

One sachet costs 100 KES22 in Mathare, the heroin depot in Nairobi; a booster of 10 sachets costs 1000 KES. This price can rise to 200 KES for one sachet in Limuru whereas in most other areas it costs 150 KES. Heroin is resold around 400—700 KES in the prison. In Kanyongo Karura, a joint laced with heroin would cost 170 or 200 KES when it is ready made with the cigarette and marijuana for smoking.

4.2.2 Ways of using heroin

Smoking

From the interviews, we understood that in the project area where MSF works, the main mode of using heroin was smoking. One participant explained that for every three injectors, there were 10

---

21 This is an estimation and can naturally vary from person to person.
22 100 KES is 0.80 USD.
smokers. Please refer to table 2 in chapter 2.3 where the ratio is shown in percentage according to the individuals interviewed. We only had eight individuals who said that they would exclusively inject. Smoking heroin meant that the heroin was laced into a joint with marijuana (Fig 3). Sometimes the joints were first prepared (Fig 4) and the PWUD would then suck up the heroin with these.

“The joint is like a straw. When you puff on the joint without lighting it up, there is some airflow. By puffing you feel the joint allowing airflow into the mouth, so you proceed to suck the heroin. The heroin slowly rises into those airways in the joint up until all the powder has been sucked into the joint.” (Personal conversation)

Sometimes the joint with heroin was amplified with a paste made of Valium or Rohypnol or a sweet mixed with saliva smeared around the joint to facilitate slow burning of the joint and to achieve a stronger high.

“I would apply Cozepam around it. Cozepam is a trade name for Diazepam/Valium. I would make a paste of the tablet by mixing it with saliva and rub it around the joint to make it more potent. The better [that it is humid] to burn slowly so that you can enjoy it longer and more of it. One can also use sweets and syrupy to make the taste better.” I10, male MAT patient, 28 y

Sniffing/snorting
Another way of using was sniffing or snorting the heroin. It was rather an exception and was mentioned by only two interviewees.

Injecting (to save money, ‘higher high’)
Injecting heroin (Fig 5) is used when people want to get a ‘higher high’ or when they do not have enough money to continue smoking. Smoking heroin is safer, and some people feel that they can better manage their drug consumption and the ‘high’.

Smoking has milder effects on the body, but one would need a higher quantity to get high, which ultimately would need more money. For instance, an individual who injects two sachets would need
five sachets if they were smoking to achieve the same effect. Additionally, our observations revealed that a higher proportion of drug users in Limuru injected drugs, as seen in one FGD where out of 15 participants, seven reported injecting drug use.

“When I started to inject, I used to feel so good. Here in Limuru, it is very cold, and someone can smoke a lot of heroin. So, the best thing for PWUDs here in Limuru is to inject, most of them prefer to inject heroin. They say that injecting is the best policy.” I23, male PE/CHW

Some explained that injecting had higher risks in terms of an infection with HIV or Hepatitis C virus (HCV) and also a ‘miss’. A ‘miss’ suggests that the vein would be missed and the place where the person tried to inject would get infected which some interview participants had experienced.

“I did shoot one day, my friend shot me, then I came to learn that it’s got a lot of risks like getting a ‘miss’ and dying...You shoot a ‘miss’ and die...and also sometimes they share the syringes and it can spread HIV and I am afraid of dying from AIDS...I’d rather die of anything else but not AIDS.” I18, male active drug user, 26y

‘Flashblood’ or ‘flash’

‘Flashblood’ is a syringe-full of blood passed from someone who has just injected heroin to someone else who injects it in lieu of heroin. It is a way of sharing heroin with another person, mostly when money is short.

“They just do it like the doctor...they inject, when the blood comes to the needle they pull, mix this and the solution of heroin and water, then shoot. You can shoot yourself or another person, or you can share, let’s say you have 5mls of the heroin and blood solution, you can shoot yourself and share the rest by shooting another needy addict in withdrawal because apparently the arosto [withdrawal] of injected heroin is much stronger than that of smoking. When injecting, you don’t think about the risk only the high. You share the heroin and the blood.” I18, male active drug user, 26y

Chasing ‘brown sugar’

Only a few participants talked about chasing heroin. It seems to be a form of using heroin that is no longer practised. It was said that heroin in the form of ‘brown sugar’ was replaced by the white powder heroin. One participant explained that the effect of the heroin is stronger when chasing and that smoking would not bring the same result hence one would turn to injecting as a result.

“They used to put the brown sugar on a foil, light up the underside of the foil and then the heroin would begin to vaporise and then we would inhale it in order to get high. ... I used to chase until the brown sugar was no longer available. The supply of brown sugar ended and now the white powder heroin came. I now began to smoke it and later on, I ended up injecting because I wasn’t feeling it when I was smoking.” I15, female ex-drug user, weaned off, 26y

We also heard that chasing is perceived to be complicated and would need a lot of paraphernalia to prepare it—a foil, something to heat, and someone to help ‘driving’ it—in the end, it is possible that one would also lose part of the heroin through this procedure.

“You need a lot of things like the foil, someone to ‘drive’ it for you and also you waste a lot and so it’s also extravagant.” I10, male MAT patient, 28y

Smoking versus injecting

It is also clearly understood by most of the respondents that smoking is less harmful. Between smokers and injectors, there appeared to be a certain competition in terms of perception. We were once told that smokers would look down on injectors but then in the interviews, we were persuaded to change our mind by the interviewees as it would be true the other way around as well and likewise injectors would look down on smokers.

23 Brown sugar (an adulterated form of heroin) is a semi-synthetic opioid derived from the morphine extracted from poppy plants. Pure heroin accounts for only 20% of the brown sugar drug; the remaining 80% comes in the form of chalk powder, zinc oxide, and even strychnine. https://rehabs.in/indian-drug-guide/brown-sugar/ retrieved 9th January 2022.
“The people in the den who smoke are clean and smart like me, they are able to maintain themselves but those who inject can even go to the extent of using the flash blood.” I18, male active drug user, 26y

In another FGD, participants explained that they would not accept injectors in their den because of the risks of going along with it.

R1: “The issue is this, we have had many cases of our fellow friends dying from injecting, so to prevent that, we have banned everyone from injecting in this area.”
R2: “Someone injecting has more problems apart from the arosto, including the collapse of veins and overdosing.”
R3 “Even if we are using heroin, we still love ourselves because injecting is a road map to death.” I46, FGD active drug users and MAT defaulters

Some participants also explained that when they tried to stop using heroin, they changed from injecting to smoking as the withdrawal from injecting was explained to be much stronger. However, the same participant acknowledged that smoking similarly did not help stop heroin use, but MAT would possibly help.

In most cases it was a friend or a partner who motivated a person to move from smoking to injecting. In other cases, either money was a motivator or wishing to use heroin ‘more efficiently’.

“The first two months, I was smoking, then one of the friends I was close to told me that injecting would give me a good high and value for money...and it indeed felt good, so from then on, I went for injection rather than smoking. ... Shooting is more effective than smoking because it goes directly to the whole system via the blood, but smoking is like wasting the drug and the money... when injected, the high is more intense and lasts longer... I would become more active, this way, I could shoot one in the morning and go out to hustle and by afternoon, I could have another then go and look for money to buy my lock-up dose.” [lock-up refers to the last dose of the day to get sleep for the night]. I8, two male MAT patients, 27+23y

The main motivating factors for switching from smoking to injecting was explained to be able to have a ‘higher high’ and the ‘sweetiest high’. Another possible reason was that a person had smoked for a long time and did not get a satisfying high anymore; subsequently, they started to inject. The other factor was to save money, as mentioned earlier.

“They say, it [injecting] is a good feeling for them and it is also economical because when shooting [injecting] you can use two sachets while if smoking you need at least five to get the same level of highness.” I18, male active drug user, 26y

4.2.3 Challenges of heroin use

Active heroin use presented well-known challenges, akin to those faced by other drug users worldwide. The primary difficulties involved the vicious cycle of addiction and withdrawal, as well as the need to generate money to purchase drugs. Users also contended with losing their homes, families, and friends, quitting school or losing their jobs, neglecting personal hygiene, rejecting themselves, risking overdose, committing petty crimes, experiencing changes in behaviour, and facing rejection and mistreatment by society.24

“Heroin isn’t good at all. It led me to neglect my hygiene and I stopped showering and started stealing people’s things and getting caught, I wasn’t eating healthy food and I was always craving sweet foods. Respect from society became almost non-existent and I was branded a thief. I could not get hired by anyone and because of that, I ended up stealing to fulfill my drug habits. Stealing from people is not right.” I5, FGD active drug users

4.2.3.1 Withdrawal – arosto

In the interviews with active drug users, it became increasingly clear that they feared the withdrawal stage greatly. This was not only related to the active heroin use practices but also when PWUD thought of starting MAT and all the conditions for preparation going along with it.25 Withdrawals

---

24 This enumeration is not exhaustive but refers to the main challenges participants mentioned in the interviews.

25 We will further go into this topic in the chapter on MAT.
were also explained differently when one referred to the heroin using method. A withdrawal from smoking was said to be less strong than that from injecting. Some also mentioned the fear and experience of withdrawal when using MAT. However, this was limited to the initial phase when MAT patients had to be adjusted to the right dose of methadone or buprenorphine.

“You know right now we have not taken the first heroin of the day, so our blood right now is boiling.” I11, male MAT defaulter, 34y

Interview participants explained that they were not ‘functional’ when in a withdrawal stage; they were not able to talk ‘normally’, work, care for their families, socialise, or maintain their daily life as they did before heroin use.

“I have a wife and one child. Since I started taking heroin it has affected my relationship with my wife negatively. In the morning I usually wake up with very low energy and a bad mood because of the arosto [withdrawal]. My wife notices that I am a very different person in the morning because I am usually very grumpy and don’t want to talk to anyone until I take my morning hit, and then I turn back to normal.” I21, FGD active drug users

Many compared the withdrawal stage with feeling sick, like suffering from malaria, a high-grade fever, headache, sweating, joint pains, itching, cold sweats, and the feeling of things crawling all over the body. “It’s hell, it’s a hell feeling” said one participant in an FGD.

4.2.3.2 Buying drugs, having a job

The primary preoccupation of all active drug users was thinking about how to get the money for their next dose. Jobs were not easily found, and most active drug users, and even some MAT patients, faced stigma and discrimination when looking for work. People did not trust them anymore, seeing them as unreliable individuals who would steal, lie, and commit petty crimes. This lack of trust made it difficult for them to obtain employment.

“All that preoccupies us for the day, is looking for money to buy the heroin. Everybody does whatever is going to bring them money, may it be casual jobs, illegal deals, or even criminal activities.” I29, FGD active drug users

“When you start using heroin, whatever will be outside your family compound, you will have to sell it or get the temptation to sell it while looking for money to buy the drug. Once you are done selling things around your house, you start getting to those inside the house. If there is a TV, you take it and sell it, if there is cooking gas, you steal it too. That forces your family members to live like there is a thief around, they close the doors, hide things from you and exclude you from most activities.” I29, FGD active drug users

Some said they would get up at 3 or 4 AM to go out to steal. They would wake up early because of feelings of withdrawal. In such a stage, people explained that they would sweat, feel tired and wasted, annoyed, and would not want to talk to anyone as they would also get aggressive until they took their next dose. Money was generated through casual jobs and mostly through breaking into houses, stealing and selling stolen items, e.g., laundry or washed blankets hanging outside overnight, fruits and vegetables in the markets like Del Monte, pineapples, phones, side mirrors or tires or vehicle name tags like Porsche, Toyota, Mercedes and X-Trail to sell these off and generate money. When an active drug user is still within the family, he or she tries to cheat and tell family members and friends that they are sick, they must go to the hospital, or that they need money for the school. Some would need up to 2000–3000 KES a day. All the money first went to drugs and if money remained, they would buy some food or provide for their families. Drug users were well aware of their dire situation and all of them regretted these conditions.

“We even don’t have jobs; we rely on very small informal jobs for 100 or 200 KES which is not enough to meet someone’s needs for heroin as well as food. We are even unable to stay with our families because we

26 Del Monte is said to be the best variety of pineapples sold in Thika.
27 Nissan X-Trail was said to be the best.
28 This is 16 – 24 USD a day.
are unable to provide for them; money to meet their needs is used to meet the needs of heroin. All the money goes to heroin.” I29, FGD active drug users

“Even five times [buying drugs], whenever you find money you rush there [to the den], all the time, every time, you don’t even eat, I was arrested for neglecting my children, I had forgotten my children.” I25, female MAT patient, 28y

The main jobs drug users did were touting at the bus station, collecting scrap metals or plastic bottles (Fig 6), or carrying goods for people at the market. Some said they were able to continue riding a boda-boda29 for some time but then would stop when they had a problem with the motorbike as they did not have the money to repair it. Very few were able to maintain work or school after starting drug use. One participant explained that he took on casual jobs:

“I am a casual worker and the jobs that I get can vary. Sometimes I go to work on people’s farms, other times I work as a porter; offloading goods from lorries and also as a labourer, whenever there is a labour-intensive job.” I4, male active drug user, 29y

Fig 6: A young man with collected plastic bottles.

Another way of maintaining a life as a drug user and getting money was becoming a pusher30 or a drug courier. By doing that, they were offered free doses, or they got money by dealing drugs.

Women would also do casual jobs or laundry for other people; however, some said they were not asked anymore as people feared that they would steal their clothes to generate money. Other women would try to find a partner and would then share the costs of smoking. Others would perform sex work, explained as ‘selling their bodies’, sometimes even while they were in a relationship. Others would move closer to Nairobi to avoid being seen by people they knew. On probing further, most women we interviewed either said ‘no, no way’, or ‘thank god, no’, when asked if they were ever forced to do sex work. The way they expressed it showed how they perceived it to be a last resort.

“We are treated badly as well as being harassed and being verbally abused. People can just assume that you went out to ‘sell your body’ in order to get money to buy the drugs, but you are the only one who knows how you acquired it [the drugs]. As a result of such harassment and name calling, your self-esteem drastically decreases, and you hate yourself.” I15, female ex-dug user, weaned off, 26y

4.2.3.3 Community, mob justice, police, and prison

Community

Community perceptions of PWUD and even of some MAT patients were negative. PWUD are criminalised by the society. It is widely accepted that PWUD choose to do drugs of their own volition or free will. Addiction is complex and consists of many different underpinnings that cannot merely be reduced to psychological or neurological elements. We dare say that an addicted person does not consciously decide to take a next dose; there is always something stronger within that pushes them to continue. Most people in the community or surroundings of a drug user have a judgemental

29 A boda-boda is a bicycle or motorcycle used as a taxi for carrying a passenger or s.

30 A pusher is a drug dealer.
attitude towards them; they do not understand why they continue using drugs. HCWs insisted that viewing it as a disease might help them understand that the problem is the addiction, not the person.

“They don’t like us, that’s a fact, they don’t. They don’t respect us, and we cannot reciprocate that with goodness, so we just live like that. ... They see and treat us like junk.” I18, male active drug user, 26y

“When you go out to look for work, people see the way we look and deny us the chance to work. That breaks our hearts, and it leads us to continue smoking so that we don’t feel these feelings of worthlessness.” I21, FGD active drug users

“One of the challenges I found in drugs is the judgement by non-users. I may come up with a very good idea or vision, but it will just be dismissed as the rantings of an intoxicated mind.” I37, male MAT defaulter, 33y

Negative community attitudes towards PWUD become more severe when it concerns women who use drugs. The society does not accept that women use drugs as it was associated with bringing shame to her family.

“Some people regard them very poorly, as prostitutes, but for us we treat them fairly and regard them as our sisters, they are just like us, when they are in pain, we understand because we have also had the same problem of arosto, so we can even offer her a few puffs so that she can feel better. Society, however, looks down upon them and sees them as bringing shame to their families. They take a woman who uses drugs as one who has no future, and who has reached the end of the road...no hope.” I38, FGD active drug users

However, in many cases respondents who were in the MAT program or worked as a PE or CHW acknowledged that when the community including neighbours and families saw the ‘change’, they would change their attitude and behaviour and further encourage them to continue their path of ‘reforming’.

Mob justice
Mob justice was mentioned a lot by the respondents. As active drug users stole if they did not find any other means to generate money, people got angry and aggressive. Whenever they caught one of them, others would join in and beating up the person, sometimes to death. It was also said that mob justice was getting more frequent and represented a considerable risk for drug users.

“Yes, many. I have seen so many dying from mob-justice if you steal someone’s phone or watch or whatever, people will come and beat you mercilessly, some will recall that they have also been robbed by another like you. ... Passers-by will not help you or they may also turn into victims. Somehow, mob-justice has become a trend.” I18, male active drug user, 26y

Some respondents also recounted that the mob could burn a person to death.

“They will beat you up and they will burn you. They will burn you with old tires. When you steal, like here, the people can burn you even before the cops arrive to arrest you. They wrap you with it and pour gasoline. A boda-boda rider might be minding his own business, but when he hears there is a thief there, he can take the fuel from his motorbike just to burn you. So, you see, that was so painful, and I couldn’t even watch.” I45, male PE/CHW

Police
Drug users recount how they suffer from police harassments. How the police interacted with drug users differed from area to area. In some places they went out to the hot spots at night to chase and dispel drug users, beat them up, and to bring them to prison. In other places, drug users explained that they would bribe them to be left alone. Many interview participants also recounted that the police and the community reported and condemned them for crimes they did not commit. This woman recounted how she was accused and put to prison for something she had not done.

“What happened is, men of the 10-house system, who knew me, and I also knew them, came to my house with the police. One of them accused me that I was selling drugs, but the fact is that I was only using heroin, and during the arrest, they did not find anything on me, but they insisted that I should be arrested. They came and broke into my home, took out my clothes and burnt them in public and proceeded to beat me in front of a crowd with the intention of killing me, as you can see, I still have marks on my back. They then dragged me to jail together with my 3-day-old baby.” I56, female PE/CHW
In other accounts, people talked about how the community interacted with the police to get rid of them.

“Because of the enmity between the people who live around these areas and us... they [the community] have liaised with the police to get rid of us and get us out of this area. There is a day the police found us here, they told everybody to lie down, and they beat us severely. They even told us to strip down as they beat us, so you can’t find anybody hanging around this area anymore and it’s been going on for a while now.” 126, FGD MAT patients

In one interview, a PE suggested to have badges for the MAT patients so that the police who harassed them like they do with drug users would know that they are in the MAT program and the path to reform.

“If they could have a centre here to go for methadone and we give them the badges. You know, even if they [the police] find you anywhere and then they show the badge, they [the police] know that you are a reformer.” 145, male PE/CHW

Prison

When in prison one had to sympathise with a group or gang to be protected. If not, staying in prison without any affiliation with a gang would lead to a very difficult and unpleasant experience in the prison.

“There are also those guys that we call mamende [cockroaches], who normally assault other men sexually in prison. So, when you are taken to prison and you seem like a ‘goody two shoes’, you are placed in the same cells as the mamende. The mamende normally pays the officers to have the lights switched off so that they get to assault their victims.” 132, couple, male MAT patient, 25y

4.2.3.4 Losing friends, quitting family

Family played a crucial role when talking about community perception. Many respondents referred to the fact that when the family accepted a drug user, the community would too. In one interview with an NGO, we were told to 'let the family understand that addiction is a disease. The person is not the problem, but addiction is the problem.' Almost all respondents explained that their family situation became very difficult when they started using drugs. Most of them told us that they abandoned their families. Some were expelled from their families, but many other drug users left their homes of their own volition because they stole from them and felt ashamed. Often, the problem was beyond the family, and involved neighbours and relatives as well.

“The way I had started living I felt that I was bringing shame to my family since I would be pointed out as the wrong example by the community.” 134, male MAT patient, 18y

“It became a problem, even with our parents, it was shameful. My neighbours didn’t want anything to do with us, No one would give me a job, because they would think that I will steal from them. People would avoid me, they didn’t want me in their homes, and no one wanted to associate with me. It was sad.” 152, female MAT patient, 35y

Even after starting the MAT program, patients felt isolated from their family as they would not trust. For instance, in case needed to distribute their property, they would not count in the MAT patient as they feared relapse to drug use. Disruption with their families, their parents and siblings or their partners and children, was always a very stressful situation for drug users.

“Heroin has disrupted a lot of things in my life. My relationship with my family and friends has deteriorated, I have not seen my younger siblings for more than six years.” 19, FGD active drug users

“Sometimes it hurts me so much, to speak the truth. Whenever I see another father carrying their kids or walking together, I just feel so bad because I imagine my children were here with me. Also, the mother made a very big mistake and told my children what a bad man I am.” 123, male PE/CHW

Drug users could not have friends who did not use drugs, ‘your best friend is the one smoking with you’, said one participant.
“You can’t have good friends apart from the ones you use with...You can’t have a pastor as your friend, or a teacher, no, your best friend is the one you search with and use together. We don’t have friends in the society. Some refer to us as the dregs of society.” I18, male active drug user, 26y

“It’s not easy to make friends with people who don’t use it because, for one, they don’t trust us, and they will always say that we will steal from them. We are isolated and also we are sometimes dirty and not presentable, so no one would want to be seen with us.” I29, FGD active drug users

One woman talked about challenges with her little daughter while she was using heroin. She was unable to care for her as she wanted to.

“My child was growing well but our relationship started changing and we were drifting apart, I wasn’t always able to take her out and had to ask someone else to do it. As much as I wanted to be a good mother, I had challenges, seeing as I had no experience of motherhood from my own mother...it wasn’t that I neglected her intentionally, it was things that were bothering me inside. One day on a weekend, I overslept and woke up at nine, smoked on my bed and relaxed. I was never able to do anything before I had smoked. The girl who used to work for me back then had gone to the shop, so we were just me and my daughter. As I was going to the sitting room, I fell down on top of the gas [cooker] and my baby was the one who took my hand and pulled me, I don’t know what happened, but I think I started convulsing and had no strength to do anything at all at all. In about 10 minutes, the girl came back, put off the gas and helped me up. This was the first time that I felt ‘Whoa this thing is going to make me die and leave my daughter to go through what I went through’.” I24, female MAT patient, 26y

HCWs from the Karuri MAT clinic acknowledged that many of the PWUD came from disadvantaged families. Some were from single-parent families, some orphans, some came without a place to stay or sleep, and most of them do not have a high education level. For this group of drug users, it was rather difficult to reconnect with their families, as the ties were already broken before even starting drug use.

When PWUD abandoned their families, people from hot spots and dens (Fig 7) where they hang around and consume heroin became their new family. This was the place and environment where they were able to recreate the feeling of belonging and of home.

Fig 7: FGD with active drug users in a den

4.2.4 Perception of heroin

Heroin was perceived in various ways. When first starting drug use, it was perceived to be a drug they craved and became a desired object. Over the course of drug use and increased addiction, heroin became increasingly associated negatively. Heroin was called ‘selfish’, ‘to be the devil’, and was also compared to a hole where it was easy to enter but very difficult to get out. It was also referred to ‘slavery’, as heroin would enslave one’s mind as explained here by a patient who stopped MAT—‘because everything you think and the actions you take are geared towards getting more and more of it’.

“When you smoke heroin, that is a ‘devil’s hole’ which you cannot get yourself out of when you are alone.” I45, male PE/CHW
PWUD said that they felt good when they had their desired dose of heroin, and that they could work, talk, and ‘act’ like a ‘normal’ person, and that they could concentrate and think straight.

“I feel that my brain has woken up, that I am more alert, I can now think...before I take heroin, my brain is in a state of inactivity, asleep.” I38, FGD active drug users

In one FGD, heroin was compared with methadone and said to be more arousing in terms of being active and alert. It helped the user wake up, feel active, and search for jobs and money, whereas with methadone they would feel more relaxed.

People said that although heroin was a sickness, they would feel sick without heroin. They called heroin their healer and their sickness at the same time. Contrary to what has been said, some opined that with heroin, people did not get sick as heroin numbed everything. People said that they would be in pain if they did not use heroin; it was compared to a ‘pain killer’, only that heroin’s effect would be much faster.

“I don’t know whether it is godly or not, but junkies rarely get sick. Unless it is an injury during a robbery or an accident, the natural illness from disease is not there, because once you get those two puffs or one puff even if you had a headache or a stomach-ache, all is gone. So, it’s kind of your medication.” I5, FGD active users

Almost all the respondents suggested that heroin was their everything. It was said to give the ‘sweetest high’. Others told us that they were ‘married to heroin’, that ‘heroin was their spouse, their family, their number one’.

“We normally refer to heroin in the streets as usinjonje [don’t taste me] because when you taste it, just once, it becomes your wife. When you taste me, I’ll become your wife for good. Taste me, marry me. We used to call it ‘Miss Pakistan’.” I19, FGD active drug users

### 4.2.5 Perception of PWUD – self-worth and self-esteem

In previous chapters, challenges of drug users, perceptions and stigmatisation of people who used drugs, community perceptions of PWUD, job-search difficulty, treatment by police and mob-justice have been elaborated on.

In this chapter, we want to also include how these perceptions influenced and affected PWUD and how it impacted their self-worth which led to self-stigma among drug users. The study team experienced that active drug users called themselves ‘junkies’ when they spoke of themselves. When we asked why they would call themselves ‘junkies’, they said:

“You know, they [the community] are the ones that call us junkies. They call us junkies because we use drugs. That name of a junkie came from the community. We accept that name because it is true that we are junkies.” I3, FGD active drug users

Being a ‘junkie’ was associated with heroin use, being dirty and careless, being homeless, living in the streets, being a thief and engaging in petty crimes, being a bad person, a person one cannot trust. And because of the effects of heroin and the nodding off, drug users called themselves we are the walking dead; we look like zombies.

“You find that anyone considered a junkie is what you are taken for. Most junkies are taken as thieves, robbers, and petty thieves but you find that most of us work to sustain ourselves. Heroin is expensive so we go to work to get that money to buy it. But if anything happens or goes wrong, the PWUD is the first suspect.” I5, FGD active drug users

Interview participants said that they were rejected by the society and that the other people do not like them and that they themselves are desperate people.

“They don’t like us, that’s a fact, they don’t. They don’t respect us, and we cannot reciprocate that with goodness, so we just live like that. ... They see and treat us like junk.” I18, active drug user, 26y
These negative perceptions by others along with their own lived experience of being a heroin user made them reject their own self. Expressions like ‘I don’t like myself anymore’, ‘I hate myself’, ‘I feel useless’, or ‘I brought shame to my family’—for what they did and what they became—were common testimonies. One active drug user said: ‘Like me now, I am a village crack’.

During the interviews with younger boys and men who used drugs, a uniform observation became prevalent. They all wore a hoodie or a woollen cap that they pulled deep down over their face (Fig 8 and 9). They all spoke with a very quiet and soft voice. When we asked them about this, they said that they did not want to be seen and recognized while walking through the streets or markets.

“When they see us after we have used the thing, they see that we start to stagger and walk like zombies. When someone tries to talk with you, they cannot hear you because of slurred speech. … When you get addicted to heroin, your life changes because one thing, you cannot maintain a family, you cannot even maintain yourself, in terms of food, shelter, clothing, anything. You are unable to do anything, and you become a useless young man who cannot look after themselves and who walks in life aimlessly. The only important thing in life at that moment is to get money for the next fix.” 140, FGD active drug users

The study team also experienced the positive effect of the study team talking to PWUD who were disregarded by society. How much they appreciated being seen and being talked to, that someone cared for them and listened to them. In one FGD, we asked how they felt:

“I feel good that there is someone [the study team] out there who is thinking about us and what we are going through, someone like you who connects us to our destinies, you are the destiny connector.” 140, FGD active drug users

4.2.6 Women who use drugs

It is a considerable finding that less women were found in the dens and hotspots and less women came in for MAT. In this chapter, we explore various reasons for that and look at the factors that influence women’s behavioural patterns while using drugs or going for MAT. In some interviews, participants referred to the ‘culture’ in the country, that women were not ‘expected’ to be using drugs, and that it was unexpected and for some, unheard of, for a woman. However, a few female interviewees insisted that this is not so much the case anymore. A female HCW also reflected on the notion that women and girls are less exposed to risks such as drug use as they have less freedom in terms of going out and moving around.

“I think first it’s because of our culture. Culture that you realise that when it comes to drugs, women are not expected to be using drugs. And when you find yourself doing it you don’t want other people to know. I don’t know I am saying it’s my thinking, it may not be right. I think for them to come out openly, come to the clinic, it really takes a big step for them. I think the culture and the perception of the people around can really be a problem. 11, female HCW

When we tried to talk about why few women are seen in the dens and in MAT, they referred again to the stigma and the harmed self-esteem. One participant even said that women did not value themselves enough thinking they were not worthy enough or did not deserve to go for MAT.
“They are many but they don’t trust it [MAT]. You must insist and counsel them because maybe most of them have had to exchange sexual favours in order to get the heroin. This results into immense self-loathing and instead of trying MAT they continue with their life in drugs.” I15, female ex-drug user weaned off, 26y

Others referred to the tests that were done at the MAT clinic and that women feared testing positive for HIV, Hepatitis C, TB, or STIs because many of them engaged in sex work. In one interview with a female MAT patient, she stated that many women who used drugs died.

“One, they are fewer. Second, most of them by now have died, those ones who started way back because most of them had gone into injecting, and they didn’t know about harm reduction. There was no knowledge about harm reduction, don’t share, don’t what. ... Most of them died because of HIV, mainly, and if there are any left, I am sure they are very young girls like you are seeing here [Karuri MAT clinic].” I35, female MAT patient, 62y

Community perception of women who use drugs is also very negative; women are highly stigmatised as this female MAT patient recounts:

“The society dislikes the women who use drugs. They wonder don’t these women love themselves, value their lives? They regard them as useless and despise them. They are lost women.” I25, female MAT patient, 28y

Participants also dived deep into the topic of comparing men’s behaviour to that of women. It was further stated that women would not start using drugs by themselves but most of them would be introduced to drugs by their male partners. Furthermore, that they had to be loyal to whoever provided them with drugs.

“For a woman, that will be a problem. You see for me as a man it would be okay if I was found in a bar and my children are starving. But it is totally different for a lady to be found in a bar, with the kid not yet starving, but crying.” I2, FGD NGO

In an FGD with active drug users, they insisted that they would not accept women in their den because of negative community perceptions.

“That will attract a lot of attention towards us and people will start saying that we have started destroying their women. That will be very bad for us. They will even call the police on us if people see us smoking and passing it to a woman.” I21, FGD active drug users

In another FGD we held in a den, participants showed a very protective attitude towards women who were a part of their den. These statements were confirmed by the woman in question.

“We take them [women] in as one of us, as one of our sisters and we wouldn’t be the source of her pain. This den here is different from others because we respect our female users unlike some, where the female users are forced to endure hardships imposed by the male users.

I as a female user agree that these guys here treated me very well and never did anything to me.” I26, FGD MAT patients

When we talked with women who were active drug users, all of them denied engagement in commercial sex work to be able to provide for their drugs. However, they acknowledged the feeling of deep stigmatisation in their social environment.

“We are treated badly as well as being harassed and being verbally abused. People can just assume that you went out to sell your body in order to get money to buy the drugs, but you are the only one who knows how you acquired it. As a result of such harassment and name calling, your self-esteem drastically decreases, and you hate yourself.” I15, female ex-drug user, weaned off, 28y

When we talked to PEs and CHWs, they insisted that many women who used drugs had to engage in sex work. One male active drug user told us that his partner went to Nairobi for commercial sex work to earn money to provide for heroin.

For these reasons of stigmatisation, we were told by other female MAT patients that women did leave their social environment when they had to engage in sex work. They went to Nairobi or other smaller cities to ‘sell their body’ and to be closer to drugs. Female MAT patients had similar
accounts—akin to the case for active female heroin users. Interview narrations revealed that some women preferred to go to Ngara\textsuperscript{31} for MAT pretending that they went to work, to not be identified as a female MAT patient.

“Even our clients from here, they come from Juja, Ruiru, or Githurai. You would not go and sell sex where you live since it will cause conflict with society. So, you will have to move from one town to the other.”\textsuperscript{47} female HCW

4.3 Behavioural patterns and ‘change of life’

As it is with other topics some chapters do overlap with information. We have already discussed some of the characteristics that come along with drug use and influence and change a person’s life journey. Behavioural patterns do change because of the challenges that go along with drug use. In this chapter we will especially focus on how drug users manage their days and how they live in the dens.

4.3.1 A day as a drug user

One drug user explained that he would get up at 3 AM to start looking for things to steal or previous stolen things to sell them later for the first dose that he had around 6 AM. By 11 AM, he explained that he would have already smoked three sachets and that he would need another dose by 1 PM. During the interview, he did not have any money, stating that he had to look for money to be able to buy the next dose. This routine would continue until he could take his ‘locker’, i.e., the last dose in the evening to be able to sleep, until he woke up again to start the same cycle. We asked a female active drug user to explain how she spent her day. She used heroin along with her partner, with whom she had two children. She did casual jobs like laundry for other people and her partner would work at construction sites. They were both enrolled at the MAT clinic but stopped because of the transport fare.

“We wake up early before the children, we smoke then I go to prepare the children and make some breakfast. Our compound is big, so we find somewhere to smoke [not to be seen by the children]. Then first I take the girl to school because they go early, then I come back and take the boy to school at 7.30. I do my housework then I go out to the farms and do a bit of work. People here like to farm; then I earn maybe 200 KES and if my husband doesn’t have money, I give it to him to go and buy some heroin and we smoke [3 or 4 sachets].\textsuperscript{16} female drug user, 31y

This life pattern was not very different for various drug users, unless they ‘lived’ in dens. It was the same for everyone who was an active drug user—dealing with withdrawal symptoms and getting money for the next dose.

4.3.2 Life in the ‘den’

Most of the drug users interviewed lived in a den at some point in their lives since becoming drug users. Often, very few women lived in a den; most places were visited by men only. Drug users went to the den to meet their friends and ‘family’, to exchange, bond, buy and use and share drugs, or to go together for jobs. Life in a den could be either of two things, a protection for an individual to be in a group or a dangerous life most of the time. Drug users could fight among each other over stolen things or money. PWUD would easily be found and arrested when staying in a den if the place was well-known to the police. Usually, individuals who lived in a den had a nickname to protect themselves to prevent identification by the authorities.

“When it reaches 6:00 AM in the morning each person is back to the den. They look for used car tires and lit them up so that they can warm up their bodies from the cold, which I did not like much to be near, because the smoke from the tires was really hazardous to the lungs. About the dens, it is a hard life. Living in a den is the hardest life a junkie can endure. It’s hard, really hard.”\textsuperscript{17} male PE/CHW

\textsuperscript{31} Ngara has a governmental run MAT clinic in the North of Nairobi.
Some dens were hierarchically organized with a leader or a chairman at the top, followed by pushers. Bigger dens would need more than one pusher—when one pusher went to Nairobi to buy more drugs, the other would still be at the den to sell to other users. In other instances, we were told that the den had no hierarchy and that they were all the same. We had the chance to talk to a leader of a den who explained his role:

“I am the one who is the leader of this base [den]. I am the controller of this place. ... As a leader, I regulate these people and prevent them from using drugs and especially marijuana in the open because we are near a public bus stop which can attract unwanted attraction.” I22, male MAT defaulter and leader of a den, 29y

We were also told that in most cases the pusher is not a drug user himself. One interview participant expressed it as: “While he is getting fat, we are getting slim”.32

“in the den there is that kind of hierarchy where the pusher is the head of the den. Sometimes, you may find out that the owner of the job [drug boss] is not the pusher. You see, if I have a lot of money, I’ll go and buy a lot of stuff [heroin], but I will not be the one selling it directly. I’ll need somebody who can sell, who will be able to stand along the road or inside the den the whole day, who will be able to run from the police every time, and somebody who can cope with other users because they are not easy to deal with. You need a tough pusher who can sell to them without losing the money. So, the pusher is always a tough person. So, you find that there are owners, who are the bosses, and their only goal is money. And then we go to the pushers, whose attribute is strength, they are good fighters, and they are keen to safeguard the interests of the owners. Then the pusher has two guys with him, who run errands and act as lookouts against the police.” I28, PE/CHW

In less structured dens, respondents explained that one person of their group would go to Nairobi to buy drugs for several people, but this person was not a pusher per se, he would only go to buy heroin for his friends. They grouped together and sent one to buy it to save travel costs. Drug users in a den also organised themselves in terms of how they went and looked for casual jobs and money:

“We group ourselves according to the hustle. There is a group for carjacking. There is a group that deals with scrap metals. And the 3rd group is the one that works in the marketplaces, robbery, snatching, and pickpocketing. What all these three groups have in common is stealing. But according to morning hours, that is, when daylight comes, we do these small jobs as a cover for the real operations that we do during the night. So, that is how we organize, survive and hustle for ourselves. And we mainly come together when we are smoking heroin, getting rid of our arosto [withdrawal] before going back to our hustles.” I46, FGD drug users and MAT defaulters

In one interview we did near a bus stop, in a den that was located behind the garbage containers, we could observe some people scramble in the garbage searching for food. At the same time, one of the active drug users started to ‘cook his food’ which was some left-over food that was thrown away that he had found and further heated up in a pot.

“Our life here at this den is challenging. We normally cook here, but sometimes we have to scavenge and rely on food in these bins, and even other times there might not be any food in them, so we might sleep hungry.” I21 FGD active drug users

FGD participants also spoke of how much the den was becoming their ‘home’: “The den is everything, the bedroom, the living room, the kitchen, your home, your family”. It is the place where they had friends, ‘company’, where they felt connected and accepted and felt a sense of belonging.

It seemed that in the dens, people were also regrouped according to the way they used heroin (smoking or injecting). As this participant explained:

“I wasn’t part of the group that used to inject, I was with the group that smoked. And since smoking is easy and shareable, I did that.” I4, male drug user, 29y

Another challenge while staying in a den was where they would spend their night. They recounted that they would sleep under market stalls, in construction sites, empty buildings, houses, in the

32 Using heroin was often referred to losing weight.
forest, or in the open. Their blanket was a plastic sheet from a rice sack, their mattress a piece of carton or at the very least, a plastic sheet. Sometimes, they make makeshift beds. They would shower in a river or a swamp or take a bucket full of water to go wash in the forest. It was also noted that many who lived in the dens would not care about their hygiene. When it was cold, they burned tires to get warm. In an FGD, it was explained that of the people who stayed in the den during the day, only 5-10% had a home to sleep.

“You had to find a large plastic paper. One you put it under your sheets and beddings and the other on top, so that when it rains a lot, the water that is passing on the ground will not affect you, it will pass under the paper. Other times, people used to sleep on the verandas and the cold was hard. The rain, cold, dust and a lot of bad things happened.” I7, PE/CHW

One female drug user explained how she managed to stay in a den and how she felt protected by this group of men she was bonded to. She insisted that she was never sexually harassed as men who used heroin were often not very sexually active.

“I used to sleep in the den. My life was in the den. In our den, there were unfinished houses and I had one that I used to sleep in together with other people, who were mostly men. I would sleep surrounded by almost 20 men, and I would sleep very comfortably without anybody harassing me in any manner.” I32, couple, female MAT patient, 23y

**The pusher**

As we heard in a quote before, the pusher had to be a tough person. Tough in terms of being able to deal with drug users, as they would want to befriend the pusher to easily get more credit for drugs. He had to be tough because he needed to run away from the police but still needed to be present and accessible for the drug users. A pusher sometimes financed their drug use by being a pusher. One said that he used ten sachets himself a day and at the same time was selling ten boosters (100 sachets) in a day which can brought him a minimum of 5000 KES.

Pushers did provide credit for drugs but only if it was in exchange for something. If someone could not pay, they would take their phone if the credit had reached a certain amount. They will not give credit to people they knew had nothing. Participants recounted that pushers could get violent and beat up drug users when they were not able to pay.

4.3.3 Quitting drug use – leaving the den

Quitting heroin is a daunting task, as interview participants have described. They spoke of growing tired of the lifestyle they had been living and expressed a desire to break free from their addiction, saying ‘they are sick of being sick’. Many had disappointed their families, and if they were married, their relationships had broken down. Moreover, they neglected their children, as most of their money went towards buying drugs. Reflecting on their experiences, they often expressed regret about starting to use heroin, recognizing the losses they suffered as a result. They wished they could start over and rebuild their lives.

“When the landlord threw my things out and locked me out of my house, I went and sold all my possessions and now I got deep into drug use. That’s when now I started sleeping outside, I stopped my job because my motorbike had been claimed by the loan collectors and I saw like my life was now coming to an end. I could no longer look after my family and there was nothing else, I was doing except looking for money to buy the drugs. I even got dirty and smelly because I wasn’t bathing and lived like a *chokoraa* [streetboy]. There came a friend of mine who had started MAT before me, and he told me that I had to stop the heroin and change and that I could do so if I joined MAT.” I17, male MAT patient, 26y

Another trigger to stop heroin was when they met a friend with whom they had used heroin together or an ex-user who was now clean, a PE or a CHW, who was now ‘clean’ and had a better life. Such an encounter encouraged them to also try to stop using heroin. Stopping heroin and starting MAT was daunting; replacing heroin with methadone or buprenorphine did not seem easy. It was not merely a medical and physical question; it had to be tackled in a holistic way by including psycho-social, economic, financial, personal, and empiric characteristics to be able to create a supportive
environment. For a drug user, it meant leaving the den, their ‘home’, and their friends and family. They had to engage in a new lifestyle and end ties with their social network and refrain from accustomed conduct and behaviours.

“MAT offers quite a relief especially to the client and the family. But then sustainability becomes a problem. Because in as much as the using stops there are still the addictive behaviour and addictive thinking, and the person has not really had opportunities where they can actually grow themselves.” I2, FGD NGO

When asked in an FGD what they would need to stop using heroin, the participants came up with suggestions that summarised various features well:

R1: “You need to accept yourself first.”
R2: “You need to have a job.”
R3: “If you are able to preserve for four good days, you can beat the arosto and come out clean.”
R4: “When someone is idle, you know, an idle mind is the devil’s workshop. Idleness will lead someone to go back to that drug, so finding a job will help motivate someone.”
R5: “If there is work to keep you busy so that you don’t meet up with your friends.”
R6: “If the MAT clinic could come closer, that would greatly help us.” I46, FGD active drug users and MAT defaulters

4.4 MAT – Methadone and Buprenorphine

In this chapter, we explore motivations and challenges to start MAT, preparation and enrolment towards MAT, and what MAT patients would need to stay in MAT.

4.4.1 Motivation to start MAT

To follow on directly from the previous chapter, quitting heroin needs motivation and readiness. Many MAT patients insisted that the mind has to be ready, and it is the person who is the one who has to be ‘determined’ to be able to stop using heroin and start MAT?

“What I can say is that the decision to stop comes from inside someone’s heart. If you haven’t decided to completely change, you will still find yourself going back to the drugs, but if you have decided to stop using heroin, you can continue with life.” I23, male PE/CHW

One HCW, experienced in working with PWUD, insisted that most women who start MAT are more determined than men and it would be easier for women to maintain MAT. A female MAT patient explains her motivation to start MAT:

“My youngest child has been a great source of encouragement and has really pushed me to finally quit heroin since she has always been telling me that I should leave that thing that I have always been smoking.” I56, female PE/CHW

“Why I would like to go for MAT is so that I can change and transform my life. You might even find that I have another unplanned pregnancy and that is not okay. So, I would like to join MAT and leave the stuff.” I29, FGD active drug users, female participant

Many are motivated by the example and inspiration of other people like partners, friends or a relative who were a drug user; they encounter them and see the changes they were able to bring to their lives with MAT.

“I want to live a good life basically because that cannot happen with heroin. I wouldn’t want my family and me to live a life filled with problems that can be avoided. In a few years to come, I would like us to have achieved something better than what we have now. I have also witnessed the change in people that come to MAT and I know that we can change too. So, that motivates me a lot.” I32, couple male MAT patient, 25y

Others have experienced traumatic events and hardship and want to change their lives for better.

“Yes, that’s the point [when two PWUD were beaten to death]. Because now I had to introspect myself and try to figure out what I can do after what had happened. At the same time this is when the CHW came through and gave me the idea about the MAT clinic and I found it exciting.” I7, male PE/CHW, 28y
“Everyone has their own story, everyone has lost a lot of things, and we all would like to restore our lives back to normal, all of us. And if you go asking around, everyone will tell you that they had a really good life before they started using heroin.” I46, FGD active drug users and MAT defaulters

One PE recounted that his motivation was to be ‘known’ in the society and that he stopped using heroin and managed to become a PE to be a role model for others to go for MAT. This goes along with the feature of being rejected and stigmatised by the society as a heroin user and this painful experience brings people to start MAT.

“We have those who have done engineering, automotive engineering, drivers, and electrical wiring. The problem is this drug. It’s the one which has brought us to this point. Society rejects us because we are on drugs, so it means if we were to stop them [the drugs] we would be accepted back into society and I believe that we can even get employed.” I46, FGD active drug users and MAT defaulters

Many were also encouraged to start and join MAT through a visit and information session by members of LVCT, PEs, or CHWs.

“There were people who used to come over and counsel the people. Racheal and Sheila were among them. They counselled us up until we went to Ruaka and that’s how I started MAT.” I11, male MAT defaulter, 34y

Another motivating factor mentioned by numerous participants was the (medical) services at the Karuri MAT clinic.

“The medical attention we receive there plays a very big role in people coming to MAT. There was another guy who was going through the same predicament as me, we talked and decided to come to MAT for treatment and then we joined the programme, even our MAT numbers follow each other.” I10, male MAT patient, 28y

When participants talked about the services at the MAT clinic, they referred to the decrease of services at the clinic. According to their accounts, they got a free lunch at the clinic when they came for their MAT preparation classes. Not getting these ‘goodies’ anymore demotivated some to continue with MAT.

“Some of them were here [MAT clinic] because of something to eat. They were not here for what was happening after eating. So, many people here decided to drop and default. Once they were given their share of food, some left. So, the few of us that decided to apply the form, we were able to get the methadone up to date. But other’s defaulted along the way since there were no more free lunches.” I13, male MAT defaulter, 38y

Motivation to start MAT can be challenged by lack of information or even misinformation if not transparent with PWUD, for example, that methadone would also be a drug like heroin, one could die. This happened before either because pushers in the den did not want to lose clients or because other drug users who are not ready to stop did not want to lose their buddy.

“No, I was living close, when on the balcony of my house, I could see the place… I had heard that there was an antidote of heroin, but they don’t like giving people information cos they don’t want to lose customers so, considering that I was a very, very good customer…whatever information they gave me was not useful. After a while, I just continued using and for some reason, I forgot that I wanted to stop using heroin.” I24, female PE/CHW

Fear of the withdrawal symptoms during the preparation and adjustment period to the right dose can be another challenge not to start MAT.

“My greatest problem with leaving heroin was the withdrawals because I knew they would last for days, not hours. If the withdrawals only lasted for hours, that could have been a different case. But I could not sleep, even when I was in the rehab facility I didn’t sleep, I only closed my eyes for five minutes and then I was up. I28, male PE/CHW

Others referred to the ‘old life’ in the den and said that leaving an ‘old love’ is difficult despite the toxic relationship. In other interviews, it was understood that some feared the ‘unknown’ and that ‘staying with the known’ felt more comfortable.
4.4.2 Preparation and enrolment to MAT

Before PWUD are enrolled to the program they are visited by a team in the dens and informed and sensitised about how they can stop using heroin and start MAT. To be enrolled to the program PWUD must be registered at LVCT to get a file and a unique identifier code. This is not only for the methadone but also for the other services that are provided. These services include reproductive health services, HIV testing and counselling, treatment of STIs, harm reduction services through the distribution of needles and syringes, and condoms and lubricants for those who need it. After filling the form, the person visits a counsellor for more information and to receive in-depth advice. Initially, LVCT requested a five-day preparation phase which was then reduced to three days, and now to one day. LVCT does the information and preparation sessions directly in the dens and hotspots now.

As discussed already in the chapter on the motivations to start MAT for many drug users, the preparation was nonetheless challenging regarding their readiness and determination. The fear of experiencing withdrawal symptoms was still prevalent and may have prevented people from starting the process as they had to wait until they got the first methadone or buprenorphine dose. Then they had to wait and be monitored for withdrawal symptoms until they were adjusted to the right dose over the coming days.

“Once we filled the form you were not given the methadone directly. You had first to go for counselling, we were told that we should stop smoking the dawa [heroin] and once we started taking the methadone, we should not chakachau [take heroin] enrolment in MAT was nonetheless challenging regarding their readiness and determination. The fear of experiencing withdrawal symptoms is still prevalent and might prevent people from starting the process as they have to wait until they get the first methadone or buprenorphine dose. Then they have to wait and be monitored for withdrawal symptoms until they are adjusted to the right dose during the coming days. while on MAT. It depends on someone’s willpower and heart. Because I can sit down here and lie to you that I want this and that and within myself it is not what I want to do. It was a simple process of filling the form and going there at the LVCT for two days, then we started taking the methadone.” I13, male MAT defaulter, 38y

For many, they are motivated to start but feel withdrawal symptoms when they wake up in the morning when they should go for preparation to MAT, so they would then first try to get their dose and once they got heroin, they might forget again what they had intended to do:

“Users normally sleep late at night, what will wake them up is not dependent on the time but they wake up depending on how they feel [withdrawal]. How a user thinks in the morning is that he first calculates whether to board the matatu and go to his responsibilities i.e., job/school, or to go to the den first and take a hit. During that time of going to the den to have a fix, that’s where most of his time is lost and that is the reason you find users missing appointments and other important matters. ... Now you see that person has already been satisfied and the arosto has disappeared, but if he would have gone to MAT also, the same effect could have been achieved, though his mind is not thinking that way because methadone is something he has never experienced. So, once a user has taken his hit and doesn’t feel any arosto anymore they are satisfied and don’t think of anything else anymore. They normally make the calculations of travelling to Nairobi first and they get really anxious because of the arosto so they end up going for their fix. If the clinic was much closer, chances are they’d be able to attend without taking a hit first. I41, male PE/CHW

Several PE experts suggested that the initial preparation phase of five days is too long and should be divided into two parts. The first part, which involves essential counselling, should be attended before individuals are put on methadone or buprenorphine. The second part, which is more informative, should be followed when individuals are already on MAT. Individuals who have already completed the preparation phase reported suffering from withdrawal symptoms and being unable to concentrate properly on the material being taught.

“The five-day induction period is too long for the incoming clients. My opinion is that the clients should be given MAT first, and then the other five days they are taught here when they are taking MAT. Because when they hear about those five days, they give up. Because they want to come and apply that day, tomorrow they are given MAT and then you guys can do the education after. The clients during the five-day session
struggle with withdrawals or are desiring to use stuff [heroin], I don’t even know how they can even learn.”

I9, FGD PE

During the interviews related to preparation and enrolment in MAT, additional challenges arose concerning treatment supporters, buddies or friends. For some individuals who could not be linked to a family member during their treatment period, they would require a close friend who is also on MAT to accompany them, motivate and encourage them daily, or a treatment supporter or buddy. In a paired interview, two young men explained how they now support each other while attending MAT and compared it to how they supported each other while using heroin.

“We had been partners-in-crime for some time, may be three years, we would meet almost every day and hustle together and use together.” I8, two male MAT patients 27+23y

Another feature that emerged during the interviews was the fear of the physical effects of MAT on the body. As mentioned in the previous chapter, this fear is a way to discourage active users from starting MAT.

“Initially, there were people who were trying to discourage me from getting into the MAT program and using methadone, saying that methadone kills and this made me very afraid and scared to start MAT. It was the counsellors who were taking care of me who assured me that MAT is good and is not harmful if one follows the doctors’ instructions. So, I decided to take the chance to change.” I25, female MAT patient, 28y

Some interviewees highlighted the lack of information sessions in certain areas and suggested that the ‘missing link’ is at the very beginning. Many individuals may not even know what MAT is or that it exists. Others noted that even if some individuals have sufficient knowledge about MAT, information and sensitisation sessions are not held frequently enough.

“The starting point is the problem, even the way you have come here you have brought knowledge of MAT to some of us who have never heard of MAT. Others know of the word MAT but don’t know what it is or the process/procedure of starting. Now, that you have come, at least we have gotten a clearer picture of what MAT is and what needs to be done” I46, FGAD active drug users and MAT defaulter

“About three months ago [the last info session with LVCT happened]. For me, I came to know about MAT from the people in Mathare, but around here [Kayongo] there isn’t much awareness about MAT. You can hear people say things like, they won’t stop a drug with another drug, because they don’t know what methadone is. They still take it as a drug. If there can be some kind of awareness, to the users themselves, their families, and society at large, it could go a long way.” I5, FGAD active drug users

Some added that LVCT would not have the capacity to enrol all who would have liked to join MAT if they did not do enough preparation sessions:

“Before they were doing it for three days, but nowadays it’s for a day. But you see it was not enough. Later on, as we talked to Richard, they organized themselves, and now they spread the information through PE around Ruiru. They tell them to go and inform all the users that on a certain day there will be a class for preparation for induction. And this is what they are doing now. So, on that particular day they have set, you will find that they have quite a number of users present waiting for them. ... And I think that it will also be a problem when we come to Thika because, I think, LVCT is a bit slow when it comes to preparing people. So, I was thinking, when we go to Thika side we will need them to be very active and do preparation almost every day so that we can induct a lot of users as many as we can.” I28, male PE/CHW

A big challenge seemed to be the transport fare, not only for reaching the MAT clinic when someone was already enrolled, but also to encourage PWUD to start MAT at all. Peer educators talked about their contests with active drug users. They often had to pay the transport fare for the active drug user to bring them for enrolment.

“Something that I have gone through is the lack of transport fare, and a lot of people who want to join the MAT program are inhibited by this challenge. Also, users around this area do go to work and it is sometimes challenging for them to leave their jobs unattended and go for MAT. I5, FGAD active drug users

33 This was specifically in Thika, as we were told that this is the area with a lot of active drug users, and even more in Juja.
“One of the major issues is the fare, for me as well as the PWUD whom I try to bring in [for MAT enrolment] because the den that I work in is quite far from the MAT clinic.” I9, FGD PE/CHW

People also talked being confused when they saw individuals going for MAT but then still coming to the den and taking heroin.

“I have heard other users telling us to go for MAT, but I don’t agree with them because I normally wonder how it works. They tell us to join MAT and they themselves, even after joining MAT, still come to the dens and they *chakachua* [methadone/heroin mixing].” I19, FGD active drug users

### 4.4.3 Perception of methadone

Several interview participants repeatedly insisted on raising awareness, sensitising, and providing more information about medically assisted therapy (MAT), specifically methadone and buprenorphine. Most respondents did not differentiate between MAT and methadone or buprenorphine, and everything was referred to as MAT. The phrase ‘I take my MAT, I go for MAT’ was frequently heard when individuals talked about taking methadone. When people talked about MAT, it did not necessarily refer to other services at the clinic.

Most respondents who were stable in using MAT and were able to regain a healthy and steady life spoke very positively about MAT. We received numerous encouraging feedback on how MAT had influenced people’s lives and helped them reunite with their families, go back to their jobs or continue their education, and rebuild their image in their social environment. However, we also encountered MAT patients who, despite receiving treatment, still struggled with their lives.

The word ‘change’ was continually used when people talked about their shift from being an active drug user to a patient going for MAT.

“For me, MAT gives one a way of ‘change’, to reform, it’s a transformation method. I have more than ten friends who have really changed, their families have taken them back, they now go to work, and we used to stay with them in the garbage bins.” I38, FGD active heroin users

“The ‘change’ is positive. Because someone no longer has the need and the urge to steal people’s things. I felt good when I was taking MAT and my behaviour improved along with my relationship with my family and friends. When you are on MAT, you are able to keep things, like the phone you have, without selling it and the junkie mentality of wanting to steal and snatch all the time is gone. Because methadone helps keep your mind clean and clear.” I13, male MAT defaulter, 38y

In general, it can be said that people who know about MAT and are taking MAT speak very positively about it and spread this information to others, encouraging them to join MAT, as exemplified in chapter 4.4.1. However, some MAT patients still struggle with finding the right dose.

“My arosto [withdrawals] never subsided. The dose [of methadone] I was being given was never enough. I was given around 200mgs of methadone, and it was never enough. So, I decided to stick with heroin.” I19, FGD active users

“When I started taking MAT, the dose that I was prescribed was low and it did not satisfy me, and sometimes in the morning, I would feel some kind of arosto [withdrawals], so I would go and smoke marijuana to feel better. I also smoked during the night so that I could get some sleep and get up the following morning to go for MAT.” I26, FGD MAT patients

Not getting the right dose of methadone was a reason why people mixed other drugs with methadone. People also talked about their doubts regarding methadone, as some MAT patients came back to the dens and still took heroin.

“I have some friends who go for MAT and when they come back to the den, they seem like they are not yet satisfied with it. They have the urge to add to the ‘steam’ of the methadone they have taken so that they can feel higher for longer, and they say that they want to smoke a cigarette or marijuana. So, that leaves me wondering what is this methadone, is it a medicine or what is it?” I14, FGD active drug users
“The reason we mistrust it is because, for example, I have never tried it. But I have seen my friends going for MAT, but afterwards, they come and take heroin. When I see that, it leaves me with a lot of doubt about methadone.” I19, FGD active drug users

Others referred to the effects of methadone on patients. It was said that they felt tired and too relaxed, whereas heroin helped them be active and work.

Other perceptions ranged from viewing methadone as a drug like heroin. Some said it was stronger than heroin, while others compared it to heroin because they still experienced withdrawal symptoms when they didn’t take it. Some even said that one would get a greater addiction with methadone.

“To talk the naked truth, my life was good when I started taking methadone. I got to save money, I could get time to talk with my wife and it was working. But the bad thing with methadone is the distance, it’s too far away from our place. My plea is that if methadone could be brought to this place, it could work very well. You know this methadone is like heroin, if I don’t take it for 2/3 days, I still feel the pain [withdrawal], you see.” I12, male MAT defaulter, 52y

“They think that methadone is a drug. Do you know why people say that methadone is a drug? It’s because when someone used to take heroin takes methadone, they feel a high that lasts longer than that of heroin.” I13, male MAT defaulter

“We were saying that, how can you stop taking stuff [heroin] and then you go to take another stuff [methadone] to cure this stuff [heroin]? Moving from the fire and jumping back into the frying pan.” I33, male PE/CHW

Peer educators spoke about how active users challenged them, saying that the peer educators themselves still used drugs. Others asked provocatively, ‘Why should we replace one drug with another drug?’

A remarkable perception referred to that methadone must be taken alone by the person whereas heroin can be shared with others:

“You know, when you are smoking your friend can give you and then you smoke, but MAT you have to go you, yourself and get it. That’s the challenge. Heroin can give you at least a puff, but if it’s MAT you have to go yourself, someone cannot get it and bring it for you.” I43, FGD active drug users

Two particularly interesting perceptions arose during the interviews. Firstly, people referred to methadone as ‘budget’ or ‘to be high on another money”, alluding to the fact that they received methadone for free. In an informal discussion with a peer educator/community health worker, it was revealed that a healthcare worker had promoted methadone as being free as a reason to start MAT.

Secondly, people referred to MAT as ‘the heroin from the government’. This perception came from their observation that the methadone was delivered to the clinic with armed guards.

“They [active drug users] tell you that that is the heroin of the government, so it’s our problem not theirs. They say it is not like normal medicine. So, when you take MAT, you are in the same calibre as someone that uses heroin. You are no different from someone smoking heroin.” I43, FGD active heroin users

4.4.4 Perception of buprenorphine

We only had a few buprenorphine (Bup) patients interviewed and therefore did a small survey with 12 Bup patients (11 male and one female) in the Bup corner. Questions (Appendix 7.2) asked included how they felt and experienced taking Bup and what they liked and disliked about it, among others.

In general, it was acknowledged that the perception of Bup changed from the beginning of its provision for the better. However, a lower uptake was observed and one CHW argued that when someone would like to switch to Bup, he or she should be below a 40mg methadone dose, which is the case for fewer MAT patients.

“Most of the clients have a high dosage of methadone, and if you have to start buprenorphine, you must be taking 40mgs and below of methadone. But a lot of clients are taking 40mgs and above. So, I think that’s another reason why buprenorphine has a low uptake by clients.” I28, male PE/CHW
Six out of the 12 interview participants were on methadone before switching to buprenorphine and were asked why they changed. The reasons given were that the methadone felt too strong, and that the withdrawal symptoms were very bad ‘arosto noma’. Other participants referred to side effects such as dozing, puking, hiccups, tummy aches, constipation, and constantly being in pain or upset.

**Buprenorphine was preferred over methadone because:**
- I liked it because it balanced my mood.
- One can miss Bup dose for up to two days without adverse effects.
- You can travel – can get take-away dose if arranged with Dr + counsellor.
- Bup is quickly absorbed, and one can feel its effect in 20 minutes.
- Bup aids in quick recovery = Kunawiri – glowing in good health – increased appetite, increased body weight and better health.
- You do not need to use a high dose, a little goes a long way e.g., three days (on 20mg) without arosto (withdrawal).

**Experiences with buprenorphine**
- Sex is better with Bup (no premature ejaculation), with methadone it takes too long before ‘coming’ or one comes to soon (ejaculation).
- Performance during sexual intercourse is ok because you feel a bit high.
- Less people use Bup, less chance of grouping and related misdirection, misinformation.
- Bup can aid in stopping cigarette smoking.
- Bup is easier to stop (wean-off).
- Most fear mixing Bup with other drugs – less cross addiction.
- Satisfied with Bup.

4.4.5 **Life after starting MAT**

This topic relates to the challenges MAT patients face when they talk about their experiences with retention and maintaining the MAT program. It is largely influenced by community perception and acceptance, family reintegration, occupational opportunities and income generating activities. It highlights the question of leaving the accustomed social environment and is closely related to the notion of belonging. Those who have successfully transitioned from a life as a drug user to being a stable MAT patient with family reintegration and support have a different perspective. However, we mainly present the voices of those who continue to struggle with their lives.

“I would wish for you to consider our lives after MAT. I know for now you are considering our lives in MAT but consider also how we can be reintegrated back into the world. I know the sensitization process is tough, but we need also the community at large to know that we exist and how to help us.” I5, FGD active drug users

“Sometimes you start MAT, but you don’t have anywhere to go afterwards, so you end up going to hang around your friends and when they are smoking marijuana, you find yourself smoking too as you keep each other company. It’s because you are not busy or committed to something, you find yourself idling with your friends since everyone else seems like they hate you.” I26, FGD MAT patients

“Like most of them say, it’s a lack of hope, even after MAT because, it is not automatic that you will get a job, you know. So, I think that is what bothers most of them. How will we be able to make a living which is not criminal, you know, which is not antisocial? That is, I think, a big question, almost everybody who is in MAT and not yet working, wonders what will happen next. They wish, they hope for something better.” I35, female MAT patient, 62y

In a discussion with a HCW, she emphasized the importance of leaving one's old environment and starting a ‘new healthy life’ with different behavioural patterns.

“We are telling them that we want them to stop heroin and start MAT. Fine, they then start MAT, then what? They are still going back to those dens, what makes you think they won’t relapse? Even for the
homeless people, so I think the only gap we have is that lack of an exit plan, a proper exit plan.” I47 female HCW

This HCW further expanded on the theme and insisted that the emotional life of the patients should be equally addressed like the heroin addiction is treated with methadone or buprenorphine. One MAT patient said, ‘they need to be taken by their hand’. Another HCW referred to the importance of emotional and social support saying that addiction was not a ‘one man show’.

“It has to be a multi-faceted approach where clients are involved, the clinic and family members too are involved as well as the community.” I49, female HCW

4.4.6 Challenges to maintaining in MAT

We have already mentioned several factors that influence people’s motivation, preparation, and enrolment in MAT, as well as their perception of MAT. In this chapter, we will focus on the main challenges people face to maintain their MAT, which include distance to the MAT clinic and daily transport fees. Second, lack of occupation and joblessness, and third, homelessness. The MAT program was criticized for focusing only on medication and not on providing opportunities to find jobs and access shelter for the homeless. On a positive note, people reported a change in their behavioural patterns, as they no longer want to engage in petty crimes.

“When you go to MAT, you go to change, and in the process of changing you become idle because of the areas you were used to going to, you now avoid them because the only thing that made you steal is the arosto [withdrawal]. And now because you don’t have arosto you cannot risk yourself anymore, so you try and find genuine work.” I46, FGD active drug users and MAT defaulters

Other positive outcomes that encouraged MAT patients to continue with the treatment were related to getting support from Matatu [minibus] drivers who gave them free lifts to go to the MAT clinic or DFD. Others recounted that they receive support for transport expenses from a family member and other participants said they moved closer to the clinic to be able to go for their daily dose and others again stated that they come by foot every day as transport fare is not affordable. Support in general from family members or other ‘treatment supporters’ was paramount to maintain in MAT, as acknowledged by this PE/HCW:

“It is easy to retain someone who has support from the family on medication than someone who didn’t have support. Because given that maybe, one was homeless and we enrolled them for methadone, they’ll still come back and stay at the den and it’s easy for them to relapse.” I42, male PE/CHW

Some interview participants explained that it was still their determination that helped them to stay in MAT when they explained their motivation to start MAT. One MAT patient explained how difficult it was and how much determination they needed to choose methadone.

“That Monday I went, and I waited, and I had a lot of withdrawals and I had decided to go back to the den, but I encouraged myself and I got strong and prayed to God not to let me go back to heroin. I took my methadone at noon, and you cannot stay from morning until 12 without smoking [heroin]. I had a lot of withdrawals, but I said, when I take that methadone, I know that I will be okay. And I took it, 30mgs.” I45, male PE/CHW

One HCW recounted what one of her clients told her about how his life on heroin was better than going for MAT:

“There are some things that they miss. First, they miss the company. It’s company they have lived with for five, ten years. The moment they stop using the drugs they feel like they are all alone. The other thing he [the client] was saying about the basic needs, he said that when you are in those dens, even if you don’t manage to steal something, your friend definitely will get something, and he/she will share. He was saying the friends those who use drugs are very generous compared to the other population.” I1, female HCW

This case example from the HCW matches what a disengaged MAT patient was referring to when he said that he is better off when using heroin.
“I’d better use heroin because when I wake up at 3 AM and get money, I can smoke, feel good, and continue with my work during the day. But now going to Karuri [MAT clinic] and coming back, that’s a lot of time wasted. If methadone was maybe nearer, I would opt to continue taking it.” I12, male MAT defaulter, 52y

“These people who want to help us should give us not only the methadone but also the capital for a job so I can feed my family. Don’t give me drug but there is no job. You only give me the drug, drug, drug. I don’t need to take that. I went back to the den to take heroin so that I am also able to steal in order to feed myself and my family.” I3, FGD active drug users

**Access to MAT and transport expenses**

Lack of money to pay the transport fare was one of the most often mentioned reasons why people would stop or disengage from MAT. The following quote exemplifies quite nicely how much money was needed to reach the MAT clinic daily.

“I went for MAT only for a month, and the money that I used up was a lot, from my perspective. So, I stopped because I was using 9,000 KES [73 USD per month], 300 KES [2.50 USD] per day, for transportation fare only. I couldn’t make it because whenever I went and came back from MAT, I found that all the work was done and that day I would make little to no money at all.” I40, FGD active drug users

“Something that I have gone through is the lack of transport fare, and a lot of people who want to join the MAT program are inhibited by this challenge. Also, users around this area do go to work and it is sometimes challenging for them to leave their jobs unattended and go for MAT either at Karuri or Ngara.” I5, FGD active drug users

Regarding the expenses for transport, we often heard people argue that if PWUD were generating money for their drug consumption, then why not for the bus ticket? A MAT patient explained it nicely in an informal talk, he said that MAT is like a ‘moral cleansing’. Other MAT patients used the word risk and said that one did not want to risk oneself anymore referring to petty crimes and the risks of mob justice and prison.34

**Lack of occupation and jobs**

The other major challenge for MAT patients was holding on to a job, earning some money or giving sense to their life by having something to do—an occupation. Interview participants talked a lot about ‘idleness’. What closely went along with it was the ‘joblessness’. The ‘idleness’ was also given as a reason why people would go back to the den, to the ‘old company’ of friends, to engage in cross-addiction and subsequently, disengage from MAT easily.

“And in that area of the MAT clinic, you become very idle, and it is very easy to go back [to the den] because you also have the same friends as before. You are not going to change. The idleness, that is the only thing. Because now you are going to change from crime to now being good. And being good in society, it’s really a challenge to make them trust you again, you see.” I46, FGD active drug users and MAT defaulters

“Most people who *chakachua* [mixing heroin with MAT] do it because they have nowhere to go, and nothing to do so they just feel, okay, let me combine this high and make the day end as it is.” I54, male MAT patient, 27y

“The active ones [on MAT], we would say that half of them are also at least accessing the methadone and the heroin. So, it beats the sense, like, of having them access methadone, and the reason why they are all doing this [mixing other drugs with methadone] is because we are not offering other opportunities for them. We are giving the methadone, that is the only opportunity we are providing them with their medication, but you are not even offering any other opportunities or giving any other kind of support, in terms of, even capacity building.” I53, male HCW

Loss of job or difficulties maintaining a job while on MAT was mentioned by many participants. Others confirmed that it would be easier to continue with heroin because they could send someone else to get heroin for them which they could not do for MAT because of the control measures at the

---

34 Please refer to the first quote in this chapter.
Others spoke of the difficulties maintaining a job as some started working at 6 AM and could not go for MAT before or after.

“I always procrastinate because I feel that I will waste a lot of time there whilst I can be looking for money. For example, in the little time that we have seated here [during the FGD], I feel like I have wasted a lot of time.” I14, FGD active drug users

“When you join MAT you struggle to get money because it comes in little by little and that cannot help meet all your needs from fare, food, clothing, and rent. It’s near impossible without assistance. Or it forces you to go back to a life of crime.” I46, FGD active drug users and MAT defaulters

In a few interviews, MAT patients referred to the competition and lack of unity among the MAT patients to work for a common goal e.g., creating a CBO or having a women’s group. Being a MAT patient did not necessarily mean that everyone would sympathise with each other. MAT patients made this reference in the interviews to questions relating to occupation and income generating activities.

“Lack of unity among the clients made me feel discouraged, because this was the way to go, so that we may be assisted. Reasons were that some of the clients felt that they were being used by the organisations supposed to help them, they saw the meetings as a waste of their time as they were not getting any direct benefits and could have better used that time to look for money for their needs like food and stuff. The peer educators who come to see them and help them are only given a stipend yet some clients feel jealous of them and refuse to cooperate unless there was something in it for them, thus the bread and milk initiative. It is true that they need to meet their basic needs, but it is unfortunate that they don’t look at the larger picture and cooperate among themselves, instead of competing in a destructive manner or insisting on incentives, whereas the efforts are geared towards helping the clients in the long term.” I37, male MAT defaulter, 33y

Homelessness
Others expressed frustration of not having a place to stay and still having to sleep out in the open. This problem was echoed by the HCWs who feared that homelessness would jeopardise retention in MAT. A shelter or halfway house could help MAT patients maintain stability with methadone until they find a job or another kind of work or activity that kept them occupied.

“Methadone has helped me, even though I have not reformed as much as I wish to. I can say MAT is good. I still sleep out under people’s vegetable stalls because I have no home; my mother threw me out of her house after I stole her phone and told me she never wanted to see me there again. She even moved house. I don’t know where to start, if only I could get a job and a room to stay even if shared.” I8, two male MAT patient, 27+23y

“I don’t know if it is achievable, but if there were shelters that could be given for some few months when they start and if gradually the person is recovering then they give space to others if it is possible.” I42, male PE/CHW

Cross addiction
Homelessness and ‘idleness’ went hand in hand with cross addiction during MAT. Most patients took other drugs while on MAT to either feel a high or because they were not satisfied with the methadone or buprenorphine dose, or because of peer pressure or as acknowledged by many, because they had nowhere to stay and nothing to do. Examples of cross addiction were:

- Methadone and Heroin
- Methadone and Marijuana
- Methadone and Alcohol
- Methadone and MCII called mic or microphone = ‘Jet-fuel’
- Methadone and Diazepam (or Cozepam) called ‘Ma yellow’, ‘C’s’
- Methadone and Benzhexol called ‘Ma white’

Most of the interview participants said that they use either marijuana or alcohol if they wanted to feel high. Alcohol is widely accepted in general but bears a high risk of overdose for MAT. Alcohol is
used in the form of spirits either legal/standardised or homemade and often laced with harmful chemicals. The jet-fuel\textsuperscript{35} consumption outside the clinic is one good example to show how people are pushed into cross addiction unintentionally. We did an FGD with a group of eleven jet-fuel consumers (ten men one woman). All of them were MAT clients and admitted to using jet-fuel because it was offered, it was cheap and because their peers or friends were using it too. Most of them told us that they had never used jet-fuel before coming to the Karuri MAT clinic. Jet-fuel is called the ‘microphone’ or ‘mike’ as the liquid is poured on a piece of fabric and then sniffed (Fig 10) and held like a microphone in front of the mouth. It was said that the jet-fuel was initially brought from Nairobi to the area around the MAT clinic and that MAT clients were influenced by these people from Githurai\textsuperscript{36} and shown how to use it. In the FGD, we came to understand that different kinds of ‘jet-fuel’ were available around the Karuri MAT clinic and that it was easily accessible as it was sold by shops selling painting supplies or hardware shops.

![Fig 10: MAT patient demonstrating jet fuel sniffing.](image)

In addition to MAT treatment, various substances are often used, with alcohol being the most commonly used, followed by marijuana and other drugs such as benzodiazepines, as exemplified by the following quote:

“Alcohol on top of high doses of methadone, usually more than 70mg, tablets such as Diazepam, Rohypnol, etc and substances like glue, MCs [jet-fuel] and the like. They are also normally users of marijuana, khat and so on...” I25, female MAT patient, 28y

The following quotes refer mainly to peer pressure and the notion of feeling bored and not busy.

“Sometimes you start MAT, but you don’t have anywhere to go afterwards, so you end up going to hang around your friends and when they are smoking marijuana, you find yourself smoking too as you keep each other company. It’s because you are not busy or committed to something, you find yourself idling with your friends since everyone else seems like they hate you.” I26, FGD MAT patients

“I have been taking MAT for two years and I can honestly say that it has helped me. But I recently came to know about jet-fuel. I was shown by my friend, and I came to use it through peer pressure. I’ve been using it for eight months, and from how I have experienced it, all I would want now is to stop using it because it has affected my relationship with my family too. The dizziness prevents me from going out and providing for my family. I would urge all of us using jet fuel to stop because initially when we came for methadone, we came to get clean and start a new life. But anybody who is using jet fuel now has reverted to a state similar to when we were using heroin, of being dirty and not looking after ourselves.” I61, FGD MAT patients, jet fuel users

4.4.7 Support during MAT

As previously mentioned, emotional support is crucial during MAT to motivate patients to continue their treatment. While moral reassurance is important, financial difficulties remain a significant challenge. Patients often received financial assistance from a family member or a sponsor. Typically,

\textsuperscript{35} Jet-fuel is referred to the fuel used by aeroplanes.

\textsuperscript{36} Githurai is a densely populated settlements located at the border of Nairobi County and Kiambu County along the Thika superhighway; it is also referred to as a slum.
families provide support in terms of housing, transportation costs, food, and other necessities, when available.

“Let’s say, my family. My mother, wife, brothers and sisters, used to support me and give me fare to come for MAT. Many addicts like me would join MAT if it was nearer them and they could stop using heroin because it is not a solution.” I12, male MAT defaulter, 52y

The support from the matatu drivers\(^{37}\) who gave free lifts was something that greatly helped MAT patients to continue their treatment. This was sometimes based on personal connections with the matatu drivers or conductors who normally collect the fares.

“They are motivated to help us because they usually know that we are going to take medication that helps us recover and they know what a person who uses kete [heroin] looks like. They see that when we start taking MAT, there is a change in us, and we are more motivated to do work and even look clean in appearance. ... By the way, the matatu people like methadone very much because they have seen the change in people who take it and who used to take heroin. They encourage us very much when we tell them that we are taking methadone and it makes them very happy. The surrounding people don’t usually know that we are going to take methadone at Ngara, but the matatu people do.” I41, male PE/CHW

Healthcare workers insisted on the psychosocial support to MAT patients to be able to stay in MAT and continue their treatment. Once again, the notion of having a treatment buddy was brought up.

“Why I talk about family, I feel like psychosocial support is what is so important because there are people who start treatment, maybe they go for 12 months then they default. So, they were committed, they paid for their transport, and they came to the DFD but then they eventually relapsed and got back”. I42, male PE/CHW

“I tried comparing clients that have treatment buddies with clients that don’t have, it’s not the same. For those that you’ve integrated with family treatment buddies, the adherence/completion level is high while the chakachua [mixing methadone with heroin] thing is minimal, unlike people who are on their own and don’t have treatment buddies. So, those that have those buddies, it’s good for them but those that don’t have any, they don’t have a sense of belonging, they belong to the streets and are homeless.” I47, female HCW

During one discussion with a MAT patient, it was revealed that their PE had become their treatment buddy.

“I have one [treatment supporter]. She is called X [PE] and acts as a kind of support together with my parent. I currently don’t have any problem with my parents, and I am open with them in whatever I am doing.” I55, male MAT patient, 21y

\[4.4.8\] The MAT clinic and its services

Perceptions and experiences with the services provided at the MAT clinic differed if we talked with HCW or with MAT patients. HCWs insisted very much on the need for more counselling and group counselling not only in the clinic but also in the DFD and the communities, including the families. One HCW even suggested that a counsellor could act like a family member when support from the family is not given.

“For psychosocial support I believe it lies more with the community, there is very little the clinic can do to actually give someone a new mentality or to actually have them thinking in a progressive way. ... it’s very amazing that you can have someone coming willingly here for five days because they want to be inducted, but once they are inducted, they no longer want to go to see the counsellor. We actually really need the psychosocial support on a family level. We also need to address the issues in the family. That is why I am talking about a CSO or something that can provide professional help to resolve such issues because the clinic in itself, cannot do so much.” I2, FGD NGO

“I would suggest, maybe the psychosocial department should be more involved to deal with individual cases because that person doesn’t have moral support or psychosocial support elsewhere. If the psychosocial

\[^{37}\] Matatus are minibuses.
department can work as a family, it be the family to that person who doesn’t have a family to support them.” I42, male PE/CHW

From a MAT patient’s perspective, the clinic was especially appreciated for its accessibility and its medical services. One MAT patient recounted that he was treated at the Karuri clinic despite not being registered as a MAT patient there.

“Karuri MAT helps a lot of clients and especially regarding the provision of many medical services. You cannot compare Ngara MAT with Karuri MAT. Because here at Karuri there are a lot of diseases that can be treated that Ngara cannot.” I9, FGD PE/CHW

“I’d say that it’s really nice [the clinic], how they treat us, how they help us because I’ve seen most of my friends now, they are good people, they are independent people, they have found their way and that is all thanks to the clinic. I’d also add that when we were coming here the spirit was very high. Since the beginning of this year [2022], I’ve seen the spirit going down. … I10, male MAT patient, 28y

Others referred to the empowerment centre (EC) and the activities they could engage in, whereas others appreciated income generating activities like the farming group (Fig 11).

![Fig 11: Members of the farming group showing their harvest.](image)

It appeared that the notion of counselling and the provision of mental health services in general was not so much known to the patients as only a few talked about it as a service they could take up. However, as said earlier, from the HCWs perspective, counselling was very much needed and therefore, more awareness should be created about it.

“I have never dared to talk to them [the counsellors] about my problems with my parents. I17, male MAT patient, 27y

“We do psychoeducation but not psychotherapy. You know, we try to teach them on so many other topics, but we never organize them to talk themselves. We need to like have more psychotherapy now, just among themselves [MAT patients] and exposing them to new ideas, exposing them to new skills.” I53, male HCW

For patients who had been on MAT longer, they were used to the different services the clinic provides. Some of them were able to attend the group therapy that was initiated by the psychiatrist in September 2022 and expressed their great appreciation.

“They do help us a lot. They help us with paralegal stuff and the application of IDs [identity cards] and health insurance. The counsellor does some home visits and those are very helpful. Also, the social workers help out those who come with very rugged clothes, and they are given clean clothes as well as a shower to freshen up.” I32, couple, female MAT patient, 23y

4.5 Health experiences and access to health care

One of the objectives of this study was the question on how active drug users perceived their health in relation to their drug use and how they perceived their health needs in regard to the MAT program.

4.5.1 People who use drug’s experience of their own health

Individuals who use drugs often have a unique perspective on their own health. Their top priority is to alleviate withdrawal symptoms and obtain their next dose of heroin, rather than focusing on
overall health and well-being. During interviews, participants emphasized that while using heroin, they do not experience physical discomfort, as the drug serves as a form of anaesthesia. However, they also acknowledged that their addiction to heroin is in itself a sickness, and the only treatment they seek is more heroin. Some individuals even referred to the drug den as their 'health centre' and heroin as their 'doctor'.

“For us, we normally have our own doctor [heroin] and once you have found money and bought it, it only takes two puffs and you are feeling better.” I46, FGD active drug users and MAT defaulters

“This here is the health centre, the den. I want you to understand, this is the medicine [heroin], when you smoke you feel okay.” I40, FGD active drug users

“As a drug user, about health, I don’t mind it. Because the sickness we have is only the arosto [withdrawals]. Even if you are beaten up by mob justice, you just get some puffs and then the pain is gone, and all problems are gone.” I33, male PE/CHW

“My health is good and all that, but when I don’t use it [heroin], I feel like I have malaria or typhoid, and when I go to the toilet, I even vomit. But when I use it, I feel better, and nothing is ailing anymore.” I14, female PE/CHW

Some female interview participants referred to their body and how it had changed because of drug use. They referred to getting slim, their skin getting darker in texture and that they did not perceive themselves as good looking anymore.

Women also spoke of their sexual and reproductive health, saying that they experienced irregular menstruation and sometimes menstruation stopped altogether but that it come back when they started MAT.

In an interview with a healthcare provider from the DFD in Ruiru we were told that most of their MAT patients are not too badly off in terms of their health condition unless they are beaten by the mob justice.

4.5.2 Access to healthcare

People who used drugs acknowledged that access to healthcare was hampered by their own appearance, their looks, and their attitude. This was reflected by the HCWs attitude towards them. All this together resulted in not seeking care when they needed for example in the case of an accident. In a private hospital or clinic, they would need to pay which they could not afford and in the public sector, they faced stigma and discrimination. In short, people simply did not go.

“I don’t go, actually none of us goes to the hospital because when we smoke, everything goes back to normal even if someone was feeling sick before.” I14, FGD active drug users

“The doctor might chase me away because of the breath that comes out of my mouth and when I go to him/her to get a prescription, the doctor has to ask whether I am using anything else. And because I am ashamed to reveal that I am a drug user, I rather avoid that confrontation altogether by not going to the hospital. So, I will go straight to the chemist because they are doing business and won’t risk losing a customer, they won’t ask any questions and directly tells me what medication I need. And if the medicine is cheap, 200 KES or below, then I buy it and go home.” I4, male active drug user, 29y

“You know, to get medical care here you have first to pay for the registration card. In that process, as you take the card, you have to wait in the waiting room. Now, I want you to picture me taking someone here to the hospital and we are a group, the way they see us, there is another picture they see us. They don’t respect us, so they don’t take us seriously.” I40, FGD active drug users

Participants also reported their experience of being the last to be served, which led to frustration and angry outbursts.
“They treat you like trash, you won’t get their attention, you’ll just stay in the line as they attend to other people, they will ignore you, they don’t want to associate with you cos you are dirty. They also do not understand us, you know sometimes when we are annoyed, we use bad language and insult people, so generally we can say that the treatment is not good. They don’t want to attend to us.” 110, male MAT patient, 29y

As PWUD could not afford formal healthcare when sick, in most cases they self-medicated with either medicines they bought at a pharmacy or with a chemist or with herbal medication.

“It’s not free [healthcare]. So, we tend to improvise in some things, like taking traditional herbs. We boil them and then we consume them. You will find that most PWUD that are using heroin, have bad teeth so will tend to apply some herbal products to reduce the effects on the teeth. IS, FGD active drug users

In a den, where people live and use drugs together, there is a strong sense of solidarity as they are always willing to help each other. They assist each other in buying and using drugs and in getting medical attention. However, if one of them gets wounded, they would first try to treat the person in the den. Only when the person needs immediate medical care, the peers would pool their resources to bring the sick person to the health facility.

On the other hand, accessing healthcare at the Karuri MAT clinic was perceived positively by all the participants, as mentioned in chapter 4.4.8. The medical services at the clinic were even cited as the reason why some PWUD joined MAT. This factor was discussed as a motivating factor for starting MAT in chapter 4.4.1.

4.6 Peer educators and CHW – the peer-led model

The PEs and CHWs play a crucial role in linking the MAT program to active heroin users in the dens as well as to link MSF activities with LVCT services. This peer-led approach is based on an LVCT/MSF partnered microplanning outreach system with a strong component of community led monitoring, to ensure that social networks of PWUDs are regularly engaged with and supported with adequate access to healthcare (Bhattacharjee et al., 2018). All PE and CHW are former active heroin users and are in the MAT program. PE work with LVCT and receive a stipend of 3,500 KES (28 USD)38, an amount that is set by the government; the CHWs are employed by MSF and receive a salary.

We must acknowledge a program such as the Kiambu project could not work without the PEs and the CHWs, that they are the link to the PWUD, and any external person is accepted only because they are introduced by either a PE or a CHW.

PEs and CHWs themselves insisted that not everyone could be appointed to that role. To be a MAT patient is not enough—one needs to be qualified for such a position in terms of education, personality, and above all someone who is respected by PWUD and communities in particular. PE who worked directly with PWUD in the dens faced multiple challenges approaching them and working with them, as we will see.

“It’s good, and a PWUD is a hard-headed person, so you must have the skills and tactics to approach and handle them, and once you succeed in creating a rapport with them, they can be some of the nicest people you’ll ever meet. I empathize with them because I have been there and by giving them respect, they too reciprocate it.” I56, female PE/CHW

4.6.1 Roles and responsibilities39

In their role as PEs, they would mainly work in the dens directly with the PWUD and support them in every way they could. This includes informing and sensitizing them about MAT and providing them with clean needles and syringe kits (NSP kits), condoms, and helping them to link with the clinic if they have medical issues or if they are in contact with the police due to an arrest. When active heroin

38 The PE get additionally 500 KES every Monday as a travel allowance and if they bring a target of 15 people/month to the health services they receive 1000 KES which sums up to 5000-6000 KES/month.
39 We will not go into a detailed description of what PE and CHW JD explains, this can be read elsewhere.
users inject in an area, PEs should also clean the place to remove dirty needles and monitor if they have enough NSP kits (Fig 12). PEs can also give naloxone in case of an overdose directly in the dens and hotspots. CHWs are more active in different facilities like the Karuri MAT clinic and the DFDs.

Fig 12: A hidden place in a field with NSP kits where PWUD inject heroin.

“My role as a PE is to mobilize PWUDs and to teach them about MAT either as a group or as an individual. When we have a facilitator coming to give a talk, we prepare the clients for the presentation. If there is someone who wants to have more in-depth knowledge about MAT before they get inducted into MAT, you take time with them and give them the necessary information.” I31, male PE/CHW

When talking about the roles and responsibilities, one participant in a FGD mentioned that they would like to extend their tasks to go for health education and sensitisation sessions to schools and places where young people gather.

“In the communities, there are no counsellors to talk to the children or teenagers to help them deal with the things that might be eating them up inside, so they tend towards drugs as a soother. Another thing, I wish that the PEs roles can be expanded, we can also not just be going to the dens only, but we can also be going to sensitive places where we know teenagers are smoking bhang or even talk to the schools on matters concerning drugs. Female PEs can go and talk to young mothers too, not always going to the heroin den all the time. We can do more for the community.” I9, FGD PE/CHW

“I would wish by the time I leave LVCT, for it to have expanded to the point that the community recognizes it. Most of the community has not yet been sufficiently sensitized about drugs and how to help all those that are using them.” I9, FGD PE/CHW

4.6.2 Peer educators – empowerment

Being a PE or a CHW helped significantly to support a MAT patient in their life situation, first by having an occupation or a job and second by feeling motivated in continuing their MAT treatment. PE and CHW felt valued and worthy, they saw themselves as role models for other PWUD to follow their path. It was a way for them to rebuild their lives and regain respect by the community and their families.

Feeling valued and of worth, being a role model

“I normally feel really good. Because people from the community who tell me that I am doing a good job, help raise my self-esteem and I can see that I am well respected in the community. When I also go to the den, I am well received and respected there too, they do see that I am a different person now and I am also working a good job in the LVCT since there is no one else working there from around except me.” I41, male PE/CHW

“We educate them on the requirements of joining MAT, like being a user of heroin. We urge them to know that you must use your own brain to decide what to do and why. As a role model, you give them a good picture of life after methadone and you can use the example of your own successes to encourage them to desire recovery from drugs.” I31, male PE/CHW

Rebuilding their lives

Many participants mentioned that being a PE or CHW helped greatly in their recovery for themselves and in rebuilding their life. They again spoke of a ‘change’ that they were able to achieve.
“I can say I have come from a lot, and I have changed, and I have made so many people change, you see. And where I was back then and where I am now, there is a very big difference because even my body, even if I am not very fat, even the people tell me that I have changed.” I45, male PE/CHW

Helping others
PEs and CHWs also referred to the notion that ‘helping others’ was an important motivating factor in their role.

“One of my major motivations is to help others, just as I was helped, to get out of heroin use. The situation that I am in right now cannot be compared to the days I was when using, so it gives me pleasure also helping others transform their lives as we have. The life of drugs is filled with crime but when someone is taking methadone, other upright and upstanding work comes your way.” I9, FGD PE/CHW

“Because I have walked the drug life and have faced the challenges that come with heroin as well as being a female user, that has really motivated me to help out my female friends who are also going through the same life I lived before. I normally feel, if only I can help even one woman get out of that life, that is quite fulfilling and okay with me, at least I will have helped someone.” I56, female PE/CHW

Regained respect by the community and family
One significant empowerment for PEs and CHWs was being respected by the community and family again.

“When we are educating the clients, the community, especially their families, really appreciate it because they know that we, the peer educators, have been drug users before and are therefore speaking from experience. They value our advice and will listen and from that, they may understand the challenges the client has been facing. They see some hope for a solution.” I31, male PE/CHW

Being ‘occupied’
The role of a PE and CHW opened possibilities of engagement and occupation for male and female MAT patients.

“Becoming a PE also supported my recovery very much, because now, they got me something to do. And before, I was just loitering around the town, and I think also that has helped me a lot. Because I am working within the MAT clinic, or within the DIC and at the end of the day I will earn something, so I think that has really helped with my recovery.” I28, male PE/CHW

4.6.3 Peer educators’ challenges
As discussed in the previous chapter, being a PE or a CHW gives people a sense of value, increases their self-esteem, and helps them in being occupied and regain respect from the community and families among others. However, when we had an FGD with PEs, we understood that they faced various challenges ranging from the renumeration to reaching the target of enrolling new MAT patients to worries in their relationship with PWUD in the dens.

Going back to the dens also meant going back to the old environment that the PE spent their time and day while they were still active drug users. It meant being exposed to the drug user’s environment and activities of buying, smoking, and injecting. On the other side, when PE went back to the hotspots and dens, they were not always received with open arms. PWUD did have expectations towards them and often asked them for money to buy drugs. PEs recounted that PWUD told them that they did this job only for the money, and that if they wanted them to join MAT, they should give them something in return. One PE said that he tried to avoid going back to the dens and perform his activities at other places where he knew PWUD would hang around.

Relationship with PWUD and emerging tenses
Women serving as PE acknowledged that they feel their job bears certain dangers and challenges when they reach out to the dens.

“It also becomes dangerous for us and our security because they will sit in that den and even the pushers will say, ‘these people are just coming here to use you, you know, the only thing they bring here are injections [needle/syringe], and most of you don’t inject you smoke’. So, it becomes dangerous for us and
especially us women. We could be going to the den one day and then we are accosted, or anything could happen, and we are chased away. Anything can happen, especially for us women, it’s very, very dangerous. So, we need LVCT to hear us and help us and give us something to give these addicts as an incentive for them to come to LVCT.” I9, FGD PE/CHW

In another situation, a PE was confronted with the pushers of a den and was accused of taking away their customers and risked being abused.

“They say that you are coming to steal their clients, and some may beat you up. They say that their income is being reduced and they are not making as much money as before when you people [PE/CHW] weren’t there yet.” I7, male PE/CHW

Active heroin user’s expectations

Expectations were mainly related to monetary compensation, either for the time they lost listening to a sensitisation session or going to the health facility or to start MAT preparation and enrolment.

“They ask us, ‘you want us to go to the clinic with you to get tested, how will that benefit us?’. So as PE if we could be given money, let’s say if we are looking for 15 people, if we are given 3,000 KES [24USD] then we would give them 200 KES [1,60 USD] each to come with us and get tested and given other services and at the end of the day, they go back to the den that would be wonderful for everyone. Because for us as PE, it’s so hard to get them out of the dens because we don’t have any money or anything to give to them.” I9, FGD PE/CHW

“They say, you have to pay them so that they can attend whatever talk you have planned because you are wasting their time instead of searching for their money to buy the heroin. They say if it was a fair exchange for time with money, then they would attend.” I9, FGD PE/CHW

“I am not [going to the den]. Even if I am given a job to go there [den], I don’t like going there. I just go to the bus terminal or to the road. Whenever you go to the den you have to give them money so that they can listen to you. And if you refuse to give them money, they start to bully you.” I3, male PE/CHW

The expectations among PWUD arose because female PEs shared that in the initial stages of the peer-led model with LVCT, they used to provide lunch and a stipend to PWUD when they reached out to the dens, which is no longer the case. This was during 2016/17 and is not happening anymore. PWUD claim that the female PEs are taking advantage of them and not providing what is due to them. They believe that the support they received before is now being withheld by the PEs for their personal benefit.

“There is no trust between us and them anymore. They feel like we are getting money, benefiting, and using them. The rift that was created when we stopped giving them those goodies, has widened more and more nowadays.” I9, FGD PE/CHW

During our interviews, a PE shared that in the past, LVCT provided PWUD with a package of self-care items including toothpaste, a toothbrush, two toilet papers, and bar soap. However, the PE noted that most PWUD sold off these items to buy heroin. Despite this, the PE acknowledged that the provision of these items gave PWUD an opportunity to attend an information session, demonstrating a harm reduction approach.

Being in the ‘old environment’ – being with active heroin users

Contrary to the assumptions held by MSF as an organization and the team on the ground, the PE have stated that it is not a significant problem for them to return to the same environment of the dens. They consider themselves as professionals and emphasized their determination and individual need to serve the PWUD community. These quotes provide insight into the mindset of the PE regarding their work and the challenges they face in the field.

“No, I have made the decision not to take it. Even if I go to the den and I am getting someone out, I tell my heart that I stopped heroin and I will never taste it again.” I23, male PE/CHW

“Change has to come from you, from within. When it’s coming from you, it’s hard for someone to ruin what you really want to achieve. It’s hard.” I7, male PE/HCW
It should be noted that while some PE and CHW find it easy to go back to the dens, we have not had the chance to interview all of them and for some, it may still be a challenging experience. In informal feedback about a visit\(^{40}\) to a den, the research team was told that it was a difficult experience for the PE/CHW who had accompanied the team. They were exposed to the smell of joints laced with heroin and the sight of people smoking, which brought back memories of their own past.

**Renumeration and reaching the target**

Another major challenge PE faced was the renumeration and the pressure of reaching their target of bringing 15 new patients per month. Some said they were afraid of losing their job if they did not bring these 15 individuals and further stated that some would modify the statistics out of fear of losing their job.

“The main challenge that I experience is in achieving the target of clients that I am required to bring for induction into the MAT program. In order to get paid, we need to bring in at least 15 new clients, and that is a big challenge at times. For example, when I go to the den to look for people to bring to the DIC [drop-in-centre] so that they can be offered free health care services, they say that they don’t really care about it because they feel fine. But they also have a problem with me coming, saying that I have come to waste their time because I am being paid by the LVCT, whereas they are trying to look for money in the den to meet their needs and I have come to disrupt them. With that in mind, some of the PWUDs don’t cooperate, and they say if I would like to take them to the LVCT for the services, then I’ll have to give them at least some money as compensation for them to agree.” I9, FGD PE/CHW

““The living conditions are very hard right now. The monetary issue is a big one since money is everything. I feel that we are not looked after properly here at LVCT and sometimes we feel also like we are not part of it. Maybe we can be given T-shirts or organise a get-together for all us PEs, increase our salaries and look after our health by paying our NHIF [national hospital insurance fund], that would greatly boost our morale and improve performance in the work we do. We should also have a person on the staff whom we can bring our concerns without feeling scared and who can bring them to the administration to be looked into.” I9, FGD PE/CHW

PEs explained further on the matter of reaching the set targets, the fear of losing their job, and the consequences such an adverse event could mean for them. Losing the job of a PE would provoke negative feedback and attitude from the people who were still living in the dens and could push the PE into a depression, sometimes to the point of going back to heroin use.

“It’s depression. You know, you were once a PE and when you lose your job and go back to the den, they [PWUD] start laughing at you. They [PE] backslide, and they start using again. Before they used to smoke, and now after losing their only source of income, they start injecting.” I9, FGD PE/CHW

In this FGD, participants insisted that there was an information gap between what the organisation and the program knew of what was happening on the ground.

“You know, us addicts we really like it when we see another person falling. So, when you become a PE and suddenly you are moving now up in the world, you’re getting better. When you lose that, the addicts will laugh at you and they will say that ‘you were so pretentious when you were a PE, but now look you are back with us’. I think there is a complete disconnect between the information that the LVCT and MAT clinics are getting and what is actually happening on the ground. The PEs cannot produce the real picture that is on the ground because of the fear of losing our jobs.” I9, FGD PE/CHW

PEs insisted that they did not blame LVCT but would like their concerns to be heard and that their concerns are not just taken seriously but also tackled. They acknowledged that LVCT is dependent on donor money and for getting the money they need to provide results and successes.

“The real problem is also from the donors because they want numbers. They work with numbers, LVCT works with numbers who then give Sheila the numbers and then they are passed down to us PEs. These numbers create a lot of pressure for us.” I9, FGD PE/CHW

---

\(^{40}\) The visit was not done by the anthropology team but another team from the Kiambu project.
The people-centred approach of harm reduction endeavours to establish a trustworthy bond with individuals who use drugs and enhance their overall well-being. The services provided should not only be available but also accessible, acceptable, affordable, and of superior quality to guarantee that drug users can exercise their right to healthcare. Drug use, especially heroin use, is an inherently social phenomenon and must always be evaluated within its social context. Most of the harms associated with drug use are either caused by or exacerbated by the social risk environment in which it takes place. Chapter 4.2.3 addressed the difficulties encountered by active heroin users, while this chapter will delve into the services offered by MSF and LVCT and how their intended recipients perceived and interpreted them.

Active drug users were mainly familiar with services like the distribution of NSP and testing activities that they were encouraged to make use of and the distribution of condoms. It was specified that the very young ones who had recently started using drugs did not know what harm reduction was.

"We have also been tested for diseases e.g., HIV and hepatitis, and we have been injected with vaccines. We know if someone is taking methadone and they have a sick family member, they can bring them to the clinic for treatment. I also heard that if you are a MAT client and you get arrested, the clinic can help mediate your release from police custody if it is within their ability to help.” I14, FGD active drug users

In discussions with MAT patients who have disengaged, they referred again to MAT patients and them being less exposed to health risks as they are in another ‘stage’ of awareness about their body and mind. They speak of their own experience as they have been patients themselves before they successfully finished MAT.

"When you are in MAT, there is less harm, as you are more conscious and cannot even share a cigarette with another, you only share with someone with whom you have confidence, and you are more comfortable with. You also avoid using other substances. Once you are in MAT, your mind starts functioning as it should. You can now have good self-care, at least taking a shower and being clean. You can also save your money as you are not misusing it by buying drugs. You have no problem with anyone and are more easily satisfied, so you have less stress.” I39, FGD MAT defaulter

With PE and CHW, we talked about how they would address the topic with PWUD in a way that they could understand what it meant and how they could apply a harm reduction approach for themselves in a human rights approach, meaning a life free of stigma and discrimination.

"Ok, you have to tell them about harm reduction, that it is that way that you can make sure that your life won’t move from good to the bad; for example, your HIV status, you can be a junkie and didn’t have the virus when you were in the dens. You have to be careful because you’ve entered into the methadone clinic, there are some things which will come up and you will have to try so much so that you won’t find yourself in the situations. About the syringes, you must find a way to convince that person that it isn’t safe at all to use someone’s needle. I7, male PE/CHW

They additionally mentioned some tensions with the police and the community when distributing NSP kits accusing them of encouraging drug use.

"Of course, there is a lot of extortion here. You see, even LVCT we had so many challenges because we were distributing these needles. So, they [the police] could not understand it from the beginning. They thought we were encouraging people to use. Even the community, ‘now you are bringing the needles to them, now you are telling them to use them,’ but they didn’t know that it is a harm reduction process. We are trying to avoid this express transmission of HIV. So, slowly they came to understand.” I42, male PE/CHW

---

41 At the time of the study in September 2022 Kenya experienced a shortage of condoms already five months.
From a HCW perspective, we were told that they also tried to talk in a language and manner to PWUD that was understood. This meant that any sensitisation or health promotion sessions were done in Swahili or Kikuyu.

In summary, the interviews indicate that all aspects of harm reduction are crucial for enhancing the health outcomes of people who use drugs.

- NSP program stopped sharing of needles, syringes and other injection paraphernalia.
- Less HIV/Hep C Hep B, STIs, TB, c/o tests, treatment and mainly no sharing of sharp body piercing instruments.
- Encouragement for consistent and correct condom use (if available).
- HP education brings awareness to users and community.
5 Recommendations

The MSF Kiambu PWUD project started in 2019; in 2020 and 2021, two other anthropological assessments were done, the first one explored women who used drugs and the other one mapped hotspots. The current anthropological study took place in September 2022 and was performed with a small anthropology team (PI, study assistant and translator, and a transcriber) along with various members of the Kiambu project.

The anthropology team applied a holistic approach considering the perspectives of various stakeholders. We closely worked with people who had a lived experience—either of being an active heroin user or a MAT patient, a defaulted or a weaned-off MAT patient and with PE and CHW who were also a part of the aforementioned groups. This was complemented with views HCWs from LVCT, MoH and MSF. All these data together led to the recommendations that follow.

We have not included family and community members and do acknowledge this limitation to be considerable. The results suggest that family and community members play a crucial role in creating a supportive environment for PWUD and MAT patients to promote a harm reduction approach.

A MAT program should entail a comprehensive and holistic approach in addressing not only the physical and medical needs of PWUD but also psychosocial and various structural challenges that PWUD and MAT patients are confronted with. The recommendations are aimed at complementing the project’s objectives in supporting PWUD to navigate the ‘new life’ on MAT with the ‘old life’ on heroin.

The recommendations are many and many might be a repetition of things that have been already discussed or have been proposed in the two previous assessment reports from 2020 and 2021. Some might be addressed or implemented already or are at least known to the team. Nevertheless, even if it might appear as a repetition, we thought it would be good to address everything that came up within the results of this study.

We do not claim that this is a complete set of recommendations; there might be others that we have not addressed; however, we hope that they are taken as suggestions based on what has been addressed in interviews. We do not know better, but we do hope to boost PWUD and MAT patients’ ability to re-build their lives and restore their broken social conditions by promoting supportive life conditions.

This study comes with an outsider view. We realise that it is easier to provide recommendations than to implement them; therefore, we would like to suggest a comprehensive workshop where the recommendations are discussed with the Kiambu team, PMR, HP, LVCT, PE, CHW, and PWUD and MAT patients, among other stakeholders.

In the first part of the workshop, the report findings will be presented and discussed for validation with the participants. In the second part, recommendations could be discussed and validated to see which ones are feasible to implement and which ones are most important, as perhaps not all of them can be addressed. As a next step, it can be decided which recommendations can be practically implemented, how, by whom, and what would be needed to implement.

Which recommendations can be implemented on a structural level, and which ones can be applied by PWUD themselves, MAT patient themselves? Where is personal engagement needed?

The following recommendations have been drawn from the analysis of the field research; this included exchanges and discussions with the anthropology team, MSF Kiambu project teams, LVCT,

42 Grondal, Valentine: Experiences of women who use drugs in Kiambu county, challenges and barrier to access HR services and MAT program, MSF OCB, 2020.


43 If such a workshop is feasible, who could prepare and facilitate it?
local MoH, and international staff working in Kiambu and Nairobi and from discussions and
debriefings with technical referents from the cell and the medical department of the OCB. Informal
discussions with colleagues at the project level, and discussions with other medical anthropologists,
and with technical specialists from SAMU have also been integrated into the analysis.
An extended literature review of articles and books related to PWUD, medical assisted therapy and
harm reduction approaches, was carried out prior to the field research and continued after the visit.
Lastly, the anthropologist’s own field experience with MSF enhanced data analysis and the
elaboration of these recommendations. These recommendations are intended for consideration by
MSF, LVCT, MoH and other partners, PWUD, and MAT patients.

5.1 General recommendations

As a premise, access to MAT should be possible for every individual. Therefore, MAT provision should
be close and easily reachable for every PWUD who would like to engage in a MAT program and for
MAT patients to maintain. We should tackle the factors that influence and impede access.
Advocate towards the MoH and NASCOP not only for medically assisted therapy treatment and
psychosocial treatment of MAT patients, but also to look at life circumstances that disempower
individuals to stay on MAT treatment.
Entail a holistic approach with patient-centred attitudes, using non-judgmental language and harm
reduction approach. The clinic should not just focus on medication or stopping heroin as the overall
objective but should also include social and mental services as well as counselling. These services
should be complemented by support for homeless and jobless MAT patients to reduce defaulting
and relapsing.
Provide continuous information on MAT. MAT is still a new concept in Kenya, as many healthcare
workers have noted, and would need to be explained and promoted on all levels—society,
community, family, and MAT patients themselves. People often know only about a rehabilitation
concept where PWUD are referred to a facility and undergo ‘cold turkey,’ which can result in quick
relapse to heroin.
Engage in a ‘health navigator’ system—having a buddy for newcomers to MAT, who can be
supported and guided from the beginning by someone who has been longer and stable on MAT.
Those who are stable on MAT can be leaders in educating others in hotspots and dens, serving as
peer educators with LVCT. Having ‘buddies’ or ‘health navigators’ for new MAT patients could help
them ease into MAT and motivate continuation.
Let us create a place of belonging at the MAT clinic for patients attending it. Maybe this concept can
be triggered through the health navigator or buddy system? Ensure to update a mapping of CBOs
and CSOs in the area44 and find out with which ones we could collaborate for which topic and how
they could help to bridge the gaps. For sustainability, when MSF leaves, the CBO can continue
working with LVCT. Again, in the realm of sustainability, train employees to be able to continue once
MSF has left.
Help to support capacity building to create a community-led organisation45 to have a half-way/re-
engagement house for homeless MAT patients, with someone in charge who comes from a lived
experience to help MAT patients in their transition from their ‘old life’ in the dens to a ‘new life’ as a
MAT patient.

44 It looks like that this is already done, so look into it again.
45 The creation of a CBO has already started.
There are already some great initiatives of self-help groups led by social workers. We encourage further assistance and support for self-help groups where MAT patients and family members come together, at least occasionally, to talk about what is happening in their lives. Such interventions could focus on mutual support and availing opportunities that will improve the self-esteem of the patients. Such support groups could take place at the CBO.

The MAT approach is focused mainly on patients, but we need to include significant others, such as family and community. Family and community members could meet at the CBO rather than at the clinic for specific topics to raise awareness, ask questions, and discuss fears and uncertainties.

Continue with the MAT patients working on their skills and talents and let them present these to the community. Dance performances, a choir, a theatre group, a concert performance - one MAT patient said he is a graphic designer, another is a computer specialist. Ask MAT patients about their talents and let them propose something. MAT patients can show the community that they are individuals with skills and talents. This will help reduce stigma and discrimination and create a supportive environment in the MAT clinic, DFDs, and surroundings.

Before going into detail to every part of the recommendation we would like to address a general recommendation that concerns the language used, it is suggested to be able to do any information, sensitisation or awareness raising session in the local language, Swahili or Kikuyu or even sheng (local slang) not only in English.

5.2 MAT clinic and DFDs

Regarding the MAT clinic, concerns were raised about how to ensure continuity of services after MSF leaves. Healthcare workers pointed out that MAT is still a relatively new service in the country, and even trained nurses and clinicians would need specific courses to treat PWUD and MAT patients. MSF should collaborate with other county staff and provide training to ensure the program's continuation.

While the study's scope did not cover it, observations of MAT patients in the clinic, their concerns raised in interviews, and information from non-users involved in their care suggest the need for a detailed evaluation of the clinic's set-up, organization, and service delivery. A more thorough study that includes both service providers and users could identify and address the challenges that exist in service provision.

- MSF should make sure that the medical staff is trained accordingly be able to continue with the clinic and its services.
- MSF should look into the clinic set up—patient flow, service provision, waiting times—and how well it is working.
- MSF should ask for an evaluation of the clinic set-up.

MAT patients and other patients at the clinic could benefit from health promotion sessions that provide information on MAT, harm reduction, counselling, and mental health. Information session or classes at the MAT clinic (general ones in the waiting area more specific ones with a schedule time and date), providing continuous information and awareness, triggering interest and motivation and keeping the patients busy during their waiting time might be helpful.

Additionally, the opening hours should be re-discussed for MAT patients who have a job or mothers who have to take care for their children.

- Review the opening hours for the Karuri MAT clinic, DFD, and EC. Interview respondents suggested that the clinic be open from 6 AM to 2 PM at least.

46 A team from the Karuri project has been visiting another project that works with PWUD at the coast in Mambas. Maybe we can look how and what works well there to maintain patients and what can we adopt for the Karuri MAT clinic.
Evaluated the issue of accessing the clinic or DFD daily: How can the challenge of generating a fare to reach the clinic every day be tackled?

Discuss the matter of transport costs—for example, is a collaboration with matatu drivers and conductors possible?

Assess the appointment flow: reduce waiting time for MAT patients. Waiting hours for MAT patients are challenging—how to occupy them while they wait?

Put a television in the waiting area.

Have services at the DFDs like hot shower or ECs.

Buprenorphine patients suggested to have more magazines and books in the Bup corner and for the mobile phones to have Wi-Fi connection to occupy the patient while they wait for the buprenorphine to dissolve and to dispel idleness.

5.3 Empowerment centre (EC)

The EC has male PE and CHW there support MAT patients and mobilise them for various matters. Is it possible to also appoint a woman at the EC?

Make the EC more welcoming, friendlier, and ‘warmer’. By friendlier, we do not mean that the appointed staff there is not friendly, we rather refer to the temperature and the noisiness of the place.

Review the opening hours of the EC. Some clients come from far and later in the day for the MAT dose and cannot attend the EC after 1 PM. Many idle around outside the MAT clinic; can they be occupied in the EC instead of hanging around and being attracted to sniff jet-fuel?

Can we ensure a hot shower? Are there contingencies for when the solar panel battery is not full? It would be a great asset for colder days without the sun.

The HP team could do a small FGD with MAT patients for suggestions for the EC, especially for women and their children and women-friendly activities (beauty salon). The EC does not offer much to women; therefore, lesser women are seen in the EC as compared to men. It needs to be women-friendly and the solidarity among female MAT patients should be worked on. It was noted that women did not get along well. Why was this? Can a short assessment specifically on this topic of solidarity and unity among women be conducted?

Could MSF provide a television in the EC with information videos, documentary videos, role models who talk about their story and journey, case studies, examples from projects at the coast, or YouTube films?

Discuss with MAT patients for other income-generating activities (IGA). Some are already in place like the farming group. Can a bigger field be rented for farming? Can we think of having a fishpond? Could we engage in laundry and cleaning the neighbourhood? Could MAT patients do arts or craft work or in collaboration with other organisations who do already craft work?

Collaboration with big Asian companies for jobs, Rotary clubs and Giants or Lions club. Rich people may have children who use drugs and are sensitive and open for funding. Could we find out more about it?

5.4 Person-centred for PWUD

On a personal level for PWUD who would like to stop heroin and engage in MAT, we can support such a decision and provide motivation with detailed and in-depth information on MAT to tackle misconceptions and misinformation.

---

47 Winnie Riitho could do it together with Morris.

48 Suggested by MAT patients.
In-depth information on what MAT is to avoid misinformation and misconceptions.

What does enrolment entail?

How does the preparation process go about?

What does it need as a precondition?

Provide more frequent information sessions done by LVCT in the dens with provision of some kind of motivation such as some kind of food or bread and milk.

Reflect on how we can motivate PWUD to attend information sessions, go to the clinic, or go for preparation without compensation or with compensation. This could be in terms of transport fare or some kind of food if there could be a budget.

Such information could also reduce fears of PWUD such as a prevalent fear that they would experience withdrawals. When they know what they can expect and what awaits them in terms of alleviating withdrawals during the process, the process is easier and can be anticipated.

MSF along with LVCT should create an ‘exit strategy’ from the den or hotspot. How can we help PWUD to leave their ‘old life’ and transition to a ‘new life’?

Discuss how we can tackle the lack of perspective and hope that their life could change when they are on MAT. A CBO could help with shelter and IGA could help with occupation.

Review who could replace the family of a MAT patient after moving on from the den if they are not involved or decline to be involved citing this reason. A treatment buddy or health navigator from the beginning should be appointed to every new MAT patient to guide him or her. This should be a person of their choice.

5.5 Person-centred for MAT patients

What is the MAT program and its process from the start and tackling homelessness and joblessness after having started. PWUD only know their life with drugs for the last years—how can this life change? How can we and the MAT program help them change in the realm of a harm reduction approach?

What is the life after starting MAT? We can provide social services to complement with mental health and counselling. Perhaps, creation of a CBO and cooperation with other NGOs.

*Every patient is unique and needs unique treatment! Make sure that every MAT patient feels comfortable and confident with their counsellor, and that there is trust and mutual respect. Counsellor-patient relationship must be one of trust and feeling well, accepted, listened to and understood! Most importantly, find ways to bring the notion of counselling into the minds of MAT patients already enrolled in the preparation to MAT as a service that can help them in coping with their life challenges.

“People might lose hope in this journey [MAT treatment] since they are trying to make their life better, but the fruits of their labour cannot be seen, you know. So, because life is life, people will meet different challenges here and there, and they might be having some family issues back at home. What leads people to relapse is that they have not faced the triggers that they had as they were using drugs, they bring them as they start taking MAT. I am saying that because, when I came here, I have only seen my counsellor not more than five times, you see, those are almost eight months down the line [September 2022]. Unless the clients are told to come and see the counsellor, nobody will come and see the counsellor of their own volition.” I54, male MAT patient, 27y

Think about how we can support MAT patients who experience mental distress and a lack of hope, and how they can make a living without being antisocial and engaging in petty crimes.

If they suffer from depression, counselling also be provided to their children.

Guide enrolled MAT patients in transitioning from their past environment (dens and hotspots) both physically and emotionally.

○ ‘MAT is a moral cleansing’.
Let MAT patients chose their own counsellors.* It should be a pre-condition that MAT patients feel confident with their counsellor; if not, counselling becomes redundant. We have evidence from the interviews that some MAT patients do not feel confident with their appointed counsellor (relevant for the Karuri MAT clinic and the DFD).

Help MAT patients improve their lives (again related to homelessness and occupation). They want to be seen and acknowledged by the community and families and this is when ‘safety’ comes back—perception of MAT patients and stigma towards them.

Discuss what can be done to support MAT patients who are homeless? A ‘home’ to stay. Having temporary shelters for people who do not have a place to stay. Think about how they will deal with regulations in such a shelter; they are used to their behavioural patterns of being independent. How can they adjust to a different lifestyle of a halfway house?

Information and sensitisation on various topics related to MAT to improve staying on MAT.

- What is harm reduction?
- Nutrition support while on MAT.
- Concept of counselling and mental health.
- Group therapy and sharing with others to reiterate that they are not alone.
- Unity among MAT patients: why is it difficult what can be done? creating unity can be based on certain characteristics like religion, ethnicity, gender/sex, interests and skills, childhood experiences, income, or similarities in understanding the world.
- Hanging around outside the MAT the clinic. Why is that so and what can be done?
- Jet-fuel and other drug consumptions what can be done?

From the MAT space, propose to the patients that they can form a group with members from the same area, and they could apply for a stipend for a meeting once a week in their area. For example, this could be to support and motivate each other with a PE chosen by the group. Connect with the social workers at the MAT clinic to help MAT patients form groups with the help of CHW and PE too.

Feeding programme

Some MAT patients suggested to support those who are homeless and have no family support in their nutritional situation. For some, a warm porridge is provided which helps them immensely.

- As an incentive and to help improve their health as most do not eat well when using heroin, a high protein meal and use of supplements would help.
- Giving nutrition education would result in an improvement of their state of health. A small ‘shamba’ (field) can be used to produce vegetables to complement a balanced diet. If there is extra, it can be sold to clients, staff, and even in the market.
- A lunch could be given after classes (attraction and management of groups—not given too early or clients will disappear—looking forward to the lunch after class will keep them coming.

Activities MAT patients could engage in

To help MAT patients engage in activities within the community they need to regain their trust first. How can we work on the person itself to restore a person’s self-esteem, self-worth, and deal with stigma and discrimination?

- Support MAT patients in raising funds for income generating activities, jobs and occupations: having a cleaning shop, washing cloth, ironing cloth, cleaning the environment, car wash, vegetable selling, beauty salon, providing ‘services for the community’ so that they can see that they have changed and are capable.
- Can we create a focal point or focal person who has the skills and is specifically appointed to support MAT clients in such matters? (Ideally a PE or CHW or a stable MAT patient, maybe a man and woman each?)

---

49 This part is linked to what was said for the empowerment centre.
Help MAT clients form a self-help group to build and regain a meaningful life.

Think of how we can amplify the empowerment centre, opening hours, keeping people busy, and having a place where they can smoke cigarettes outside the EC.

**Capacity building**

This section is again linked to IGA that were previously mentioned. Can we engage in:

- Providing vocational trainings, such as technical trainings, crafts, and other opportunities for MAT patients to improve their skills, find a job, or generate income? Most MAT patients have some formal education, ranging from Form 2 to Form 4, and can easily learn new skills.
- To provide vocational training, we should involve the government, as there are polytechnics in all countries that can offer training in various fields such as mechanics, driving, plant work, tailoring, carpentry, masonry, painting, catering, food processing, hair and beauty therapy, and more.
- We should also involve clients in caring for the environment by encouraging them to plant trees, nurture them, and sell them for income. This will not only provide them with a source of income, but also keep them engaged in positive activities.

"Clean PWUD – clean environment"

There is a strong need to help clients rebuild their personality by engaging them in activities that boost their morale, raise their self-confidence, and help them feel worthy, productive, and valuable members of society.

**MAT patient’s motivation and recognition**

During informal conversations with MAT patients and PE, they expressed a desire to have something that shows and proves that they are MAT patients or PE and that could spark conversations with community members or family about being on MAT. It was suggested to have t-shirts with slogans such as "I love taking MAT" or "FOM NI KUCHANGE" (meaning recovery).

This motivation and recognition of MAT patients is related to what was discussed in the chapter on initiation into heroin use, peer pressure, and the influence of friends. Let us transform the idea of peer pressure into an idea of peer empowerment so that MAT patients can use their influence in a positive way to encourage their friends who have used heroin to start MAT.

5.6 **Specific women centred approach and services**

The study results have shown that women themselves have acknowledged a reduction in the stigma against them in certain areas, specifically in Nairobi. However, this cannot be compared to rural and semi-urban contexts. Women still feel the need to hide if they use drugs and are forced to engage in commercial sex work, as shown in chapter 4.2.6. WWUD and engage in commercial sex work prefer to attend services in clinics that are specifically dedicated to sexual and reproductive health and key population groups. It has been noted that they have their own designated places to go.

- Continue raising awareness and sensitisation in the communities regarding stigma towards and discrimination against women who use drugs.
- Educate the community about the challenges and difficulties faced by WWUD, and how they can support them. Share case studies of women who have overcome addiction and stigma, to demonstrate that recovery is possible. For example, we have a very nice case study of a female PE who was shunned by her neighbours when she was a WWUD and was later on, when she was a MAT patient and became a PE pleaded by one of the same neighbours to help their son who is a PWUD. Such a story can show that no one is spared of such a life change within his or her family.
- Facilitate access to MAT services for women, by working with PE and CHW to identify barriers and find solutions.

---

50 Please refer additionally to the report from Valentine Grondal on Experiences of women who use drugs.
Review MAT services to ensure they are women-friendly, including opening hours, childcare, peer support, and access to SRH services like family planning and safe abortion. Identify where women who use drugs access SRH services and offer specific counselling and support to promote safer sex and protected sex.

5.7 Family

What interview participants talked a lot about was the theme of trust, who trusted them, who lost trust in them, and how they could rebuild trust with their families and within the community. If the MAT patient has support from their family, involve them from the beginning.

- Involve parents/family in the treatment. Inform them in the preparation phase itself that they are needed throughout the MAT process and make use of champion parents for the sessions. They then could talk like peers to encourage other parents.
- Engage in regular home visits and to every MAT patient if wished so.
- Provide counselling for families and MAT patients together?
- Help families to better understand their MAT patient and what does it mean to access MAT daily.

Provide information and sensitisation specifically aimed at families:

- What is a PWUD?
- What is MAT?
- What is a harm reduction approach, what does it entail?
- What is counselling?
- Sensitisation on what is group therapy.
- What is relapsing and defaulting? (Explain that it is also a part of recovery.)
- What is recovery?
- What is socio-economic re-integration and why is it important for staying on what? What role does the family play?

If the family is the root cause of an individual’s drug use and they are now in MAT, conduct a family assessment to identify what kind of psycho-social support the family needs. This support could be provided through a CBO with trained family counsellors and would involve family therapy where the MAT patient could encourage their family to meet with the counsellor. It's important to establish collaboration between the patients in the MAT clinic and the support system in the community, so that they can communicate with each other.

5.8 Community

Continuously provide community sensitisation as part of the MAT program on a regular and consistent basis. Community sensitisation could also be delivered through radio sessions, including interviews with MAT patients sharing their stories. When conducting activities directly in communities, plan them with the HP team to have outreach activities where a team goes to communities and talks about topics related to PWUD, addiction, MAT, harm reduction approaches, and more. From the beginning, discuss and plan these activities together with community leaders to engage them in supporting MAT patients to regain their place in the community and rebuild their lives. Give community leaders the power and importance in this support because we need them.

MAT patients can engage in various activities such as doing laundry, having a car wash place, cleaning the environment, and more. MAT patients can come up with ideas for their area, and with support from MSF and LVCT, they can approach community leaders with their proposals and seek funds from the government. Activities MAT patients could engage in doing laundry, having a car wash place,
cleaning the environment etc. (We have a CHW who has a good relationship with an MP who saw the changes in him and promised to support, but this support has never materialised. With the help of MSF, we can try again).

Raising awareness and sensitisation should include responses to these questions:

- What is a PWUD?
- What is addiction, and why do people who use drugs engage in petty crimes (talk about addiction, not free will but the addiction is a disease)?
- Explain what it means if someone has engaged in MAT. What is MAT, how does it work, what does it entail, why is defaulting and relapsing part of the recovery?
- What is a harm reduction approach, what does it entail?
- Why NSP are distributed, what is its use and risk reduction?

It was suggested that sometimes there might be people in the community who would like to help MAT patients but do not know where to go or find them, giving them a job, an occupation an opportunity. Can we have a point of contact for such propositions and offers?

5.9 Churches and religious leaders

Religious leaders are well connected with the religious community of their churches or mosques. They have a considerable influence on people in terms of what they say and do. Can we try to include some of the religious leaders for a supportive stigma-free environment for MAT patients and PWUD? I know this is difficult—we were told so in interviews—for example, parents who are pastors had difficulties accepting when their child was a PWUD. Can we ask priests or pastors to talk in the church to not to stigmatise PWUD and to motivate PWUD to enrol into MAT? Themes they could address in the church can be discussed with the HP team and PE/CHW.

5.10 Schools

Many interview participants have stated that they started smoking heroin in schools, with their school mates and friends either out of curiosity, to ‘fit in’, or due peer pressure, very often, without knowing the consequences of addiction.

Schools are an important place to raise awareness on what addiction to various drugs can entail. Let us go to schools and talk to students and have specific age sensitive sensitisation on marijuana, heroin, addiction, how PWUD suffer, and lastly, how they are trapped in the cycle of addiction, money generation and petty crimes.

5.11 Police

From the interviews we have understood that the police are still a group of people who highly criminalise PWUD, sometimes to the point that they plant evidence to bring them to jail. MSF is currently conducting a sensitisation for the police force; however, there is a high turnover of police officers in the lower cadres. Despite knowing that MAT patients are on medication and showing their cards, they still harass them.

Could MSF review this matter and consider who should receive sensitization, how often, and how to address the high turnover of lower-level staff? It is recommended that these sensitization sessions be planned in collaboration with the directors of police stations, prisons, and other higher-level officials. MSF should engage with the officer commanding the station (OCS) who was reportedly supportive of MAT patients and encourage him to instruct his officers to stop harassing them. It is

---

51 Talk to James maybe we as an organisation can approach this MP?
important to emphasize that MAT is a new intervention in the country and thus requires ongoing sensitization efforts.

“If we are able to work together with the police and the community then it will be very easy for us to reintegrate these people back into the community. Because you know, the perception that the community and police have is still that old perspective of a drug user. But right now, we need to make them also understand the process of methadone. Because the majority of them, not even the police, even the significant others, think it is instant, you start taking methadone and you change.” I27, female HCW

Creating a positive environment for MAT patients is crucial to ensure the success of their treatment, promote stability, and facilitate their journey towards improved health and wellbeing.

- Perform continuous sensitisation sessions with the police, making them participatory by putting them in the shoes of a PWUD or MAT patient. Use role plays to simulate different scenarios and engage both high and low cadres in the training.
- Additionally, consider include county commissioners in discussions with their deputies or other officials in local administration to advocate for the decriminalisation of PWUD and MAT patients.

5.12 MSF and LVCT-Health

In general, interview participants expressed high levels of satisfaction with the services provided by MSF and LVCT. It was suggested that LVCT should conduct introduction classes more frequently in the dens. Additionally, some interviewees mentioned that LVCT can be slow in preparing people for MAT and recommended that MSF provide support in this regard.

For the preparation sessions, LVCT should inform families that MAT is a long-term process, not a one-day program. Families should also be prepared that their involvement may be necessary throughout the MAT process, including attending clinic appointments and counselling sessions.

We recommend that LVCT sit down with PE staff to better understand the challenges they face in their work, such as low remuneration, meeting targets, and fear of job loss.
6 Conclusion

The results of the study show the complex realities faced by people who use drugs. Their lives as active drug users revolve around addiction and withdrawal symptoms and the daily struggle to find money for the next dose. PWUD are criminalised and subjected to stigma and discrimination. They are exposed to mob-justice and police harassment and experience rejection by their families, community, and society as a whole.

When active drug users try to stop using heroin and engage in a medically assisted therapy, the process of ‘change’ begins, first in a PWUD’s mind and later ideally, also physically. Transitioning from heroin to methadone or buprenorphine can be a positive and disempowering experience at the same time. Individuals often struggle with balancing the transition from a life of heroin use to methadone treatment, both from a medical and a psycho-social standpoint. While MAT is necessary, it may not be sufficient without addressing the mental, social, economic, and behavioural factors that initially led to opiate dependency.

It is crucial to acknowledge that the success of a MAT program goes beyond just dispensing medication. A MAT program must take a comprehensive and holistic approach to address not only the physical and medical needs of PWUD, but also their psychosocial and structural challenges.

In conclusion, transitioning from heroin to MAT is a complex process that involves moving from powerlessness to empowerment and back to powerlessness.

Therefore, attention to social and economic support is necessary for individuals transitioning to methadone. A package of interventions should include psychosocial support, economic integration, and structural interventions to address vulnerabilities. The program should also work towards destigmatizing drug addiction and MAT, through community outreach and education.

By taking a comprehensive and person-centred approach, MAT can have a meaningful impact on the lives of PWUD and their families.
7 Annex

7.1 Topic guides

In-depth interview guide

Thank you for agreeing to talk to us today. We (PI, PE and assistant) are working in the Karuri MAT clinic with Médecins Sans Frontières/MSF/Doctors without borders – an international medical organization. MSF has opened a clinic for PWUDs in Kiambu County at Karuri hospital and work with an organization called LVCT Health in the community to provide outreach services for PWUDs. We would like to talk to you about your experiences and perceptions of a person who uses drugs (or used drugs when talking to and individual already enrolled in MAT), your life, how you access healthcare etc. to better understand your life as a PWUD. As discussed in the informed consent, everything you tell me will remain confidential, and there are no right or wrong answers to my questions. The interview will take approximately 30 – 60 minutes. We can also have a break if it is too long and you can decide to end the interview at any time without any consequences and you do not have to answer any questions that might make you feel uncomfortable or upset.

The life of active PWUD

Understanding the daily lives, patterns of behaviour and profile analysis of active users:

- Knowledge of age, background, job, family etc.
- Family relations and connection to community (including other PWUD and the ‘pushers’)
- Information of the use of drugs: type, methods, mixing of drugs etc.
- How PWUD perceive their health needs including MAT programs?
- How is their drug use perceived and intertwined with health?

Introduction/Warm up

1. Can you tell me a little bit about yourself? Can you introduce yourself?
   Prompts: age, place/village of origin or actual residence (language), marital status, family background, number of children, education, occupation, job, income, kind of drugs used, when drug use started, for how long, method used for the drug intake? Which drugs do you mix and why and when? Where do you use the drugs (hotspots, dens, etc.)? Reasons to mix drugs, to change drugs? How much do you spend on drugs? Money spent in general in a day or money needed in a day for drugs and life (including for family, kids, partner, …)

2. What can you tell me about your life before and since you are using drugs?
   Prompts: why started with drugs, started by smoking or injecting and what prompted the mode of use, family situation, person who influenced starting on drug use, differences in life before and since using drugs, challenges, advantages, what is most important to feel good, to live a good life,

3. Can you tell me a bit how your health has changed since you use drugs?

4. Can you tell me what are your needs in terms of your health? What or whom do you need to be healthy?
   Prompts: mental health, physical health, family relations, partner, community relations, acceptance by family, partner, community
Challenges in enrolling in MAT programs

Knowledge about the challenges and enablers in enrolling in MAT programs:

- Which factors influence the PWUD's health seeking behaviours?
- What can motivate PWUD to start on MAT (either methadone or buprenorphine)?
- What are the (perceived and experienced) barriers for PWUD to accessing and enrolling in MAT programs?
- What are the challenges faced during the MAT preparation period before enrolment? (Duration, content)
- Which challenges are there in maintaining MAT treatment?
- Why do previous MAT clients become lost to follow up? What can be done to support them?
- Is there a difference in the challenges of PWUD stopping (defaulting) and PWUD never enrolled in MAT program?

5. Can you tell me what you do when you feel sick?
   **Prompts:** sick in general, from drug use, pathway to health facility, reception and treatment, stigma, discrimination

6. Can you tell me what is your experience of the preparation period before enrolment in the MAT program?
   **Prompts:** Duration, information, content, …

7. Can you tell me what you know and what is your experience on how to enrol (and in case of stopping to re-enrol) in the MAT program?
   **Prompts:** knowledge, services, location, what does enrolment mean, appointments, for how long, etc. what is the sense of the MAT program? What do you need to join the MAT program, how can the MAT program help you? How or where can you find the MAT program? Distance, means to reach it, costs for transport, opening hours, experience for re-enrolment, what are the services you would still be eligible even after stopping?

8. Can you tell me how you decided to join the MAT program?
   **Prompts:** Who or what influenced this decision? How is the decision taken, what makes such a decision easier or more difficult? What are the perceived and experienced barriers and enablers to access and enrol in the MAT program? What was your motivation to join MAT?

9. What could be the reason why people do not start or do not continue the MAT treatment?
   **Prompts:** what could be the reason for stopping (‘lost to follow up’) or not being able to continue taking MAT treatment, which support would these individuals need to stay in the program? Re-use of heroin or other drugs, distance, not reachable, no money to pay for transport… What could be the reason why people want to start on MAT yet do not want their doses of methadone increased and still want to use heroin at the same time?

10. How do you see a person that ‘stopped’ or is not able to continue taking MAT treatment? How do you see a person who never started MAT program?
    **Prompts:** reasons for stopping, reasons for not starting at all, stigma, distance, transport problems, stability, family relations

11. How do you think your family or community sees you when you are taking heroin and how do they see you after starting MAT?
    **Prompts:** How do they see you when you take methadone or buprenorphine? How is it different when you are taking methadone, buprenorphine, or you stop MAT?
PWUDs perspectives of harm reduction and outreach services

Review the services of harm reduction and outreach activities provided:

- How is the notion of harm reduction perceived by the PWUD?
- Which harm reduction and outreach activities are offered, and which are used by PWUD?
- Which other activities are requested by the PWUD?
- How to reach PWUD?
- According to PWUD what is the best way/channels of communication of service promotion e.g., of the new decentralized fixed dispensing sits (DFD)?
- How to improve the collaboration and support to partners and KP CSO?
- How can MSF, MoH and the MAT clinic be more involved in outreach activities and the community?

1. Can you describe what harm reduction means to you?
   **Prompts:** opinion about harm reduction, knowledge of the term harm reduction, services of harm reduction

2. Can you tell me which harm reduction and/or outreach activities are offered? Which ones do you use?
   **Prompts:** knowledge of harm reduction: what it is, what is the meaning (attitude and philosophy), services/methods and outreach activities. How do you feel about the harm reduction performed by health staff? Harm reduction within the community? preference for any, any of these are already used, dislike of any? Which ones are applicable (condom use)? Which ones are difficult to apply? which ones are used; which ones do others use? Which ones are most liked, or easy to apply, challenges?

3. Can you tell me which other activities PWUD would like to access?
   **Prompts:** any other activities people would like to see? Role of peer-led CSOs? Activities that engage family or community? Day care for WWUD or PWUD with babies, Beauty salon, barber shop, income generating activities, gathering place, washing place (dignity, reduction of self-shame and self-stigma), empowerment centre

4. Can you tell me how we could best reach PWUD and especially WWUD?
   **Prompts:** What are their needs, where can we reach them, at which time, how, non-stigmatising way to reach them, how do families/communities look at WWUD and how does that impact their access to services and activities?

5. How in your opinion could we improve the collaboration between KP CSO and other partners?
   **Prompts:** collaboration between whom wanted, practicable, useful, helpful

6. How in your opinion could MSF, MoH and MAT be more involved in outreach activities and the community?
   **Prompts:** which outreach activities, meetings, discussions, agreements, presence, target groups, collaboration between MSF and MoH

I thank you for taking the time to answer these questions and assist me with my research. Do you have any questions you would like to ask me?
Role of peer-educators/CHW in the peer-led model (asked to peer educators)52

I would like you to tell me about your role and perspectives as a peer-educator in the peer-led model. If things come up in the discussion that you don’t feel comfortable about, just let me know, and will move on to talk about something else.

1. Please can you start by telling me a bit about your working day as a peer educator?
   Prompts: Working hours/schedules/sites, working in teams /alone, planned activities/ key messages and health talks, materials to work with, monitoring activities

2. What motivated you to apply to be a peer educator? Probe on competing priorities
   Prompts: How/who/when informed about the job/ How was the application/ any difficulties/ identity documents / CV/ compatibility with being an ex PWUDs

3. Please tell me a bit about your main responsibilities as a peer educator.
   Prompts: contact other PWUDs in area/hotspot/plan and record of your activities/ chaperone colleagues to MAT clinic/ health talks/ key messages/ motivate access to care/ support and listening to peer problems/ liaise with MSF multidisciplinary team and local health providers

4. What type of interactions do you have as a peer educator in your community and with other PWUDs/ other peers or colleagues, health staff?
   Prompts: respect for job/ friends’ and colleagues’ perceptions since you are in this job/ how other PWUDs engage with you since having this job, interaction with health staff, discrimination, which activities they would like to be more involved, activities they would like to take ownership, feeling respected and listened to by PWUD

5. Tell me about what you have learnt from working as a peer educator?
   Prompts: MAT program, NSP, keep on staying on MAT,

6. How do you see the value of your role as a peer educator? How do other PWUDs see you in this role? How does health staff see you in this role?
   Prompts: knowledge, skills, trust, relation to family, to partner, to other PWUDs, relationship to clinic staff

7. Is there anything that MSF could do to support you in your role as a peer educator?
   Prompts: specific trainings, members of peer educators, quantity and quality of HP materials, participatory activities

8. What challenges do you experience as a peer educator seeking medical and psychosocial services? (could you give me some examples)? What can be done to improve your HSB?
   Prompts: health-seeking behaviour, mistrust, jealousy, changed behaviour from colleagues, judgement and expectation to change, risk of robbery, temptation to take heroin,

I thank you for taking the time to answer these questions and assist me with my research. Do you have any questions you would like to ask me?

52 These questions will be only asked in interviews with peer educators who are former PWUD.
Group discussion guide (only if deemed appropriate)

Facilitator’s welcome, introduction and instructions to participants

Welcome and thank you for volunteering to take part in this focus group. You have been asked to participate as your point of view is important. We really appreciate your willingness to talk to us. As discussed in the informed consent, everything you tell us will remain confidential, and there are no right or wrong answers to my questions. You are free to leave the group discussion at any time and do not have to answer any questions that might make you feel uncomfortable or upset.

All what is said within the group will stay in the group and will not be shared with anyone outside the group. Please do not talk to other people about what was said here in the group to keep confidentiality about what was said in the discussion.

Ground rules

• The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.
• There are no right or wrong answers.
• You do not have to speak in any particular order.
• When you do have something to say, please do so. There are many of you in the group and it is important that I obtain the views of each of you.
• Everything that is said in the group should be respected as someone’s view – even if others may not agree.
• You do not have to agree with the views of other people in the group.
• If you have any question now or during the discussion, don’t hesitate to ask.

Warm up

First, I’d like everyone to introduce themselves. Can we all think of a nickname that we will use in this group?

Introductory or engagement question

I am just going to give you a couple of minutes to think about what are the main challenges of people who use drugs? How do your days look like? Is anyone happy to share his/her thoughts or opinion?

Exploration Questions

1. Please tell me about the main challenges PWUDs (specify if heroin users, methadone or buprenorphine user, if they are active, enrolled, or stopped) and especially women and young people who use drugs face here in this area in relation to their health and well-being?
   Prompts: main health problems, reasons for these health problems, perception of these health problems in relation to drug use, access to health care, reception at the facility, differences for women, men or young people

2. Please tell me about your experiences and challenges in enrolling/remaining and returning in MAT program.
   Prompts: challenging/hindering/facilitating factors, motivation to start, challenges to maintain, difference to using drugs and taking MAT, stopping MAT, why some never enrol?

3. What is your opinion and experience with harm reduction and outreach activities?
   Prompts: first explain what harm reduction entails and which outreach activities exist, then ask about activities, services, methods, most liked ones, disliked ones, location
7.2 Interview questions for MAT patients taking buprenorphine

1. Why Buprenorphine (Bup) and not methadone?
2. How did you feel about taking Bup?
3. What is your experience in taking Bup?
4. What do you like about Bup?
   What do you dislike about Bup?
5. What do you think about Bup?
6. What are your fears?
7.3 References


Richards, H.M., & Schwartz, L.J. (2002). Ethics of qualitative research: are there special issues for health services research? Fam Pract, 19, 135-139.


### Week 1

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>29 August</td>
<td>Flight VIE to Nairobi</td>
</tr>
<tr>
<td>Tuesday</td>
<td>30 August</td>
<td>Briefing coordination: HR, Log, supply, PMR, HoM</td>
</tr>
<tr>
<td>Wednesday</td>
<td>31 August</td>
<td>Briefing Kiambu project: HPAM, ARO,</td>
</tr>
<tr>
<td>Thursday</td>
<td>1 September</td>
<td>Briefing Kiambu project: PMR+MAM, organising study with LVCT, interview</td>
</tr>
<tr>
<td></td>
<td></td>
<td>transcriber, ARO discussion</td>
</tr>
<tr>
<td>Friday</td>
<td>2 September</td>
<td>Organising study with LVCT, 1 IDI HCW Kiambu MAT clinic</td>
</tr>
<tr>
<td>Saturday</td>
<td>3 September</td>
<td>Revision</td>
</tr>
<tr>
<td>Sunday</td>
<td>4 September</td>
<td>Revision</td>
</tr>
</tbody>
</table>

### Week 2

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>5 September</td>
<td>Ruaka: 2 GD LVCT DIC, 3 FGD PWUD Kosovo Den</td>
</tr>
<tr>
<td>Tuesday</td>
<td>6 September</td>
<td>Gikuni: 4 PI PWUD, 5 FGD PWUD, 6 IDI PWUD, 7 IDI PE</td>
</tr>
<tr>
<td>Wednesday</td>
<td>7 September</td>
<td>Karuri MAT clinic: 8 PI PWUD MAT, 9 FGD PE LVCT, 10 IDI PWUD MAT</td>
</tr>
<tr>
<td>Thursday</td>
<td>8 September</td>
<td>Gachie: 11 PI PWUD defaulter, 12 IDI PWUD defaulter, 13 IDI PWUD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>defaulter, 14 FGD PWUD, 15 IDI PWUD weaned off/clean</td>
</tr>
<tr>
<td>Friday</td>
<td>9 September</td>
<td>Wangiже: 16 IDI PWUD, 17 IDI PWUD MAT, 18 IDI PWUD, 19 FGD PWUD, 20 IDI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PE LVCT</td>
</tr>
<tr>
<td>Saturday</td>
<td>10 September</td>
<td>revision</td>
</tr>
<tr>
<td>Sunday</td>
<td>11 September</td>
<td>revision</td>
</tr>
</tbody>
</table>

### Week 3

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>12 September</td>
<td>Limuru: 21 FGD PWUD, 22 IDI PWUD MAT defaulter, 23 IDI PE LVCT, 24 IDI CHW</td>
</tr>
<tr>
<td>Tuesday</td>
<td>13 September</td>
<td>Public Holiday</td>
</tr>
<tr>
<td>Wednesday</td>
<td>14 September</td>
<td>Ruiru: 25 IDI PWUD MAT, 26 FGD PWUD MAT, 27 PI HCW, 28 IDI CHW</td>
</tr>
<tr>
<td>Thursday</td>
<td>15 September</td>
<td>Ngewa: 29 FGD PWUD, 30 IDI PWUD MAT defaulter, 31 PE</td>
</tr>
<tr>
<td>Friday</td>
<td>16 September</td>
<td>Karuri MAT clinic: 32 PI PWUD MAT, 33 IDI PE, 34 IDI PWUD MAT BUP, 35 IDI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PWUD MAT</td>
</tr>
<tr>
<td>Saturday</td>
<td>17 September</td>
<td>revision</td>
</tr>
<tr>
<td>Sunday</td>
<td>18 September</td>
<td>revision</td>
</tr>
</tbody>
</table>

### Week 4

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>19 September</td>
<td>Ruaka: 36 HCW social worker, 37 IDI PWUD MAT defaulter, 38 FGD PWUD, 39</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FGD PWUD MAT defaulter</td>
</tr>
<tr>
<td>Tuesday</td>
<td>20 September</td>
<td>Thika, Kivulini: 40 FGD PWUD, 41 IDI PE LVCT, 42 HCW field officer and ORW</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LVCT</td>
</tr>
<tr>
<td>Wednesday</td>
<td>21 September</td>
<td>Juja, Mathare: 43 FGD PWUD, 44 PI PWUD MAT, 45 IDI PE LVCT</td>
</tr>
<tr>
<td>Thursday</td>
<td>22 September</td>
<td>Thika, Makongeni: 46 FGD PWUD, 47 IDI HCW LVCT</td>
</tr>
<tr>
<td>Friday</td>
<td>23 September</td>
<td>Karuri MAT clinic: 48 IDI PWUD MAT, 49 IDI HCW addiction counsellor, 50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDI HCW nurse, 51: IDI PWUD MAT</td>
</tr>
<tr>
<td>Saturday</td>
<td>24 September</td>
<td>revision</td>
</tr>
<tr>
<td>Sunday</td>
<td>25 September</td>
<td>revision</td>
</tr>
</tbody>
</table>
### WEEK 5

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>26 September</td>
<td>Karuri MAT clinic: 52 IDI MAT patient, 53: IDI HCW addiction counsellor LVCT, 54: IDI PWUD BUP</td>
</tr>
<tr>
<td>Tuesday</td>
<td>27 September</td>
<td>Ruiru: 55 IDI MAT patient, 56 IDI PE, 57 IDI HCW</td>
</tr>
<tr>
<td>Wednesday</td>
<td>28 September</td>
<td>Karuri MAT clinic: 58 IDI PE, 59 IDI CHW, 60 IDI MAT patient, 61 FGD MAT clients using JET FUEL</td>
</tr>
<tr>
<td>Thursday</td>
<td>29 September</td>
<td>Karuri MAT clinic: debriefing preparation, last clarifications</td>
</tr>
<tr>
<td>Friday</td>
<td>30 September</td>
<td>Karuri MAT clinic debriefing, EA office presentation</td>
</tr>
<tr>
<td>Saturday</td>
<td>01 October</td>
<td>revision</td>
</tr>
<tr>
<td>Sunday</td>
<td>02 October</td>
<td>revision</td>
</tr>
</tbody>
</table>

### WEEK 6

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>03 October</td>
<td>Buprenorphine corner assessment</td>
</tr>
<tr>
<td>Tuesday</td>
<td>04 October</td>
<td>Handover to assistant and transcriber</td>
</tr>
<tr>
<td>Wednesday</td>
<td>05 October</td>
<td>Flight Nairobi to Vienna</td>
</tr>
</tbody>
</table>

PI paired interview, IDI individual in-depth interview, FGD Focus Group Discussion, PWUD person who use drugs, PE peer educator, LVCT Health, DIC drop-in centre, HCW healthcare worker
### What Drugs do people use in the dens?

<table>
<thead>
<tr>
<th>English term</th>
<th>Swahili/Sheng</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Benzos and cosmos</td>
<td>Ma-c, Ma-white, Taptap, Tembe, Koroga.</td>
</tr>
<tr>
<td>2. Heroin</td>
<td>Daba, Kete, Kichuri, Stuff, Mondo, Dibi.</td>
</tr>
<tr>
<td>4. Jet-fuel</td>
<td>Msii, kamic, kamlele, mic, microphone</td>
</tr>
<tr>
<td>5. Rohipnol</td>
<td>blue, bugizi</td>
</tr>
<tr>
<td>6. Bhang/marijuana</td>
<td>Ndom, gode, kishash, kitululu, kishada, ngwai, tire, kichoku, chocolate, kiroko, kihaha, international hub</td>
</tr>
<tr>
<td>7. Miraa/Khat</td>
<td>Aluta, kajingjong, veve, asili, miti, goks, jaba, kangeta.</td>
</tr>
<tr>
<td>8. Cigarettes</td>
<td>Fegy, kasigala, fwaka, ngem.</td>
</tr>
<tr>
<td>9. Alcohol</td>
<td>Tei, ng’ang’o, cham, biko, makali, keroro, maji</td>
</tr>
<tr>
<td>10. Tobacco</td>
<td>Chaves, kacheng, kandondo.</td>
</tr>
<tr>
<td>13. Crack (stonish)</td>
<td>Kamzungu, kimawe</td>
</tr>
</tbody>
</table>

### What medication/drugs are people using (drugs from the clinic as well as from outside)?

<table>
<thead>
<tr>
<th>English term</th>
<th>Swahili/Sheng</th>
<th>Dosis (Mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diazepam (peers say Artane is the same)</td>
<td>Tap-tap, ma-white, tembe, koruga,</td>
<td>500 mg for 1 tablet</td>
</tr>
<tr>
<td>2. Trihexyphenidyl</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Largactil/Benhexol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Lorazepam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Alprazolam/Xanax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Any other drug</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Valium</td>
<td>Ma-yellow, ma-c, njugu or tunjugu</td>
<td>5mg</td>
</tr>
</tbody>
</table>
The Vienna Evaluation Unit

The Vienna Evaluation Unit was established in 2005, aiming to contribute to learning and accountability in MSF through good quality evaluations. The unit manages different types of evaluations, learning exercises and anthropological studies and organises training workshops for evaluators. More information as well as electronic version of evaluation and anthropology reports are available at: http://evaluation.msf.org